WHO NEWS RELEASE

Human Sexuality: a Neglected Subject in Medical and Nursing Schools

(The following was issued simultaneously by WHO in Geneva and New York on 7 January).

Human sexuality is inadequately taught in the majority of the world's medical and nursing schools. This is the conclusion reached by experts from nine countries at an international meeting in Geneva, convened by the World Health Organization.

While sexual attitudes and behaviour vary, sexuality is nonetheless part and parcel of all societies the world over. There is, however, only a "grudging recognition of its importance in medical and nursing education".

"Students in many parts of the world grow up in cultures that evade direct confrontation with sexuality: sex acts are private and secret, and are only referred to by indirect suggestion, or by joking .....", the experts' report says. "This may lead the health practitioner into defensive attitudes, blaming the patient for inadequacies or over emphasizing organ dysfunction and avoiding any reference to feeling."

The report, entitled "The Teaching of Human Sexuality in Schools for Health Professionals" says: ".... it must be stated very emphatically that a knowledge of reproduction and contraception does not of itself provide the training needed to deal with sexual problems." Thus while there is routine concentration on those subjects, a subject so central to human health as sexuality is passed off with "more than ordinary neglect".

Handicapped by a lack of formal training, the physician and the nurse often find themselves "personally embarrassed and professionally incompetent" when faced with a patient's sexual problems. More often than not, the patient is turned away with nothing but a superficial reply.

And even worse, the experts find that frequently "physicians are themselves referring patients with sexual problems to non-medical counsellors". Such a trend, the experts decry as "unfortunate".

Working with information available, which the report acknowledges as only "fragmentary", the experts were able only to record the following:

— In **Colombia,** the study of human sexuality was introduced into a number of universities by ways of seminars, in the face of opposition to the revision of medical curricula. Some teachers then incorporated material on human sexuality in their regular courses, an initiative that students welcomed. But the results suggested that the medical student "is simply a late adolescent who has assimilated the attitudes and inhibitions common to his culture, and that without special training he is poorly equipped to deal with the sexual difficulties of patients."

— In **Czechoslovakia,** a one-semester elective course in medical sexology is available to senior students at the Charles University, Prague.

— In the **Philippines,** a unit teaching human sexuality, as part of a course on family planning and related health care, is offered by the Medical School of the University of the Philippines, and a course "exclusively on human sexuality" to nursing students by the Philippine Women's University.

— In **Switzerland,** from 20 to 25 hours' teaching on normal sexuality and sexual pathology is available at the Medical School of the University of Geneva.

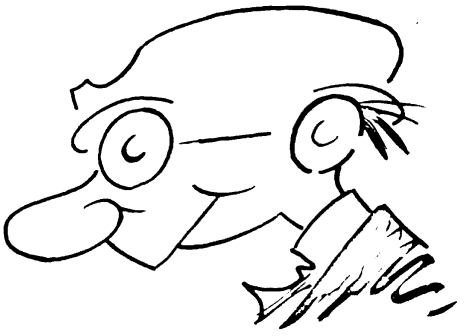
— In the **United Kingdom,** a questionnaire sent to 1968 graduates of a number of medical schools showed that only 57 per cent of those replying had received any teaching in "normal psychosexual development".

— In the **United States,** programmes in human sexuality are offered by 94 out of 110 medical schools. Although nursing schools do offer "some formal study" in human sexuality, they are still "far behind medical schools".

To help acquire "non-judgmental" attitudes, many students may need help in coming to terms with their own sexuality, and much expehimentation has been carried out to discover how this can best be done. A student's own sex history may be discussed in private interviews, or he may participate in group discussions of case histories, the report says.

"A third method, now under trial in the United States", the report notes, "involves the use of films portraying sexual behaviour with unusual candour". A group discussion follows, which usually shows "some degree of sexual arousal, shock and sometimes embarrassment, disgust, or hostility" on the part of students. But, "by talking over these reactions", the report says, "the group soon becomes relaxed and discovers that apprehension and discomfort have vanished".

Examinations in Kuala Lumpur



By Prof. Colbourne

It was a little surprising to find the University Campus guarded by sections of steel helmeted soldiery, not, I was told, to protect the examiners from the students but for other reasons. In fact the students treated the examiner politely and the soldiers were affable but the motor traffic in Malaysia had increased enormously and was terrifying; Petalang Jaya had become a motor jungle. Helmetless motor-cyclists drove with a nerve and abandon that made their Hong Kong counterparts seem like snails.

I was involved in the third examination or **Peperiksaan Ketiga.** Unilingualism has proceeded further this year and although I can, luckily, still distinguish **laki²** from **perempuan²*,** I found that making a claim for expenses in Bahasa Kebangsaan was something of a problem.

This examination is a combined effort in social and preventive medicine (not yet community), elementary medicine, surgery, paediatrics etc. Fail one, fail the lot. But a bad (but not too bad) result is one can be compensated for by brilliance elsewhere. Swings and roundabout I suppose.

I stayed in the house of a relative of one of the Hong Kong lecturers. Living there was a medical student; a tough young man who played scrum half for the Malaysian National Team. Luckily he passed the third examination last year and was preparing for his finals, which, once the third examination is passed, are a lesser hurdle than in Hong Kong. In spite of their imminence he was still involved in his dangerous pastimes — hockey if there was no rugby football. Do Hong Kong medical students devote themselves so violently to these rough games ?

After the examination the examiners had a splendid dinner in the Jaguar restaurant in Petaling Jaya. At the next table was a party of successful students. It is doubtful which party was more relieved and exhausted.

The next day, I set out for Penang and reached Singapore in error, but that is another story.

***Editor's Notes:**

laki² — laki laki = gentlemen in Malaysian.

perempuan² — perempuan perempuan = ladies.

The Editorial Board wishes to thank the G. P.s who are so co-operative in filling in and returning our questionaires. Their valuable suggestions will be of much help in improving our Caduceus.

The McFadzean Memorial Issue has been published. But owing to technical difficulties encountered in the delivery of the issue via the BMA, we wish to apologise to the GPs for the delay in sending them the issue.

（上接第二版）

思議了。

當天傍晚，Y君的電話來了，他彷彿說了許多話，但主要是說他如何遲才知道Department改變了主意，和他怎樣忙于耽在博物館裏。

第二天，我見到T的時候，他向我道歉昨夜的惡作劇，我大概已經原諒了他，因爲我又要忙於準備考實驗之故。

而C，則似乎許許久久沒會見他了。有一天，我們終于碰頭，我心平氣和的問他爲什麼那天不回電話給我，可是，平日貌似善良的他，却忽然顯得兇惡起來。

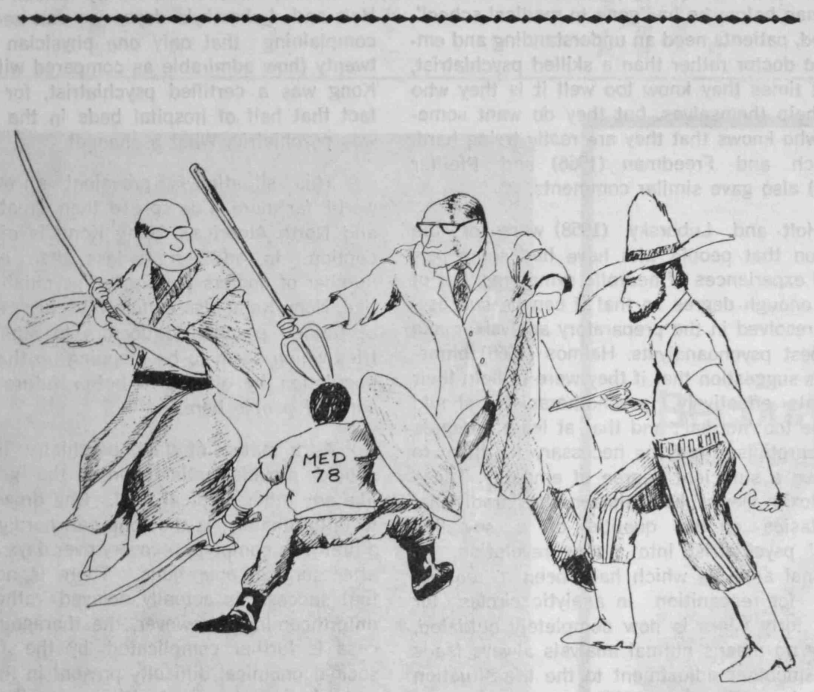
「那天並沒有出成績，我如何打電話給你，如果說要打，我豈不是要打一萬個電話！」他頗不平的駁。當然，這件事也是沒有結果的。

對於這連串微小而複雜的事，我無從解釋，更談不上用道德的眼光來弄清誰是誰非了。我倒想，怨和恨是不必的，因爲我不是也曾辜負朋友所託嗎？那我已很羞赧而無能追究別人了——只是爲什麼，我的朋友，你們各自有你們自己完美的辯護呢？爲什麼當事發時，大家雖都是在小難中，而人心，却已顯露如斯呢？爲什麼即使是同宿舍的同學，同房的同學，也要把「貼士」隱瞞；而即使在考試後，還對別人佯裝成事前什麼「貼士」也沒有呢？爲什麼人和人之間偏要充斥著自私自利的茅刺，來作爲日常生活的保護殼，而把自我匿藏在它之內，輾轉辛苦而生活呢？

我無從解釋。我只是嗅到一股腥風，由包圍着我們的廣漠吹進來，又從這裏吹出去。這股風，也把我從美麗幻想中吹醒，使我覺著四周的高牆與嚴峻，清冷與寒威，而進入了一個清醒的噩夢。

這個小小的微波，於顛沛造次之間，自不免只堪爲日記中一小段的墨浪吧。然而，這個墨浪和許許多多天前、許許多多天後的他個墨浪不是遙相呼應，合成一股洪濤，齧蝕著人的心嗎？

王爾德曾說：「從前不流淚的人現在流淚了。」我忽作奇想，在這個殖民小島上，日子愈倥傯，價值觀念愈混亂，多年之後，大概從前流淚的人也不什再會流淚了……



To Professor With Love

編者的話

春天，對醫學院的同學來說，是一個考試的季節：先是二年級的1 st M. B.，隨之而來的就是一年級之學期測驗及三年級之 2nd M.B.，最後就是五年級同學之畢業試。

提到考試，很容易便與學習課程，教授方法甚至整個醫學教育扯上關係來。

× × ×

其實，一、兩篇文章，只能代表着少數人的觀感，相信其他同學對醫學院內的考試制度及教學內容及方法等，亦有很多意見，我們極歡迎各位來稿，討論着這個多年來存在着的問題。

在排版方面，今期和從前畧有不同。我們嘗試用較多漫畫，顏色印刷，和用圖畫作底紙等。希望各同學能給予我們更多意見。

ELIXIR和啓思在不久的將來，會携手探討醫學教育的問題，希望各位同學能積極參與；側聞將有一位醫學教育專家來港，對現有之課程進行一個全面性的檢討，這是一個令人興奮的消息，希望經過這一串的探究及檢討工作，能給醫學院帶來嶄新的一面！

「觀塘社區健康發展計劃」研討會

有關觀塘社區健康發展計劃的性質、歷史、和計劃的內容等，啓思在二月份的英文版已作有詳細的報道，這裏不便再複述一遍。茲僅就啓思及健康委員會在三月初舉行的一個有關該計劃的研討會，擇錄如下。出席是會者包括該計劃的工作人員之一李棣旺先生，健康護理士馮女士、幾位外賓及十數名來自各班的同學。並由李先生發表演說，馮女士放映幻燈片等。

幾個政府機構

社區健康計劃是由幾個政府機構合辦的。例如民政署、房屋署、福利署、醫務署等都有協助推行該計劃。至於其間有沒有互相推卸責任的問題存在則很難說。例如反吸毒問題，各部門都十分賣力。但對另外一些問題，則可能大衆都不肯做。所以部門的合作與否要視乎問題的本質而定。

白皮書及健康計劃

白皮書似乎沒有提及和包連社區健康計劃在內。但另一方面，伊利沙伯醫院却經常遣送病人來基督教聯合醫院來作（After-care）。

醫務署態度不熱心

政府對社區健康計劃的推行，一直保持觀望態度。（如果計劃辦得出色，政府便可能援手。）而醫務署對於這計劃，也顯得不及民政署、福利署等熱心。原因可能是醫務署的觀念，側重于治療而不重于Community Appraach，才會出現這種現象。另一方面，市民也不易接受該計劃，大家都祇信賴受過專業訓練的醫生、技術人員等，無形中做成「專業壟斷」的局面。財政上的困難當然也是阻撓社區健康計劃廣泛推行原因之一。

困難重重

由於羣衆對健康計劃所傳播的知識往往發生曲解，從而杯弓蛇影，怕這怕那；什或亂置藥物，則後果更加不堪設想。所以，在推行健教之時，有關方面（指健康計劃的屬下機構）務必要審愼行事。而且能夠接受某種知識的年齡，也因人而異。譬如性教育，羣衆能接受的年齡的劃定，就已是件頭疼之事。至今，香港仍未有一個完妥的健康計劃（Health Psogramme）。

觀塘——社會的一環

由於經費問題，社區健康計劃至今仍局限於官塘，未發展到全港性。因此，我們承認這個計劃只限於這個社會的一環，効用是有限的。但我們深切希望其他社區能參加我們的行列，攪好這個計劃。

未來展望

希望能自給自足，由於物價上昇，診費也會由四元提昇到六元，這個上昇似乎很大，但我們給予病人四日藥，對於貧苦大衆，診費也會減少。如果因爲不加診費而引致這廉價而有意義的服務也失去，這不是更可惜嗎？

FACTS AND FEATURES IN PSYCHIATRY

By Dr. Bernard LAU Wai Kai

The prevalence of suicide among the doctors of medicine has long been recognised (Coleman and Broen, 1972; Blachly et al, 1963; Dublin and Spiegelman, 1947). Indeed suicide might be called a vocational hazard for the psychiatrists (Freeman, 1968; Wheelis, 1956; Registrar General's Decennial Supplement, 1954). Sim (1974) attempted to explain the outstanding high suicide rate among doctors by the following reasons: ease of access to drugs, skill in their use and knowledge of medicine, ability to assess prognosis of many physical conditions they may have, worst interpretation of any relatively harmless symptoms, and depressive element in hypochondrical delusions. On the other hand, the editorial in the British Medical Journal (1964) attributed the disproportionate numbers of suicide among psychiatrists to the factor that some who take up psychiatry probably do so for morbid reasons. However, Freeman in America (1968) contended that the intense emotional experience involved in completing their training has brought about crises that some of them were unable to endure. It is also my experience that from the encounter with the patients, various sources of conflicts might be aroused in the psychiatrist which would otherwise have been repressed for life and causing crises now and then for no apparent causes. In that sense, the psychiatrist can gain fruitful insight into himself. For some, it is sad to say, insight could be a horrible thing and is simply beyond tolerance, at times proved to be detrimental or disastrous to the psychiatrist himself. Surprisingly enough in Hong Kong, the suicidal incidence of psychiatric doctors is still around zero. This could be due to the relatively young generation of psychiatry, rapid turnover of psychiatric doctors and perhaps the comparatively wholesome personality pattern of psychiatrists in general. So, what is a wholesome personality of a psychiatrist?

The measure of a desired personality of a psychiatrist has for some time been the task of many chairmen or directors of selection boards and training programmes (Holt and Luborsky, 1958; Kreitman, 1962; Caine and Smail, 1969). Every single item of ideal has been included; among the more characteristic ones are 'emotionally stable, concientious, genuine, tough-minded, less neurotic' (Caine and Smial, 1969); 'mature, intelligent, competent, sensitive, warm, selfcontained, even-tempered, independent in thinking and judgement' (Freeman, 1968); good in acumen, curious but careful in search of cues and the what lot. In fine, one can say that what is said above can well be found in any advertisement of jobs in a newspaper or magazine. Nevertheless, Karl Menninger in his article "What are the goals of psychiatric education?" (1952) aptly summarized the situation into a few sentences. 'The psychiatrist as a person is more important than the psychiatrist as a technician or scientist. What he does has more effect upon his patients than anything he does. Because of the intimate relationship between patient and psychiatrist, the value system, standards, interests and ideals of the doctor becomes very important... These are for the most part characteristics of the man before he has gone to medical school'. Indeed, patients need an understanding and empathic doctor rather than a skilled psychiatrist, as at times they know too well it is they who can help themselves, but they do want someone who knows that they are really trying hard. Redlich and Freedman (1966) and Pfeiffer (1972) also gave similar comments.

Holt and Luborsky (1958) were of the opinion that people who have had some personal experiences of neurotic symptoms, but of mild enough degree so that it can be successfully resolved in the preparatory analysis, make the best psychoanalysts. Halmos (1965) phrased his suggestion that if they were to help their patients effectively, psychotherapists should not be too 'normal', and that at least a degree of 'neuroticism' may be necessary for them to achieve a sufficient degree of empathy. These paradoxic views have thrown the traditional phantasies on the qualities of a so-called 'good' psychiatrist into a new revolution. A personal analysis which has been a requirement for recognition in analytic circles for some forty years is now completely outdated, for by no means normal analysis always leads to a smoother adjustment to the life situation that arises (Freeman, 1968).

According to McLaughlin and Parkhouse (1972), decision to go in for psychiatry was taken in about one third of the cases as a medical student, in one third after qualifying, and in a further third only after a year's experience in the specialty. The reasons for making such a decision are usually either because psychiatry is an important and interesting branch of medicine or because they have curiosity and interest in people's emotions and actions. I can readily add a few more here as relevant in Hong Kong. Apart from the aforesaid 'noble' reasons, the availability of a training post and the adequacy of the training facilities are among the more attractive ones. The promising prospect of promotion in view of rapid expansion of mental health services and the less vigorous competition on entering into private psychiatric practice should not escape mentioning. In the eyes of those with foresight, the ease of application for psychiatric posts in hospitals abroad can be by itself a good enough reason. Do some doctors taken up psychiatry for want of an alternative?

Notwithstanding all this, recently, the difficulty of recruitment of doctors into psychiatric fields has come to be an undeniable fact. This subject has been brought up in various articles of late (Brook, 1972, 1974). In the Editorial of British Medical Journal two years ago (BMJ, 1973), it was admitted that psychiatry is less popular nowadays than decades ago when the wish to become a Freudian psychoanalyst some days was overwhelmingly occupying the mind of every medical graduate and student (Holt and Luborsky, 1958). In fact, as early as 1950's, it was noticed that despite strenuous efforts made in past years to encourage more young physicians to enter into psychiatric residencies, there had been no proportionate increase and, in fact, there had been some ground lost in the past few years (Albee and Dickey, 1957). The decline in attractiveness is obviously shown by the statistical result that only two out of one hundred and forty six medical graduates take up psychiatry as their career (McLaughlin and Parkhouse, 1972). When we try to look back on Holt and Luborsky's days, we can see them complaining that only one physician out of twenty (how admirable as compared with Hong Kong was a certified psychiatrist, for all the fact that half of hospital beds in the country was psychiatric. What a change!

This situation is prevalent all over the world, far more wide spread than Great Britain and North America. Hong Kong is of no exception. In addition to less than expected number of doctors joining the psychiatric practice, Hong Kong also suffers from her rapid loss of trained psychiatric doctors to other countries which seem to be mopping up the skilled population by offering a better future to all sorts of people here.

As a matter of fact, psychiatry in itself should provide satisfaction to the graduates like any other medical field. One drawback of it, unfortunately, is that one can hardly expect a dramatic complete recovery over days as seen after surgical operations. There is no doubt that success is actually delayed rather than unforthcoming. However, the therapeutic process is further complicated by the frequent socio-economical difficulty present in the background of most patients. We can easily remove what is sick and abnormal from the patient, yet we can hardly touch the very roots of the sickness. No wonder a number of psychiatrists pass a pessimistic look on the mental illness, and they advocate the import of curing the 'sick' society itself (Laing and Esterson, 1964; Szasz, 1962).

Yes, psychiatry can be a frustrating career, we have to admit, but we cannot equally deny that it is even more, if no less, challenging to every new medical graduate contemplating a career in the next few years to come. Should he wish to open his eyes wide to catch a few glimpses of the destiny of mankind and the injustice of society, psychiatry is a good choice. In fact, turning to the other side of the same coin, society needs him.

在小難中

有人說醫學是神聖的，而醫生之職，自然也是神聖不可侵犯的了。可是，朋友，你使管拿放大鏡、顯微鏡去看看醫生們的皮肉，天！你會驚訝他們的和平常人的竟是如此這般一樣。我在寫本文的時候，耳際只有「齊瓦哥醫生」中Komarovsky被推下樓梯時那句對白：

"We're made of the same kind of clay."……

× × ×

十一時多了，Y君的消息還是沒有。昨夜我不是曾千叮萬囑他今天代我查考試結果嗎？莫不是出了什麼意外？莫不是他忘了？不，他不會那樣不負責任吧？……我忽然想起寄宿中的C君，大概他可以幫我，於是便撥了個電話給他，託他關照，而C君也滿口承諾了。

接通了，聽電話的是飯堂的老板。

「對不起，麻煩你請二年級的同學電話……」

接者，老板喊了幾聲，有人拿起聽筒了。

「喂，是誰？」

「是我，××。你是T？怎樣，出了Result沒有？」我問。

「出了，四個『丁』，十二個Pull-up's。」

「我怎麼樣？」我問。T和我是同組的。

「不知道，你自己回來看看好了！」

這樣，電話便掛斷了。

我又急又恨又惱，好句「白頭如新」——七年中學，兩年大學的結交，到頭來不值一分鐘的援助……

終于還是由兄駛車送我回校。當我踏出車門，走近圖書館門口時，便見到T等站在那裏，見我落魄失魂的模樣，却毫不介意的加强了他們的笑面。他們一直都在笑。……

原來成績未出！Department在三時左右早已貼出通告，取消了翌日原訂的口試。老天！……這世界的人眞是太不可

（接第三版）

偶感隨筆

王

三月二日星期日下午，拿了一叠組織學的實驗指引，跑到公園去。雖然十八小時之理論試逾已答過了，但休息一天後，總也得收拾心情，準備應付那解剖科之實驗考試。

一踏入公園，就發覺東角的鐵絲網給剪下了，而在那邊的草地上，却放着一堆堆的沙石及數十包英泥，細看之下，才知原來是在鋪設一條石級，好讓那邊廛租屋的居民能更快的走上這個公園來。

工人大約有十多個，有男有女，多是年紀上了三十歲的，只有一個十來歲的青年。由於那邊山坡十分傾斜，不能使用「鷄公車」，故大部份之人力皆用於運輸方面；沙是用壓袋盛着，托在肩上，而用以砌梯級之石塊，則用鐵絲綑着，用竹槓挑下去，每人每次只能挑着兩塊行走（每塊大約有六塊磚頭那麼大）。這樣的運輸方法，自然進行得極緩慢。

坐了一段時間，發覺那堆石塊竟沒有多大變動；心裏想着：「眞沒用，其實每次可挑四塊或更多的石頭才對；爲什麼要用這種古老的方法，難道沒有更好的方法嗎？」其實，自己太「高估」別人了，若是換了自己，就是挑着兩塊磚，走不到數十步，定會覺得疲倦，更何況是在那六十多度的斜坡上，日繼日的每天行走超過八小時呢！相信自己工作不到幾小時，便會從那斜坡滾下去……雖有又從「學者」之眼光去看，想找出一些既簡單又快捷的方法，去「幫忙」他們。苦思良久，什麼槓桿原理，M.A.V.R.等，都在腦海中巡行一遍了，但却找不到什麼；唉，我中學時代的物理數學不知走到那裏去了。

負責運石的有三人，其中一個四十歲左右的，身材肥大，走在斜坡上的小徑時，手扶着鐵絲網，步伐緩慢，跟在他後面的那青年便說笑的催他快步；其實，他這般「穩扎穩打」，大概不單只珍惜自己的性命，同時更想着家中待哺的小孩。突然間，我想到他們的安全問題；背着那麼重的東西，走在那麼斜的山路上，而沒有任何扶持，萬一失足……我不敢想下去。我們這一羣從事醫療工作的人，往往只知等到事情發生後，才去作一些補救工作，而未能於事發前作一些預防的功夫。事實上，現代之醫務工作，不再單只是治療疾病與損傷，而且還包括了預防疾病與損傷及建立市民之健康等工作。可惜的是，到現時爲止，大部份從事醫療工作的人士，還是把全部時間放在病房或診所之治療工作上，而未有留意到導致疾病及損傷的眞正原因。

大約三時卅分左右，他們停下手，聚在一起，大概是休息的時候；衆人的眼光都集中在其中幾個人的手上，我亦好奇的行近看看是什麼會事。果然不出所料，他們其中四個在賭「十三張」，其他的就「各爲其主」的從旁授計；眼着我又走到茶亭後面，發覺那幾個女的也是圍在一起，玩着「十五胡」似的東西；眞令人嘔心唯一空閒的時間，却虛耗在這些費神又害五相感情的玩意上。其實他們只是可憐的，受着社會風氣的影響；看！受着「高等」教育的大學生，竟亦有願意以通宵麻將消遣其假期者；本港的高官大爵，身爲馬主及馬會會員者，亦大不乏人；再者，英皇御准的賽馬，也拿着「御准」之招牌，在各地開設外圍投注站，並鼓吹着「多樣化」的賭博，以「愚」市民……

四時左右，他們又再次帶上手套，繼續工作；五時許，他們就收拾工具，乘一輛貨車離去。他們有些在談笑，有些靜坐，一角等待着回到家裏的一刻，有些却還在談着剛才「十三張」之事……我不知所措，我只能默默地祝福他們！

Deadline for Essays

Please note that all essays for publication in any coming issue are to reach the Editorial Board by the end of the month preceeding that issue.

The views expressed by our contributors are not necessarily those of the Editorial Board.

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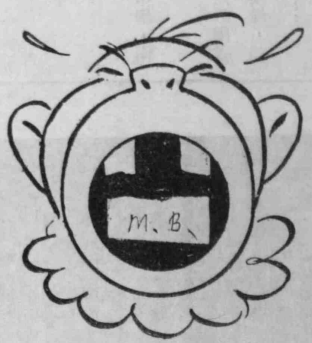
思啟



瘋

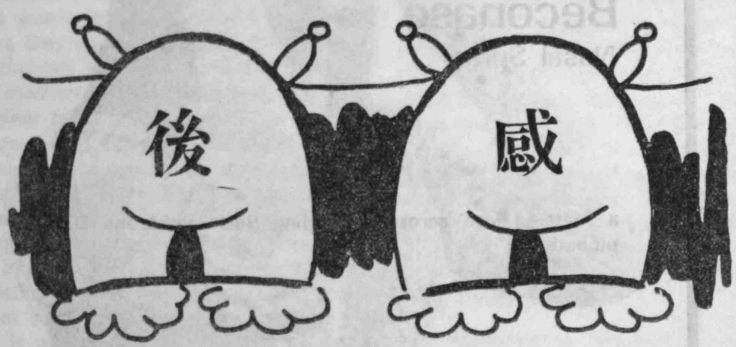
□□

睡不穩書齋風雨黃昏後
記不了胸Muscle與手骨頭
嚥不盡Leeson Manter咽滿喉
翻不盡Lehninger內深重透
展不開的眉頭
捱不明的更漏
恰便似那握不住的度數唉唉
流不斷的白水盈眸

某某仁兄曾對過我說：「假使你M.B.肥了，你眞是會發瘋的。」當時我想什麼，也不甚記得了，只覺得大家都像在抓着空氣，恨着自己一般無聊，因爲那時節太不適宜思索，只適宜五點後鐘，呆逗在餐廳吃冰，望着烏蠅打盹。

忽然間，M.B.出現了，像在噩夢中的魔鬼一樣，它來了，來了。看，它那血盤大口，它的猙獰咀臉，獰笑，咀咒，要吃下一村一百六十人，……當時我的情感是那麼複雜，我既怕它，又憤慨的恨它。兩年內所學的一切一切，又怎可以在三數天內全嘔出來呢？不過，嘔不出來，便要肥了，肥了，豈不是浪費了政府的血汗金錢？教授們兩年內的苦功？於是我試圖嘔下一大堆胡亂的思念，此刻、此刻當我慢慢從噩夢中回復知覺之時：

數不盡生理生化解剖系
讀不完Gardner Ganong滿案頭



記一次大戰

庸

初入醫學院時，高年班的同學曾循循善誘，勸我珍惜第一年的大學生活，多參加活動，少入圖書館，當時不住點頭稱善。

開學不多久，却發覺每天不由自主地大清早跑回來，佔個較前，而又要靠近布幕的位置，以一流速記手法抄那些瞬息即逝的字、圖畫，以及一切出現的怪東西。講師說完了，百多人一窩蜂地又衝往另一間演講室，繼續不顧一切地抄自己不知是甚麼的東西。

平日嘛，看書和瞭解上課時急急抄下的東西已應接不暇，一叠叠的筆記，一本本的厚書，讀了一次又一次，總是溫故如新。好容易等到有週末或假期，不是爲了能去玩耍，而是因爲少上幾堂，可以少讀幾十頁書罷了。

三科東西，每科最少要費十多天才能看過一遍，解剖科尤爲費時，但考試却是速戰速決，隔一天考一科。平日熟讀的，一片模糊，所以在考試前，必定要「多、快、好、省」地看過一遍，讀得稍慢的，可苦頭嘗盡了。

考完了，還要一天又一天地跑回來。圖書館門外，總是堆著三五七人，愁眉苦臉，互訴衷情。平日連報告版也不屑一看的，都頻頻出現在報告版前。名單終於出現了，有歡然離去的，亦有忘形大叫，手舞足蹈的。誰知道，那些面露笑容的，不少仍在心坎裏浮現著可怕的疑問：我沒有Straight Fail呢？

這就是一羣身經百試，一向奪優取良的「優秀份子」入醫學院首次體驗的悲、喜、哀、樂。

想起一年多的拉記生涯，想起這個考試，猛然感覺到毛澤東曾經說過一段有關學制的話是多麼的令人神往：『**現在的考試辦法是對付敵人的辦法，而不是對付人民的辦法，實行突然襲擊，出偏題，出古怪題，整學生。這是一種考八股的文章的辦法，我不贊成，要徹底改革。我主張公開出考題，向同學公佈，讓同學自己看書，自己研究……先生講書有的囉囉蘇蘇，應允許同學打瞌睡。你講得不好，却一定要人家聽，與其一同睜著眼睛，聽著沒味道，還不如睡覺，可以養養精神，可以不聽，稀稀拉拉，休息一下腦筋。**』

啟思錄

幻夢與恆永

每文

「逝者如斯，而未嘗往也；盈虛者如彼，而卒莫消長也。」

從一剎那可以得到永恆，但並非任何一剎那都是永恆。永恆的實現，不是如一般所想由於突襲的「靈感」，而是由點點滴滴累積下來對該事物認識的畫龍點睛。其意義在能綜合及透視觀察與被觀察者之各種變化，抓住事物本身。

如果爲了某種自我滿足，只取事物一部份變化，作其一廂情願的孤立而喻之爲永恆，那毋寧說僅是夢幻，因爲這種「永恆」，端賴一己執着的長久，與事物本身眞相無關。一個摸象的盲人，或最能滿足於象如大柱的境界，但維持這境界的代價却要是無窮痛苦——他要「永恆」地避免接觸所有違反原有印象的東西，須得放棄他的本能，包括理性，最後便只有早死才可以得到解決。

眞正的永恆，不需要任何形式的保護，它能經得起考驗。只有心底明知它不是永恆的人，才會搜索枯腸地緊抓着他們的夢幻不放，陶醉於所謂曾經有過的「愛情」、「理想」、「眞理」、「美麗」……及什麼什麼。

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