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Journal of the Hong Kong University Medical Society

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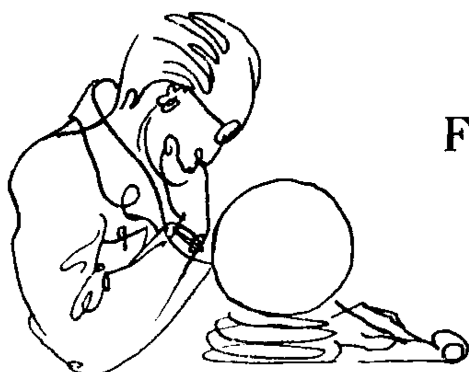


FACT, FANCY AND OPINION

Alabaster Legs

Two days before the Fiftieth Congregation of our University in October last, an article concerning a graduand appeared in one of the local newspapers which shocked and horrified many of the students and members of the Staff who happened to read it. It would be difficult to conceive of a more inane piece of journalism, and one is surprised that a reputable newspaper could allow its fine record and high standing in the Colony to be degraded in this manner.

There is no point at this date (nor is this the place) to comment in detail on the inaccuracies, half-truths, and plain indecencies of which this 'literary' effort was composed; but it is only fair to the student involved and to all the students here, that one glaring impudence be answered.

Those of us who have studied at a University know that it was not as an afterthought, nor with an airy wave of the hand, that we graduated in the liberal arts, or in science, or became doctors, lawyers, architects or engineers. If the writer of the article had ever taken a University degree, surely he ought to have known this. All the young men and women who graduated last October *earned* their degrees in a University which demands (and is given) the highest standards of scholarly achievement. What is more, these standards are continually being tested by the eminent men who act as external judges for our degree examinations.

It would be a pitiful state of affairs if the public were to be influenced by the author of this calumny on University life in Hong Kong, and the Editors of the newspaper concerned must think more carefully before publishing any more of this 'gutter press' type of article in their columns.

'Charity' Clinics

In a small area like Hongkong where the pressure of an enormous population throws a heavy strain on the medical profession, the existence of charitable organisations could, if properly controlled, do much to ameliorate suffering and relieve thousands of families of the burden of worry inevitably associated with ill-health.

No doubt some charitable organisations do a great deal in this direction; and a few like the remarkable Marianne Reichl Aid to Lepers Group seem able to command sufficient financial support to continue their work successfully from year to year.

There are, however, other agencies at work in the Colony whose real activities are hidden behind a thin veneer of "charity", whose *raison d'être* is the accumulation of money at the expense of the poor, and whose minimal services (at a price) do little or nothing to relieve those desperate enough to need their help. When one learns that a single individual or group may own chains of these 'clinics' – and if we accept them at their own face-value – then we must re-define our ideas as to what constitutes *charity*. Fortunately, there would seem to be no grounds for indulging in such a radical exercise. For one thing it would be difficult to improve on St. Paul's definition; and for another, sufficient is known about the pernicious practices in these 'clinics' to

make it most unlikely that charity, philanthropy, or any other virtuous attribute enter into their purposes. Their hearts, we fear, are not so full as their coffers.

Fortunately, too, efforts are being made to protect the public against exploitation by the 'charity' clinics; and as recently as 30th May, 1957, the Chinese Medical Association formed a sub-committee to go into the whole matter. One important feature of their work is to arrive at a legal definition of *charity* as applied to the clinics, so that it will be possible to distinguish between the good and the bad. Certain recommendations have been put to the Medical Department, and there seems to have been a favourable response from the authorities on this matter. It is to be hoped that it will not be long before the public is informed of the results of these deliberations.

The Critics

We have received the usual dreary complaints about *Elixir's* lack of clinical articles. It is true that there have been few serious contributions to *Elixir* in recent years – serious, in the sense that new and weighty medical facts of world-shaking importance have not appeared on our pages. But surely something is far wrong with our critics' reasoning powers if they think we can conjure clinical articles from the void. We have said before, gently, and with some depth of feeling that we would be glad to have as many articles as possible from the Faculty – on all subjects, whether grave or gay. The result has always been the same.

We are delighted to be able to reprint Professor Daphne Chun's Inaugural Dissertation from the Chair of Obstetrics and Gynaecology in this number. But we must remind our critics that if there are no other articles of a clinical nature in this issue, it is their own fault – collectively and individually.

Come off it, chaps! If you cannot or will not contribute, you will do us all a singularly good turn by *thinking* first and talking afterwards – long, long afterwards.

However, EVERY DOLLAR HELPS A SCHOLAR, so *Elixir* must go on. Our Scholarship Fund progresses at a reasonable rate, and should top the 10,000 mark by the end of the year – if all goes well.

We are most grateful to our contributors in this issue.

Mr. Harold Visick

The sudden death of Mr. Harold Visick came as a shock to all his friends in Hong Kong, especially to those in the University. Harold Visick was a good friend to *Elixir* and most willingly contributed articles which often reflected his deep interest in Science and in the History of Science. The circumstances of his death are all the more tragic when it is remembered that he was due to leave the Colony within a few weeks, and every one knew how much he looked forward to his retirement.

Our deepest sympathy goes to Mrs. Visick, in her grievous loss; but we hope that it will be some comfort to her to remember the high esteem in which her husband was held by so many people of different races and creeds, and that his kindly personality will remain with them in memory for the rest of their lives.

* * *

Answers in H.K.U. Matriculation Examination.
"One of Elizabeth Bennet's sisters was Lycidas."

* * *

"I would like to go to Rome to see the Pop."

* * *

(On Rose Maylie in *Oliver Twist*) "There are many ladies like her who would take trouble to help a poor boy, who would wait for hours on the London Bridge and things like that."

* * *

"The Habeas Corpus Act was suspended for a time, but two years after unions were made legal".

* * *

"Clara Barley (in *Great Expectations*) was Herbert Pocket's financee".

* * *

MATERNITY SERVICE IN HONG KONG

ITS PAST, PRESENT, AND FUTURE

1. THE PAST GROWTH

The barren rocky island of Hong Kong was formally and peacefully ceded to the British Crown in 1841, to the shame of the Chinese and British authorities. Both sides changed their views in the next 20 years. For the first few years the colonists' confidence was repeatedly shaken – by fires, which burnt down the new Chinese market quarters twice in 1841; by typhoons, which unroofed nearly every house on the island twice in the same year; and by diseases. Epidemics of all kinds menaced Hong Kong from these early times, and in 1843 what seems to have been malaria, though first named "Hong Kong fever", was so widespread that everyone who could afford to leave, including the Governor, took temporary refuge in the Portuguese peninsula of Macau, some 40 miles to the west. Outbreaks of plague, dysentery, remittent fever, typhus, enteric fevers, cerebrospinal meningitis, and yellow fever were frequent.

Public Health Services were organised to tackle these infections, and their success is shown by the fact that, despite the 2 World Wars with the accompanying influx of refugees, Hong Kong has for some years been free from the 6 quarantine diseases. No maternity service was started in the Colony until the present century, though there had been some western-trained doctors (from Canton) working here since the Colony's foundation. The main part of the midwifery was done by midwives with no regular training, apart from practical experience and information passed from one generation to the next. It is true that pregnancy and labour are physiological processes, but their complications and difficulties often have serious consequences. Sometimes the mothers were left with such permanent injuries as chronic pelvic infections, genital prolapse, or urinary fistulae; and handicaps in the infants, resulting from birth injuries, and deaths from these causes, were also unduly common.

As early as 1887, it was clear that the western doctors recruited from outside were too few to meet the demands of the population (Fig. 1) which was rising steadily by both immigration and the natural excess of births over deaths.

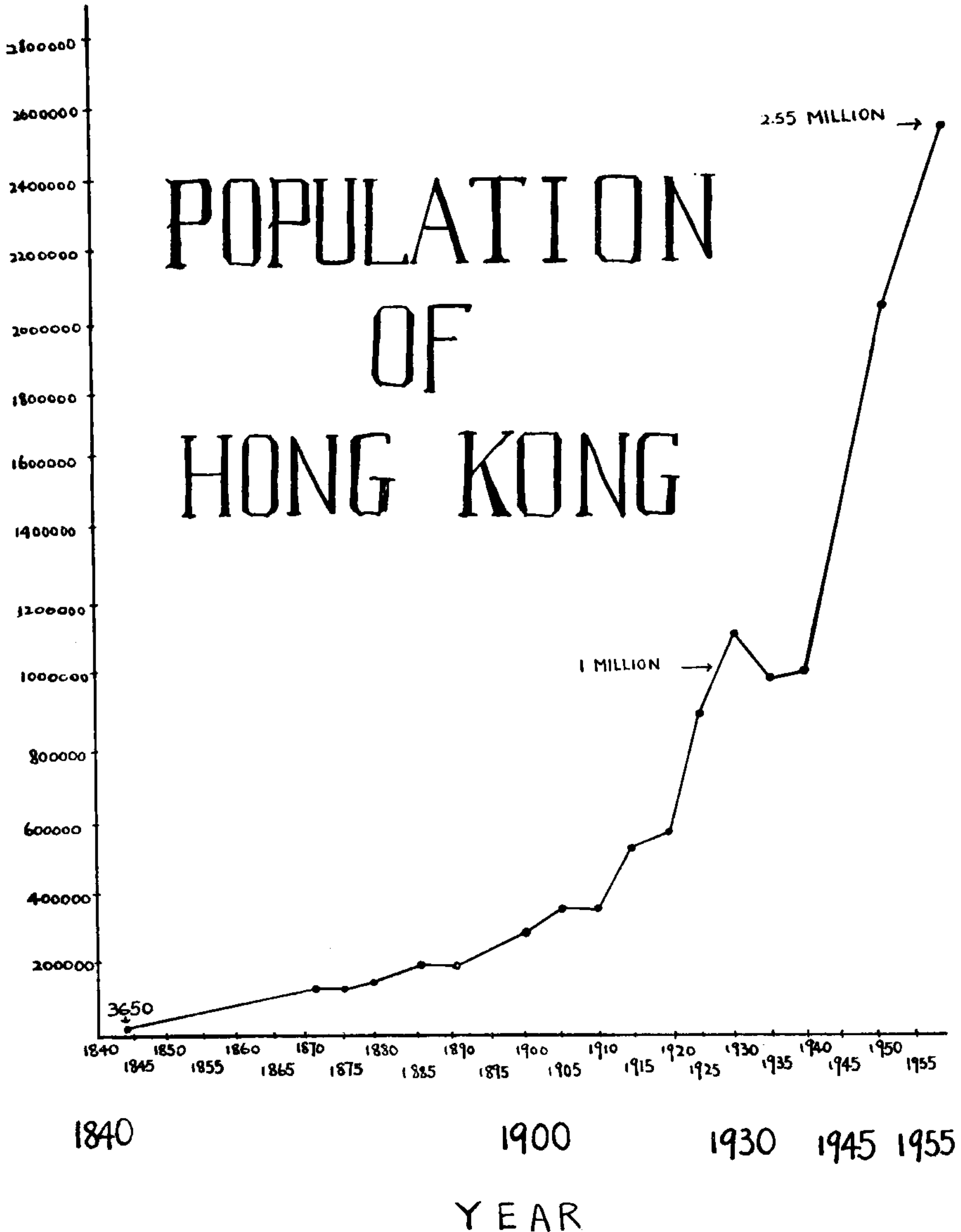
The Hong Kong College of Medicine was founded in 1887 at Nethersole Hospital by Sir Patrick Manson and James Cantlie. Its promoters started with no endowment and no buildings of their own. Clinical teaching was arranged in the wards at Nethersole, and the hospital also provided some rooms for lectures and for resident students. This College continued until the University of Hong Kong was founded in 1912 when it was merged to form the Faculty of Medicine of the new university.

The original college course which lasted 4 years, was later extended to 5 years, and ultimately to 6. This made our M.B. a registrable qualification in England and allowed our graduates to practise in most parts of the world.

The development of the Maternity Service in Hong Kong can be said to have started with the arrival of Dr. Alice Hickling – or Sibree, as she was then known. She came from the London Mission to the Nethersole Hospital back in 1904, and started to train midwives more or less on the modern pattern. When her trainees graduated they gradually but steadily replaced the old "practical" midwives, who had done splendid if uninformed work in the Colony and delivered most of the population from the days when Hong Kong was a small fishing-village. By 1910 it was possible to appoint a Midwives Board on the western fashion, and to forbid anyone not registered by them to practise midwifery in the Colony. It was Dr. Hickling who, having joined the Government Medical Department after her marriage, began the district maternity service.

A Midwifery training school was opened at the Government Civil Hospital in 1920,

Fig. I



but more and more trained midwives were then needed, so Dr. Hickling, with Dr. S. W. Tso and others opened the old Tsan Yuk Hospital as a separate maternity training school, with 30 beds. That was in 1922. The prime object of this training school was, of course, to make it possible for more Chinese girls to realise their ambition of

becoming midwives. The 30 beds sound negligible nowadays, when we have eight midwifery training schools in the Colony, turning out 50-60 midwives a year, but it was a fine beginning. For in its first full year of running, the Tsan Yuk Hospital admitted over 400 patients, and in five years the figure had risen to a thousand, with an all-time record, scored in the crowded post-war years, of over 7,000 admissions a year; the amount of overcrowding is best forgotten. Nineteen twenty six saw the welding of a close link between Tsan Yuk and Hong Kong University, when medical students were given room and facilities for doing their obstetrical training at Tsan Yuk as well as at the Government Civil Hospital. Nineteen thirty seven saw the transfer of Gynaecological cases to the new Queen Mary Hospital, leaving Tsan Yuk completely free for obstetrics. Much of the credit for this new liaison between Tsan Yuk and the University must stand to the account of Professor R. E. Tottenham. The link was strengthened by his successors, Professor W. C. W. Nixon and Dr. D. K. Samy, until, when Professor Gordon King took over in 1938, he was able to realise the dream described by Professor Tottenham 30 years before. "The union of the University Department and Tsan Yuk," said Professor Tottenham, "should lead in time to our having one of the best midwifery centres in the Far East". Professor King's energy, backed by the generosity of the Jockey Club, assured the replacement of the old Tsan Yuk by our new hospital, which, in the view of Professor N. J. Eastman, visiting Professor of Obstetrics in 1956, has few equals in the world. No wonder that there is such a demand for babies to be born in the Tsan Yuk; and indeed no less than a tenth of our total new arrivals manage to win a place in the hospital's cots. The fine staff and equipment of the new hospital have undoubtedly played a big part in the fall in our maternal and infant mortalities as illustrated in Fig. II & Fig. III which show the difference in maternal and infant mortality before and after the war.

2. THE PRESENT SERVICE

Rather over half the deliveries take place in hospitals and rather under half

Fig. II

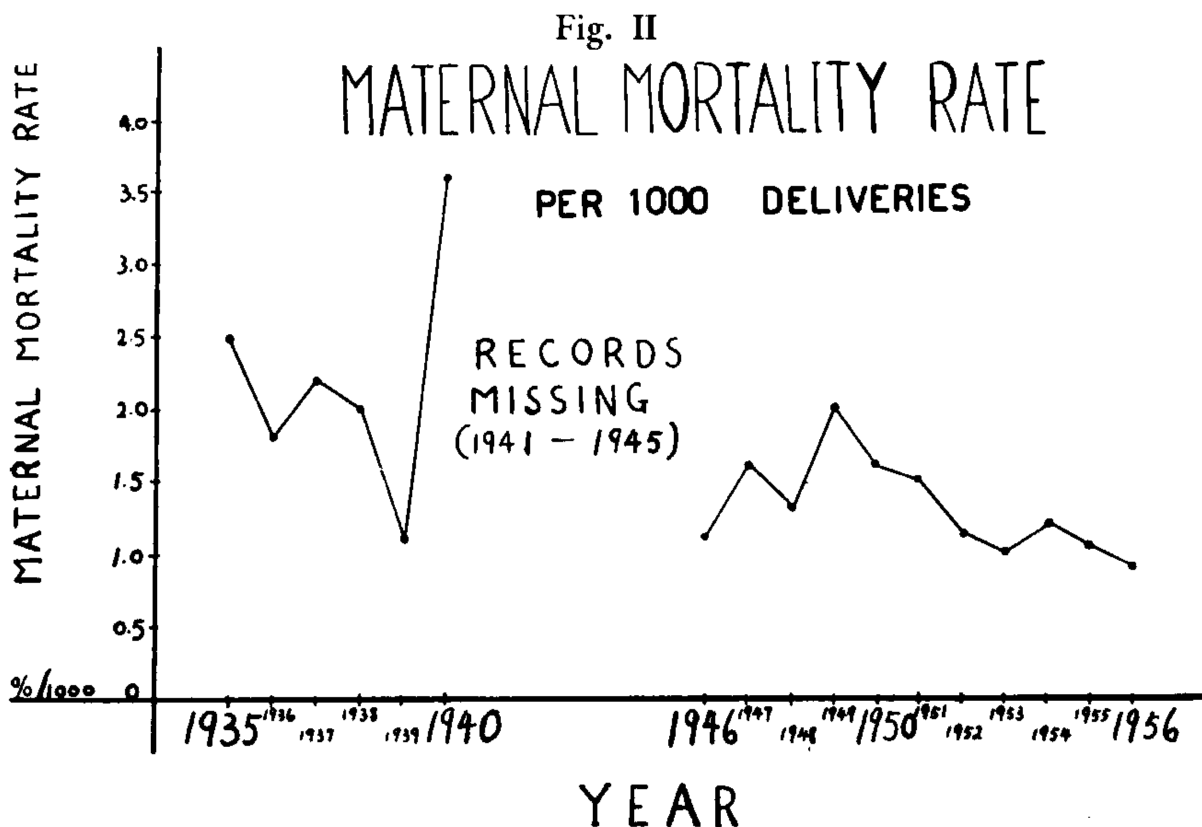
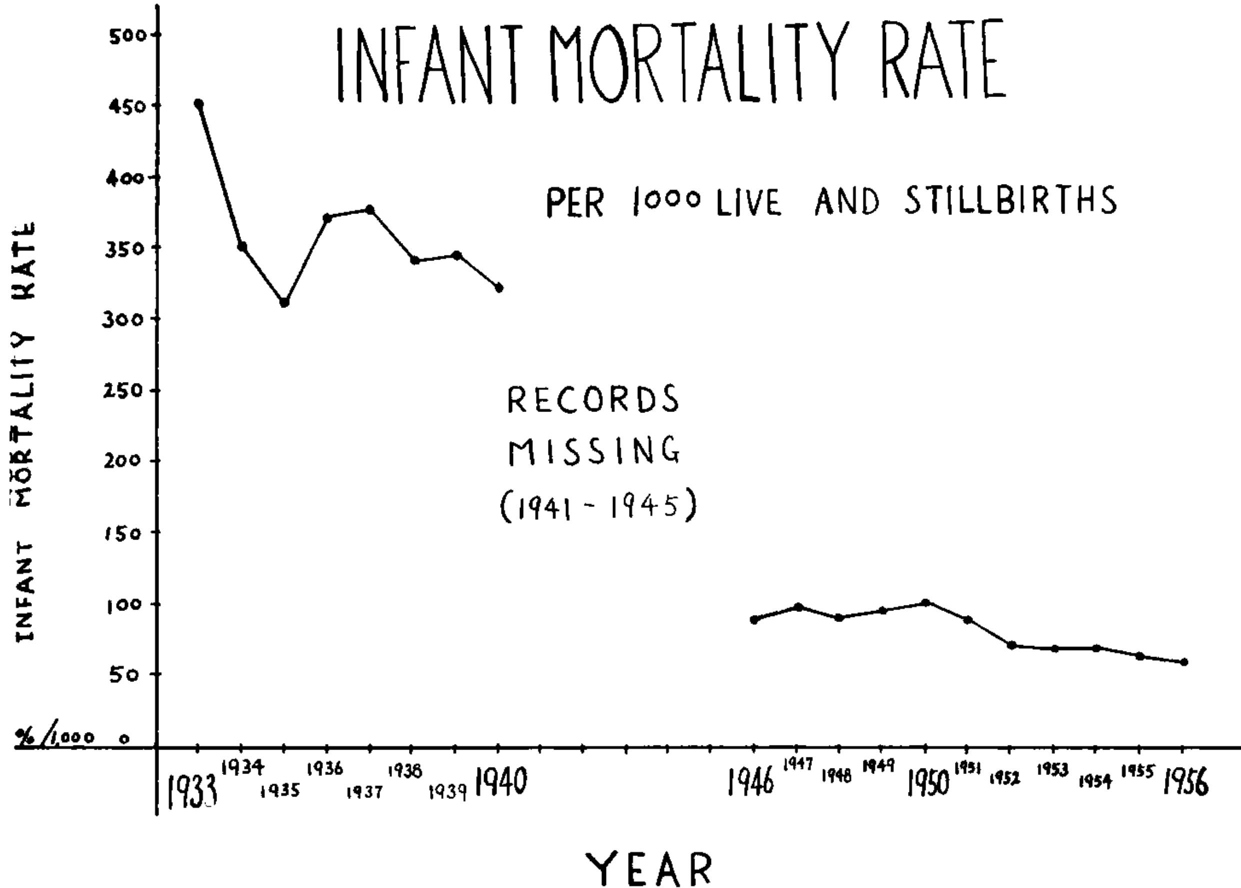


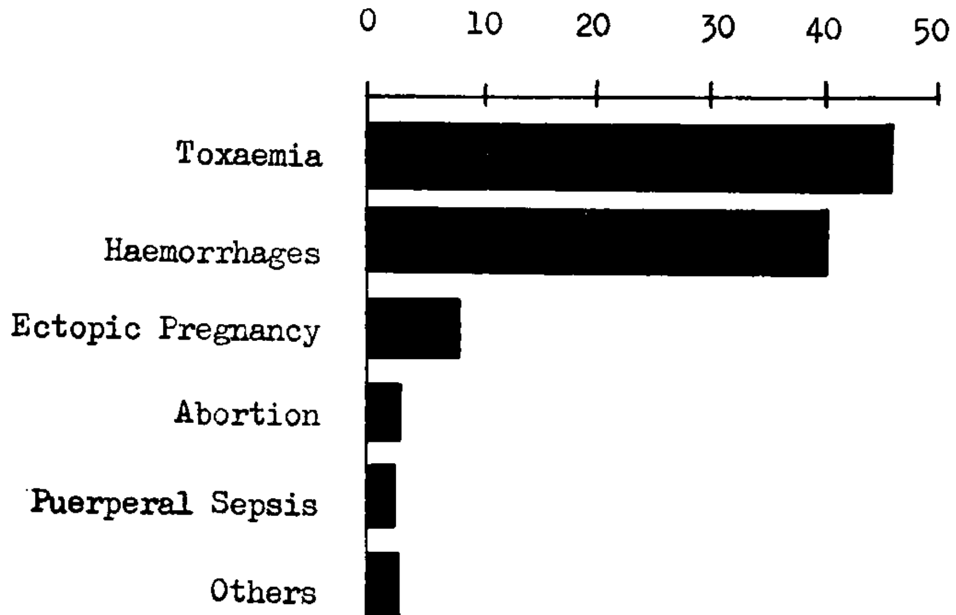
Fig. III



in maternity homes, the remaining being carried out in the patients' own homes. There has been the same sharp rise seen in other countries in the proportion of confinements in institutions of some kind, since the war. Here the proportion of "institutional confinements" rose from about half pre-war to no less than 94 per cent. in 1956. The present generation of expectant mothers have no doubt acquired hospital-mindedness, though the reasons they give for preferring their confinements away from home vary widely. The commonest and perhaps best reason given is that they receive better attention in hospital and can receive a doctor's aid at once if they need it. Then, the mothers undoubtedly get more rest in hospital or maternity home than in the bosom of their family. The other reasons given are mainly financial. In some cases women are driven to seek admission for their delivery because their principal tenants charge so high a fee for every child born in their houses. Then, many of the poorest families can only afford to rent a bed-space for the whole family. This is obviously unsuitable for childbirth at home. On the whole, the cost of confinements for the poorer people in hospital is relatively low. In the general wards of the Tung Wah group of hospitals the beds are free, a fee being charged only if the patient wants a private room. In the Government hospitals there is no charge in the general wards for those too poor to pay; except those in private wards the others are charged $1.50 a day for maintenance. The Nethersole Hospital caters to the middle and higher economic groups and can therefore charge $75 – $100 for a delivery.

Over 90 per cent. of the cases are delivered by midwives, but this does not necessarily mean that the midwife is responsible for the whole confinement, for many of the women have been seen at some stage by antenatal officers, consultants or resident doctors.

There are 8 private hospitals with 120 maternity beds in the Colony, which are



Causes of Maternal Mortality.

responsible for delivering about 3,000 cases a year, a few being supervised by specialists and the main number about equally divided between general practitioners and midwives; these again cater mainly to patients in the middle and higher economic ranges.

These brief notes tell us little about the actual services provided for women in labour; but in fact they are far from ideal.

The number of personnel, including the junior medical staff and midwife is far from adequate to meet the present demands in all the hospitals. Only Tsan Yuk, Queen Mary and Kowloon Hospitals together with the Kwong Wah and Hong Kong Sanatorium and Hospital have consultants with specific training. Trained consultants are needed to raise the standard of obstetric care as well as adequately to train the junior staff. Tsan Yuk needs more consultants to ensure that the Obstetric Department of the Hong Kong University may fulfil one of its functions of increasing knowledge by research. The other hospitals in the Colony should have consultants *in charge* of their maternity departments to care for the patients, improve the standards and ensure specific training of the junior medical staff.

The 133 maternity homes, with 489 beds against the 798 beds in the hospitals are mostly operated by private registered midwives, only 12 homes being included in the Government Maternity Service Unit. The homes undertake normal cases only, the abnormal ones, *when detected,* being referred to hospital. About 80 per cent. of the patients admitted to homes receive some previous antenatal care; most of them stay 1-3 days in a home after delivery.

Domiciliary Midwifery is done by Government – employed and private registered midwives, the 2 branches dealing with 3.5 per cent. and 2.5 per cent. of the total births in the Colony. Here again, all abnormal cases are referred to hospital *when detected.* Many of the women booked with midwives are seen antenatally in the maternity and child-welfare clinics; but in 1956 only 60 per cent. of the total actually received antenatal care, and the average number of antenatal visits per patient was only 2.

3. THE FUTURE— A CHALLENGE TO MIDWIFERY

In the past 20 years childbirth has become a far safer adventure almost everywhere. In

this Colony the maternal mortality in 1955 was less than half its percentage in 1935. In England, over the same period, the fall was even more striking, the maternal deaths in 1954 being only a sixth of the number in 1934. In both countries, the improvement gives reason for solid satisfaction. Nevertheless, in the comment of Sir John Charles, London's Ministry of Health's chief medical officer, *"the number of maternal deaths is still higher than it need be and constitutes a challenge to the practitioners of midwifery"*. It is to face this challenge that the future plans of our Colony's maternity service must be directed.

The ultimate aim of any maternity service is to ensure that every pregnancy under its supervision culminates in a healthy mother with a healthy baby. It will strive primarily to reduce to a minimum the number of women and babies who die or are injured through the mishaps of childbirth; but it will also do all it can to reduce the pains, discomforts, and even social upheavals of pregnancy, labour and puerperium.

By studying the detailed analysis of maternal deaths in the Colony in Table I, and Fig. IV representing the causes of fatal cases in 1956, one sees that toxaemia of pregnancy and haemorrhage have taken the leading places which, in the days before the sulphonamides and antibiotics, were filled by the bacterial infections. Deaths from infection began to fall sharply after the war, as illustrated in Fig. V, and we can now boast that 12 years have passed since the last woman died in Tsan Yuk Hospital from sepsis complicating childbirth; and there were only 2 such deaths in 1956 in the whole Colony.

Why then has there been no equal drop in deaths from toxaemia and haemorrhage? The main reasons seem to be the lack of antenatal care; the inadequacy of blood transfusion facilities; and the shortage of obstetrically trained medical practitioners and specialists. The amount of antenatal care has shown a praiseworthy increase; but the Ministry of Health's studies of

Fig. V

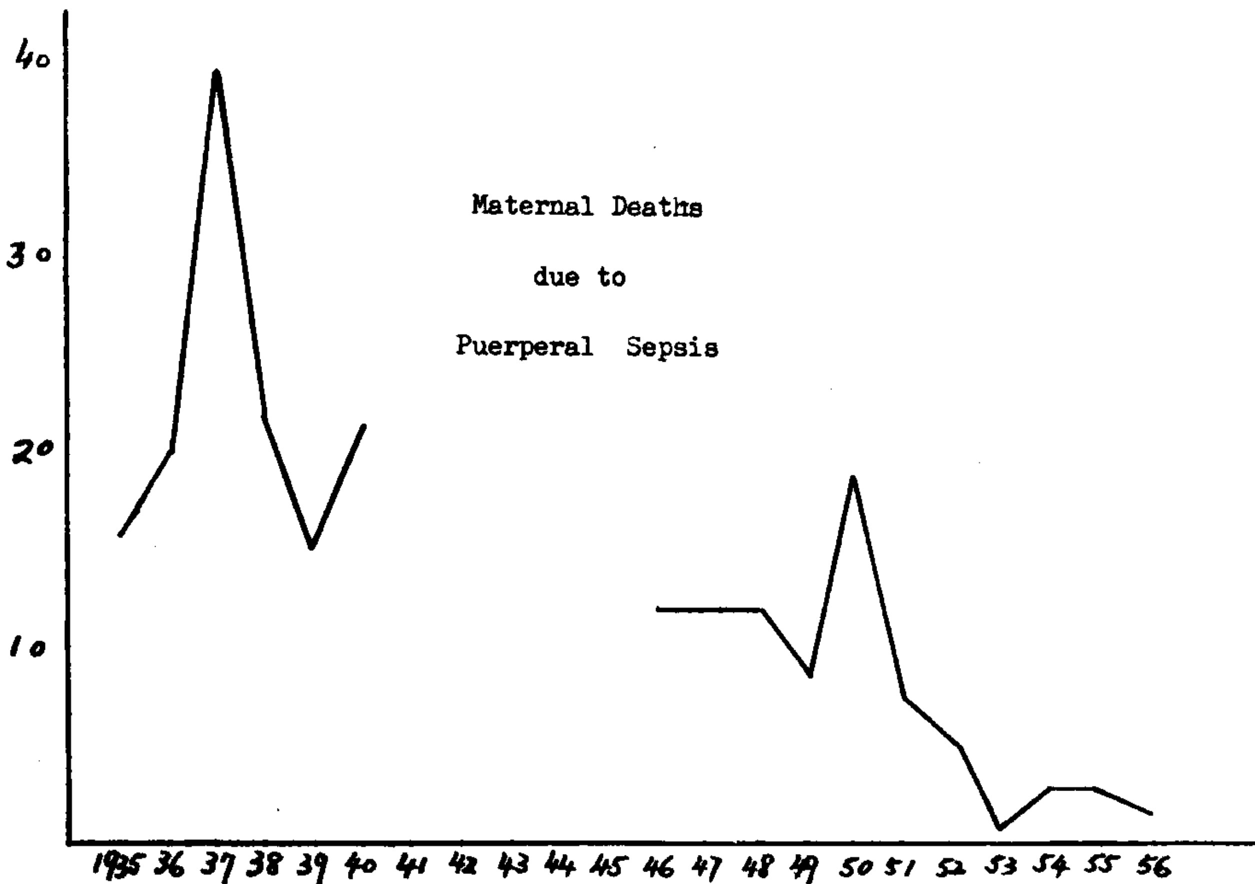


Table I

ANALYSIS OF MATERNAL DEATHS IN THE WHOLE COLONY

	1935	1936	1937	1938	1939	1940	1941	1942	1943	1944	1945	1946	1947	1948	1949	1950	1951	1952	1953	1954	1955	1956
Toxaemia	1	15	19	24	46	137	Records missing (1941 – 1945)					9	15	15	50	31	33	21	25	38	48	36
Placenta Praevia	7	6	5	14	8	4						4	2		7	5						2
Other Haemorrhages	7	7	18	11	6	10						7	19	22	16	18	43	31	31	29	31	7
Ectopic	3	3	8	9	1							1	8	16	7	6				3		7
Abortion		1	2	2	8	2						7	5	7	6	13	7	4	1	3	3	2
Puerperal Sepsis	4	5	11	7	6	10						4	4	6	6	7	3	3		5	4	2
Others	26		11	8	17	5						4	17	5	9	15	25	25	18	22	16	2
Puerperal Embolism and sudden death	2	1														2						
Puerperal Eclampsia	14											3	1	1	4	2				5	5	4
Cerebral Haemorrhage in Puerperium																1						
Delivery complicated by APH or PPH															13	5						22
Delivery complicated by Retained Placenta																						4
Anaemia of Pregnancy															1							
Total	64	38	74	75	92	168						39	71	72	119	105	111	84	75	105	107	88
Mortality Rate per 1,000 deliveries	2.53	1.33	2.22	2.02	1.70	3.67						1.23	1.62	1.47	2.12	1.70	1.59	1.14	0.97	1.24	1.16	0.90

maternal deaths in England clearly show that the most serious source of errors that lead to a maternal fatality is "inefficient or insufficient antenatal supervision; and this is especially evident in deaths from toxaemia of pregnancy". Some of the deaths in the English enquiry are ascribed to lack of integration between doctor, midwife, hospital and clinic; and others to the patient's refusal or failure to seek advice. Of the deaths due to toxaemia of pregnancy, no less than 52 per cent. were thought by the English committee of experts to have been avoidable, in the sense that death "followed some departure from the then accepted standards of satisfactory care".

Table II

	Booked	*Unbooked*
Maternal Morbidity -	5.52%	13.84%
Maternal Mortality - -	0.02 per thousand	1.02 per thousand
Premature Rate - - -	7.50%	32.70%
Stillbirth-rate - - - -	12.15 per thousand	90.50 per thousand
Neonatal Deaths - - -	19.40 per thousand	136.40 per thousand

ANTENATAL CARE

There can be no doubt that the antenatal supervision now provided for expectant mothers in the Colony is dangerously insufficient. This is not to attach blame to anybody – the position is much the same in England, where antenatal work is probably as good as in any country in the world today. Yet, if evidence of the value of antenatal care, properly and fully applied, is sought, it will be found by comparing the results in booked and unbooked cases confined at Tsan Yuk.

Different amounts of antenatal care probably account for such difference as the lower mortality among the rich than in poorer class patients. The rich, besides being better nourished and in a better state of general hygiene, are well enough educated to realise the importance of seeking advice directly they know themselves pregnant. Later, of course, they can choose the most experienced practitioners and specialists and be confined in the best-equipped private or Government hospitals. At Queen Mary Hospital the results of this difference can be seen, since this hospital admits both private and third-class patients; and in the last 6 years there were only 2 deaths in the private wards, both from heart disease, against 10 deaths – 5 from eclampsia, 3 from haemorrhage, and 1 each from purulent meningitis and heart disease – in the third-class wards. These fatal cases of eclampsia were all admitted as emergencies. It is just such deaths following emergency admissions that antenatal care, given as early as possible in pregnancy and to as high as possible a proportion of the mothers, seeks to and can succeed in reducing or actually eradicating. Careful early examination of patients to detect unsuspected rises in blood pressure, albuminuria, puffiness of the ankles, or other mild signs of ill-health will allow arrangements to be made for the admission of these patients to hospital in good time, and if necessary for preventive medical treatment well in advance of labour.

Antenatal care, then seems clearly the way leading to reduction in deaths and illness from toxaemia.

How about haemorrhage, the second of our present-day "mode of death"? Here the need is for better transfusion organisations. *Emergency Flying-squads*, fully equipped for transfusions, should be provided throughout the Colony and the New Territories, so that emergency cases can be resuscitated *before transfer to hospital.*

Secondly, every hospital should be equipped with its Blood-bank, so that blood will be immediately available for emergencies. The public, too, should be made

to realise that this can be a life-saving measure, and there should be no lack of donors for the blood-banks.

CONCLUSION

We must provide adequate and efficient maternity and infant-welfare services. The task ahead is tremendous.

We must educate and inspire everyone in the Colony to take an active part in attaining good health for themselves and their children. The time a pregnant woman spends in hospital is short; for the major part of her pregnancy she is at home. Here we must start our task. The women must be educated in the principles of antenatal care and nutrition, the latter enough to ensure a suitable diet for the family. With the co-operation of the Health Authorities, much can be done by propaganda on posters, films shown in cinemas or on the streets, and health exhibitions.

Next we must have still closer co-operation between the health services of the Colony. The antenatal officers should be interchanged regularly between the clinics and Tsan Yuk, so that the hospital may see the patients' difficulties in their homes and the staff of the antenatal clinics may study the hospital's problems at close view. We need strong help from the health visitors, more particularly with antenatal defaulters to attend hospital. One or two visits to an antenatal clinic, it must be realised, does not constitute antenatal care.

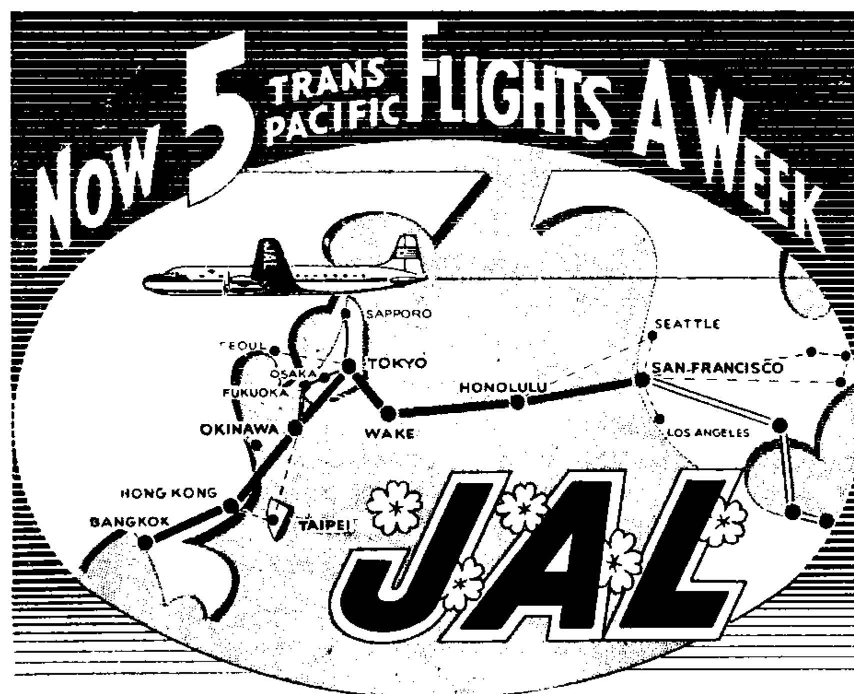
With close co-operation, the enemies of ignorance, faulty diet, poor hygiene, and lack of antenatal care can be wiped out.

I should like to finish my lecture by quoting from a friend's letter as it seems to me to sum up.

"We must aim at planned motherhood instead of emergency motherhood. Planned motherhood at its best can be applied only in the early stages of pregnancy, when most pre-existing disease is remediable, and when the unforeseen can be caught or at least suspected at its earliest stage."

Simple as it sounds, this is the revolution in modern obstetrics.

PROF. DAPHNE CHUN.



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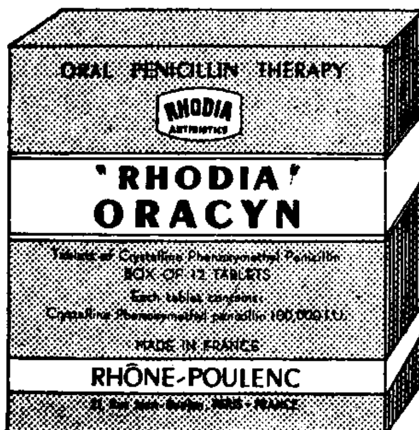

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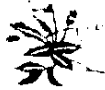

HONG KONG CRICKET

(Sixty people were fined recently for betting on cricket-fights and for cruelty to animals)

I saw the breathless stag two miles from shore.
The baying hounds, still baying in the bay,
Regretted the departure of their prey.
The huntsman shed a modest drop of gore
Assuring doubting watchers that once more
The Englishman's averse to being wicked.
I realised again quite forcibly
That Hong Kong cricket matches aren't quite cricket.

The hunting of that ruddy carnivore,
The fox, is sanctioned by the P.C.A.
They understand the hunt for him is play.
(That's why they have to stop his earth's front door).
The little sport, by no means feeling sore,
His body torn to pieces in a thicket,
With his last breath is almost sure to say
That Hong Kong cricket matches aren't quite cricket.

The timid hare, that graceful herbivore,
Will automatically leave his hay
To soothe the gentle gentry for the day.
The European driven birds adore
The whining contents of the smallest bore.
All join the fox and stag (and humble cricket)
To reaffirm the decent British Way.
For Hong Kong cricket matches aren't quite cricket.

Oh Prince of Darkness! At the close of play
Declare we're batting on a sticky wicket.
Where man is bats and reason balls, betray
That Hong Kong cricket matches aren't quite cricket.

WALLACE THOMPSON.

WHAT WAS WRONG WITH LOUIS PHILIPPE?

by PEDAGOGUE

While alive, kings and princes, conquerors and tyrants all receive adulation, but once dead they are subject to the harsh laws of deflation. Not only historians but even teenage boys and girls can blow their reputations to fragments with a few well chosen phrases. Let us listen to the voice of the student laying bare the facts of history in his examination answers. For instance, if an historical figure has been ruthless enough during his lifetime he may still be remembered with a certain amount of awe. Witness the following:

"Piccazzo was a cruel man, and the Incas of Peru were repressed until they staged a resurrection". (Oberamergau please note).

"Napoleon had a strong and good equipped army so – 'he saw, he went, he conquered.'" (Julius Caesar please note).

This is all right for the dictator types, but how do less forceful characters fare at the hands of school children? Well, as an example let us examine the career of Louis Philippe as seen through a mass of examination papers. There he is then:

"Louis Philippe was a sensible old man who sat on the throne of France. When he was a boy he was a bourgeois and he learnt their tricks. When he grew up he shaved himself, he walked about in the streets with nothing for protection but his umbrella, he dressed himself instead of his butler, and he prided himself on his abilities to cut thin slices of ham which he learned from a waiter with whom he had a lodging. Since he was a middle class his government made suits to the middle classes; thus it was improperly organized. In fact he was only suited to be a corpulent business man sitting comfortably at the milestone without any incentive to change. Yet at these times the peasants in France were suffering, and the working classes led a poor and indecent life. But Louis Philippe did nothing to help these poor peasants. Their sufferings were enough to choke the life out of these poor people. Many of the workers were jobless and many old soldiers went for to hang themselves. But as long as Louis Philippe sat on the throne he forgot everything which made the labourers feel headaches. At this time the wheel of the use of capital increased in velocity and everything was on a casheral basis. Louis Philippe himself was a solid bourgeois who led a simple life and invested his income in storks and shares, preferably those of England.

Once he gave audience to the philosopher Alex de Toxville, but Louis talked to him 'long windy' so that this philosopher could say nothing longways. In his foreign policies he would gladly help in order to place his son on the Belgian throne, but his own seat was not yet warm and he dared not to offend Palmerston who proved a far greater match for Talleyrand the old craftsman. Thus Louis Philippe was oblivious that one day he would have to face some nice music when the idea ripened in the hearts of the army that he was a fat old slop. They were full of scorns about a King who dressed in an umbrella and a top hat, and had a palace full of progeny. Lastly but not leastly this solid old bourgeois who forgot everything was sent packing away to England in a brown raincoat. He passed the rest of his life in England and lived in Brighton with a favourite old cat.

There may be more about Louis Philippe, but the above is what I can think of".

祝讀者新年快樂

By courtesy of Mr. Keith David, 1957.

"THE FOUL DISSENTIONS OF THE FACULTY"

(Dr. Garth)

Whether the medical students are really superior to students of the other Faculties or not, I cannot say. Up to now we have not adequate means to find out. Paradoxically, the medical students boast, yet hide their gifts. Apart from examinations, they seldom care to let their talents shine, not even in their own *Elixir!* When I read about Michelangelo, the renowned Italian painter, sculptor, architect and poet, or Leonardo da Vinci, one of the greatest all-round geniuses, I begin to wonder whether it is because the Almighty is less bountiful to our generation, or the talents given are undeveloped that we seldom see versatile students. Perhaps, there are many a "mute inglorious Milton" in the Medical Faculty. After all the doctor and the poet are not opposed to each other; the Greeks believed that Apollo was the deity of physic, melody and song.

Professor Edmund Blunden in his article " Physicians and Poetry " has pointed out many a doctor who was more than just a physician. In his comprehensive survey, he noted doctor-poets in the various centuries. The outstanding example in the 16th century was Sir Thomas Campion. In the next century came Sir Thomas Browne, and Henry Vaughan. The 18th century especially was a period of physician-poets. In this, more than in the other centuries, the medical doctor participated in the literary activities of the day. Garth, Arbuthnot and Armstrong were poets and friends of poets; their literary career went side by side with their medical profession. Others concentrated more on their literary career, like Sir Richard Blackmore, George Sewell, Tobias Smollett, James Grainger, Mark Akenside and Oliver Goldsmith. The fact that Chatterton, Coleridge and Keats almost became doctors is worth pondering. Robert Bridges, who abandoned medicine at the age of forty and later became Poet Laureate, is another manifestation of God's many gifts to man.

It is not my aim to persuade the medical students or practitioners to abandon their worthy pursuits, unless they find it intolerable and want to take another degree. I only wish that they would use their many gifts while at the same time they are studying or practising medicine. Their daily contact with suffering humanity, provided that they do not regard the patients as abnormal specimens, must provide food for thought. What a wonderful experience it must be to be able to usher in new life, to cure, to preserve life, and to safeguard health. What pain when you are fighting a losing battle with death over your patients, and see them fade and waste under your eyes. You will see men die. Each man meets death differently. You will hear the sad but not still music of humanity, and become a "sadder and wiser man". The eagerness to relieve pain and suffering and the feeling of your own impotence will lead you to hope for and dream of new epochs in science and medicine. You will ponder at the mysteries of life and death, the significance of life, the dignity and worth of man, the value of suffering. No wonder when Keats and Bridges abandoned medicine, they became poets of a high order.

Though not every one of us can become a Keats or a Bridges, yet it is not inconceivable to be a Garth, an Arbuthnot or Armstrong; to be good doctors, and at the same time writers of considerable merit. The case of Garth is especially notable. He was associated with eminent poets and writers. When Dryden died, he pronounced a Latin oration over his remains. He was the early encourager of Pope. A firm Whig himself, he was intimate with Addison, both politically and personally.

Garth was famous in the medical field. When George I became king, he was knighted, and received the double appointment of Physician-in-Ordinary to the King, and Physician-General to the Army. He was a Fellow of the College of Physicians

in 1693. His best poem *The Dispensary* was written in 1699; this is still worthwhile reading because here is a doctor writing a poem about doctors and apothecaries in a provocative and humorous manner. What is more, there is a seriousness behind it. The poem is an appeal as well as a warning.

The Dispensary is a mock-heroic poem in six cantos in which Garth attacked the apothecaries and some members of the College of Physicians who objected to the founding of a dispensary for the sick poor. "It was on the side of charity against the intrigues of interest, and of regular learning against licentious usurpation of medical authority," as Dr. Johnson commented. In those days, the apothecaries, supported by some of the physicians, had ventured to prescribe as well as compound medicine. These apothecaries were shocked when the physicians gave advice *gratis* to the poor and established a dispensary of their own for the sale of cheap medicine. *The Dispensary,* which can be compared to our modern free clinic, was a serious threat to their trade. Garth described the worry of these men most skilfully in heroic couplets:

> " *Our manufactures now they meanly sell,*
> *And their true value treacherously tell.*
> *Nay, they discover too, their spite is such,*
> *That health, than crowns more valued, cost not much:*"

It was truly a great threat to the business of these rich and influential apothecaries. They had been accustomed to be the sages who promised "Future health for present fees". They were consulted by many for various purposes:

> " *Some by what means they may redress their wrong,*
> *When fathers the possession keep too long.*
>
> ....
>
> *Poor pregnant Lais his advice would have,*
> *To lose by art what fruitful nature gave;*
> *And Portia, old in expectation grown,*
> *Laments her barren curse, and begs a son.*
>
> ....
>
> *And old Lucullus the arcanum prove*
> *Of kindling in cold veins the sparks of love.*"

The doctors who backed up these physicians did not escape Garth's censure, though the attack was humorously presented. Mirmillo in the poem represented the popular, successful trader. In his soliloquy he said:

> " *Long have I reign'd unrival'd in the town,*
> *Oppress'd with fees and deafen'd with renown.*
> *None e'er could die with due solemnity,*
> *Unless his passport first was signed by me.*"

Yet Mirmillo had no peace and rest because he was involved in this battle against the establishment of the Dispensary. Garth observed that he was not likely to be troubled by the mistakes he made, "the dead will ne'er complain." Anyway they cannot in this world, but Garth warned his brethren that they would in the next! In the visit to the underworld, the combatants met the spirit of a dead physician. He was doomed to stay on a barren beach "till the angry powers relent!" He was tormented by the spirits of his dead patients who were the victims of his "ill conduct". But trader-physicians were very popular in Hades; as Charon told them:

> " *Our awful monarch and his consort owe*
> *To them, the peopling of their realms below!*"

Himself a doctor, Garth was amused and puzzled by the fact that doctors, who at least profess to care for the life and well being of the patients should "lavish their own!" With the eye of a humorist, he gave us a whimsical picture of the Dispensary. The medical man is left behind, and the humorous poet is speaking now:

"Here phials in nice discipline are set,
There gallipots are rang'd in alphabet.
In this place, magazines of pills you spy;
In that, like forage, herbs in bundles lie.
While lifted pestles, brandish'd in the air,
Descend in peals, and civil war declare.
Loud strokes, with pounding spice, the fabric rend,
And aromatic cloud in spires asend!"

It would be a mistake to take *The Dispensary* lightly. By writing this poem, Garth hoped to contribute his share in the just battle against the apothecaries and physicians who had turned their profession to a trade. As he said in the Preface, he aimed "to rally some of our disaffected members into a sense of their duty." Through the mouth of Harvey in the poem, Garth gave the final verdict to the matter. Harvey in the underworld said to the goddess Health:

"With just resentments and contempt you see
The foul dissentions of the Faculty.
How your sad sickening art now hangs her head,
And once a science, is become a trade,
Her sons ne'er rifle her mysterious store,
But study nature less, and lucre more."

Though the Doctor in Chaucer's General Prologue to the *Canterbury Tales* justified his love of gold thus:

"For gold in phisik is a cordial
Therefore he lovede gold, in special."

Yet this is an excuse rather than a justification. Sir Samuel Garth's poem can still be read with enjoyment, since human nature changes but little.

Dr. Arbuthnot's relationship with the poets and writers of the period was even more intimate. He was the friend of Pope, Swift, Gay and Prior, and shared with his brother wits, mostly keen Tories, in many humorous publications called forth chiefly by political events. With Pope, Swift, Gay, Parnell, Congreve and others, this eminent physician to Queen Anne started the Scriblerus Club in 1713. The satirical *Memoirs of the Extraordinary Life, Works, and Discoveries of Martinus Scriblerus,* published in Pope's works 1741, was chiefly, if not wholly, written by Arbuthnot. The design, as expounded by Pope, was "to ridicule all the false tastes in learning, under the character of a man of capacity who had dipped into every art and science, but injudiciously in each." Dr. Arbuthnot displayed extensive and curious learning in the sketch of the character of Cornelius Scriblerus, and the oddities and absurdities he fell into with regard to the education of his son. Here is an illustration:

"The old gentleman so contrived it, to make everything contribute to the improvement of his knowledge, even to his very dress. He invented for him a geographical suit of clothes, which might give him some hints of that science, and likewise some knowledge of the commerce of different nations. He had a French hat with an African feather, Holland shirts and Flanders lace, English cloth lined with Indian silk; his gloves were Italian, and his shoes were Spanish . . . . "

The old gentleman called this "Travelling at home." Arbuthnot's wit and humour is evidently shown in this work. Another monument of his power is the *History of John Bull*, 1712. His design was to ridicule the Duke of Marlborough and turn the nation against the French war. The character of John Bull (The Englishman) is succinctly stated:

"Bull, in the main, was an honest, plain-dealing fellow, choleric, bold, and of a very unconstant temper; . . . . very apt to quarrel with his best friends, especially if they pretended to govern him; if you flattered him, you might lead him like a child. John's temper depended very much upon the air; his spirits rose and fell with the weather-glass. John was quick, and understood his business very well, but no man alive was more careless in looking into his accompts, or more cheated by partners, apprentices, and servants . . . . "

In the poem *Know Thyself*, 1734, Arbuthnot revealed another side of his literary power. When he was writing on the double nature of man, he lacked the epigrammatic polish of Pope, but he had a sincerity and humility not so easily apparent in Pope's works. He recognised man's littleness and appealed to God for enlightenment in the road to self knowledge.

" O Truth Divine! enlighten'd by thy ray,
I grope and guess no more, but see my way."

His explanation of the fall of man is admirably thought out and expressed. More than Milton, he has justified the ways of God to man in these two lines:

" Who acts by force impell'd can nought deserve;
And wisdom short of infinite may swerve."

Dr. Armstrong was careless of his literary fame, and he very often was anonymous in his writings. However his literary power was recognised by Swift, who declared: "He has more wit than we all have, and more humanity than wit." Swift also appreciated Arbuthnot's musical taste; and accepted his recommended singers for the choir at St. Patrick's in 1726. His friendship with Pope was particularly happy. In his Epistle to Dr. Arbuthnot, he called him the friend who had helped him "through this long disease, my life." In his letters to Pope, Arbuthnot often gave him advice; and that with regard to Pope's satire is especially notable. He was quite seriously ill when he wrote to Pope: "And I make it a last request, that you will continue that noble disdain and abhorrence of vice, which you seem naturally endued with, but still with regard to your safety, and study more to reform than chastise, though the one cannot be effected without the other." Though Pope in his letter answered that general satire in times of general vice has no force and is no punishment", and in his "Epistle to Dr. Arbuthnot" he still pursued somewhat his usual satirical and mocking style, yet he appreciated Dr. Armstrong's intentions and finally abandoned dangerous satire.

The 18th century witnessed another intimate and fruitful relationship between the medical man and the poet, Dr. Armstrong and James Thomson, the poet of the *Seasons* and the *Castle of Indolence*. Dr. Armstrong himself was quite a poet, and was the author of *Art of Preserving Health* and the five stanzas written by him on the Seven Deadly Disorders in the *Castle of Indolence* for Thomson show considerable mastery of the Spenserian stanza and are rich in humour.

There are undoubtedly, many a potential A. J. Cronin, Somerset Maugham, Dr. Arbuthnot or even a Keats in the Medical Faculty. I sincerely hope that these gifts will not be buried, and used not only profitably, but well.

MONICA YICK.

SUMPTUOUS INTELLECTUAL FEAST IN STORE

World Famous Local Actors To Excel

(Contributed)

As is well known the Man in the Street is fortunate to be able from time to time to feast his starving soul with some spiffing renditions of well-known plays by some of the better playwrights such as Shakespeare etc. Little does the Man in the Street realize as he pursues his humdrum existence that he will soon have an opportunity to experience one of the most dramatical presentations presented by that well-known local group *The Hongloon Corps de Drama*. As is well known this well-known Corps comprises units from every walk of life, representing a magnificent example of international co-operation, and a shining light to the whole community. They have chosen to break away from the usual stage representations such as Shakespeare etc. and have elected to attempt an entirely new play by the new Irish-American dramatist Agape Clutterbutty. This play, which breaks nearly all the well-known stagey conventions of the usual sort will come close to the heart of most of the audience here and may remind them of their own humdrum existence, since it is placed in a hypothetical spot in S.E. Asia in which the Man in the Street is guided to happiness by an intellectual élite of the Platonical type. The author has cleverly contrived to indicate however that in fact the place is a real Existentialist hell.

The usual well-known actors who have charmed the local Man in the Street for so long will be walking the boards as is their wont, and the public is informed that everyone is simply on tip-top form. The sets and the costumes have been designed by a well-known local vacuum-pump designer and will certainly constitute a new high in the well-known dramatical history of S.E. Asia.

Nite of Vibrant Symbolism

Corps de Drama Charms Vast Audience

(by Soapley Foamer)

Whilst *A Clutch of Hagfish* is admittedly a difficult play there was little doubt last nite that the Hongloon C de D rose to the occasion and gave us all one huge intellectual fillip. Never before have I seen a cast give of themselves with such consummate skill. The intense shock of the dark stage during the first act set the capacity audience agog for what was to follow. As for the sets and costumes, they filled the eye with breath-catching awe, and it was a real delight to me that the designer had chosen to place his actors in their colourful Tyrolean garb against the sombre background of a Lutheran cemetery.

The accoustical properties of the theatre are known to be very bad, but I can truthfully say that I heard every word from the back row of the stalls. The obscure symbolism of Agape Clutterbutty's writing does not affect its almost unbearable beauty, and this together with the cast's sensitive interpretation combined to give us one of the most intellectual nites the public has experienced since the performance of the C de D's last play. As I sat in the bar with the Producer during the last two acts, I could not help musing how lucky we are in this most beautiful part of a beautiful world.

NEW PLAY PUNK

Hongloon Corps de Drama Flop

(*by* Alastair Blardie)

When will the local amateurs learn to choose plays well within their scope? I have urged often enough in these columns, and insist once again, that awkward and inexperienced actors should never be asked to strain their abilities and their audience to the extent they did yesterday evening. The thing itself *A Clutch of Hagfish* by Agape Clutterbutty is completely meaningless and it is not surprising that the cast made so little of it. Why the first act should have been performed in total darkness is beyond my thingmibob, since it tended to nullify the effect of the costumes. It was only during the second interval I discovered that the entire cast wore skin-diving outfits during this part of the play. This may have accounted to some extent for my inability to hear a word from the front row of the stalls. It is not surprising that of the sprinkling of people who turned up more than half walked out during the second act.

Whilst Agape Clutterbutty gives the cast little chance of conveying any meaning whatever across to the auditorium it might have been helpful, to say the least, if the cast had devoted more time to learning their words.

The sets and costumes, designed by a well known vacuum-pump expert seemed out of character but were to some extent cleverly useful. But if the sets are clearly meant to be 12th Century Italian, why should the costumes (apart from the fantastic first act) have been Early Sung Dynasty? Surely the Public here is more intelligent than to be subjected to this sort of fourth-rate village hall stuff?

Let us hope that the Hongloon Corps de Drama will think more carefully before inflicting themselves and the paying public with this sort of degrading exhibition.

New Play Performed

Charming and Disappointing Production

(by Hope de B Knisely-Balance)

The Hongloon Corps de Drama gave what I can only describe as a curate's egg performance last night. Seated half-way back in the stalls I only heard about fifty per cent of the lines and could not judge whether it was due to some of the actors mumbling or to the accoustic qualities of the theatre. There were times when I enjoyed myself, although I confess that the blackout during the first act was intensely irritating. At the time I thought it must be part of the symbolism – and I enjoy symbolism on the stage. I liked the set very much and congratulate the designer on choosing some lovely colours, but I was a little bit puzzled as to what it represented. However, like everyone else I know what I like in art. The costumes on the other hand were a mixed bag. The young gentlemen were charming in their Edwardian suits, but the ladies I'm afraid did not quite come up to scratch. There were some moments of – shall I say, light? The Producer is to be congratulated for having given us one or two quite tidy little cameos at times which did much to enliven a somewhat messy stage. But I find it difficult to decide whether I liked this performance by the Hongloon Group better than their last one. I think I do.

" A CLUTCH OF HAGFISH "

Elixir regrets that action on the part of the Hongloon Corps de Drama prevents appearance of a critique of the recent performance of Agape Clutterbutty's "A Clutch of Hagfish". It was intimated to us that no tickets would be made available for use by our stage critic.

WINGED CADUCEUS

"Sundown in the Dead Heart of Australia . . . . ."

Dreamy mauve of evening creeps over the downs of stones – – Diamantina Downs, the name a mockery. There is a river somewhere . . . . . the colour of a cold cup of tea. Often enough that is mockery too. You can ride within thirty yards of it, and never know it is there, yet it is a thousand miles long . . . . . eighty yards wide for a thousand miles, ... eighty miles wide in the floods, brimming silver these withered plains. In the big droughts it vanishes into thin air.

But the river is there now . . . . A flight of shell parrots goes by, 'greeneys' . . . . . .

A yellow dog lopes in to the river. He runs as a dog whipped and hated . . . . . A mob of brumbies comes down over the bank, ten or eleven mares and two little foals blithely trotting. The black stallion lifts his head and sniffs the wind. They are away, their hoofs a low thunder on the sand.

For there is something else on the downs . . . . . nature's enemy, the stranger in the silence. Man.

He lies with his head on his arm, thrown from his horse and done . . . . . he has dragged himself backward on aching arms for six stony miles, but he cannot make the river a mile away. Through the long delirium of night he is thirsting, twisted in pain, under the dry, glittering stars. . . . .

A stockman rides out on the sandhill at daylight, ... Shading his eyes, he sees cattle over towards the river. Heads down, tossing their horns, they are playing about something as cattle will. . . . . .

So he finds his comrade lying unconscious on the stones, puts an arm round his shoulders and tilts a water-bag to those dry, muttering lips. Then, ... leaving a water-bag near by, he gallops seven miles to a mustering-camp to send a black-boy back with a billyful of tea. He is away on a seventy-mile ride to the shack on the river they call the head-station, to rouse it with a shout in the midnight, telling the news to a lonely woman with a baby in her arms.

At daybreak a signal comes over the air – – 400 miles over the air . . . . . a pair of pedals whirring to conquer the cruelty of miles.

Rumbling over the clouds he comes, the Man from Heaven, his wheel-tracks vanishing in the void.

He sees the wind on the plains . . . . . the rivers flowing . . . . . the sandhills smoking . . . . . and the cool, clean ablution of the dark following rain. With every beat of his little single-engined plane he looks down on the boundless vista of Australia. . . . . . .

He flies from rain to drought as no lightning can leap the distance. Nothing sees him, not even the wandering kangaroo. Yet hearts are beating to the timing of that engine, and hearts alone are the being of the country.

He is a spark of human spirit that flashes in the blue, the will to cure. . . . .

Not far off Heav'n, in the Precincts of light a little white drift of smoke brings him down.

From the torture of the stony downs to the coolness of white sheets, relief from pain, and the gentleness of a woman's hands seems, to the sufferer, but an hour . . . . . of sleep.

Such are the stories that might be told of a Flying Doctor every day."

Thus does Ernestine Hill open her story, "Flying Doctor Calling".

In 1880, in a small village in Victoria, was born a boy, who, in the fullness of time was ordained into the ministry of the Australian Presbyterian Church, and who, in 1912, was destined to be the founder of the Australian Inland Mission. Australia is a continent 2,974,581 square miles in area, larger than the continent of Europe (if one excludes the vast territories of the U.S.S.R.) Yet in all that space, the Australian population of 10 million is to be found settled largely on the Eastern and South-Eastern

fringe of that vast land. The "Dead Heart" is still, the land of the pioneer, the adventurous soul, willing to endure the hardships of this unpredictable area to carve out some of the largest cattle and sheep "stations" in the world, or to carry the necessities or the mails to these pioneers. In this large area, much of it desert except in the "wet", the lonely homesteads may be as much as 100 miles apart and sometimes more. But loneliness was not the great fear in 1912. The impossibility of securing medical assistance led to many a death which might have been avoided, had expert attention been closer to hand.

From its foundation, the A.I.M. set about establishing small hospitals and nursing homes in outback towns of Western Queensland, Cape York Peninsula, the Northern Territory, South Australia and Western Australia . . . . . at Broome, Port Hedland, Hall's Creek, Carnarvon, Marranboy, Cloncurry, Beltana, Oodnadatta, Victoria River Downs, and elsewhere. Still, the isolation of the homesteads remained unconquered. The swift development of aviation during World War I gave John Flynn the idea of establishing a flying doctor service. Aircraft could overcome distances, but the problem remained that an aircraft was of little use if the pilot did not know where his services were required. Flynn himself stated the problem as "to make the dumb Inland to speak, and its deaf distances to hear". To answer this, that other great invention of the present century, radio, was to play its part.

Driving all over the continent, in his T-model Ford through sandy wastes, through creek, flood, mica hills or plain bush, John Flynn listened to the great silence and dreamed that the new-born wireless might provide the answer to his problem. All that was wanted was a simple transmitter-receiver of low cost, light weight and simplicity such that a station-hand could operate. This was too great a challenge for those early days according to the experts. Undeterred, he studied radio - telephony himself, sought information from radio specialists and enthusiastic amateurs and with the aid of a partially disabled returned soldier, George Towns, evolved a "transceiver", powered by a generator driven by the engine of his faithful car. From Oodnadatta, Flynn and Towns tried their set but were disappointed. However, they were surprised to find later that a message sent by radio from Cordillo Downs, 300 miles to the east, had been heard in Oodnadatta – the first crack in the great silence of the Australian "bush".

Towns was forced to give up his part through continued ill-health, but Flynn was now able to enlist the aid of a brilliant young electrical engineer, Alfred Traeger. Traeger rebuilt Flynn's set and travelled north with Flynn to Alice Springs, where the set was again tried. This time, their messages were heard in Adelaide, 1,000 miles to the south. The set was a success. The problem was now to find a suitable method of providing power for the set, power such as would be readily available at an isolated homestead. Accumulators were hopeless for they were both costly and heavy, contained dangerous fluid, doubly dangerous in view of the rough tracks over which they would have to be transported, and required recharging, a process quite beyond the capabilities of the stations at that time. Traeger's genius soon found an alternative, for, within two years, he had developed a generator driven by pedals, which would develop 20 watts at 300-400 volts. The stage was now set for the inauguration of the Flying Doctor service.

Backed by the A.I.M., a trial period of a year was commenced with Cloncurry, Queensland, as the base. Dr. George Simpson of Melbourne was the first flying doctor, and the aircraft was provided by the infant QANTAS (Queensland and Northern Territory Aerial Service). The first flight was made in August, 1927, and as a result the life of a miner at Mt. Isa (Queensland) was saved. The success of this experiment led to the appointment of the first full-time flying doctor based on Cloncurry and the service was established in 1928. During its first year, the doctor flew 20,000 miles, treated 250 patients, and saved 10 lives. The service gradually grew but by 1933, it was clear that the financial burden was too great for a church missionary organisation. As a result, the A.I.M. assisted in establishing a new national organisation which took over the Cloncurry base. The organisation of the new aerial medical service was planned carefully by Flynn on a State basis,

THE
JOHN FLYNN MEMORIAL CHURCH

the State sections eventually being co-ordinated under a Federal body.

New bases were established until at the present time, there are 12 in existence. These are:—

Cloncurry, Q.	(1928)
Wyndham, W.A.	(1935)
Port Hedland, W.A.	(1935)
Kalgoorlie, W.A.	(1937)
Broken Hill, N.S.W.	(1938)
Alice Springs, N.T.	(1939)
Charleville, Q.	(1943)
Meekatharra, W.A.	(1949)
Charters Towers, Q.	(1952)
Port Augusta, S.A.	(1955)
Derby, W.A.	(1955)
Carnarvon, W.A.	(1955)

At each of these bases is a control station, the centre of a radio network to which, on allotted frequencies, are linked the outpost radio stations. The control station is regularly manned and calls for medical attention receive immediate priority. Stations and homesteads have been encouraged to provide themselves with inexpensive but comprehensive medical chests, approved by the Service. The Flying Doctor advises and prescribes over the radio link, and, if necessary, is prepared to fly immediately to any seriously ill patient anywhere within his allotted area, and even beyond, if his colleague in the neighbouring area is called to another case. Many of the stations have constructed suitable airstrips and, as a result, a system of regular medical visits is now made. During flight, the doctor is in constant communication with the control base and outpost stations. This service now receives substantial grants from the Federal Government but it is still run on a voluntary basis. The services of the Flying Doctor are *free,* and are extended instantly in time of need to all, with no distinction of colour, caste or creed, and with no calculation of cost or fee. The primitive Australian aborigine is treated along with the manager of the largest cattle station.

Other similar services are maintained by other organisations. The Bush Church Aid Society of the Church of England maintains a base, complete with all necessary services, at Ceduna, S.A. At Cairns, Q., an Aerial Ambulance Transport Brigade carries out its important task: and in Northern Territory, the Federal Health Department maintains a flying doctor service, the Northern Territory Medical Service.

Today, this vast network of radio communication is widely used for commercial purposes as well as the humanitarian work of succour and healing. The pedal radio is now obsolescent, and is being gradually replaced by battery-operated transceivers which are in effect radio-telephones. These are now widely used for the transmission of telegrams, and, when not in use for more urgent business, may be used as ordinary telephones. The lonely woman on the isolated station can now call up her neighbour 500 miles away to talk about the affairs of the homestead, the weather and the 101 things which women chat about. In this way, the isolation of the Interior is being gradually dissipated, and the settlement of this great area of land is naturally proceeding.

After Flynn's death in 1951, a cairn was erected on the Stuart highway, the new arterial road from Alice Springs to Darwin; the plaque on this cairn is inscribed:—

Commemorating
"FLYNN OF THE INLAND"
The Very Rev. John Flynn, D.D., O.B.E.
of the Presbyterian Church of Australia.
1880 – 1951.
His vision encompassed the Continent
He established the Australian Inland Mission
and founded the Flying Doctor Service
He brought to lonely places a Spiritual Ministry
And spread a Mantle of Safety over them
By Medicine, Aviation and Radio.

(Continued on page 33)

Arthur James Ewins, F.R.S.

A. J. Ewins, for many years Director of Research at May & Baker Ltd., died, after a long illness, at Bedford on Christmas Eve. He was born at Norwood in 1882 and was educated at Alleyn's School, Dulwich. In 1899, he joined the staff of the Wellcome Physiological Laboratories at Brockwell Hall at Herne Hill and worked under the late Professor George Barger. He graduated from the Chelsea Polytechnic in 1906, receiving his B.Sc. with Honours and in 1914 he was awarded his D.Sc. Subsequently he worked at Brockwell Hall with Dr. (later Sir Henry) Dale on acetylcholine, (which he had isolated from ergot in 1914) and choline esters. These very important biochemical and physiological investigations formed the beginning of a long and valued friendship between Ewins and Dale and when Dale joined the Medical Research Committee (War Council) in 1914, Ewins went with him and continued his chemical and biological research.

After some investigations into methods of preparation of German drugs—the supply of which was suddenly cut off by the War—Ewins joined May & Baker Ltd. at Battersea early in 1917 and for some years he undertook the management of the production side of the factory. During this time he was concerned with the manufacture of neoarsphenamine at the Bell Lane, Wandsworth Works of May & Baker. This, coupled with his earlier biochemical background, helped to arouse his interest in Chemotherapy which lasted throughout his life. He gradually developed the analytical and research laboratories and transferred his activities, little by little, to research. Under his guidance, a flourishing research organisation grew up and he was eventually appointed to the Board of Directors as Director of Research. Numerous publications in the Journal of the Chemical Society bear testimony to the activities of his research team in the field of organic arsenicals and other chemotherapeutic substances. He also published many papers in the Biochemical Journal and the Journal of Physiology.

Perhaps his best-known achievement was the discovery in 1937, with his colleague Phillips, of sulphapyridine or M & B 693, the first chemotherapeutic agent for the treatment of pneumonia. This was followed, in 1938, by the synthesis of sulphathiazole by his co-worker, G. Newbery. After this came the discovery of the aromatic diamidines which are curative for trypanosomiasis and leishmaniasis. One of the best known of these, pentamidine, is widely used for the protection of humans against African Sleeping Sickness.

In 1943, Ewins was elected a Fellow of the Royal Society. He continued to direct the research organization which he had built up until his retirement in March 1952. A man of quiet temperament, but of firm decisions, his pleasures were working in his garden, reading and motoring.

Chinese New Year Bazaar

By courtesy of Mr. Keith David.

In 1953, the service was honoured by Her Majesty the Queen when she graciously granted it the title "Royal Doctor Service of Australia". In 1956, the John Flynn Memorial Church was opened in Alice Springs. In August, 1957, the Australian postal service provided its tribute by issuing a 7d. stamp (illustrated here), which, unlike the usual commemorative stamp, is to continue in use indefinitely as part of the regular postal series.

Despite these tributes, "the real memorial of Flynn will be in the prosperous towns, the busy industries and the smiling pastures that will come when the Great Centre and the Great North (of Australia) are developed, as they will be developed. That will be his real and lasting memorial, and no man could have a finer one." (Field Marshal Sir William Slim, Governor-General of the Commonwealth of Australia).

In writing this article, I am indebted to Flying Doctor Calling by Ernestine Hill; the Philatelic Bulletin of the Australian Post Office; and to the Australian Government Trade Commissioner, Hong Kong.

G. C. ISRAEL.

Elixir regrets that owing to action by the Crafty Art group our Art Critic was slung out of their recent exhibition before he got a foot properly over the door. Our Art Critic informs us however that he did manage to glance very rapidly round the exhibits on his way out and assures us that in his opinion the whole thing looked lousy.

PUTTING IT BETTER

One of the most notable things about the Hong Kong landscape is that we have no railway junctions. There is, however, nothing particularly sad about that. What traveller in Britain cannot picture a long windswept platform with a usually rather malodorous waiting room, a locked and dark refreshment room, and, in the more sophisticated examples, a bookstall, also locked? It was once on such a station, with about an hour and a half to wait on a winter evening, that I first began to think about the subject of these few words. For after one has finished reading one's detective story, one's copy of *Woman* and the Pelican Book, bought earlier in the day as a result of some impulse towards self-education, on Saint Thomas Aquinas, or Juvenile Delinquency, or Intestinal Parasites after one has read all these, there is nothing to do but to read the notices posted up on the station. (Advertisements, of course, are not to be read). And it was while I was idly reading the instructions to railway men on the working of the baggage lift that I lighted on the harmonious phrase, "Should the actuating apparatus prove inoperative. . . . . ."

I did not invent this: I can't imagine the kind of person who did. But somebody – long dead, I should imagine, as the notice had an air of having been there for quite

some time – thought that this was the way to tell a railway porter what to do if the lift didn't work.

And then I thought that all our lives we are both guilty of and the victims of *Putting It Better.* From the day when our mother begins studying *Clothes for the Lady-In Waiting,* through the process by which we ourselves become a *Little Stranger,* until the day we *Pass Away* and our *Remains* are *Interred,* we go on wrapping up the more brutal facts of our existence in arch, elegant or tasteful evasions. And yet, one can understand this only-too-human fear of calling birth and death by their right names. What does baffle the imagination is the image of a ghostly railway porter calling: "Hi, Bill, the perishin' actuating apparatus is inoperative again."

Doctors, as doctors, are likely to be acquitted of the charge of pretentious diction, of Putting It Better. Very often they really can put it better – more accurately, I mean. Their way of talking, indeed, often seems to the layman to be a subtle form of flattery and encouragement. We feel that it must be more distinguished to suffer from a virus infection (which seems to indicate a day in bed, with one's household anxiously administering medicaments) than it is merely to have a cold (which sends us, sneezing, depressed and unflattered by the attentions of others, to work as usual). It is certainly more consoling to be told one's ailment is of psychosomatic origin than it is to have one's nearest and dearest assuring one that it is *Just Nerves,* or, worse still, that one is *Only Imagining It.* We are all of us the better for a little professional jargon, even when, or perhaps specially when, we don't understand it.

It is our everyday talk that is mangled by the itch for Elegant Expression; and, of course, the curious verbal habits into which some journalists seem to fall make it impossible to put a thing simply. For example, we might well read one day: "Residents in Pokfulam Road observed a large cigar-shaped object proceeding in the direction of University Hall. Why only *residents?* Are we to conclude that the object would have been invisible to any strayed reveller from Kowloon Tong or Aberdeen who happened to be in Pokfulam Road at the time? Or is it that we – those of us with a settled income and everything fine about us – are too exalted to be referred to as "people"? It would not matter if we were all, every one of us, residents, but, alas, it seems that if you happen to live in, say, an orphanage, you are not a "resident" but an "inmate". It follows, then, that those of us who are too grand to be called simply "people", and too rich to be called "inmates", live, not in houses or in flats, but in "residences". By the way, are the inhabitants of university halls "residents" or "inmates"? I imagine they are "residents", in accordance with the high status conventionally accorded to learning.

But a strong contender for the title of *Master of Putting It Better* is the clerk of a little Northamptonshire parish church in the eighteenth century. The Lady of the Manor had, as they said in their unpolished English, been brought to bed of a son. (No doubt they were already thinking of how to *Put Better* this simple and explicit and workmanlike phrase). According to the Anglican liturgy, the mother should come to church to give thanks for her safe delivery. But there were things in the service that would never please:

"O Lord, save this woman thy servant: who putteth her trust in Thee." But could you call the Lady of the Manor Woman? You could not, said the horrified Parish Clerk, who offered his own emendation:

"O Lord, save this lady thy servant: who putteth her ladyship's trust in Thee."

When you come to think of it, the most solemn moments of our lives are remarkably lacking in respect, and miss many opportunities of *Putting It Better.* For instance, those words about being "met to join together this man and this woman in Holy Matrimony" – can such indecently blunt words as "man" and "woman" be uttered over the heads of members of the very best families?

When a Woman becomes a Lady is ill-defined, though all Ladies seem able to recognise the distinction. I call to mind a humble but necessary establishment in a town in Kent: nowadays I think it would be a "*Powder-room*" or a "*Comfort station*" but in my youth it was known, inaccurately, as a "Convenience". It had, I remember, a door made of ground glass; and worked into the glass was the simple

Anglo-Saxon word "Women". But the chivalrous City Fathers, one supposed, had given orders that this should be amended; and when I was last there a paper sticker had replaced the offending word with "Ladies". There were no women in the chivalrous town – all were ladies. Indeed, *Putting It Better* is so ingrained a habit of speech that in some circles one can gain a reputation for being foul-mouthed if one does not *Put It Better:* for example, our beautiful and aristocratic golden retriever bitch Jill has had to bear being referred to by well-meaning persons as a *Lady Dog*.

Desire to impress, desire to avoid what is thought to be coarse, desire to appear to be in the right social group – all these drive us on to *Put It Better*. And we cannot escape; even calling things by their right names may become a kind of affectation. Nevertheless, let us away with our *Actuating Apparatuses*, our *Residences* and our *Ladies;* to speak of Works, Houses – or Flats – and Women is, after all, neater and less fussy.

MARY VISICK.

Elixir regrets that owing to action by the Police our Music critic was debarred from the recent Inter-Hong Bagpipe Contest. Our Music critic will not be available for any concerts for some considerable time.

Quemoy Shelled

Taipei, June 13.

The Nationalist-hell offshore island of Quemoy was to-day the target of 40 shells fired by the Chinese Reds, the Defence Ministry here reported.—Associated Press.

—The devil it was!

CONTRIBUTIONS TO THE MEDICAL SOCIETY SCHOLARSHIP FUND

Since our last issue went to press we have received the following donations to our Scholarship Fund:—

Mrs. B. M. Church	$1,000.00
Dr. Esther Anderton	3.00
Dr. Chan Shung San	10.00
Dr. Chu Kwok King	50.00
Prof. Daphne Chun	100.00
Mrs. D. A. Collins	18.00
Dr. Fok Wing Kan	50.00
Mr. N. J. Gillanders	13.00
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These gifts are most gratefully acknowledged. The Fund's total to date is $8,447.80.

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8th November, 1957.

The Editor
ELIXIR

Sir: Not completely abashed by the last well-deserved verbal thrashing your readers gave me (in the time of your esteemed predecessor the P.E.E.) I would like to ask another question. What about inter-hall inter-faculty debates? These produce gifted speakers, and much wit and wisdom edify the hearers: but, Sir, must the motion *always* deal with some such topic as "Do women make good mothers?" Let's agree that women *are* funny; and that their place is, or is not, in the home, on a pedestal, in the doghouse. . . Many other fields of human speculation there must be, but we leave them untilled.

A reason is often given: we must avoid debating any subject which might lead to political controversy. If we cannot discuss a controversial subject without losing our tempers then clearly we are right to refrain. But is not a university precisely the place where we (I say "we" advisedly) ought to be discussing "hot" subjects coolly? But, we say, we aren't interested in politics. How can any thinking adult say that? He, or she, must have some ideal pattern of life in his mind and that pattern, unless he is a hermit, or a moron, must include his relations to other people outside the family, to the community, to the state: any picture of the community and the state as they are or as they might be is a political picture. If we cannot discuss these pictures freely and publicly, and in discussing learn each to modify his own picture or to strengthen it against valid criticism – then, though we have enough Ph.Ds to fill the Loke Yew Hall and enough honours graduates to fill Tai Lam Chung Reservoir, we are not doing one of the chief jobs of a university. We are not enjoying the use of our minds, neither are we growing intellectually towards the citizenship of a free society. "Discussing politics" does not mean slanging-matches between the Buffs and the Blues, with or without recourse to fisticuffs; neither do I suggest that we would necessarily benefit by heated discussion of the rival claims of Taipei and Peking, or of Peking and Washington. I am thinking rather of such motions as these:

So that the tender susceptibilities of our *lady* readers (God bless 'em) may not be too vigorously assaulted, or the delicate feelings of our *female* medical students shattered, we have taken the liberty to delete two letters from the ninth last word in the above letter, and have substituted a dash in their place.
Most Medical *gentlemen* will realize what the original word was; but we feel sure they would agree that members of the *Weaker Sex* (God bless 'em) should be sheltered from strong language of this sort. Amen.

EDITOR.

that nationalism is an enemy of world peace;
that a salaried medical service is contrary to the interests of doctors and patients;
that liberty and equality are incompatible;
that "property is theft";
that capital punishment is a necessary safeguard;
that in the Age of Sputnik a Faculty of Arts is redundant;
that in no circumstances can censorship of books be justified;
that dictatorship is no necessarily evil.

Your readers will soon think of better suggestions; but I suggest humbly that any one of these would be more in keeping with a university occasion than the usual topic. Or is it that we pack our brains away at five and look forward to a nice, brainless evening full of d — n silly yacketting about women? I don't believe it.

Yours,

MARY VISICK.

Elixir regrets that there will be no review of the amateur pile - driving marathon at present in progress in the Colony. After an unfortunate accident our Industrial Critic had to be collected in a bucket and is now being re-constituted at the Queen Mary Hospital.

NOTES AND NEWS

Elixir congratulates Professor F. E. Stock on his appointment to the Deanship of the Medical Faculty in place of Professor L. G. Kilborn, who resigned in November, 1957.

* * *

Congratulations to:

Dr. Chow Wei on passing the M.R.C.O.G. examinations. Dr. Hu Shih Chang on admission to Membership of the Royal College of Physicians, Edinburgh. Also to Chan Hong Man, Chan King Ching, Chan Tit To, Cheng Shiu Kai, Chong Foon Wah, Choy Ching Chung, Hira Keswani, Ganesh Krishnan, Ng Wing Hong, David Blaise Wai Pau, Poon Kwok Chung, Edward Pui Wai Yee, Yeow Meng Tin, on obtaining the degrees of Bachelor of Medicine and Bachelor of Surgery.

* * *

Welcome to:

Dr. P. H. Teng, Dr. G. C. Turner, Dr. Carl Gruhzit, Dr. T. T. Young, and Dr. James Chisholm . . . on joining the Staff of the Medical Faculty.

* * *

MEDICAL PUBLICATIONS

The *Gazette* lists the following publications produced by members of the Medical Faculty which may be of interest to our readers: —

H. C. Kwaan and A. J. S. McFadzean (with J. Cook): "On Plasma Fibrinolytic Activity in Cryptogenetic Splenomegaly", *Scot. Med. J.* (2:137, 1957).

H. C. Kwaan, R. Lo, and A. J. S. McFadzean: " On the Production of Plasma Fibrinolytic Activity within Veins ", *Clin. Sci.* (16:241, 1957).

H. C. Kwaan, R. Lo, and A. J. S. McFadzean: "The Production of Plasma Fibrinolytic in Vivo by Serotonin (5-Hydroxytryptamine) Creatinine Sulphate", *Clin. Sci.* (16:255, 1957).

P. S. Kan and N. J. Eastman: "Coiling of the Umbilical Cord around the Foetal Neck", *The Journal of Obstetrics and Gynaecology of the British Empire* Vol. 64, No. 2 (1957).

D. Chun and P. C. Hou: "Spontaneous Regression of Pulmonary Metastases in A Case of Chorionepithelioma", *The Journal of Obstetrics and Gynaecology of the British Empire* Vol. 64, No. 2 (1957).

C. C. Liang: "The Formation of Complexes Between Haemoglobins and Plasma Proteins in a Variety of Animals", *Biochemical Journal* (1957, 66, 552-558).

Doris E. Gray and Shiu-May Loh: "Metabolic Effects of Alpha Tocopheryl Acetate on Some Plasma Lipids in Human Subjects", *International Symposium on Enzyme Chemistry* (1957, Paper 420, 1-5).

A. C. L. Hsieh (with L. D. Carson): "Role of Adrenaline and Noradrenaline in Chemical Regulation of Heat Production", *American Journal of Physiology* (1957, 190, 243-246).

A. C. L. Hsieh (with L. D. Carson and G. Gray): " Role of the Sympathetic Nervous System in the Control of Chemical Regulation of Heat Production", *American Journal of Physiology* (1957, 190, 247-251).

J. H. Y. Fung: "Peutz Syndrome", *British Journal of Surgery* (1957, 45, 48).

* * *

Dr. Doris E. Gray read a paper entitled *Influence of alpha tocopheryl acetate on some plasma lipids in human subjects,* at the Symposium on Enzyme Chemistry in Japan in October 1957.

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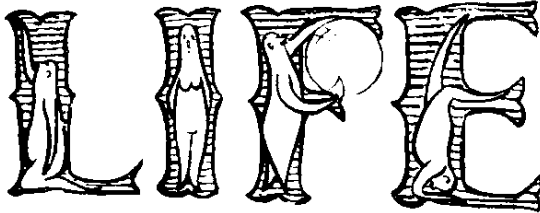
3rd year:	Robin Yip.
4th year:	Hong Sek Pui.
5th year:	Mak Woon Kwong.
6th year:	not elected.

A MENTAL

by Dr. W. B. Terhune, M.D., Associate Clinical Professor of Psychiatry, Yale School of Medicine.



I will adapt to life immediately, completely and gracefully.

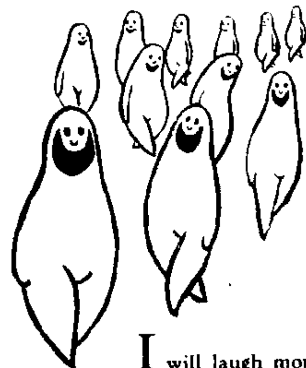
I do not expect to get precisely what I want in this world. I will not kick against the pricks of life. I expect trouble and have accepted inevitable difficulty, that I may be free to accept opportunity unhandicapped by a sense of difficulties.

I know that fear, anxiety and worry cannot hurt me. They threaten to destroy, but they possess no weapons other than the ones I give them. Even though afraid, anxious and worried, I shall continue with my usual activities, knowing that fear is the normal stimulus to courage.

I CHOOSE to see the good aspects and meanings of life. I do not deny that ugliness and evil exist; I do not overlook them, but having seen them I CHOOSE TO LOOK FOR THE GOOD.

I will know myself, accept my liabilities, and cultivate my assets.

I will avoid undue fatigue.



I will laugh more every day

I will work, rest, exercise, play—every day

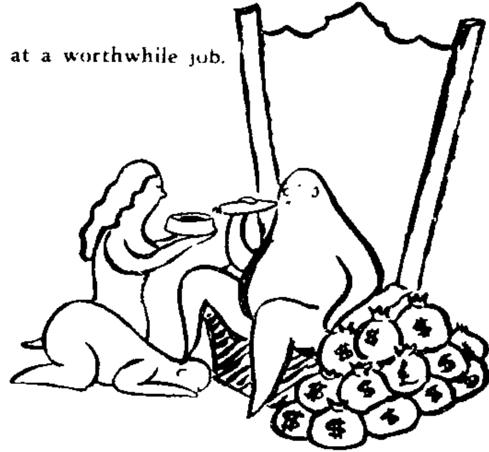
I will form good habits of living, thinking, acting, speaking and feeling

Considerable interest was aroused by Professor Terhune's lecture in the Chemistry Building on March 28th, 1957. We reprint above the sixteen items of Dr. Terhune's creed for the general edification of our readers.

HYGIENE CREED

From: " Emotional Problems and what you can do about them," William Morrow and Company, Inc., Newyork, 1955.

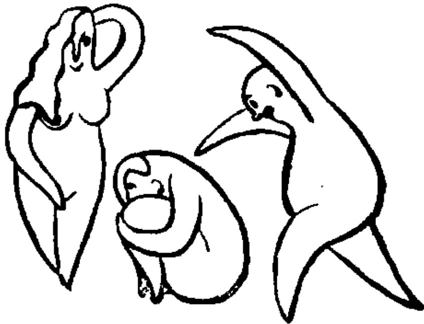
I will work at a worthwhile job.



I believe: that self-pity, suspicion, envy, jealousy and revenge, are useless sentiments. That loyalty, courage and kindness are dependable sentiments; in them I will put my trust.

I will face facts, discount my likes and dislikes, and cultivate an objective point of view.

I know and will help others to remember that humanity is a vast reservoir of love, courage, helpfulness, strength and ability. I shall draw on it without limit to help others and myself.



I believe in God, and with His help I will make my life significant.

I will make clear-cut decisions and abide by them. I will ask for counsel, and consider it without argument, but let NO ONE make up my mind for me.

I will discount harmful emotional urges, avoid emotional orgies, and keep away from emotionally undisciplined people.

We do not feel personally to be made of such stern stuff, and therefore take no responsibility for our naughty artist's naughty comments. We feel, however, that Dr. T., will take it in the friendly spirit in which it is meant. May it make his (and others') daily dose of laughing a bit more palatable.

HELP

THE

Scholarship Fund

To date $8,447.80 have been set aside for the Hong Kong University Medical Society Scholarship Fund. Please become a subscriber to ELIXIR NOW

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Report on WHO Study Group on Social and Preventive Medicine

Manila, October 16 - 29, 1957

by

Professor Leslie G. Kilborn *

1. Introduction

The Study Group was organized by the WHO Regional Office for the Western Pacific, and was attended by representatives from New Zealand, Australia, Fiji, Singapore, Cambodia, S. Vietnam, Hong Kong, Philippines, Taiwan, S. Korea and Japan. Each region was invited to send at least two persons, preferably a professor of social medicine and the dean of a medical school. An area having more than one medical college was limited to four representatives. WHO itself was represented by a secretariat of four persons, – Dr. Edward Grzegorzewski, Director of the Division of Education in Geneva, Dr. Thomas Chia-chi Ma from Taiwan, Dr. Hidetoshi Shiga of the Regional Office in Manila and Dr. Alwyn Smith, WHO Lecturer in Public Health, University of Malaya. In addition, a number of "observers" were present, most of whom made significant contributions to the study group.

The meetings were held in the Institute of Hygiene of the University of the Philippines, whose staff did everything possible to be of help to the Study Group, including the organization of mid-morning and afternoon coffee breaks.

Because of bad weather a number of the participants, including your representative, did not reach Manila in time for the opening session, which was largely given over to addresses of welcome. But practically all members of the Study Group had arrived by beginning of the afternoon session on October 16th. The secretariat had prepared an excellent agenda, which was followed fairly closely. For the majority of sessions the nearly forty participants were divided into two sub-groups which discussed the various agenda items, while a recorder made a record of each group's deliberations. Following sub-group consideration of each major division of the agenda, the findings of each group were presented, both verbally and in mimeographed form, to a plenary session and discussed by the entire Study Group. The organization was excellent, and the members of the secretariat were kept busy in preparing minutes, completed questionnaires and other documents for distribution to the participants. An extremely efficient interpreter provided the French speaking members with simultaneous translation through ear-phones of all deliberations in English, and subsequent translation into English of all remarks made in French.

2. Definitions

At first there was some uncertainty over the definition of Social Medicine, as distinct from Public Health, Preventive Medicine, Hygiene, etc. However, Sir Charles Hercus, of New Zealand, cleared the atmosphere by stating that he understood medicine as "great medicine – social, promotive, preventive, curative and rehabilitative," and that it was not necessary to dissect it; "medicine could not be anything else but social. The job of doctors, in view of the excellent development of para-medical disciplines, was to use these adequately." He felt that no doctor had completed his task until individuals were enjoying the best possible state of health, and socially they were performing what was to them satisfying work. If a doctor stopped short of this he was not practising *great medicine*.

Thus, early in the seminar the group was saved from becoming entangled in a wordy maze of quibbles over definitions, and this in spite of the fact that the majority were dependent upon foreign languages, and in the case of English upon two strains of that language which often use the same words with different meanings.

3. Objectives of Social Medicine

The first session was devoted to a discussion of the objectives of undergraduate medical education in general and of the more specific objectives of the teaching of social and preventive medicine. The majority were willing to accept, with only slight modifications, the objectives of undergraduate medical education formulated by the Association of American Medical Colleges in 1953 (see J. Med. Educ., *28*, 57-59). In regard to the teaching of social and preventive medicine discussion revealed that a change of emphasis in the medical curriculum, or in teaching methods, was necessary in most medical schools in order to convince the student of the importance of social factors in the aetiology, course, treatment and prevention of disease. It was felt that the student should be made to feel that the role of the doctor involved responsibility for the maintenance of optimal health in his community. He should be so trained that as a doctor he would be actively concerned with the promotion, preservation and restoration of health, and never forget that he is a citizen with civic duties which are proportionally great because of his specialized knowledge.

4. Curriculum

Considerable time was given to consideration of the content of the curriculum and the best methods of teaching Social and Preventive Medicine. It was generally felt that a beginning should be made during the premedical education of the future medical student by including the elements of social science, psychology and mathematical training which would help him later to cope with medical statistics. The teaching of biology, normally done at this stage, should be orientated towards human biology and include some notions of social biology.

There was general agreement that the preclinical courses of anatomy, biochemistry, physiology, etc. should include work in human genetics, growth, nutrition and biostatistics, so that the students' familiarity with these disciplines might be assumed by the teachers in social medicine. Similarly, other subjects often included in the course in social medicine might be dealt with by other departments, such as mental health and environmental hygiene particularly as related to microbiology.

In the clinical years especially, very close coordination between the Department of Social Medicine and all the clinical departments was considered essential. In the discussion of curriculum content it was pointed out that the Department of Social and Preventive Medicine is not necessarily directly responsible for actual tuition in all aspects of the subject matter, since the clinical departments can take part in stressing the prevention and social aspects of disease. But it should be the responsibility of the head of the department to see that students are exposed to the entire field of study, if not in the clinical departments then in separate courses arranged by the Department of Social Medicine. The desirability of having on the staff clinicians conscious of the social and preventive aspects of medicine and public health specialists possessing clinical skills was emphasized. Some of the requisite attitudes might be developed by holding regular clinical social pathological conferences, in which both clinicians and members of the Department of Social Medicine participated.

Some of the more important problems which it was felt should be included in the curriculum were: the health resources of the community, including both medical and social agencies, together with information regarding their availability in the light of economic and other practical considerations; epidemiology, in its modern sense of the study of the behaviour of diseases in human populations, and not restricted to a consideration of the spread and control of communicable disease; a limited amount of student participation in local health and medical care programmes; medical ethics and law; the techniques of disease prevention and information on local procedures for putting these into effect; and a certain amount of "traditional" public health teaching, since its problems were not only among those met daily by the doctor in many parts of the Western Pacific Region but were also important in imparting a sense of history in regard to the achievements of preventive medicine. The value of field surveys carried out during vacations, particularly by senior medical students, was endorsed. This type of work has been very well developed in

both the University of Malaya and the University of the Philippines, and exhibits of reports made by the students of these two universities received favourable comment.

The importance of teaching through clinical media was apparent in all discussions, and there was considerable emphasis upon the use of the clinical-social medical conference, and ward rounds conducted jointly by representatives of clinical departments and the Department of Social Medicine. Many of the participants stressed the function of the dean in bringing about coordinated programmes of teaching. The Study Group, although conscious that it had "little influence in the matter of selection of deans of medical schools", felt that "it would generally be in the interests of integrated teaching if choice of deans were made from men with the widest possible approach and background. This would gradually ensure the acceptance of the social approach to medicine within the clinical courses."

Sir Charles Hercus emphasized the need for frequent curriculum revision, and outlined the means for achieving this in New Zealand where a standing committee on curriculum constantly reviews the situation. However, he also pointed out that the curriculum is only "a matrix on which the spirit is hung," and that "facts can result in anaesthesia of the brain for medical students." The medical student must become "an educated person" before he is able to practise "great medicine."

5. Organization of the Department of Social Medicine

It was agreed that the functions of any university department included three phases: teaching, research and community service. A Department of Social and Preventive Medicine differed in no way from any other department in this respect. The achievement of a proper balance among these three functions could not be determined by general rules, but would depend upon the situation prevailing in each area. For example, the amount and type of community service which a department should render would depend upon the extent to which modern knowledge was being implemented by other agencies. In some areas a Department of Social and Preventive Medicine should, perhaps, give a lead by providing an example of the kind of health care which could be provided. But the majority of participants felt that while the actual provision of health services was outside the scope of a university department such a department usually has a definite role to play, either by acting in an advisory capacity or by actual representation on administrative and policy making bodies. There was general agreement that a close relationship should exist between the university department and community health services, either by joint appointments to part time work in each or at least by consultative service between the two.

All participants agreed that a separate and independent Department of Social and Preventive Medicine is necesssary within a medical school, if these functions are to be carried out. Even though the teaching of some subjects normally included in the curriculum of social and preventive medicine might be assigned to other departments, nevertheless it is essential that there be some department responsible for such teaching and for coordinating efforts throughout the medical school. In addition, the development of research in social and preventive medicine requires a specially trained staff.

Although the size of the staff of a Department of Social and Preventive Medicine would depend upon the number of medical students, whether or not post-graduate teaching were being carried on and the extent to which community service formed a part of the department's normal work, it was recognized that a minimum academic staff should consist of a full-time professor and at least one other full-time medically qualified person. The main requirement is quality, and this is particularly important in the case of the head of the department. He should be able to command the respect of his colleagues, the students and the community leaders in the health services. Without a full-time professor the department cannot be said to exist as an independent department. In addition to the full-time staff, part-time lecturers are usually required to cover the various forms of specialized instruction needed. (I was embarrassed to have to report that the University of Hong Kong has no full-time staff in social medicine, the only medical school which has been

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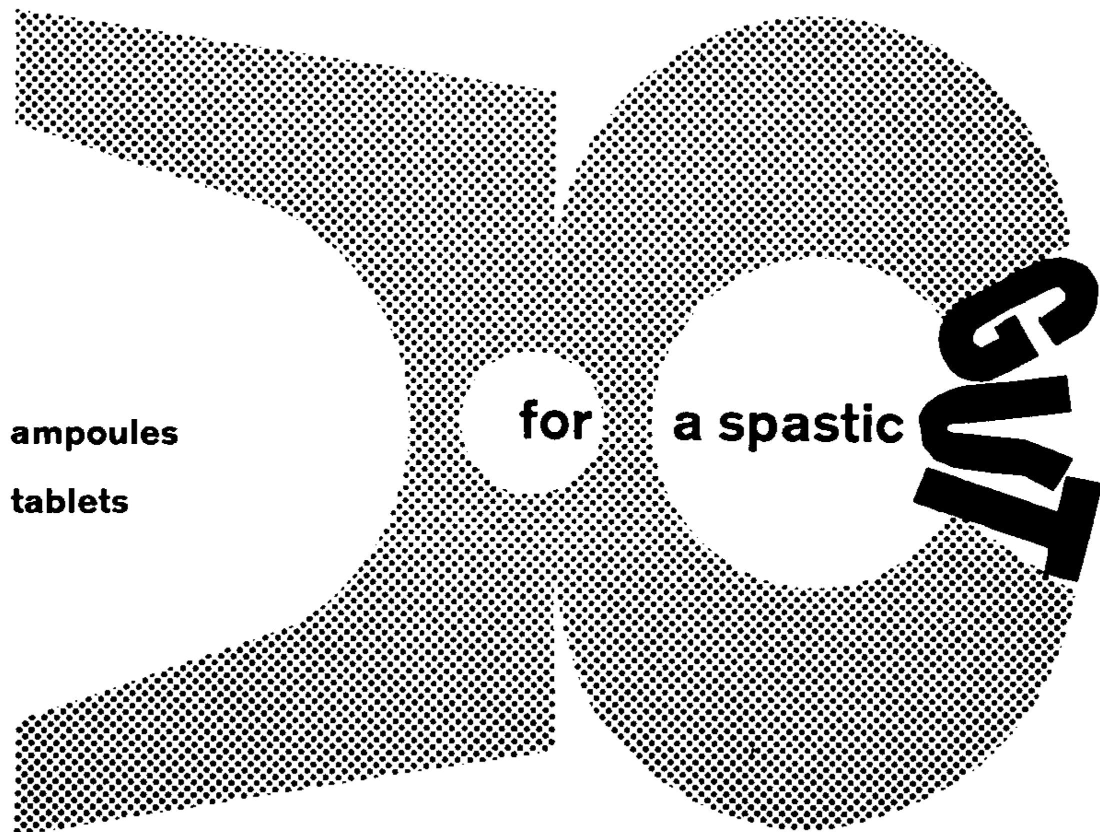

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in operation for any length of time in the Western Pacific Region without at least one full-time professor in this department. Each of the 46 Japanese medical schools has two professors, one of public health or hygiene and the other of social or preventive medicine.)

Although problems regarding the qualifications and experience considered desirable for staff members and difficulties in the recruitment of suitable persons were discussed at some length, these are not particularly relevant to the situation in Hong Kong.

6. **Relationship with Other Departments**

This formed the next item on the agenda, and it was discovered that the existing situation in the universities represented varied from cordial cooperation on the one hand to extreme autonomy and isolationism on the other. However, most believed that the degree of cooperation possible is more dependent upon personality factors than upon any attempt to adopt and enforce general principles. The major causes of non-cooperation were felt to be psychological and personal. Ideally a common spirit of approach to all problems in the medical school is desirable, and some believed that this is more readily attainable when there has been a common training experience in the past. In addition, the role of the dean was considered to be important in securing cooperation, but the group expressed the opinion that "all deans do not have adequate authority either by virtue of personal characteristics or by virtue of administrative structure."

It was generally agreed that formal integration cannot solve all the problems connected with coordination. At certain points of the curriculum integration can be advantageous but many subjects do not fit into an integrated teaching programme, – especially the type of integration now being tried out at Western Reserve University. Three serious disadvantages may result from too complete an integration: (1) the value of carefully spaced repetition is lost when all repetition is closely related in time; (2) integration of the curriculum discourages the student from making his personal integration of the different aspects of medicine; (3) integration of courses may involve the disintegration of the individual course and prevent a coherent development of subjects which require presentation in an orderly form. Rejection of schemes for formal integration, however, does not imply that coordination in some aspects is not desirable. For example, joint seminars, ward rounds and clinico-socio-pathological conferences involving several approaches to a similar problem may be of considerable value.

Stress was placed on the need for facilities for social intercourse among the members of various departments. Some participants were convinced that most difficulties spring from a lack of sufficient opportunity to develop friendly personal relations, both among members of different departments and also among those of different seniority within the same department.

7. **Comprehensive Health Care**

This topic was discussed in plenary session only, after Dr. Grzegorzewski had spoken of the meaning of comprehensive health care and the responsibility of the medical school for teaching comprehensive medicine. He stated that no formal definition of the term was possible since it has various meanings in different areas. For example, he contrasted "the clearly defined but relatively limited types of comprehensive care services provided by such social organizations as the armed forces" with "the widespread and more diffuse services organized on a country-wide basis, as for example in Great Britain or the U.S.S.R."

He also pointed out that "medicine had advanced from the point where the general practitioners could meet all the recognized needs for health care, to the point where the allied and specialist services had grown into a large and complex system." We cannot expect the patient to be aware of all these para-medical services, and it becomes "the duty of the general practitioner to marshal all the resources available for the service of his patients." An investigation at one well-known medical school had revealed widespread student ignorance as to the extent of available health care. Medical schools must ensure that the students trained in them are informed of the various health care services and of the methods of invoking their aid in the total treatment of the

patient. It is probably necessary, he claimed, "to acquaint the student with the scope of existing health services before he entered his clinical years so that he would begin clinical studies with a grasp of the total services available".

An interesting experiment in the teaching of comprehensive health care in the medical school of the University of Tokyo was described. This was based on a small 200-bed hospital serving a population of about 150,000. Attached to the hospital were several special guidance units, including a geriatric unit, a well-baby clinic, a mental health clinic, a social service unit, a unit for eugenic counselling, and an industrial health unit. The students were brought into close contact with the work of each of these units.

The group was reminded that the acceptance of a comprehensive health service would not reduce the work of the medical profession but would probably result in an increase in the amount of declared sickness wherever a national health service like that of Great Britain was introduced. However true this might be, the function of the university department of social and preventive medicine was to teach the importance of maintaining the total health of the whole community, and students should be presented with principles to guide them in their thinking about the role of medicine in community service. Developments would be best achieved if the medical profession was properly orientated in its thinking. Although much can be said for the creation by universities of comprehensive health clinics for student training, other agencies must not thereby feel themselves absolved from the need to make provision for the whole community.

8. Practice Facilities

There was complete agreement that all community facilities related to health should be used in medical teaching. These might include rural and urban health centres, student health centres, chronic disease treatment centres, mental health clinics and hospitals. Use should be made, wherever possible, of the statistical, evaluative and planning services of governments. Governmental and other health agencies usually benefit by contact with a university as the latter provides a healthy source of constructive criticism which often results in an elevation of standards.

It was felt that in the use of health centres for educational purposes a proper balance must be maintained between teaching and service. Experience at such centres can involve both observation and participation by the student, but of the two actual participation was believed to be the better means of learning.

The group felt that "public-health sightseeing" is desirable for medical students when properly organized. Visits should be made to water and sewage undertakings, even though a detailed knowledge of the working of such plants is not required of the undergraduate.

The teaching hospital itself is a valuable community service freely available for teaching. Clerkships in the various fields of health work are excellent methods for securing a knowledge of their functions. The group also discussed experiments proceeding in some countries which afford students an opportunity of working with selected general practitioners. An alternative method is that of creating general practice units within the teaching hospital and assigning students to periods of work within such units.

9. Special Interest Groups

These occupied the attention of the participants for the final day and a half of the conference. There were about six such groups, and I was asked to be chairman of the one on "Cultural Studies". Its findings are difficult to summarize, but the group considered culture in relation to the understanding of students, patients and communities. Culture was defined as "interpersonally transmitted ways of living in respect to habits, behaviour, customs, traditions, law, religion, and systems of education." It was apparent that conflict between the ideas of scientific medicine and the cultural environment surrounding most of the students and patients was inevitable in the greater part of the area represented at the conference. Some felt that it would be wise to require medical (or premedical) students to study the cultural patterns existing in their regions, since some are so completely isolated during their school days that they no longer understand, or are completely

unaware of, the cultural factors which often determine the behaviour of patients in hospital and clinic or in the home.

Other cultural factors which operate in this region are: the necessity for the majority of students to study in a foreign language or to use foreign language textbooks; authoritarianism in home and school life resulting in the unthinking acceptance of whatever the teacher says, and consequent inability to think for themselves; the use in textbooks of illustrations drawn from a background of foreign history and culture and therefore meaningless or misunderstood by the student; the strong influence of speculative philosophy in some oriental cultures, which leave no place for experimental work.

One result of the discussions in this group was to show the serious handicap under which many of the medical students in this area have to work. The students of Australia and New Zealand, for the most part, are not faced with these difficulties.

10. **Visits to Places of Interest** were arranged, and those attending the study group very much enjoyed most of these. Some of the health work in the Philippines is most impressive. The Institute of Hygiene of the University of the Philippines, under the direction of Dean H. Lara seems to be doing a first-rate job. Among the other places visited that appear to be doing good work were both rural and urban health demonstration and training centres and the Manila City Health Department.

Participants were invited to a number of social affairs in the homes of the W.H.O. Regional Office officials, and one very pleasant evening was spent watching Philippine dancing on the roof of the Malaria Institute of the Manila Department of Health. However, as is usually the case, the most valuable part of the conference was the opportunity to meet some of the leading men in the fields represented in the conference. Sir Charles Hercus of New Zealand, Dr. Edward Grzegorzewski of Geneva, Dr. Thomas Chia-chi Ma of Taiwan, Professor T. A. Lloyd Davies of Singapore and Dean Hilario Lara of Manila were all outstanding in the contributions that they made, although it is probably not fair to single them out from the large number of those who made valuable contributions.

* The WHO study group was attended by Professor Kilborn in his then capacity of Dean of the Medical Faculty.

THE END

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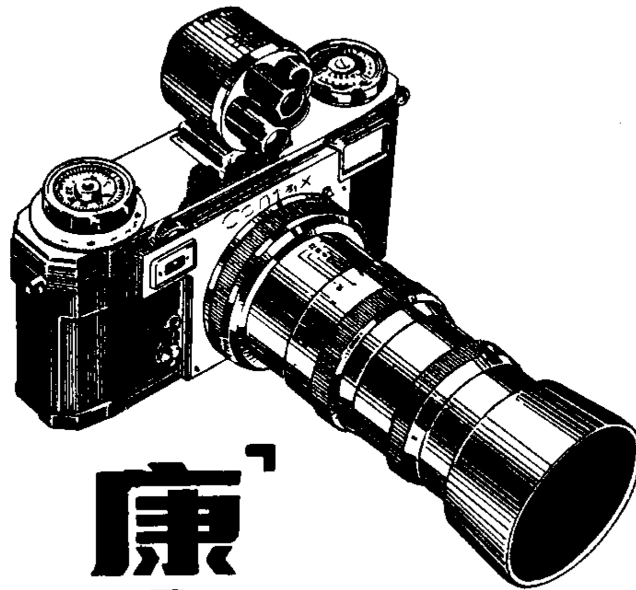

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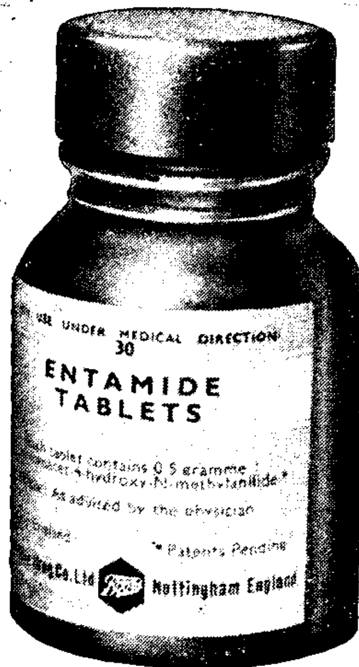

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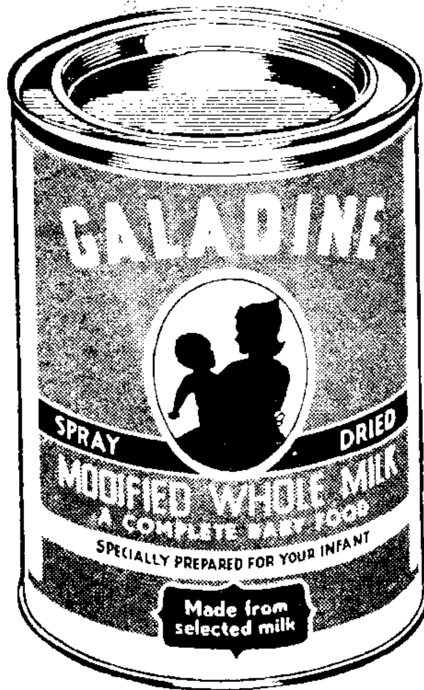

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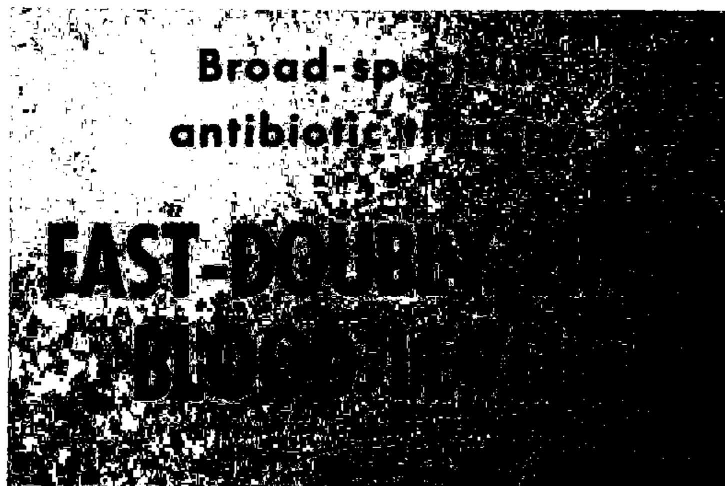

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