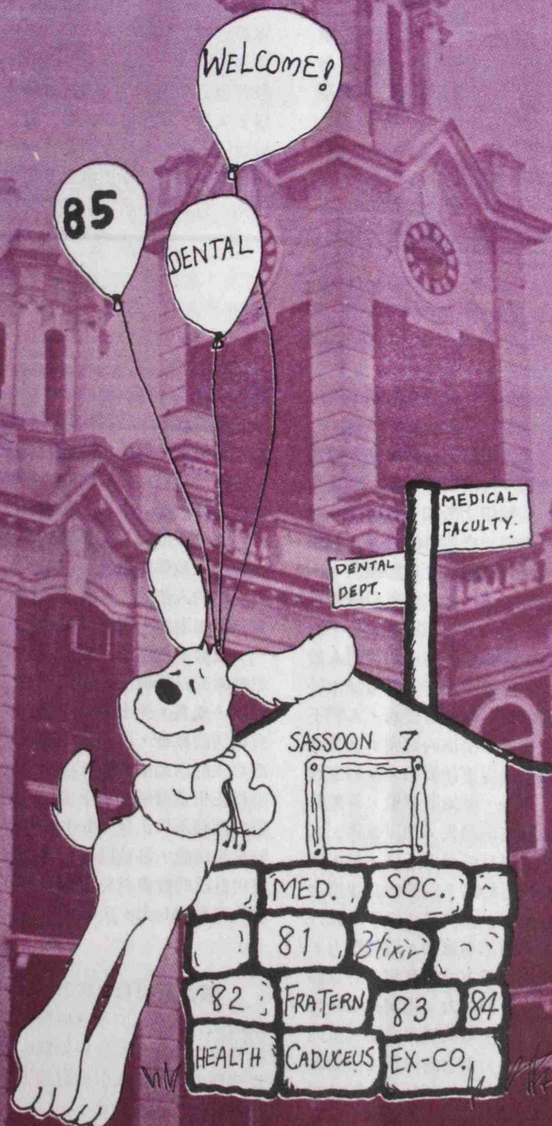
# 啟思

# Caduceus'80

HONG KONG UNIVERSITY STUDENT UNION MEDICAL SOCIETY PUBLICATION

香港大學學生會 醫學會刊物 第十二卷 第四期




## 編者的話・・送舊迎新

相信每個曾經參加過迎新的同學，想都會同意，迎新是他的大學生活中，最有收穫和值得回味的活動。對於某些同學來說，甚至可能是他進入大學後唯一參與過的活動。故此，學生會內各屬會、舍堂，都隆而重之，籌辦一連串多姿多采的迎新活動，來歡迎新同學。而對於新同學來說，迎新更好比作進大學前的蜜月期。大學內各樣的事物，都對他們來說是十分新鮮的，所以，新同學應開放自己，盡量接觸參與，使自己更了解這間大學的一切，從而使自己能好好利用這個良好的環境，培養自己，使能在將來更好好地服務社會。

今年醫學會辦的迎新與往年辦的有所不同。

由於兄弟會的停辦，迎新改由干事會另行組織迎新籌委，籌劃設計今年的迎新活動，成績是好是壞一時間很難逆料，不過，這次的迎新可說對兄弟會未來的存在問題，是一個考驗。

另一項在迎新期間的大型活動，由健委會辦的健康展覽，今年將停辦一年。多年來這個展覽象徵着醫學生關心市民大衆，提高市民的健康醫療的認識，這個崇高的理想亦是醫學生能親身接觸社會各階層的好機會，更是新同學投入醫學會活動的開始及建立一個高低班共同合作的基礎，雖然今年健展不辦了，但代之而起的是健委會另外一項有意義的捐腎運動，這項運動的成功與否有賴新舊同學的共同努力，推廣。在此我們謹祝這個運動能夠成功。

談了這麽多關於迎新及新同學的，我們可不要忘記我們的老大哥——已畢業的醫科八〇。雖然他們沒有經過好像進大學一般的迎新活動，便要投入工作。

迎接他們的可能是抽不完的血，寫不盡的牌板，多個無眠的晚上。但是，相信大家都會盼望着這個日子的來臨，我們在醫學院內學到不少知識，平日更給病人的身體上，加添了不少的痛苦，現在可以好好地應用在我們的病人身上，報答他們。看見病人的康復，便是對一個醫療工作者的最大欣慰。一切的辛苦也拋諸腦後了。

雖然我們沒有什麽歡送的儀式，但希望在這裏祝願他們工作愉快，並以醫科八〇的一個口號為結：

「團結互助携手齊邁進，
萬衆一心並肩為人羣」。

# 同學們，不要作風氣的奴隸

## —致港大醫科同學

**親愛的同學：**

昨接啓思十一卷十二期和十二卷一期合刊。在從王源美教授談醫科教育與道德說起一文中，馮康同學提出一個問題：（初升三年級的同學進入病房時）「他們有沒有機會找到個好的可跟隨的可學習的典範？」馮同學說：「我們之中實在有太多同學對什麽都『沒有什麽所謂』了。於是，前輩做什麽，大家也跟著做什麽，好的壞的都會一代一代的傳下去。」這是一個所有習醫者須正視的問題。但是馮康同學在後面卻强調：「任何錯誤都不可能是單方面做成的。如果要責備同學們不能堅持服務病人心態的話，我們就必須對目前醫學院內的課程教學同時作出批判。」在文末且自嘲的說：「在目前的條件下，我們恐怕連想（討論道德）的機會也沒有呢！」

讀到這樣的話心中很難過。我們眞是這樣輕易把自己的責任，自己的問題一下推到「環境」身上嗎？我們為自己解釋了：風氣如此，積習如此；或是太忙了；或是沒有典範，這就可以安心了嗎？我們心中沒有一個呼喚，要我們挺直脊骨站起來嗎？

故新亞書院院長唐君毅先生曾說：「在任何團體——包括學校——中，皆有比較清潔的人或習於汚濁的人。大率「高貴自尊」與「卑賤諂媚」之分，「公正」與「偏邪」之分，「好逸」與「任勞」之分，「眞誠」與「詭詐」之分，「有所不為」與「無所不為」之分……」唐先生要求我們「能好人能惡人」，要有「反省」，要作汚泥中的蓮花。馮康同學說：「我們無須作任何的道德說教」「我們任何人都不喜歡呆板的道德討論說」「這年代絕不是高舉論語或聖經說道德的年代」。好像說：今天不流行這個了，請不要再要求我們反省。那今天流行的是什麽？是「實驗是檢驗眞理的唯一標準」這一類口號嗎？是隨人腳跟，學人言語嗎？是「見賢莫思齊，見不賢而㪚眼」嗎？

我無意針對馮康同學，我上面引述他的話亦不是他的全部意思（他原意大概是雙方都有不是，但環境所限，同學們不能做些什麽，因此跟我們說教也沒有用。）我只是希望指出，我們隨時隨地有自我反省的能力，隨時隨地可以判別是非，也隨時隨地可以**從自己開始樹立風氣**。閱明報特稿報導，麻醉師一人施兩台藥的事，醫生們，醫學會大都緘默甚至說「不過分」，只有王源美教授直說這是「不應當」。這不是榜樣嗎？我們同學中有沒有人翻一部麻醉學書，找出答案，而直說自己的見解？孔子說「見義不為，無勇也」，我們是不知是非，還是無勇氣？

同學們，讓我們拿出勇氣來，從自己做起！顧炎武先生說過兩句了不起的話：「天下興亡，匹夫有責」。這話為什麽了不起？因為一向的風氣是人民不參予不開口，只望上面的朝庭將官把事作好，作不好也就無法了。但事實不是這樣的。我們每天反省一下（這並不須多少時候精神）：是不是在隨波逐流？是不是把問題推到別人身上？是不是塞了耳朵不聽別人（如王源美教授）的勸言？是不是聽了，卻害怕自己勢孤力弱而不敢站穩自己的立場？醫學界的風氣如何，確是匹夫有責！

美國七十年代叫作The ME generation，可以譯做「利己的一代」。這兒的學生最會批評老師不好，課程不好，有些積極的意見帶來好些的改變，但大部份時候只是各自「為己」，伸大手掌向人要這個那個，彷彿這樣就解決了自己所有問題。這兒婚姻有問題，也必是先罵對方不尊重自己個人，父子不和，也是父親不尊重自己。人似乎淪落為只會苛索不會自主自己努力的一團私心。我們要作好一個人，便不能不反省；要作好一個醫者，為了病人，更不能不要求自己，正視自己未曾做足夠的地方。

港大的校訓不是「明德」？為什麽我們竟然喪氣不敢辨「明」是非，拿出道「德」的勇氣？大學之道，豈不在「明明德」？豈不在「新民」？「新民」是什麽意思？不是要我們把舊的不良風氣和積習掃個淸光？重「新」樹立一個「新」風氣？

同學們：不要甘心作風氣的奴隸！風氣還須從我們開始去樹立！敬祝

學安

海外一同學 **區結成謹啓**

五月一日

（又：寫這一封信時我曾有些猶豫：這樣在海外向你們直言是不是過份？是不是越俎代庖？但心中這些話不能不說。有一天我們會一起工作，我們需要一同努力，一同對風氣負責。同學們對我的的話有共鳴或異議，我都樂意聽取。歡迎來信告訴我你們的看法。）

**編者按：本文作者區結成同學是在美唸醫的香港學生，月前讀過啓思刊登馮康同學一文（從王源美教授談醫科教育與道德說起），讀後有感，便寫成以下文章，希望啓思代為刋登，編者以激發同學關心未來責任為目的，轉登全文如下，又區同學更歡迎各同學的任何意見，有意聯絡者可向編委會接觸。）**

# 健展壽終正寢了？

**靈靜**

每年到了七八月，總是有一班同學在 Medic 內奔波忙碌，在白文遜樓裏跑上跑落，在圖書館內搬書翻閱，為的是在籌備 Medic 一年一度的健康展覽。對社會大衆來說，健展雖然在他們心目中的地位日漸降低，但它倒能提供同學們在暑期中一個很好的課外活動，俾同學們可以通過展覽籌備工作去自我學習，以及可以與社會外界接觸，更重要的，健展能給予幹勁十足的新同學一個參予Medic 活動的機會。

九月通常是展覽的好日子，所以八月尾也正是籌備工作進行得如火如荼的時候。在這密鑼緊鼓的期間，每天都可以見到同學在 Medic 釘釘鎚鎚、剪剪貼貼或是寫寫畫畫，搞到天翻地覆；展品堆滿了整個休息室，乒乓球桌也要暫時充當着大工作枱，不少同學更要匍伏在地上寫字繪畫，但他們都很興緻勃勃地埋頭苦幹。新舊同學們打成一片，笑聲滿堂，氣氛極度融洽。這樣的情景，比小孩子們在沙灘上堆堡壘還要歡樂，比星期日的彌敦道還要熱鬧。

可是，在八百多雙眼睛注目下，今年的健展連僅僅一句的遺言也沒有留下，便溜去得無影無蹤，找不到半點足跡、半點線索。我不禁會問：為什麽？為什麽你會這般忍心離開我們？

猶記舊年暑假所舉行的健展「對症下藥」打破了一向單調的只在大會堂一處舉行展覽的傳統，轉而變為流動式展覽，分別在港九四處地區舉辦，使我們要傳達的訊息更能普及大衆，這當然是一項新嘗試，效果是事先不能估計的，但外界的反應卻意外地令人鼓舞，先後有觀塘社康服務中心、荃灣聖公會麥理浩夫人中心及堅尼地城觀龍樓屋委會向我們借用展品展覽。本來，在香港現時這樣的環境下，不會有很多人還會注視這一類的活動，做工的只顧上班，讀書的只管學校裏一世也吃不消的功課，誰有心情專程來參觀說教式的展覽呢？可是，舊年的反應，使得我對健展發展的前景抱有非常樂觀的期望。在我心目中，舊年的是一個好嘗試，新的里程碑，今年的定必可以更跨進一步，更臻完善成熟。我這樣的信念，卻被現實完全粉碎。對健展的死亡，我感到大惑不解，我甚至不敢接受這千眞萬確的事實。

健展之死，應該歸咎是誰的責任呢？是社會的錯？香港展覽場地之缺乏乃人所共知，其競爭之激烈，比會考升中還要厲害。健展無處容身固然使它的死亡。但並不能算是構成死亡的原因。因為可以像去年一樣，健展實行以流動形式舉行，這亦不失為一個可行的解決的辦法。那麽，是觀衆的錯？觀衆的人數在近年來似有降低的趨勢，這可能由於普遍的健康教育已經大大提高，人們不再重視這種由醫學生搞的健展了。又或者是人們生活變得更加緊張，無暇來欣賞展覽罷。可是，要增取觀衆，首先是要檢討過往健展的過失，加以改善，充實內容，使其更具吸引力。這才是正確的做法。是校方的錯？同學的功課壓力無疑是日益增加，尤其是新學制的實行，使不少同學喘不過氣來。這種壓力，不免會遏止同學某方面的理想，將精神轉投在求生方面而努力。塡鴨式的教育，製造了一班沒生氣的讀書機器。是同學的錯？近年來，大學內的學生活動顯著減少，參與人數也大不如前。關社活動沒有新發展，仍然停留在關艇時代那種模式當中。同學間的社會意識日漸下降，多數人顯出有各家自掃門前雪的想法，對健展的意義也可能變得模糊不清。可能，歸根究底，錯就錯在健展本身。健展或許是太老套、太不合時宜了。六年來，香港的人與事都歷遍滄桑，而健展仍大致保守着當年的模式，這可能與現時的人產生「代溝」問題，導致其被忽視和淘汰，因而鬱鬱而終。

健展雖然死了，但它能否像聖經上記載的耶穌般復活，在明年重現於同學眼前？或者，死去的可能眞的死去，沒有復活的機會，可是，健展的失去由什麽形式的活動來補償？今年又有何活動來眞正担當健展所留下未完成的重任？這些問題不單止是 Medso 幹事或健委幹事來決定，各位同學也需負些責任，提出自己的寶貴意見，俾能集思廣益來解決這件 Medic 大事。

**編者按：健展是醫學會每年重要活動之一，又是新同學參與醫學會活動的好機會，但今年健展停辦既成事實，啓思刋登上文，旨在引發討論，希望同學能共同關心健展前途。**

# 煙雨五年

林孤舟

清晨，由瑪麗醫院步下，只見烟雨漫天，腳底下的醫學院，就只是一個迷濛的景象，但也是一段難忘的回憶。

攻讀預科時，唯一的目標，就是要進入港大醫學院。入學試放榜後，考取了三、四分的同學，固然不會再作出其他的選擇了，就是只有八分的我，也還不抱着姑且試試的精神來投報嗎？在當時，所謂愛心，所謂名利，就只不過是腦海中的一些名詞吧了。面試時，拯救疾苦的答辯，其中又有多少是台詞式的背誦呢！

考進醫學院，赫然成為了新貴。消息轉眼間便傳遍親隣，一切人際關係也起了變化。父母固然是喜上眉梢，劏鷄還神不在說了，同時，也贏得了親友的嘉奬；碰着他們時，往往聽到一句：「幾時做大醫生呀！」或索性是：「他日我來看病時，不要收費太貴啊！」雖然自己私下和友好交談時，口中也會說：「他們的說話眞是剌耳。」但心底間，不覺還是有點甜絲絲的。

迎新營內，高年級的同學不停地解說，甚麼是「放認鬬爭」、甚麼是應有的心態，這些對一羣初入醫學院的青年，無疑是一種很重的心理負担；再者，五花八門的活動，簡直令人目不暇給；漫不經意地，自己也不知在多少份宣傳單張上簽了字。但最令人惱怒的，莫過於他們不停地訴說個別學系及老師的短處，令新同學建立了一個難以磨滅印象，間接影響了日後的學習情緒。

大學的生活，不竟是和中學的不同，花了差不多一個學期，才能適應。

一年級時，也曾參與各種不同類形的活動，但大都是走馬看花似的，雖然接觸到各種不同的人和事，不過卻是忙得要命。但是最繁忙的還要算是當班委的同學們了。一位曾經當過一年級班代表的同學說：「在任期間，我根本沒法子在圖書館裏讀書，每每坐下來不久，就有高年班的同學跑過來，對我說某些某些事情。」這種席不暇暖的經歷，眞是有苦有樂。但希望各「高」班同學緊記某一年級班代的說話：「你們說得太多了！為甚麼不找我班的其他班委商量？況且，把你們的經歷勉强和我們的情形相比，是絕對不公平的！」

一年級轉眼又過了，考試前的壓力，只助長了暑假的寬裕。不論是出外遊歷，參與活動，或是學習一些新的事物，總比百無聊頼或元龍高臥地渡過暑期來得要好。曾經看見某同學在紙上寫着：「人生最要緊的是：『善用時間。』」

二年級開始了，也開始參與領導活動的行列，會議變成日常生活的一部份，但往往卻是不知所謂，與會者大都各持己見，或互吐苦水，會後，十居其九是沒有結果的。「所謂『認中關社』，所謂『放認鬬爭』，主要還不是象牙塔內一些激憤的會議嗎？」實地視察，或眞正參與及推廣的人，卻很少，至於市民的得益就更少了。某屆幹事會主席也曾指出：「今日侃侃而談的人兒，他日還不是會為他們的 MRCP 或 FRCS 而忘卻一切嗎？」畢竟，又有多少人能知行合一呢？

大學生畢竟還是學生，除了「沒有甚麼能力」之外，所謂走訪，所謂調查，只不過是往動物園看動物式的訪問，或是把報張剪剪貼貼的工作吧了。某屆副會長曾指出：「與其漫無目的地做學習，倒不如搞一些直接對市民有得益的活動。」筆者雖然未能完全同意她的意見，但卻讚同某屆幹事的看法。「單憑認識而希望同學日後對社會有所行動，是絕不可靠的。」

每位大學生，每年花掉納稅人三萬大元，醫學院的同學在畢業後數年便月入近萬，這是成績優異的報酬嗎？某同學在迎新營曾說：「在你現在輕鬆快樂的時候，也沒有嘗試去幫助一些你相熟，但是因考試失敗而傷心的同學；醫科畢業後，你會幫助一些你不熟識，而且還給你帶來麻煩的病人嗎？」你會嗎？

醫學生深懂捐血救人的道理，但每次紅十字會前來募捐血液時，也只得百數十位同學嚮應，某老師曾說：「To morrow you will be mad of blood for your patient！」而紅十字會的一位姑娘也說：「Shame! you See QM (Queen Mary)is just over there!」可惜聽見她們說話的人實在太少了。據聞香港仔的一羣工人，曾經令紅十字會的血袋不敷應用，需要急需數十個增援，看來這羣大專學生，不比起這一羣學識低微的工人了不起多一丁點兒呢！莫怪乎，某教授說：「中學時代，參與服務社會的活動及捐血的次數，應在入學資格之列。」

「醫學生服務社會的風氣很差！」一位熱心的同學說。同學們，你同意嗎？

三年級很快又到，也廿二歲了，不少同學也成雙成對，自己也顯得形單影隻了。甜蜜的戀愛，仙境般的二人世界，不時在腦海中盤旋。在她窗底之下，幾許徘徊，憧憬着月夜花間，及碧波白沙的暢遊，一切一切，也可以抛之腦後。衣着開始改變，談吐也變得溫文了。輕鬆笑語和失魂落魄，反覆相間，別人看在眼裏，也笑在心內。

三年級，是上醫院學習的時候，同學們也開始幻想畢業後的去向。個別同學被某些老師的風采迷倒，希望能拜倒門下。內科、外科、兒科和婦產科醫生的影子，不時在眼前浮現。另外有些同學，則覺得香車美人更為重要，「我想買艘遊艇」之類的說話，只是個中一例。最妙的，莫過於某君的抱負了：「我想當一名私家醫生，擁有一幢像沙宣道下面一樣的別墅，閒着時，也回大學教教書。」

世界上可能沒有八臂金剛，「但身上有十隻手的病人」，一個醫科三年級的學生就有很多機會看到了。雖云：

「放認鬬爭，口裏言談皆實話；<br>
　望聞問切，眼前病者是全人。」

恐怕要寫成：「口裏言談皆廢話<br>
　　　　　　眼前病者已非人！」

同學對學習的熱忱，本是無可厚非的，但是這往往卻為病人帶來了很多不必要的麻煩和痛苦；可惜不少同學卻認為這是理所當然的。反過來說，又有多少醫學生願意在衆目睽睽之下，解衣脫褲，給一羣陌生人檢查呢？恐怕，不願意的主因，是因為他們明白到別人是沒有權利來檢查自己的吧了。一、二年級的同學，你會恥笑他們嗎？

三年級也是寂靜時間的開始，同學們都普遍覺得自己「老了」。隨着功課壓力的增加，及對活動熱情的消卻，他們也開始歸隱了。社會和醫學生的距離，漸漸變得遙遠，能夠重出江湖的，畢竟是少之又少。嘗聞：

「斷戟沉戈志未消，<br>
　但經奮發續前朝，<br>
　春風不與謝郎便，<br>
　勿敵明春健無年。」

未知可否改為：

「春風給與謝郎便，<br>
　勿敵明春健康年」呢？

四年級是全面接觸臨床醫學的時候，也是醫科專業訓練的重點。其間雖然沒有令人留級的考試，但書本的壓力，卻能令最懶惰的同學也要勤奮起來。朝八晚六地上堂，已經令人筋疲力竭，但專科學習時期，內科的巡房，又往往在晚上八時、十時，甚至凌晨二時方才完結。同學們在活動上的撤退，沉重的功課是絕對的主因。况且，「書唸不好，將來苦了你的病人。」

專科學習時期，全班分成五大組，相熟的同學也因為分處不同的組別，漸漸也顯得陌生了；一切情仇愛恨，也會因為時間的消逝而淡忘。

醫學院十三個學系之中，並沒有一個教導同學如何去當一個好醫生。雖然社會醫學系，向同學們介紹了一些關於社會的知識，但卻被大多數同學所忽畧。尙幸近年的兒科學系，也鼓吹認識社會及醫療的風氣，也點綴了單調的學習生活。

在病房內，醫學生往往單方面的獲取利益，但卻沒有為病者作出任何貢獻，只有在學習產科時期，才感覺到自己是在幫助別人，嬰兒呱呱落地的叫喊聲，不僅令產婦們喜悅，也令自己手忙腳亂。

五年級的後半年，是生死存亡的時刻。雖云：「醫生的名銜是等着自己。」但每日也需要面對這幾本書，和那叠筆記，內心眞是悶得發毛。很不容易才拖到考試。

最後的考試，也是這五年的得失。試後的歡樂，也只是職業醫生生活的開始。畢業後，但覺自己站在一個渡頭上，面對茫茫人海，自己是一隻孤舟，是病者心目中的苦海慈航，也是別人心目中的豪華郵輪。種種的責任也開始落在肩膊上，自己的錯誤，可能就是病者生命的損失。病者、家庭，還有自己。中學時代的同學，與自己遙遙相隔，面見時，就只有訴說頭暈身熱的。大學的同學，也正在各自策馬揚鞭，在自己的路途上奔跑，而這艘孤舟也需要啓碇出海，海外無蓬萊，何處覓仙蹤。朋友，下次再見。

**編者按**：同學們！當你看完這篇文章之後，有何感想呢！林孤舟同學所描繪的五年醫科生活是否有你的寫照呢？

文章寫來似乎是「灰」了一點，但希望藉此對大家有點衝激，並使大家平日放在一旁的問題，能重新思索找出自己應走的道路。

# In Memory of my late father

Teo

He has died four years – my father. Sorrow was over long ago and what now remain are just bits and pieces of reminiscence. What sort of man was he? A good doctor? An unresponsible father? A pitiable old men? Or, a walking monument of the past medical era? – Now still no conclusion. His life was full of medical doctrines, romantic love stories, war time battles, and whatever things you could think of from the lifetime experience of a seventy year old man. Being a HKU medical graduate in 1932, he was one of those privileged few who witnessed the first opening of QMH (Queen Mary Hospital). His bow tie, fluent English and gentlemanly manners reminded one of the faded-glorious past. A few days before his death, he hammered this statement into my heart: – doctor is the best profession. He said it because he respected his profession, had lived up to its requirement and wanted me to do the same. I would be very proud if at my death I still had the courage to pass this message to my children. Indeed my father was a man of principles: – during wartime he was a missionary doctor in Kwantung, during peace he never overcharged his patients. He had taught me how to live a noble life as a doctor, how to care warmheartedly for the patients but still remain emotionally detached to the degree of best benefit to both parties. In him I see sincerity and charity and the way of living. For this I respect and admire him.

Yet a man cannot be good in all respects. His prolonged separation from the family, his cold attitude after his return, his strict and rather uncompromising personality and his many romances contributed little to the well-being of the whole family. However, his full responsibility for my upbringing was undoubtful. During his seperation, he was far away but yet close, after his return, he was close but yet remote. All these make one perplexed, puzzled and unable to choose between love and hatred.

I remembered that day when he looked through the window with his deep sunken eyes, his wasted hands hanging limply by his sides, his mind sunken in a deep sea of thoughts. It was two months after his deadly disease had haunted him. What had passed through his mind then does not really matter now but I still wished I knew. Trying to recollect the past? Tempting to draw a conclusion to his whole life? Praying for our final forgive? Thinking of my future? Or, was he thinking anything at all? How stupid was I not to ask him at that moment! Now I can only console myself with imagination.

During his last days confined to bed, tears glistered in his eyes again and again begging us to grant him peace in his soul by forgiving whatever wrong he had done. Though in great pain he continued his fast-losing battle with the cancer, and we stood by in total helplessness. He refused to die in hospital and also all the injections that could only add to his agony. He knew just too much about medicine after his forty years of practice that he finally decided to die humanly without its support. A man after all has his right to choose to die naturally admist the tender loving care of his closest relatives and not in a cold and artificial hospital environment. Humanity is indeed what a doctor should endeavour to possess during his whole lifetime; this was the last thing I could learn from him.

Today I have graduated and in front of me I expect to encounter many things my father had encountered, joy or sorrow, glory or disgrace. I will never be another him. But in him I see virtus that will guide my future and wrongs that warm me to avoid. May I humbly dedicate this piece of reminiscence to my beloved late father and to all those who remember his virtues and forget his short-comings.

× × ×

# 生命何價！

聆

早上到婦科門診，七個新症中，有四個是要求人工流產的。唉！想今早也不會學到什麼的了。最怕見到T.O.P的，問來問去還不是那兩個原因，所以每次都是猜輸那個去 Clerk Case 的。

「什麼原因不要胎兒啊？」

「已經有兩個孩子了，再生我又不能做工賺錢，所以不要了。」才三十歲的婦人這樣回答。繼續問下去，知道她丈夫每月賺二千餘元。她自己也能賺差不多一千塊。兩夫妻每月賺三千多元，養多個孩子有什麼困難。心想這個Case一定唔Pass……。醫生看後，也覺得全無理由去替她墮胎。一面向她解釋墮胎的危險，一面勸她養下這個孩子，之後替她做絶育手術。可是婦人堅決地說：「這個孩子我決定不要的了，你不替我做，我找私家做！」醫生聽了這話，眉頭皺了。實在醫生怕聽到這話，因為若病人去找些非正式醫生做手術那麼就好像讓病人走進死亡的危險。婦人見醫生遲疑了，便理直氣壯地告訴醫生「我吃了些註明『孕婦忌食』的藥，恐怕生下孩子會畸形。」嘿！分明吃藥想打下胎兒，這算是什麼藉口。這時醫生好像找到了什麼似的，雖然一面責罵婦人好亂吃藥，一面在病歷表上寫上：For T. O. P. Anxiety State。

× × ×

回到病房，看看今天的急症病人，幾乎所有都是與流產有關的，不是 threaten, inevitable 就是 incomplete 或 septic abortion。戰戰兢兢行到其中一個病人床邊，心裏盤算着，孕婦現在的心情一定十分惡劣了，怎樣安慰她才是。怎料和她談上了，發覺她一點緊張或傷心的態度也沒有。心想她眞放得開，我也慶幸能在輕鬆的氣氛下完成我的工作……後來和同學談起來，才發覺我的想法實在太天眞！

× × ×

墮胎這個老問題，本來已丟在腦後好久了，但看了政府在四月廿五日頒佈的一項初訂法案，不能不令我再三思想。這個法案，名為人身侵犯（修訂）條例。建議下列人士在要求下能進行墮胎：

甲、孕婦年齡不足十七歲；

乙、孕婦在前此三個月內曾向警方報案，自稱乃下述罪案之受害者：亂倫、强姦、迫姦、誘姦或迷姦。

丙、胎兒出生後極可能有身心不健全情形而足以造成嚴重傷殘。

這個法案若獲得通過，香港又會多一個世界第一的美譽，就是擁有世界上最寬容的墮胎法例！早些時英國國會辯論得如火如荼的 Corrie Bill，正要將現行的墮胎法例收緊，而香港竟提議將法例放鬆。誰說香港永遠跟着英國的鼻子走！可喜可賀？這法案眞替全港十七歲以下的少女帶來絶大的喜訊——享受吧，可無牽掛的玩。「我們會幫助妳解決任何問題。」（不須廿四小時內）全港有女初長成的媽咪，你們再也不用三更半夜地等候女兒從舞會回來，她們的事你無須担心。十七歲以上的女孩子，法例沒有忽視了妳們。妳們萬一有不幸或不慎，可有三個月的時間，去考慮妳的遭遇究竟是强姦、迫姦、誘姦或迷姦！還有其他已婚或未婚的婦女，只要妳曾服用孕婦忌食的藥物，便可名正言順地接受墮胎手術了！

相信最不高興是保良局的總理們，沒有未婚媽媽，沒有棄嬰，保良局可關門了！傷殘者們，明年雖是國際傷殘者年，但不要高興，政府已明確表示你們是一羣需要消滅的廢物。我想總有一天小欖醫院要關門，老人院也要關門了，政府既然認同了墮胎乃解決問題的最好方法，這套哲學不也可以用在其他社會問題上？

Trandate

the first alpha-beta blocker for all grades of hypertension right in principle-working in practice

**Effective in all grades of hypertension, mild, moderate and severe**
"Labetalol is a useful anti-hypertensive agent for patients with all grades of hypertension and the present study would suggest that an additional advantage is the rapid fall in blood pressure when the drug is given by mouth."
(Serlin, M.J. et al. *Brit. J. clin. Pharmacol.*, 1979, **7**, 165)

**The onset of antihypertensive action is rapid . . .**
"The hypotensive effect of labetalol was apparent within 2 hours of drug administration and was maximal by 4 hours."
(Breckenridge, A.M. et al. *Brit. J. clin. Pharmacol.*, 1977, **4**, 388P)

**Side effects are rarely a problem and usually transient**
"The total number of side effects attributable to labetalol were small and none prevented an increase in dosage."
(Pugsley, D.J. et al. *Brit. J. clin. Pharmacol.*, 1979, **7**, 63)

**. . . Which simplifies individualisation of optimal dosage**
"Good blood pressure control was obtained easily and the treatment regimen was simpler than that with previous therapy received by the patients. Few incremental changes in dosage were required and all but 6 (10%) patients were controlled by labetalol alone."
(Harris, C., *Curr. med. Res. Opin.* 1978, **5**, 618)

**Even in patients resistant to other antihypertensive agents**
"The results of this study indicate that labetalol is an effective antihypertensive drug, particularly in view of the fact that the majority of the patients were uncontrolled on other antihypertensive drugs or drug combinations."
Bolli, P. et al. *N.Z. med. J.* 1977, **86**, 257)

**Patients feel better on Trandate and the treatment does not restrict activity**
"It is therefore particularly encouraging that 74% of patients in this study reported that they were much less tired, more energetic, more active physically and more mentally relaxed than when on their previous antihypertensive therapy."
(Scott Manderson, W., *Practitioner* 1979, **222**, 131)

**Trandate Injection provides rapidly effective control of hypertensive emergencies**

As a bolus injection . . .
"Labetalol given intravenously is highly effective for the acute reduction of blood pressure. In this series no serious side effects were encountered and the drug seems particularly suitable for use in hypertensive emergencies."
(Rosei, E.A. et al. *Clin. Sci. mol. Med.*, 1976, **51**, 497s)

Or as a continuous infusion . . .
"Labetalol, given slowly by graded intravenous infusion, with continuous monitoring of arterial pressure, is our current treatment of choice in hypertensive emergencies."
(Brown, J.J. et al. *Lancet*, 1977, **i**, 1147)

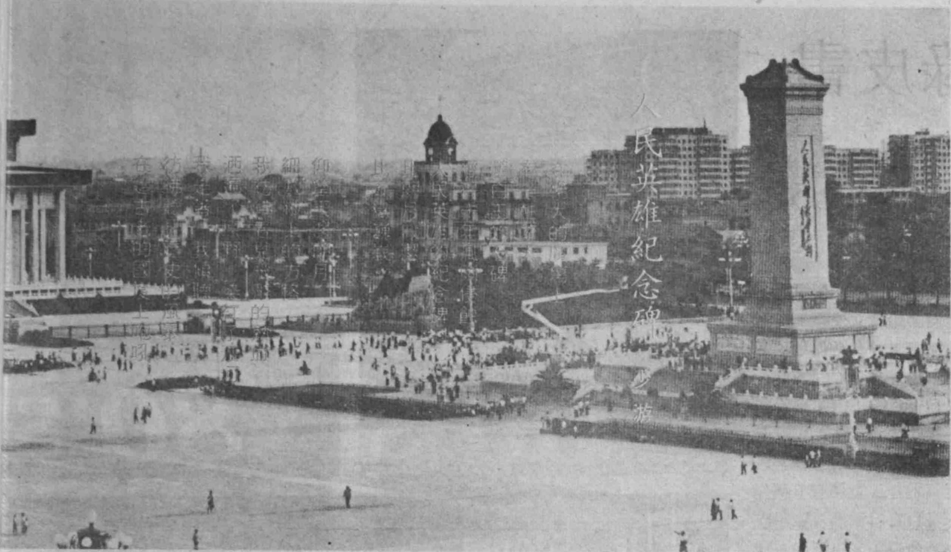
- For the newly-diagnosed hypertensive
- When side effects are causing problems
- When control is inadequate on existing therapy
- To replace complicated multi-drug regimens

Trandate (labetalol)

Glaxo Trandate is a trade mark of Allen & Hanburys Ltd. London E26LA, England, a member of the Glaxo group of companies.

車，靜靜的在等待……等待下一班小輪送來另一班的夜歸人。小輪還未到，那計程車司機木然的坐在車廂裏，抽着烟等待着，裊裊的青烟冉冉升起、膨脹、破裂，最後混和消失在迷茫的夜空中。無聊的等待。我呢？我在等待什麼呢？

那計程車司機別過頭來望了我一眼。奇怪嗎？一個人無聊的站在這兒。他好像並沒有看見我（我還存在嗎？），又別過頭去抽他的「總督」——由頭到尾都咁好味。他疲倦了似的闔上雙眼，面上沒半絲的表情，手上的香烟還在冒着烟。剎那間他彷彿已成了一尊石像——是一尊大麻石雕鑿出來的石像；那冷漠的面孔上還能見着風雨磋磨出來的紋路；額角眼尾的深坑藏着多少年的光陰；那緊聚的眉尖訴說着一段段的喜怒哀愁。他有多少個晚上就是這樣的坐着、等待着那些夜歸的人呢？




着幾點菜汁；一條揉皺了的領帶掛在那半截短頸上，垂在那鼓起來的肚腩上；捲高了的袖子露出一截絲瓜似的手臂，紅蘿蔔似的手指拿着一條紅手絹在抹汗。這個人可能剛才還是衣冠楚楚的週旋於一班朋友之間，大談財經馬經、研究對女人的品味、甚至討論一下世界政治局勢。他也可能顧盼自豪的引述一兩句名人語錄，剖析現代的文藝思潮。現在他張着兩片倘染着油光厚厚紅紅的嘴唇在喘着氣，滿佈血絲的雙眼被堆在臉上的脂肪擠成兩條縫，一隻手掠着頭上稀薄零亂的頭髮，另一隻手又拭着猩紅臉上冒出來的汗珠。是麼？人不就是最醜陋的動物嗎？當他們穿上華貴的禮服，他們儘可以吹噓人是萬物之靈，把仁義道德掛在嘴邊，寫在橫額上；但當外表的一切再掩不住他本性中的野性時，仁義道德就成了他偽善的證人，良心就成了他的行刑官。

猛踏下了煞掣，車子頓的停住了。多謝先生十三元半。見着他滿臉不忿的掏出車錢下了車，口中還唸唸有辭，不覺心中暗笑起來：五毛錢已經可以看到許多人的口臉。

把錢放進錢箱，開着車子慢慢的駛回碼頭去。生活就是如此，像一個永不終止的循環，重複再重複——這就是生活的節奏。把陌生的人送到陌生的地方去，然後再回到那冷清的碼頭去等待另一個陌生的人去另一個陌生的地方。

街上冷清一片。才近一時呢。還有五個小時——五個小時的等待。明早收更回家去亞蘭已經要起來弄早餐給兩個小鬼，好讓他們吃完上學，跟着亞蘭也要回工廠開工。就剩下我一個人在家蒙頭大睡。啊欠……呀！過了農曆年還是換回日更的好，至少能多點時間見到老婆仔女呢！

我心中突然有了憐憫，這是一個可憐的女人，並非如一般人所想像的，值得鄙視唾罵的淫婦。我望進她失神的眼裏，想起「天地不仁，以萬物為芻狗」。

我甚至忘記去擺脫她那一雙手。先生，十五元……只是十五元。我搖了搖頭。她垂下了頭，我臂上的雙手也鬆開了。十元好嗎，先生？我再用力的搖了搖頭。我分不清她臉上的表情是失望還是悲哀，甚或是被侮辱？她不作聲了，靜靜的又退回她的暗處，靠在那冰冷的燈柱旁，等待着。

我從錢箱中抽出一張十元鈔票來，走到她的前面，塞在她的手心。她的手好冷啊！她驚愕的抬頭看着我。你也許不會明白，不過明不明白並不重要。我笑了笑便轉身向車子走去。我想她還是在驚愕的望着我，但我沒有回頭，心中很滿足，比來那回事更覺滿足得多。

好靜，四處的燈火照得通明，更顯出這兒缺少了些什麼似的——是了，是人啊！沒有了人的世界原來是如此的空寂虛無。但是至少還有我這一個人。

我看着掉在地上的那半截香烟，它還在不甘心的燃燒着，一縷縷的烟柱還是冉冉的填塞那片壓人的空虛。似乎它還在等待，等待它主人的再來，再執拾起它？

我呢？我在等待什麼？那計程車司機嗎？似乎我沒有什麼要等待的。人生有太多的等待，我也搞不清要等待的是什麼了。

不如歸去。我不想回去的地方——我也不討厭回去的地方。反正人生就是許多的無奈，想不想去又有什麼關係呢？

那房東太太可能還在等待我回去，好好的給我一頓臭罵呢。

（完）

青年書屋 筲箕灣道140號3樓 5-691614
青年圖書中心 亞皆老街昌明大廈H座一樓 3-954311
（由黑布街入）

專售醫科用書

## 啟思十年文集

**你想** 知道十年來醫學院內發生的大事嗎？對醫學生活動有更深的了解嗎？認識更多有關醫療問題的探討嗎？得到一本富有趣味性的文集嗎？

如果是的話，只要你在下面填上姓名，地址便可，請寄「香港沙宣道七號，香港大學醫學會收」

姓名＿＿＿＿＿＿＿＿本數＿＿＿＿

地址＿＿＿＿＿＿＿＿＿＿＿＿＿

每本定價港幣八元，（醫學院內老師及同學將免費獲得一本）

**又** 啟思十年文集現徵求中英文名稱，歡迎同學參加，稿件可交／寄回香港大學醫學會，一經採用，將獲贈紀念品一份。

# 「地區行政模式」綠皮書的解剖

石天

## 簡介

本年六月六日，港府發表了「地區行政模式」的綠皮書，引起了關心香港前途的人士的普遍關注。

綠皮書有幾點主要的內容：（一心把新界的地區諮詢委員會，改為區議會，職權相若，區議會內有若干民選議員。（二）把新界的行政模式推廣到市區去。據悉此經驗早已在觀塘試行七月，獲得滿意的結果。但市區內的區議會並沒有民選的議員，而且為避免與市政局的職權重覆，權力將比新界區議會為小。（三）市政局議員的選舉將改為分區制，議員席位由十二席擴大到十五席，但官委議員數目亦作相應的增加，保持目前的平衡。市政民選議員列席區議會。（四）擴大選民資格，無論是新界區議會或市政局議員的選舉中，凡年滿廿一歲在港居留滿三年者俱有投票權。

## 政制改革的歷史

綠皮書發表後，衆議紛紜。本年八月底就是政府搜集民意的截止日期。本文在短短的篇幅內，只能簡單介紹和勾劃綠皮書出現的背景，至於這份綠皮書的優缺點，將來的白皮書又會以什麼面貌出現，即只有留待將來有機會再討論。

綠皮書發表後，署理新界政務司徐淦曾經表示這不是「政制的改革」。（六月六日在香港無線電視新聞部主辦的電視座談會的講話）徐氏雖然這麼說，但大多數論者都認為具體上綠皮書談的雖然是行政的問題，卻不能否認它也有濃厚的政治引伸背景。在這裏，想談談香港曾經提出過有關政制改革的討論。

其實早在十九世紀，在港的英商就曾經要求民選的制度。但有系統的政制改革的提議。只是在四十年代才由楊格提出過。一九六六年，曾經出現過一份迪堅遜（Dickinson）報告書，該報告書提出成立各區的分區議會，全部民選產生。另方面，市政局的研究小組在當時卻認為應成立一個大香港市議會，然後再分層成立分區議會。這些比目前綠皮書都大胆得多的建議可惜都因為六六、六七年的騷亂和暴動而被放棄了。有趣的是，為什麼經過了整整的一個七十年代，政府有關政制改革的建議反而是後退和保守了？說到這個問題，我們就不能不整體地回顧一下政府近十年來如何建立它統治的哲學。

## 什麼叫做諮詢性民主

一九六六年的騷動事件，予政府一個極大的教訓。正如民政署長華樂庭今年初在對香港觀察社所作的一次演講中所提到，當年的政府官員甚至不能相信市民對政府有所不滿。針對是次騷動事件，政府連忙做了調查分析，報告中主要提出了幾個方面的原因，一個是社會福利的不足，二是青年人缺乏社會歸屬感和精力過剩，最後的一個重要原因是政府缺乏與市民溝通，而公務員給人也是一個惡劣的形象。

這裏想着重談的是最後一個原因。一九六八年，港府開始設立民政制度。民政署及其分區辦處主要就是作為政府搜集民意的渠道，也是政府順利地推行政策的輔助工具。在後來提出了社區建設的概念後（這點往後再談），民政署下更掌握着一個極其廣泛的消息網。民政辦事處現在定期地作民意調查（稱作 Mood Test），又負責起協助各區組成基層組織的工作，所以，又可以說，民政辦事處是政府行政機關的指頭。

另一方面，在一九七三年，政府推行了綠皮書制度。在重大政策正式決定前都會發表以引起民間的廣泛討論和批評，藉以參考大衆的意見。

此外，政府又成立了三百五十多個各類型的諮詢委員會。成員包括政府官員和市民，於是在制訂政策前可以聽取更多方面的意見。

十年以來，政府在諮詢民意制度的設立上日趨成熟，但從沒有把中央機構內的任何決策權力下放於民，整個政制仍然是舊式的殖民地政度。這就形成了香港特有的民主模式，則名為「諮詢性民主」（Consultative Democracy）。

經過了十年的經驗，港府發覺市民並無對此制度有太大的不滿。政府的實踐結論是：市民要求的不是一個民選的政府，而是一個能尊重民意，能解決問題，有效率的政府。當然，這樣的一種市民見解，難免沒有政府自己所作的宣傳所影响。正如今次的綠皮書在前言中就說香港的特殊條件要求其穩定（意思是指香港是中國領土的一部份？）根本就否定大規模改革的任何設想，所以，這次綠皮書首先就是發展諮詢性民主的政策，把聽取民意的能覺更細緻、更有系統地伸展到基層。

## 地方行政的發展

上面提到，市民要求的除了是一個尊重民意的政府外，也要求一個有效率的政府。長期以來，政府的效率都時常為人所詬病，各部門之間互相推卸責任，缺乏統籌，工作積壓是極為常見的現象。

一九七二年，政府針對這個問題，曾經根據一份名為麥健時報告書進行了政府部門內部的改組，因為這個問題與本文關係不大，這裏便從略了。

一九七六年，港督在施政報告中首次提出了「社區建設」的概念，開始了地區行政的先聲。現在全港劃分為十個大民政區，下有七十八個分區，分區之下還沒有極多的居民組織。這些居民組織早期曾以街坊福利會的形式存在，後來政府發現這些福利會除了賑災之外無大功能就推動成立業主立案法團，可惜收效仍然不大。在清潔運動和撲滅罪行運動中，政府終於找尋到一種比較理想的居民組織形式，就是互助委員會。這些互委會都是在民政分處的協助下成立的，現在數目已超過三千個，人數已接近三百萬。如果要數最有羣衆基礎的組織，則非互委會莫屬了！

除了組織互助委員會這類基層組織外，政府在各民政區在近年來則經常組織一些協調會議，包括政府各部門的在員，共同協調解決區內所遇到的問題。這樣，便減少了下情上達，部門間的溝通，和再上情下達這樣的曲折，大大提高了政府的效率。因此，雖謂觀塘的區管理委員會的經驗是借鏡於新市鎮，事實上在市區內亦已有了雛型。現在根據綠皮書的建議，無非把區域重新劃分，把過去已實行的政策制度化，也把民政主任的位置變相地提高了，因為民政主任將會是區管理委員會的主席，已經儼然是一個區長！

如果綠皮書的這個建議眞的能有助於改善政府的行政效率，那麼，政府的建立一個聽取民意、有效率的政府形象便可算成功了。

## 新界土地的使用

新界，對英國人來說，是一塊租借地，租約在一九九七年便要港期了。因此，一直以來，香港市區與新界的發展是截然不同的。新界也形成了一套自己的行政模式，由於傳統的土地主權關係，新界人有了他們的代表機構，他們有權選舉各鄉村代表，代區委員會和間接選出鄉議局的議員。鄉議局對港府的新界政策有極大的發言權，這是與其對土地的傳統擁有權有關。

近幾年來，中國對香港的態度越來越清晰，香港市區的發展亦已到了飽和的程度，香港政府就開始把發展的目標移向廣濶的新界土地。在龐大的建設計劃中，首先是新市鎮的建立。在計劃中，荃灣、沙田、屯門三個主要新市鎮的人口將超過二百萬，再加上大埔、粉嶺上水、元朗等比較小的市鎮，人口將接近三百萬。港府的目標是把一半的全港人口遷移到新界地區。

建立新市鎮的種種由此而來的問題這裏不談，只想談一個管理的問題，遷進新市鎮去的多原是市區內的人口，因此，政府就在在這些市鎮中設立了管理委員會，有利於新界傳統的理民制度，掌管這些管委會的是市鎮專員，另外又設立諮詢委員會，以補充傳統鄉議局的職能。這樣的兩套平行的行政制度幾年來就一直存在着。一直以來，政府的傾向是謀求統一，並進一步促成新界與市區行政的一致化，但碍於鄉議局傳統勢力的强大又不敢輕舉妄動。這次提出了這份綠皮書，可說是發出了最後的訊號，就是謀求市區和新界行政的統一，提高市政專員，區管理委員會，區議會的地位，把傳統的諮詢機構放在一個次要的位置。

## 結論

從上面的討論中可以看得到，這份綠皮書的要點基本上是政府近幾年來政策的發展和制度化。更重要的，我們看不出有什麼民主的擴大。新界的區議會雖有民選議員，但其功能主要還是限於諮詢性，綠皮書說把諮詢二字删去，只不過是因為目前這些委員會已有「一些」行政的功能。這些「一些」是什麼？無非是一些文化康樂活動，最具體的也就是荃灣的大會堂。市區的區議會更連民選議員也沒有，綠皮書只模糊地說各區選出的市政局議員可隨意列席區議會。如果這份綠皮書是作為政府要開拓新政制的第一步，我們可以拭目以待。如果它只不過是政府把其一貫政策完善化和制度化以作為一個階段的結束，則所謂鼓勵居民參與政事只能是一句空話。

# 夜車

旁觀者

下了船，隨着寥落的幾個夜歸人步出了天星碼頭，看着他們踏着急促的步伐消失在四方八面的黑暗裏——急不及待回到他們溫暖的家去？（也許他們的家並不溫暖，但最少有一張溫暖的牀；一個人有一張溫暖的牀，他也就不能再對其他有所奢望了。）我呢？除了回去開門時會聽到那血壓二百三十的房東太太幾句含糊的咀咒外——我沒有急的必要。唾面自乾麽！

下意識的扣上了外衣的鈕子，冬夜的寒意倒眞個不含糊呢。剛才船上見過的幾個鬼仔鬼妹正在嘻嘻哈哈的擠上一輛計程車，我不禁皺了皺眉頭。眞的不明白那些洋鬼子的道德觀念為什麽和我們中國人的會如此截然不同。

剛才在船上，他們三個人狂呼怪叫，旁若無人，惹得全船的人都報以奇怪的目光，他們卻彷彿更加得意，委實幼稚得可憐。三個都長着一頭長長的金髮，年紀頂多不過十七、八歲，長得都很帥。尤其是那女孩子，身材面貌都有點兒希臘雕塑的味道，湛藍的一對大眼睛眨呀眨的，加上開朗嫵媚的笑靨，確是萬分可人。可惜她的作風大胆得叫人咋舌：抱着這個男孩子厮磨一會，轉過頭又跟另一個攬作一團。眞教我失望得很，看來現在年輕的一代眞是越來越「早熟」；正如某君所謂：「現在只有在電影院裏才找得着純情！」眞個是「純情不再」嗎？那計程車是遠去了，但夜風中還依稀飄來他們的嘻笑和尖叫。

× × ×

不會覺得厭倦嗎？——這無聊的等待。他又望了我一眼，狠狠的吸了兩口手中將盡的香烟，黑暗中重燃的烟火照見他緊束着的雙眉；緊蹙着的眼裏彷彿充滿了思潮，又好像是受不了那陣陣的燻烟。烟火熄滅了，化作飛灰，黑暗中再看不見他面上的表情。可能他面上根本沒有任何表情。

## 十三元半的旅程——司機的自述

等待……為了生活就得等待。等待那陌生的歸人拉開車門、叫出一個地址、踏油門、落旗，隨着計程錶的每一次跳動：二元五、三元、三元五、四元……是向右轉吧？倒後鏡中那猪頭似的肥臉先是一陣錯愕，隨後那大得有點誇張的頭顱才勉强的點了一下。

五元……五元五……六元……是去喝喜酒吧，先生？他扯下掛在頸上的領帶，解開了襯衫領口的鈕子，露出了短頸上一團白皙的肥肉，然後才愛理不理的回答了一聲「是」。好沒趣兒的。

街上悄悄靜的，冷漠的路燈泛着灰藍的冷光，一幢幢青灰的大厦從兩旁掠過——是什麽？像是走過墳場一列列的墓碑，看着一個個墓中人的姓名，而覺得自己是獨自一人的那種感覺：不是恐懼，不是驚慌，而像是一個脫離了現實世界，毫無感覺的旁觀者，站在雲端俯瞰着地球在無限的虛空中翻滾旋轉，看着其上蟻樣的人們的熙熙攘攘。那是感情上的一片空白，是時間上的一段遺失。

九元五……十元……十元五……沉寂的車廂裏只有後廂裏陣陣沉重的呼吸聲和偶而計程錶的跳動。快一時了，亞蘭睡了沒有呢？小敏小賢應該早睡熟了吧！明天是他們學校水運會。暑假教曉了小賢游水，他明天參加了初學組，小賢也游得不錯的，不知道會否贏到獎牌回來呢？其實學校也眞是的，（現在天氣已經轉冷）才舉行水運會，眞見他的大頭鬼，凍壞了學生又怎樣辦呢？明天小賢也許會贏的。

前面的交通燈轉了紅色，我慢慢的把車子滑前。「衝過去吧！」我耳畔傳來後廂尖銳急促的「命令」。先生，衝紅燈是會被抄牌的，甚至可能被罰停牌半年呢。車子還是慢慢的停在紅燈前，他邊喃喃自語邊靠回座位去。

紅燈——紅黃燈——準備——綠燈——踏油門，車子又慢慢的開動了。我們跑計程車的就要遵守交通規則，不論是否夜深無人，紅燈就是停止，那怕你願不願意，就像死亡那般的教人無奈；那是你要接受的現實，其實現實並沒有什麽選擇的可能，你有一口氣在就要受生命的限制，跟着別人定下的規制去跑你的路。紅燈就是停止，你祇有等待，等待再變成綠燈，再無奈的去繼續你要行的路，不能流連半刻，遲疑半刻。

轉了街角停車吧！十三元……亞蘭可能還在那殘破的衣車前埋頭的踏着腳踏車衣服。農曆新年還有兩個星期吧？也得替兩個小鬼添兩套新衣服。就在這裏停啊！他雙手扶着前座的靠背急促的叫着。好哇！看準了計程錶快要再跳便寧願馬上下車嗎？住在九龍塘這兒的想也算得上是有錢人吧！竟然連五毛錢都要斤斤計較？我偏要整治整治一下你。輕輕的踩下了煞

「本台今日節目到現在已經全部播放完畢，請各位明晨六時再繼續收聽……」

關上收音機，那首熟悉的「祖國」國歌尙飄繞在車廂中。——祖國？那是誰人的祖國呢？應該是紅鬚綠眼的鬼子的祖國，我們這些黃皮膚黑眼珠的人算得上嗎？我們拿着香港身份證，每年要納各種的稅，儲備金是一大筆一大筆的往祖家運，但是我們又算個啥呢？就是要去英國旅遊，也得申請入英籍，再向英國的領事館簽什麽證的。呸！去你的高等華人！

難道我們香港人就是沒有根的？何處是我們的家鄉？請告訴我：誰是中國人？也許我們不應抱怨香港人的短視，甚至他們的自私自利，眼中祇有物質享受的毛病也值得原諒。因為他們什麽都沒有——就連一片屬於他們的土地，一塊他們可以叫做「故鄉」的土地也沒有，所以他們不能不把握着所有他們可以捉摸到的，你能怪他們現實嗎？那是香港人的悲哀。

那一陣子突如其來的靜默眞叫人難受，空洞洞的，彷彿刹那間墮入了無聲的世界，耳畔的嗡嗡聲令人覺得耳膜快要震裂般。巴不得載個客聊上幾句。今天晚上好像特別冷清沉寂似的。

停了車，隨身帶着錢箱，鎖上車門，三步作兩步的跑進公厠去方便方便。也好，公厠裏一個人也沒有。前幾天老馬就是入公厠方便之際，給人打刦，錢箱丟了還不算，大腿還挨了一刀，眞是倒霉倒到了家。其實我說要錢還不是乖乖的雙手奉上好，錢財身外物，免得身體受罪。

解決了整個人都輕鬆得多，剛走出公厠外突然暗處探出一隻手來挽住我的臂。誰？我慌忙擺脫了那隻手的糾纏。好瘦弱的手，留長了的指甲上還塗上血紅的指甲油。先生，要過夜嗎？二十元就成啦。那雙骨瘦如柴的手又來挽着我的手臂。她的臉孔也從暗處冒了出來。濃濃的胭脂蓋不過她瘦削的面龐上的病容；薄薄的唇上塗着口紅，多麽的像鮮血！嘴角勉強的掀着笑容，（你要買笑嗎？笑！）露出兩排微黃的牙齒。深棕的眼蓋膏更顯明了那雙深陷失神的眼。

是的，那不是一雙晶瑩的眼，裏面再也找不到什麽靈魂的閃動，頂多是一個沉淪了的靈魂在那裏呻吟哀號。但——我看見了哀求，那埋藏着的許多辛酸痛苦，我不敢去細想其中許多悲慘的故事，是什麽教我眼前這個弱小的女人丟卻了自尊與羞恥，是命運？是滿天的神佛？是前生作孽今生受？（那是女人最古老的行業，也是女人最後的資產，你為什麽要問？有人問過同樣的問題沒有？有！但是生活依然是生活，你只是來世上生活，你可以改變生活嗎

又回到碼頭，船還沒有來。我點了支香烟，用力的吸，讓那陣辛辣的感覺直漫延到喉頭，然後緩緩的再吐出來，看着那霞霧似的輕烟在面前浮沉舒捲。兩個小鬼又快要考中期試，得叫亞蘭多督促他們溫書了。其實兩個小鬼倒很要得，上學期兩個都考了全班第一名。看來升上中學是不成問題的。小敏小六，小賢小五，再過兩年兩個都讀中學，我再捱五、六年待他們中學畢了業，出來做事總可以賺上千多元一個月，可以幫補一下家用。不！要是考得上大學，一定要小賢入大學，最好是讀醫科，將來做醫生，不但在社會上有地位，而且聽說月入六、七千元。那時亞蘭就不用再回電池廠上班了。她的那份工眞的要命，空氣汚濁不在話下，尤其是那掙炭棍的部門，雙手整天都沾滿炭屑，下了班就是用肥皂洗了又洗也還是洗不掉。我是勸了又勸，她硬説工資好不肯辭工。

誰叫自己日搏夜搏每個月才有千來元收入。唉！一切的指望唯有在小賢小敏的身上了。「家無讀書子，功名何處來」。我們窮人家，還不只是寄望兒女爭氣，考上大學，將來做大醫生、大律師或者大工程師之類，那就「一人得顯貴，萬代亦沾恩」。瞧人家張大叔，自從兒子做了醫生之後，現在自己買了洋樓，雖然不過七百來呎，但終究是自己的，租金飛漲是不聞不問。單是他每朝早挽着孫兒，托着雀籠上茶樓那份悠閒，就教人羨慕死啦。

明早回去一定要叫亞蘭好好的管教他們兩個讀書。尤其是現在改行了什麽新的中學派位制，可是一步也不可以放鬆。測驗考試都要考得好才有希望派到出名的學校讀中學。是的，一定要他們讀好書。中學、大學一路的上啊上啊！

只要再捱過這七、八年……啊欠！等待吧！人生就是免不了要等待。啊欠……

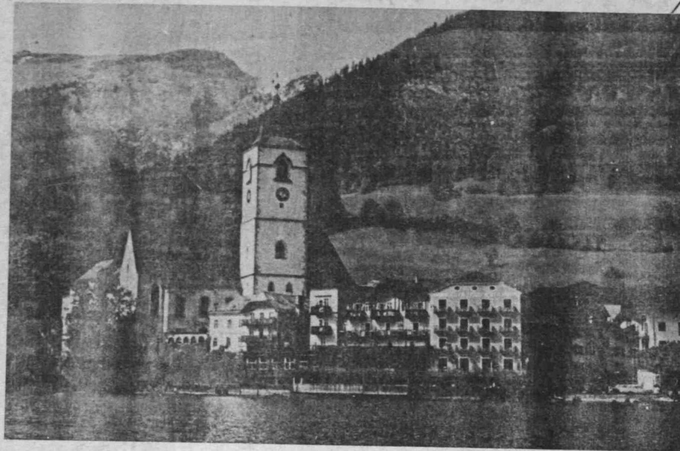
## 等待，回家

船又泊岸了，走過來一對年輕的男女，手挽着手頭並着頭的，喁喁細語的一刻溫馨，沉醉在二人世界裏，狹窄得容不下第三者。那男的彷彿在訴說着一篇又一篇的情詩：摘星星攀月亮，一個跳躍上雲端化作牛郎織女，轉身墮落紅塵又變作比翼鴛鴦。那女的滿臉嬌羞，輕嗔淺笑，掩不住心底的蜜意濃情，任那流波顧盼，瀉下星星無數。

那甜蜜的一雙擠進計程車的後廂，那計程車司機彷如未覺，待那男的叫出一個地址之後，那司機才滿臉無奈的戴上手套，狠狠的吸了

# 歐遊拉什談

青斯



## 我是中國人！

我雖然不是一個盲目的民族主義者，但每當有人用一種帶鄙視的語氣問我是否日本人之時，總覺有點刺耳，不對勁，唯有強作笑容，說個不是，心裏卻暗暗責道：難道你們些外國人連中國人也識不得嗎，聽聽我們的口音也該知道不是日本人。其實，說一句公道話，東方人的面孔並不容易互相分辨出來；更何況連好些日本人也要把我們當做他們的同族，實為之氣結。困難的程度就猶如叫我們去分辨一個法國人及德國人的面孔一樣。也難怪他們會猜我們是日本人，因為日本的遊客多，本來被認錯國籍並不是什麽大不了的事；他們若說我們是韓國人，我們定不介意。但碰巧日本人在上兩次大戰中都曾做過很多令中國人不能忘記的慘事，是我們上一代的仇家，自然地對民族自尊的要求就更明顯；又加上他們那種鄙視的語氣，叫我們怎樣去吞下這口氣呢！戰爭時受日本人欺負，想不到戰後又要被人當作日本人，不禁大嘆一句：中國人那裏去了。我們中華民族的八億子民究竟都比不上這個小日本嗎？

在香港的時候，我們沒有機會去感受這份民族感情。對年青的一輩而言，中國是一個很遙遠的地方。他們大都以香港人自居，佬然說其香港話。但當我們置身於數千里外的異地，穿插在金頭髮藍眼睛的人叢中時，這份民族的感情就在被人誤作日本人的情況下，表露出來。當我們說出「我是中國人」時，就好像要將中華民族五千年來的優秀文化在短短幾個字中纖毫畢現地表現出來。

「我是中國人！」

「我是中國人！」

有些時候，做其假日本人——基本上沒有人能夠第一句就問我是否中國人——也不是沒有好處。起碼他們會將一些他們看不慣我們的行徑都入到日本人的眼裏去，例如在維也納坐在草地被趕，在街道旁開餐被人凝視等，以保持中國人的美譽，也好讓日本人去捱吓苦頭，以補償他們對中國造成的創傷。這個玩意也不錯吧。當然，我們都不是有心的。

## 工商業發達的西歐·落後的中國

西歐諸國普遍上工商業都非常發達。尤其是西德，能夠從一個戰敗國的身份在短短三四十年間，發展到現階段的經濟建設，倒是一個大奇蹟。其實，整個歐洲受戰火摧殘的程度不下於中國，為什麽中國的經濟建設到現在仍是一團糟呢？又是數百年的積弱，文革十年及林彪四人幫的禍害嗎？還是中國的傳統文化，傳統舊思想，舊觀念及封建的色彩把中國勒住了？單就人口方面，中國就處處被她那八億人口牽制着。在奧地利，她們的人口增長率是零，而要政府鼓勵結婚，鼓勵生兒育女，對比是何其大呢！孫中山先生當年遍遊歐美，就曾經創下他的五權分立制度及訂下一套建國方計，但是卒之沒有機會實行。不過，我想就算實行，成功的機會也不大，因為中國太大了，食指浩繁，單要全國人有得食就夠繁複了。幅員廣大，各地方發展的程度也有所不同，政令既不能太死板，又不能讓各省各自為政。行政之繁複，也助長新的官僚層出現，這一切都使中國百上加斤。不過，我們也不宜妄自菲薄，因為西歐的經濟復甦實有賴美國在戰後所給予的經濟援助的。

## 風土人情

能夠欣賞到各地的風土人情，倒是一件賞心樂事。英國人的高傲；法國人的愛美；德國人的踏實；奧國人的樗檏自律；義大利人的訐狡、懶惰，全都儘收入眼簾之下。

**奧**國的民族服裝尤為特別，惹人喜歡。女人一襲衫裙，裙腳及膝，沒有袖的就內加一件白襯衣，而人人的裙前面都有一塊圍裙狀的巾。給人一種青春活潑的氣息。除了民族服裝特別之外，住在奧國的人，也有一種與世隔絶之感覺。一來奧國風景秀麗，二來自兩次大戰之後，奧國已成為一中立國，再加上民風樗檏，有點仙境意味。但是，奧國人是很自律的。地車、城市車等基本上都沒有人查票，但是人人都買票的。横過馬路的時候，雖然左右都沒有車輛駛來，但他們一定要等行人綠燈亮了才肯過馬路。所以我們這羣香港客，處處都似乎在扮演 Law Breaker 的角色。我們就因為不知道公園內的草地不准踐踏，還以為身在海德公園，坐在草地上吃晚餐，就惹來途人怒目相看，而有位好市民居然報警，要得麻煩警伯開來勸喻我們離去。可見一斑。

**德**國人比起其它都顯得友善。他們都肯主動地以英文和我們交談。曾經有都次在萊茵河上的一個子鎮 BINGEN，我們下了船後，欲橫過鐵道前往火車站，但碰巧閘是長期鎖上了的，欲過無路。此時只見車站上有人伸頭窗外，打手勢向我們示意。當初我們還以為他要我們繞過另一條小路，誰不知一分鐘之後，只見一名十來歲小子衝出來，替我們開了閘，並引領我們去搭火車赴法蘭克福，更可見一斑。只可惜我們未有充份的時間，在每一處地方逗留上多些時間，好讓我們對當地的風俗習慣、生活等有多些體驗。

## 流浪者

在旅程當中，也碰過不少這樣「流浪者」。他們住在那裏，就在那裏找工作；住厭了，就移去別處國家。這樣的流浪生活是多麽的浪漫，寫意呢！當然，這些流浪者都以白種人、澳洲人等居多，東方人也有。我們就遇見過一位日本大學生，從教授申請了一年的假期，去歐洲工作及體驗異地生活。不過，東方人的例子不太多呢！流浪者的另一形式，就是街頭的表演。別小看他們是普通的江湖佬賣什技。其實他們的技藝都十分精湛，造詣之深，並不與等閒之輩同類。他們大部份都以樂器為主，有小提琴、結他、簫，也有小型樂隊呢。收入當然不大穩定，但是那種自由及浪漫，卻惹人羡慕呢！談到歐陸風情，除了「流浪者」之外，不可不談歐陸茶座及白鴿。露天茶座在整個西歐大陸均可見到，大部份都設在寬濶的行人道，廣場或市集上，收費並不便宜呢。但他們所欣賞的是那種情調：能夠坐在一旁，靜觀人生百態，欣賞着生命，享受着時間的過去……，一種靜與動的對比。假若你是作家而找不到靈感寫作的話，定要到那些地方去走走。不過，只因為他們的行人道濶，車輛少，污染少才能有如斯情調。起碼巴黎的很多露天咖啡座，已經因為空氣的污染，而被迫罩上的玻璃。白鴿的普遍情度更不下於茶座。白鴿像徵着和平。歐洲經過兩次大戰戰亂之後，人民基本上都希望和平。只有白鴿才能大模私樣地越過那柏林圍牆而不被機槍掃射。不過，東柏林的白鴿可就比西柏林少得多了。上了年紀的老人家都喜歡飼養狗隻。我想此舉主要是將空虛的時間寄托在狗兒上吧。這也倒是明智之舉。因為狗是忠於主人的，有時比自己的兒子還來得可靠。

## 意大利——騙子集中營

天下烏鴉一樣黑。騙子是無分國籍的。然而，義大利人的騙人技倆就似乎比較超卓。吃了千五里拉的義大利粉，卻要付六百里拉的 Cover Charge（上蓋費）及三百里拉的服務費；明明吃餐是奉送麵包的，卻來個多謝二千里拉。那街上賣的幻燈片，就正正是可近看而不可遠觀之。把它拿在手上來看還可以，但一經幻燈機放映在幕上，就會有意想不到的失望——一張色調奇差而又滿佈火車軌的幻燈片。而意大利的火車又是最不會令你失望的——假若你想它遲到的話。所以，你永遠有充裕的時間去趕火車。它是「永遠都遲到的火車」。曾經有一次，我們自佛羅倫斯乘火車返羅馬。車程約需三小時。但那班火車自佛羅倫斯開出的時候，已比原定遲了一句鐘，再加上奇慢的車速，火車返抵羅馬之時，已是午夜十二時，比原定遲了三個小時。你也不能不服。義大利的火車給我們留下了永遠難忘的記憶。

## 最美的地方

旅程中，最美麗的地方莫過於薩爾斯堡（SALZBURG），威尼斯及萊茵河。薩爾斯堡是電影「仙樂飄飄處處聞」的拍攝地方。市內保持有一份中古氣息，再加上傳統的奧地利民族服裝，這個莫札特的故鄉確實令人留戀。市郊更有美麗的景色，聳入雲霄的阿爾卑斯山脈，還有寧靜的湖泊，如詩如畫的農莊、鄉村。整個城市的寧靜，就有如世外桃源一樣。威尼斯的晚上也是一處令人流連忘返的地方。每當夕陽西沉，躲在聖馬可廣場後面之時，坐在船上，聽一兩首義大利民謠，欣賞着遠方的海鷗在下沉的火球前飛舞，令人胸懷舒暢，煩惱倦意全意，就像 SANTA LUCIA 的歌詞一樣。華燈初上的威尼斯，比起它的夕陽更有情調。一排排的干道拉（GONDOLA）載着一批批的遊客，在大海及河道上遊戈，那邊有人奏起手風琴，這邊有人唱起義大利民歌，令人陶醉。

其實，只要我們有這份閒情逸志，能夠抛開一切煩惱，無論去到那一處地方，都能欣賞到那地方別於人之處，都會愛上了它。旅行，除了增廣見聞之外，還可以助我們抛開塵世的煩惱，好好地去享受一下大自然的美。不過，無論怎樣長的旅程始終都會結束的。

香港其實也是一處很美的地方——暫且撇去她的交通及居住問題不談。蓋因為我們已經從一個被剝削的位置，晉升為一個輔助剝削者。而剝削者才有那份閒情逸志去欣賞香港的美！

美是醜惡的概念！

一九八〇年七月廿四日

**編者按：** 文內副題由編者加上

# The frustrations of a University Teacher

– Dr. J. C. Y. Leong
(Senior Lecturer, Dept. of Orthopaedics)

The provision of a comprehensive orthopaedic service by the Department of Orthopaedic Surgery, University of Hong Kong has been in existence for the best part of thirty years. The Medical & Health Department has undoubtedly contributed its fair share as well. However, whilst the government's part of the service has expanded considerably with the opening of Queen Elizabeth Hospital in the sixties, and Princess Margaret Hospital in the seventies, both located north of the harbour, on Hong Kong Island the University has retained full responsibility for the treatment of orthopaedic patients.

It is commonly accepted that medical teachers in a university have at least four functions to fulfil, viz. teaching of undergraduates and postgraduates, provision of a medical service, research, and administration. As research and publication remain the main basis for judgement of an academic's performance as well as for his suitability for promotion, it is only fair that the institution employing him viz. the University, should ensure that he is given enough time and facilities to pursue his research interests. This is not to say that he should not give a fair share of his available time to teaching and his professional duties. Ideally, research, teaching, and service should occupy about equal proportions of his time, with adminstration taking up a much smaller proportion.

Within the clinical departments of the University of Hong Kong, the provision of teaching staff has been based primarily on the number of medical students being taught by the respective departments at any given time. This has resulted in the "smaller" departments, teaching specialty subjects, having a disproportionately small number of teachers. The fact remains that these so called small departments may have as large a service commitment as the so called big departments. Another consequence has been the marked discrepancy in the time available for research to teachers of different departments. It is a well known fact that teachers in certain departments enjoy the luxury of being "off ward duties" for months on end to undertake research activities.

It has been the practice to provide government medical officers to "small" university clinical departments with a large service load. This is an attempt to alleviate some of the work of university teachers. However, the great majority of government medical officers provided are only in training, and cannot be relied upon to shoulder much responsibility. In addition, the number provided not uncommonly falls short of government establishment.

In the final analysis it is my considered opinion that, whilst there should be an element of dedication and keen interest in research and advancement of knowledge if one purports to be an academic, in all fairness, it is the responsibility of the University Authorities to apportion to its teachers ample time to engage in such pursuits.

Furthermore, this should be comparable between departments because each department has as important a role to fulfil as any other. Otherwise, university clinical departments revert back to mainly service rendering, which any government clinical unit can well undertake to do.

# Comments On Problem In Orthopaedic Practice in H.K.

— A group of orthopods from PMH

This is a vast subject to be discussed on papers alone and indeed it is the most concerned problem among all colleagues. Instead of trying to labour too many words on details and personal opinions, a brief guide-line pooled from different view points is presented. The emphasis is made on two major areas: teaching and service, with opinions from the senior (Consultant, S.M.O.) and junior (M.O. & H.O.) accommodated.

**I. Teaching**

**A. Undergraduate**

- The curriculum be more appropriately emphasized on the teaching of concepts and general principle of orthopaedics.
- Introduction to various subspecialties in orthopaedics.
- Exposure to orthopaedic practice in other hospitals.
- Standard of teaching staff fluctuate.
- Expertise from other Units should be accommodated.

**B. Postgraduate**

**1. Pre-Fellowship**

- No organised programme in surgical training in general; haphazard posting like "Brownian Movement".
- Limited exposure.
- A rotational scheme among various units and subspecialties is desirable.
- Organised postgraduate training course: weekend course, day seminar, etc.

**2. Post–Fellowship**

- No system of continued education
- No substantial provision or supervision in overseas training
- Overseas training period of 3-6 months is too short
- Sponsorship for conference and meeting should be allowed
- An annual meeting of the Hong Kong Orthopaedic Association — active participation and original contribution should be encourage.

**II. Service**

- Workload too heavy.
- Lack of facilities for research and expansion of service.
- Liaison among various Units required.
- Lack of evaluation of work performance of individual clinical unit.
- The charity-based public medical service may need revision. More contribution from the public may help to raise the quality of the service and prevent abuse of the service.
- Supporting facilities need improvement. (esp. staff quantity):
  - X-ray
  - Prosthetic & orthotics
  - Physiotherapy, occupational therapy
- Lack of convalescent beds.
- Improvement in working condition to minimise disparity between institutions and private practice.

(adapted from Newsletter, Hong Kong Orthopaedic Association, Issue No.2)

# MEDIC 拉雜談

M. D.

問：你知不知道醫學院的前身是甚麼？第一任 Dean 是誰人？而將會上任的又是誰？

答：很容易啫，Medic 前身是香港中華醫學院，於一八八七年八月成立，第一任 Dean 是白文信醫生（Dr. Patrick Manson）。而謝嘉樂教授（Prof Hsieh）將會代替高本恩教授（Colbourne）為下任院長。

問：Medic 總共有多少 Department？

答：小兒科！Medic 共有十三個 Department。

問：Medic 現時女生共有多少人？

答：Medic 女生現時有八十人（不計八五在內），各級分佈如下：

八一：廿六人
八二：廿一人
八三：十人
八四：廿三人
八五：？

約佔總人數百分之十三點五。

問：政府每年平均用於培養一個醫學生共需多少？

答：大約每人每年三萬多元，由此可見，培養一名醫生要用去納稅人很多金錢，所以你們畢業後，應盡力為社會服務。

問：我想你也知道醫學院有 Clinical Residence 的，那你知不知道它可以容納多少人？

答：那裏有雙人房四十五個，單人房兩個，另外還有一層 Master's Flat。

問：民以食為天，你知不知道 Medic 附近有何地方可以吃飯？

答：Medic 之 Canteen 在陳蕉琴樓，如不喜歡，可以到下面羅富國的 Canteen，如果有腳骨力的話，可以行上瑪麗的 Houseman Canteen，如有私家車的話，也可以到華富邨的碧麗宮酒樓。

問：講一些上 Lecture 時的情形來聽。

答：好！講些「貼士」你聽。在李樹芬樓上堂夏天要帶棉衣，冬天要帶氧氣筒。最好學會速記，否則抄 notes 也抄到手軟。要聽書最好坐在前排，但是要休息最好要坐後D。

問：人人都說醫科難讀，你知不知道近幾年來的畢業及格率是多少？

答：雖然醫科難讀，但醫學生多數都很勤力，所以每年都過百分之九十五的人數畢業？

問：Medic 的教師有多少？

答：教授級（Professor）有十八人，高級講師（Senior lecturer）共有三十八人，講師（Lecturer）共有一百二十二人，數目也不少啊！

問：你又知不知道最少和最多人上的堂是什麼？

答：最少人上的當然是 P.E.（體育）堂，最多人上是：哈！是考試前的 Revision Lecture。

問：聽說 Medic 的運動成績一向很好，那麼 Medic 共奪得多少次 Omega Rose Bowl？（註：Omega Rose Bowl 是獎給每年奪得院際運動比賽總冠軍的。）

答：Medic 的運動成績確是驕人，Omega Rose Bowl 共舉辦了十七年，Mecic 總共奪得十二次之多，為各院系之冠。

問：在醫學院有一年了，那你知道醫學院的正確地址？

答：這個……這個……待我查查看先。啊！是香港薄扶林沙宣道七號。

問：一年來，你對上 Practical 的感受如何？

答：在一年級時，所學的三科都要上 Practical 但感受各有不同。上 Biochemistry Practical 時，每次總是要 Pipette 和 Centrifuge。上 Physiology Practical 時，則像在醫院檢查身體，而上 Anatomy Practical 時，則「六人一屍，三人一邊；一人讀書，一人劏屍，幾人 Fussy。」

問：人總會生病的，那麼要在大學包兆龍診所睇病的手續怎樣？

答：通常是要預約的。步驟是先打電話四九四六八六，講下姓名，faculty，幾年級和所預約之時間，也可以指定某一個醫生的。

由於篇幅關係，還有很多有趣的問題，不能盡錄，下次有機會再講多些給你聽吧！

# An interview with Professor Colbourne

Caducean

Professor Colbourne, a fine Englishman who spares a humorous chat with every student he meets even in his busy hours, is going to leave in the coming November. Professor Colbourne came to Hongkong in 1973. Besides being the Professor of the Department of Community Medicine, he assumed Deanship of the Faculty since early 1978.

Professor Colbourne told us that his major hobby is reading, both medical books and non-medical ones, including fiction, and with current interests in history and biography. He maintained that physical exercise is also important. So he plays golf. Moreover, he is a good Bridge player. (He was joint winner of the Trophy last year. He would like to present the Trophy for competition again this year – see who can win that.)

In actual work, on the other hand, Professor Colbourne devotes much of his life to medicine. He has long been a community physician. Moreover, his experience as a medical educator has made much contribution in this field. In the vacation, we had an interesting talk with the Professor. The following are the main extracts.

**Q:** First of all, would you like to tell us your personal history? May be your family background to begin with?

**Prof:** Yes. My father was a solicitor. I was always expected to become a lawyer so as to take over my father's lawyer firm in South England. But my father died in my early age. My mother remarried and I happened to be brought up in a family in which people are interested in literature and the stage. Actually one of my step brothers is an actor in one of the popular TV serials.

So that is my family. When I grew up, I chose neither lawyer nor the stage but medicine.

**Q:** How about your academic history?

**Prof:** I qualified in medicine during the War. I went to India and Burma as a medical officer in the Army. And it is during that period that my interest in tropical medicine developed. After the war, I took a refresher course and then went to work in Africa. I was first a general duty medical officer who was responsible for medical services in the district, both preventive and hospital services. Later, I concentrated on the preventive side and worked as a Malaria officer of the Ghana government.

After Ghana became independent, I worked as a Malaria advisor of the WHO in Sarawak. At that time, a Malaria Eradication Programme was being undertaken in the West Pacific region.

After those years of practical work, I turned to the academic side. I returned to London and became a lecturer in tropical hygiene.

Later I was a Professor of Social Medicine and Public Health in Singapore for five years. Then I returned to London for a few years. In 1973, I came to Hongkong and in 1979 took over the Department of Community Medicine from Professor P.H. Teng.

My main field work was Malaria research and when I came to Hongkong, I found myself much interested in the pattern of diseases here. I am impressed by the importance of carcinoma of the lung in Hongkong, especially that of women. My main research was the epidemiology of the Ca of the lung.

I am now a community physician. But before that, I have had a background of general medical experience. I think that it is very important for one to be exposed to a wider field of medicine before he narrows himself to a specialized part.

**Q:** After working here for over six years, do you find any problem as far as medical education is concerned?

**Prof:** I think this can be divided into two parts:

First, there are the questions of the Department of Community Medicine: When I arrived here, the department was in a stage of transition. Professor Teng ran the department for many years when he was also the Head of the MHD. The department had only just become a full time academic department. There were lectures, given by part time lecturers who are mostly staff of MHD. When I took over, I found that foundations Professor Teng had laid, now enabled the department to branch out in different directions. I think the main way to do is to involve students in practical work, so as to let them see what the community and social problems are in Hongkong. Certainly they must understand the medical and health services in Hongkong and the epidemiology of important diseases here. But I think these practical experiences are much more important than the information delivered in lectures.

Second part of the problems begin when I assumed Deanship: I think my Deanship coincides quite closely with the establishment of the new curriculum. In the new curriculum, as far as the Department of Community Medicine is concerned, the behavioural science and the General Practice course are much emphasised. A review of the Behavioural Science course is being done and I know that the General Practice teaching will develop further.

**Q:** Do you think that students do benefit from the Community Medicine course?

**Prof:** Yes, but it varies with different parts of the course and individual students. Some students feel that the course is quite away from what they expect to do as doctors and they do not get much from it. Some students are convinced that the community approach to medicine is extremely important. I think they benefit much. Of course, there are many in the middle that are interested in some aspect and less so in others. For most students, they would understand best when they had some field experience in medical social cases and T.B. epidemiological studies in the paediatric specialty clerkship.

Another benefit, I think, is the knowledge of the set-up of the medical and health services in HongKong. It is essential for every medical worker here to realise he is a member of a team though it may not be very interesting subject academically.

**Q:** What can the Dean do here as far as promotion of medical education is concerned?

**Prof:** The Dean is the Chairman of the board of Medical Faculty. His duty is to draw together the various problems of the departments so that communication and co-ordination are facilitated. Mechanisms have been set up for these functions. In addition, there are various landmarks in which the Dean plays important roles. For instance, preparations of plans for every triennium, development of a new curriculum and, say, organization of contacts with foreign bodies such as the GMC. Moreover, another important role is to make sure the students understand the objective of what they are doing. The students' official seats in the board of the Faculty and other committees as well as more informal contacts are an important machinery for this.

**Q:** Do you find co-ordination between departments difficult?

**Prof:** It is a very difficult point. Some universities try not to have departments at all. Some universities try more integration. But much work for co-ordination has to be done if integration is to be achieved. Sometimes there is not enough time for preparation of actual teaching if you spend too much time integration. So a balance has to be struck. In our faculty, there is now an integrated term in the third year in the new curriculum. Judging from students' responses, the integrated teaching was enormously successful last year. (actually the first time) But it involved much hard work by Professor John Wong and Professor Hsieh who acted as the coordinators.

*Professor Colbourne: a M.O. in the Army, a community physician, our Dean, and an English gentleman.*

**Q:** What do you think are the social roles of doctors?

**Prof:** The social roles of doctors can be discussed in three aspects.

Firstly, there is the physician's role in primary care. Patients always have the feeling of being physically or mentally unwell. They need the doctors to find out what the problem is. After that, the doctor has to reassure the patient if the case is not serious, or if the case is serious, active management has to be sought out. In all these cases, technical expertise is demanded from the doctors by the patients. Patients want a sympathetic doctor who understands their problems including social problems but also expect a doctor to be efficient and up-to-date.

Secondly, there is the role of community physician. In such context, health education and prevention of diseases are the main concern. Such doctors have to co-operate with other professions.

Thirdly, doctors may act as medical administrators such as advisors and organizers of medical services.

**Q:** What are the new emphasis of medical training?

**Prof:** This is much related to the changing pattern of medical services.

Medical practice is becoming more and more complicated. What we are doing now is a training for a specialized career in specialty at the end of the medical course. However many of our students are going to be general practitioners after graduation. So continued training after graduation is essential. There has to be an organized post-grad. training and the question of training of GP's has to be solved. This is now just as important as training for other specialties.

**Q:** Now that paramedical services are being developed in Hongkong, is there a tendency for the paramedical staff to take over doctors' role of primary care?

**Prof:** There is a change in the pattern of medical service. The focus of the problem is one of expense. As Professor Hutchison said, even the more wealthy countries can't afford completely first class medical service. So there has to be a choice of utilization of medical resources. But who is going to decide the priority?

In many developing countries, it is not possible to produce enough university graduates as doctors. Paramedical staff offer the major first line service.

In developed countries, the priority has to be decided within the community. In Hongkong, neither the medical profession nor members of the community seem to prefer the substitute.

**Q:** Finally, are you satisfied with the medical students here?

**Prof:** I am never satisfied with anything. (Laughing) Nevertheless, the intellectual standard of the students here is high. They may be too academically oriented. There is a tendency for an overemphasis on theoretical work and not enough practical work. On the whole they are an easy group of people to get on with. (and to play bridge with)

Don't you agree with Professor's view on you, medical students?

# INTEGRATED TEACHING

—Chan Kwok Cheung

According to statistical evaluation, the integrated term is welcomed by students, so it is said.

Good heavens! Welcomed by students? I hope it is not because they are interested in seeing different departments trying to 'gain the upper hand' in the session.

Fortunate or unfortunate, I have been a 'guinea pig' for 2 weeks in the integrated term rehearsal last year. It was a waste of time, considering the time spent (the whole morning) and the effort on the part of the lecturers. (I have not been to any integrated term sessions held this year. There might have been much improvement, I hope.)

The teaching we have is essentially compartmentalized. I still remember the integrated teaching in neurology in second year – it was 'integrated' just because all the departments concerned taught neurology in that term. Each lecturer still gave the lecture independently, with no integration at all on the subject. The lecturer in anatomy might like to subdivide the cerebellum in a phylogenical way, while the lecturer in physiology might like to teach on a different anatomical subdivision of the cerebellum before he proceeded to physiology.

No better was the integrated term. Each lecturer just gave his own account of the subject. And in presenting the clinical material, the lecturer would reiterate the anatomy, physiology or biochemistry as necessary. Without real integration as it was conducted, the session could well be done by the clinical lecturer alone.

The 'integrated term' is a very good idea, because it shows the Faculty's realization of the importance of integrated teaching and efforts put on it. But I do not see this as the final solution, as the aim should be integration at every step of the curriculum. In a brief chat with Professor P. Chen (University of Malaya, external examiner of Community Medicine in 1979). I was fascinated by the interdisciplinary approach in the medical school of University of Malaya. So I suppose this is not an impossibility.

I see the following as the minimum towards the above goal. In the preclinical years, the basic sciences of medicine can be taught in a more interesting way by introducing the clinical relevance. The emphasis should be on 'what can go wrong' rather than diseases or the difficult-to-remember syndromes. In the clinical years, the teaching should be more on presenting symptoms and signs with pathophysiological correlation rather than giving long lists of common and rare manifestations of diseases. It is certainly much easier to remember if one knows why something happens or why something is done.

A great worry about the 'integrated term' is that some lecturers may back away from an integrated approach in ordinary lectures, as 'there will be a term for integration in the third year anyway'.

A heavier dose of integration is what we need.

# G.M.C. REPORT— A SUMMARY

Following the visit by a delegation of the General Medical Council of U.K. in April, the G.M.C. has confirmed that it will continue to recognize the degrees of M.B.,B.S. of our University for the purpose of full registration in the United Kingdom.

A report was also received, commenting on our M.B.,B.S. curriculum and teaching facilities. The main points are summarized below.

**(A) Admissions**

1. There are relatively few female students and mature students. (students aged over 30)
2. The undergraduates are highly motivated and extremely able students. Secondary school education, with its traditional emphasis on book learning and memory training, ensures that the students have a tolerance for didactic teaching and a capacity to absorb and retain facts to a degree not matched by the majority of their U.K. counterparts.

**(B) The new curriculum**

1. In some subjects the factual load had been compressed into, rather than reduced within the new curriculum.
2. The students welcome didactic teaching. However, a more critical and independent approach is wanting – students should be encouraged to learn more for themselves, particularly in laboratories and wards.
3. Introduction of an intercalated year of study (say after the pre-clinical studies) leading to a B.Sc. or similar degree will benefit future staff recruitment and medical research.
4. The integrated term's teaching is an encouraging beginning to the problem of rather compartmentalized curriculum. However, at present stage it is still more of an introduction to clinical practice than a bridging course illustrating the relevance of the basic medical sciences to clinical practice and patient care.
5. Students generally do not appreciate the relevance of preclinical studies to clinical application. More integrated teaching programmes can perhaps help to alter this outlook.
6. More staffing and funding are needed for Behavioural Science.
7. Teaching of general practice, which emphasizes continued primary care, is inadequate.
8. Clinical teaching in certain specialties, such as Ophthalmology, ENT, geriatrics, should be increased.
9. The students would welcome more time for the subject of 'medical ethics'.

**(C) Assessment**

1. In students' mind, the important concern appears to be 'passing examinations'.
2. Greater participation of external examiners is needed.

**(D) Academic staff and facilities**

1. The staffing level is currently adequate in preclinical departments, but problems may arise with the annual introduction of 76 dental undergraduates.
2. Staffing in certain clinical subjects is inadequate.
3. The overall availability of clinical facilities are just adequate for the present student load. However, sometimes there are still too many students in a bedside teaching group.
4. Expansion of Psychiatry and Paediatrics facilities are high priorities.

**(E) Knowledge of English**

The graduates possess the necessary knowledge of English as defined under the Medical Acts of U.K.

**(F) Internship**

1. The existing arrangements for the recognition of the internship scheme in Hong Kong should continue.
2. Recognizing the educational nature of the intern year training, introduction of clinical tutors and establishment of teaching facilities in regional hospitals are desirable.
3. For some posts, the interns have to be responsible for too many beds to allow them adequate free time for further education.

Because of inevitable changes over the coming years, the GMC would maintain a close scrutiny of the M.B.,B.S. curriculum, and a further review may be necessary in 5 to 10 years' time.

Most of the recommendations are welcomed by the Faculty Board. A conclusion has also been reached that a serious attempt must be made as soon as possible to implement the recommendations in the report to ensure continued recognition.

However, lack of resources is the limiting factor. To improve teaching in the medical curriculum to meet the Faculty's Triennium (1981–1984) and the recommendations in the report, the medical school has to depend on funds allocated by the U.P.G.C. The possibility of improvements in clinical teaching facilities at QMH (particularly Paediatrics and Psychiatry) rests entirely on the hands of the Medical and Health Department.

Also, the comments on the curriculum and teaching arrangements are considered by the Syllabus Committees in their continuing review of the curriculum as a whole.

The complete report of the GMC delegation is available on request from the faculty board members.
Fellow students are strongly invited to voice their opinion on the GMC visit or report.

*Student Members of the Faculty Board*

**八零年啓思編委會**

**顧　　問：** 黃志昭博士
**總 編 輯：** 袁維基
**編　　輯：** 袁寶榮　袁兆燦
**常務秘書：** 林文英
**行政秘書：** 關鼎樂
**財　　政：** 林紹艮
**流　　傳：** 劉修華
**對外聯絡：** 高興基
**資　　料：** 馮志榮
**去屆代表：** 何汝祥
**專題組：**
胡兆雲　馮志榮　李淵舜
沈祖明　高興基
**美術設計組：**
何大偉　李啓祥　謝文華　關鼎樂
陳惠娟　余國照
**文藝組：**
劉耀南　李啓祥　陳惠娟　謝文華
何大偉　梁耀昌　丘國維　黃就明
鄺沃林　范德穎
**時事組：**
何汝祥　曾繁光　袁兆燦　馮志樂
翁德璋　高興基　關子凱　林禮根
孫偉浩　袁寶榮　葉麗嬋
**記者組：**
梁永雄　林文英　黎滿勝　鄭鎭秋
林家慶　姚家聰　孫偉浩　馮小玲
**其他編委：**
甘啓文　方平正　張錦流　郭天福
劉少愷

The Editorial Board wishes to thank Glaxo, Hong Kong, Ltd., for its support.

# Kidney Donation Campaign

**I. INTRODUCTION**

In Hong Kong approximately 500 people die of kidney disease each year, yet in the past ten years, less than 50 patients with renal failure have received kidney transplantations to save their lives.

A person with end-stage kidney disease has to rely upon dialysis treatment to kidney transplantation to maintain his life. Dialysis is expensive, time consuming and poses a considerable burden upon the patient's life, whereas kidney transplantation offers the hope of a radical cure and a return to normal living.

In Hong Kong, we have sufficient expertise and equipment to carry out such operations. The small number of transplantations performed is entirely due to a lack of kidney donors.

We seek to improve upon this lack of donors through this campaign.

**II. AIMS**

1. To arouse the awareness of the public to the need of kidney donation as a cure for renal failure.
2. To increase the number of potential kidney donors.
3. To educate the general public concerning the nature, prevention and treatment of kidney diseases.

**III. TARGET AUDIENCE**

The general public, i.e. from secondary schools upwards.

**IV. TIME SCHEDULE**

The campaign will be conducted in 4 stages:

1. July 24—Aug 15 Initial formation of all working groups. Contact with external organizations
2. Aug 16—Sept 1 Preparation of teaching material e.g. booklets, pamphlets, slides, etc.
3. Sep 2—Sep 15 Training of social workers and students
4. Sep 15—Oct 15 Actual presentation to the public

The campaign will officially end on Oct. 15.

Further requests for talks by outside organizations may be handled by a core group of students for a further period of 3—6 months.

**V. WORKING GROUPS**

A. Internal publicity

Functions:
- to recruit man-power
- to increase the number of kidney donors among medical students

Responsibilities: to arouse the awareness of every medical student to the campaign by means of:
1. Internal newsletter
2. Posters
3. Class coordination
4. Banners
5. Orientation programmes of newcomers (Welcome Day and O-camp)

B. External Publicity

Functions:
- to disseminate the campaign message to the public
- to recruit social workers from outside bodies as extension officers
- to seek advice from external medical organizations

Responsibilities:
1. To contact the following for publicity
   - RTV, TVB, RTHK to arrange for preparations of special programmes for this campaign and to replay taped programme from 鑑鏘集 。
   - Commercial Radio and RTHK
   - Newspaper (SCMP, HK Standard,華僑，星島，大公，文滙，商報，東文，明報etc.)
   - Magazines (Reader's Digest, 香港電視 etc.)
   - Star Ferry

   A news conference will be arrange for news reporters in mid-September.
2. To contact the following for arrangement of time and venue for training of social workers and preparation for speakers for talks:
   - City District Offices
   - The Hong Kong Council of Social Service
   - Hong Kong Federation of Youth Groups
   - Kwun Tong Community Health Project
   - Central Health Education Unit of MHD to arrange for secondary schools
   - Social Development Committees
   - Mutual Aid Committees
   - YMCA, YWCA
   - Police, Fire Services, Red Cross, Scouts, Armed Forces etc.
   - Union Social Service Group, etc.
   - Nurses Association
   - Other post-secondary institutions
3. To seek advice from the following organizations:
   Hong Kong Society of Nephrology Ltd.
   Hong Kong Kidney Foundation Ltd.
   Hong Kong Medical Association
   British Medical Association (Hong Kong Branch)
   Hong Kong Chinese Medical Association

C. Information Collection

Function: To provide information for trainees and the publication of booklets and pamphlets

2 categories of information will be required:
1. Medical Knowledge
   - nature of kidney diseases and their treatment
   - misconceptions about kidney diseases
2. Kidney Donation Procedure
   - who can donate
   - reasons why people do not donate
   - matching and transplantation procedures
   - experience of other countries
3. Interactive interviews with kidney patients and donors will be arranged.

D. Fund Raising

A campaign fund is urgently needed to meet the requirements as detailed in the following budget:

| Item | Amount |
|---|---|
| Stationery | $500 |
| Slides | $500 |
| Booklets(10,000 copies) | $10,000 |
| Pamphlets(20,000 copies) | $3,000 |
| Stickers (7000 nos) | $7,000 |
| Posters (3000 copies) | $2,000 |
| Donor Cards (10,000) | $2,000 |
| Miscellaneous (banners, transportation, postage etc.) | $5,000 |
| Total | $30,000 |

**VI. ORGANIZING COMMITTEE**

*Chairman:*
Tse Kong (謝 江)
*Vice-Chairman:*
Leung Chung Ying (梁松英)
*Secretary & Treasurer:*
Lee Shing (李 誠)
*External Publicity*
Chan Shek Chi (陳碩志)
Fung Chi Wing (馮志榮)
Cheung Siu Ching, Philip (張少清)
*Information:*
Liu Hing Wing (廖慶榮)
Leung Sing Fai (梁承輝)
*Advisers:*
Dr. Andrew S. P. Hua, *Dept. of Medicine, HKU.*
Miss Mona Lo, *Kwun Tong Community Health Project,*
Central Health Education Unit, M & H. D.

*Campaign Headquarters:*
Medical Society, H.K.U.S.U.
*Address:*
Medical Students' Centre,
7, Sassoon Road, Hong Kong.
Tel: 5-870586
5-8781-213

# GALA PREMIERE '80

The Gala Premiere is a fund-raising project of the Medical Society, H.K.U. S.U. This year's Gala which was held on July, 18 at the Imperial Cinema, featured the "Islands in the Stream". The film based on Ernest Hemingway's famous novel, also known as "Islands in the Stream" which reveals the finest part of human nature, is a superb mixture of excitement, fascination and subtleties.

The funds raised will be alloted to the Elixir Loan Fund, which helps many needy medical students complete their education and to the Central Fund of the Medical Society for various activities.

Although it was raining at the Gala night, over 300 guests attended the cocktail party at the foyer of the Imperial Cinema. We were highly honoured by the company of:

the President of Medical Society, Dr Vivian Wong,

the Vice-President of Medical Society, Dr. C. L. Lai,

the Hon. Treasurer of Medical Society, Dr. F. Tang,

the Associate Members' Representative of Medical Society, Dr. Y. C. Lam.

Our Patrons – Prof. M. J. Colbourne, Sr. Mary Aquinas, Dr. George Choa, Dr. Peter C. Y. Lee, many doctors and friends.

Unfortunately, other Patrons, Dr the Hon. K. L. Thong, Dr. K. S. Lau and Dr. Henry F. K. Li were unable to attend the occasion which would otherwise be even more enlightened.

Dr. Vivian Wong and the Chairman of the Organizing Committee, Mr. Kam Chak Wah each delivered a speech, after which was the presentation of souvenirs to our Patrons and Presidents.

This year, we managed to raise about $35,000 over 90% of which was contributed by the doctors, who have always been showering us with concern, kindness and generous support.

Besides being a fund-raising occasion, the Gala Premiere '80 also succeeded in providing an opportunity for friends and members of the Medical field to gather together to have some fun, which is in fact one of our prime aims.



承印：忠誠排字植字公司 灣仔船街15號二樓C座 5-280745