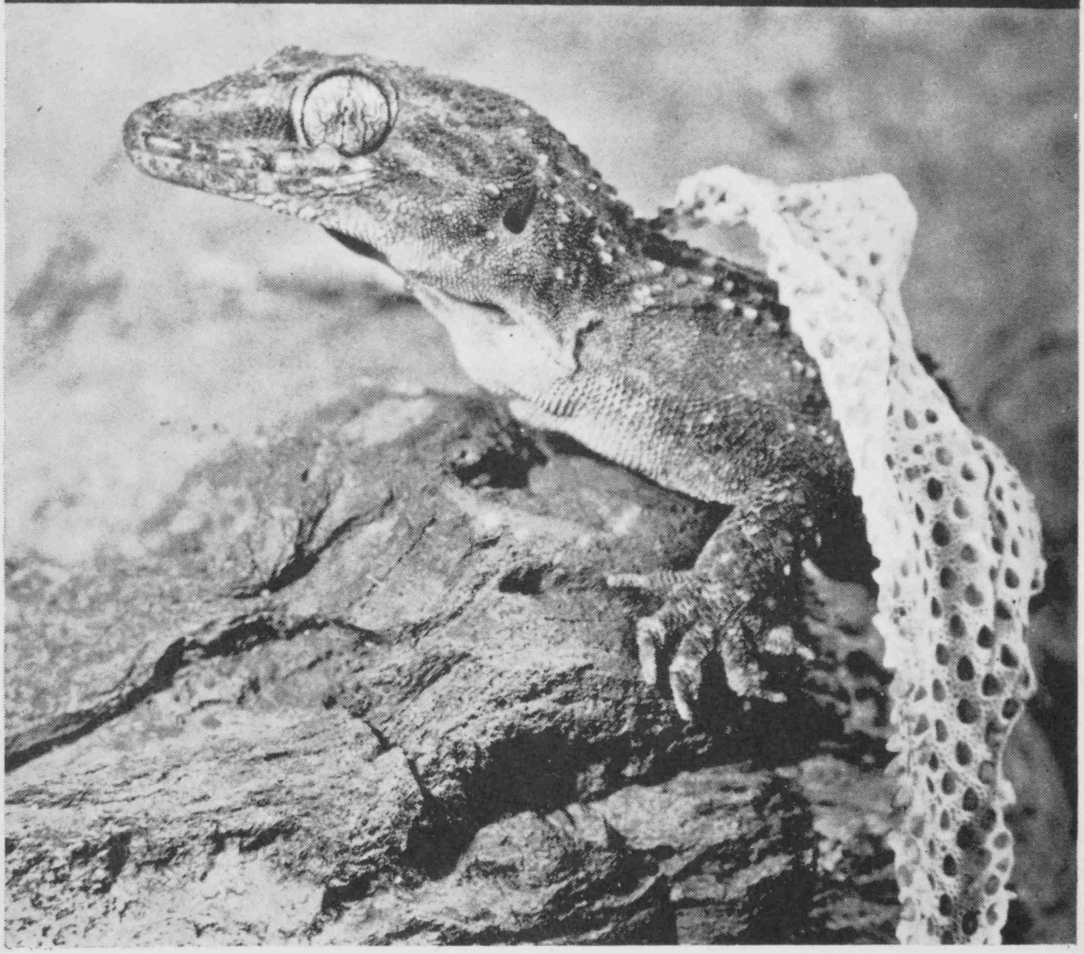
ELIXIR 1974

The next best thing to a new skin. Metosyn.



The Gecko, inhabiting S.E. Asia and parts of Europe, sheds its skin all year round. The new skin is soft and delicate with the texture of velvet.

Patients with inflammatory dermatoses may often wish that they could step out of their old skin with all its defects and, like the Gecko, emerge with a healthy new skin. Unfortunately, they can't–so for them the next best thing to a new skin is 'Metosyn'.

"It would appear that 'Metosyn' marks yet another advance in topical steroid therapy and that it is the topical steroid of choice in the management of psoriasis." *Brit. Jnl. of Dermatology*, (1972), **86**, 310.

Further information available on request.

Metosyn TRADE MARK

THE QUEEN'S AWARD TO INDUSTRY 1967 1968 1969 1970 1972

A complete treatment system for inflammatory dermatoses.

Imperial Chemical Industries Limited, Pharmaceuticals Division, Alderley Park, Macclesfield, Cheshire. PH 788/A/2

Sole Agents in Hong Kong:- **ICI (CHINA) LIMITED.** Union House, 16th Floor.

CONTENTS

Bacteria develop resistance not patients!

Chronic cystitis, pyelitis, pyelocystitis — and most other genitourinary infections — have such high recurrence rates that one tends to consider *patients* resistant to therapy — NOT the responsible bacteria.

Resistance of gram-negative bacilli to antimicrobials develops in two ways:

(1) on the *chromosome*, within the *same species*, or

(2) on an *R-factor plasmid*, an extrachromosomal resistance gene capable of *interspecies transfer*.

R factors are primarily responsible for drug resistance among *Enterobacteria*. R-factor transfer is rapid. Resistance to as many as 9 antibiotics may be acquired simultaneously. Chromosomal resistance occurs rarely. It is limited to the same bacterial species.

R-factor plasmids mediate infectious resistance to multiple drugs, playing a significant role in the trend toward diminishing effectiveness of common antibacterials in urinary tract infections.

Wintomylon is unique

Wintomylon is the ONLY clinically available antimicrobial agent that not only inhibits chromosomal DNA synthesis — and exerts a potent bactericidal effect — but also disrupts R-factor plasmids and blocks their activity. This unique dual action helps explain why, unlike other antibiotics, Wintomylon retains its remarkably high efficacy after long-term clinical use.

Wintomylon — provides effective bactericidal action in acute and chronic urinary tract infections

Wintomylon — is active against more than 90% of gram-negative uropathogens

Wintomylon — disrupts normal functioning of the gram-negative bacterial cell

Wintomylon — prevents the rapid spread of R-factor resistance to other antimicrobials

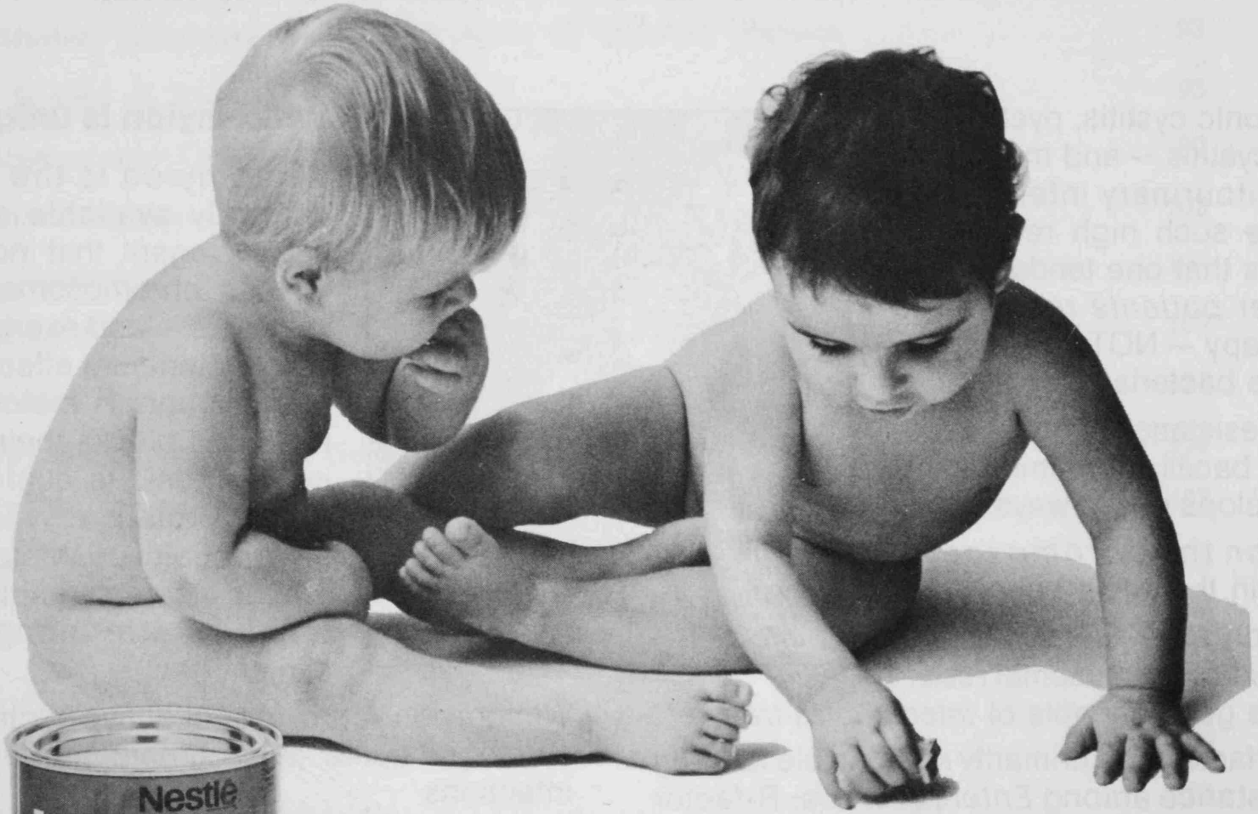
Supplied: Scored tablets of 500 mg nalidixic acid. Wintomylon Suspension (250 mg nalidixic acid per 5 ml teaspoonful).
For complete prescribing information see package insert.

Wintomylon

Reg. Trade Mark brand of nalidixic acid, NF

developed through research by Winthrop [W] Pharmaceuticals of merit for the physician

Do all babies need the same formula?



Both Lactogen formulas are enriched with all the necessary fats, vitamins and iron – and are made and guaranteed by Nestlé.

We don't think so

Different babies have different needs! LACTOGEN is ideal for most babies. But, for those who need more protein, we have developed LACTOGEN FULL-PROTEIN.

If there is danger that the formula is stretched to economize – or that milk feeds are replaced by poor quality weaning foods – then the baby will certainly need the extra protein that LACTOGEN FULL-PROTEIN can provide.

LACTOGEN

lets you choose the formula baby needs

ELIXIR

OFFICIAL PUBLICATION OF THE MEDICAL SOCIETY
UNIVERSITY OF HONG KONG

Pfizer announces a New Broad-Spectrum Antibiotic *specific* for Urinary Tract Infections

new

GEOPEN* ORAL

(CARBENICILLIN INDANYL SODIUM)

Outstanding Effectiveness in Acute and Chronic Urinary Tract Infections by virtue of...

☐ Broad-Spectrum Action— active against...

- *Enterobacter*
- *Enterococci*
- *Escherichia coli*
- *Streptococcus*
- *Staphylococcus*
- *Proteus mirabilis*
- *Proteus morganii*
- *Proteus rettgeri*
- *Proteus vulgaris*
- *Pseudomonas*

☐ 96% satisfactory clinical response in acute infections due to *Pr. mirabilis, E. Coli* or *Pseudomonas*

☐ Achieves exceptionally high urine levels in biologically active form

DESCRIPTION

Geopen Oral (carbenicillin indanyl sodium) a semisynthetic penicillin, is the sodium salt of the indanyl ester of carbenicillin. Geopen Oral is acid stable and well absorbed following oral administration. It represents an oral formulation of carbenicillin for use in the treatment of urinary tract infections.

INDICATIONS

Geopen Oral is primarily indicated in the treatment of acute and chronic infections of the upper and lower urinary tract and in asymptomatic bacteriuria due to susceptible strains of the following:

Enterobacter	Proteus morganii
Enterococci	Proteus rettgeri
Escherichia coli	Proteus vulgaris
Proteus mirabilis	Pseudomonas
Streptococcus	Staphylococcus

Geopen Oral may also be used as oral follow up therapy to initial parenteral therapy with carbenicillin in urinary tract infections.

Susceptibility testing should be performed prior to and during the course of therapy.

DOSAGE AND ADMINISTRATION

Geopen Oral is available only as a coated tablet to be administered orally. It is recommended that it be taken with or after food.

In an adult the usual dosage range is 0.5 to 1.0 gm. q.i.d. A dosage of 0.5 gm. q.i.d. is usually adequate in the treatment of acute **E. coli** urinary tract infections. If doses larger than 1.0 gm. q.i.d. are required, therapy with parenteral carbenicillin is recommended.

HOW SUPPLIED

Geopen Oral is available as film coated tablets. Each tablet contains 500 mg. of carbenicillin indanyl sodium equivalent to 382 mg. of carbenicillin.

Detailed information available on request.

Pfizer

*Trademark

Editorial

Medical students are among the most speculated and least understood student groups in Hong Kong. They often give other people the impression of being narrow-minded and book-wormish, or on the other extreme of being playboyish. Is this picture true?

It is possible that some students may present this picture, but they do not represent the whole student group, nor does such represent the sole character of an individual.

Academically, medical students have to work hard. They have to read up books after books, journals after journals, and study cases after cases. That is not all. Some even carry out research projects, and, although by no means outstanding nor spectacular, these represent the students' strife to acquire and consolidate knowledge through their own sweat. Indeed, it is the pride of every medical student to learn that the Hong Kong Medical Association Prize, uncontested for since it was set up in 1970, has been awarded this year to a third-year medical student.

What about the other aspects? Their sports are second to none in the University, and they have taken up many responsible posts in various associations. Whenever they could, medical students always answer to the call for service of the society. They are by no means contented to be isolated in the ivory tower. Various projects, such as work camps, visits and especially exhibitions, as will be described in this edition, had been initiated, organized and carried out with the most earnest and enthusiastic participation of medical students. The service they render the public may be trivial, nevertheless at the same time, they have educated themselves in academic knowledge and, more important still, in the art of communication with the masses.

The Elixir thus serves as a record, or even more, a monument, of the colorful life of the medical students. The endeavours and achievements may act as encouragement and guidelines to their future profession, and, perhaps, as stimulants for those to come. However the expression of these could only be made possible by contributions from the students themselves and it is therefore especially pleasing to see that in this issue a large portion of the content is contributed by the students, echoing the aim of former editors of Elixir, that 'Elixir is to be a magazine entirely by the students, for the students and of the students'.

IN ASTHMA
Becotide INHALER
puts steroid therapy in its place

Becotide Inhaler contains beclomethasone dipropionate BP, a steroid which differs from those previously administered to asthmatics by aerosol in that it is highly active within the lungs in doses which are not systemically active. Used as an aerosol it provides remarkable control of asthma without causing significant systemic effects. This result is attributable to the intrinsic properties of the compound and to its localisation at the intended site of action.

Becotide Inhaler ensures for your asthmatic patients

- ☐ **Effective treatment—equal to that of oral prednisolone**[1,2]
- ☐ **Freedom from steroid side effects including adrenal suppression**[3,4,5]

References:

1. *Brit. med. J.*, 1972, 3, 314.
2. *Lancet*, 1973, 1, 151.
3. *Brit. med. J.*, 1972, 1, 585
4. *Lancet*, 1972, 1, 1361.
5. *Brit. med. J.*, 1972, 2, 110.

Glaxo

Glaxo Hong Kong Limited
9th Floor, Block B, Watson's Estate, North Point, Hong Kong.

Becotide Inhaler is an aerosol preparation of beclomethasone dipropionate BP.

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DONATIONS TO ELIXIR LOAN FUND OF MEDICAL SOCIETY

We wish to express our gratitude to the following for their kind donation to the Fund:—

Dr. Harry Fang	$200.00	Dr. K. K. Yeung	$100.00
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(Up to 5th June, 1974)

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The following donors give generously to ELIXIR and their donations are gratefully acknowledged.

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For those who wish to donate or subscribe to ELIXIR, please kindly forward them to:

The Financial Manager,
ELIXIR,
c/o Medical Students' Centre,
Sassoon Road,
HONG KONG.

Inquiry about subscription to ELIXIR can also be made at the above address.

Cheques should be crossed and made payable to the ELIXIR Account, the Medical Society, University of Hong Kong.

MESSAGE FROM THE DEAN

Writing for the Elixir is not new for me since I was a contributor as an undergraduate, albeit the articles were written under a pseudonym. It was the only way that we were able to take a pot shot at our teachers without incurring their wrath. Most of them did not take kindly to our cracks; however, present day teachers are, I think, much more open-minded and understanding!

Students often lament the fact that there is a lack of communication between them and their teachers. Can this be for want of trying on their part? I am sure that you would be pleasantly surprised if you were to give it a try. Perhaps the time is ripe to formulate a plan wherein senior students will counsel juniors and in turn, the former by interested teachers in the Faculty. In the meantime, you have this very excellent magazine which reaches every student in the Faculty, so I hope everyone gives it his support to the general benefit.

A.M.C. Yau,

Acting Dean,

Faculty of Medicine.

Message from the President of Medical Society

Once again time has come to welcome another new issue of the Elixir. The publication of the Elixir is one of the major events of the Medical Society and is always awaited with ardent interest, though at times not without some impatience. The Journal is not only a document of the Society's various activities but also a testimony of the intellectual climate in the students body at the time. For these the Editorial Board no less than all the Contributors deserve our utmost gratitude.

Among the notable contents of this issue are scientific papers reporting original research carried out by students. If this should, as one would wish it to, represent a trend, it may be a healthy sign of maturity in our Medical School wherein students are no longer merely content with acquiring knowledge already in print but take on themselves the challenge of enquiring beyond it and extending its horizons. It is possible that an article published in this Journal in 1965 on Medical Student Research Training has finally rallied serious support from students and staff. I, for one, shall look forward to seeing continuous efforts in this direction in future.

S. C. TSO

Message from the Chairman

Medical students have changed a great deal during these few years. Not only are we more conscious of happenings around the university, but also of the surroundings that we are living in.

This year, the Medical Society has played a more energetic role in the consolidation of unity and comaradeship among fellow students. Through our unity, we have maintained the glory of championship in the Interfaculty Sports Competition. Moreover, through the eagerness and co-operation of fellow members, we had successfully launched our first boldly attempted grand function, the Medic Concert, in which both staff and students actively participated and enjoyed.

Externally, we have kept constant vigilance on the Medical Health and Education problems in Hong Kong. Forums were set up on Doctor's Shortage and the Second Medical School Issue. Exhibitions were held on Anti-smoking, Family Planning, and General Health & Diseases to the public. Needless to say, all these achievements were the results of active participation of fellow members with the expert guidance of zealous staff members from various departments.

"Give A DOLLAR AND SAVE A SCHOLAR" has been the motto in the raising of the Elixir Loan Fund. I am proud to tell the generous donors and contributors to the fund that a double-fold sum of HK$20,000 was distributed to 16 needy medical students, as compared with last year, and an additional amount of nearly HK$6,000 was successfully raised to replenish the fund this year, through the Annual Medic Ball.

The Elixir Journal has always been a reflection of students' life and ideas, and has maintained a good record of the activities of the Medical Society. It is heartening to see that the journal is published again successfully, and to all the members of the Elixir Board, my very sincere thanks.

EDDIE CHAN TAT
CHAIRMAN
MEDICAL SOCIETY
H.K.U.S.U.

MEDICAL SOCIETY
H. K. UNIVERSITY STUDENTS' UNION
SESSION 1973-74

ANNUAL GENERAL REPORT

The session 1973-74 of the Medical Society, H.K.U.S.U. began on 6th November, 1973, with the following elected as members of the Executive Committee:

Chairman	Mr. Chan Ka Kam
Vice-Chairman	Mr. Chan Sui Po
General Secretary	Miss Young Wan Yin, Betty
Financial Secretary	Mr. Ting Kar Wai
External Affairs Secretary	Mr. Sy Chiu Kai, Tommy
Social Secretary	Mr. Tsoi Ting Kwok, Peter
Sports Secretary	Mr. Koo Ping Kong, Kenny

With the resignation of Mr. Chan Ka Kam, the 1st Extraordinary General Meeting was held on 26th November, 1973 and Mr. Chan Tat, Eddie was elected Chairman of the Executive Committee. After the resignation of Mr. Sy Chiu Kai, Tommy from the post of External Affairs Secretary, Mr. Ng Wing Chung was co-opted to the post in the 1st Council Meeting on 10th December, 1973.

The following were the office-bearer of the Executive Committee as from 10th December, 1973.

Chairman	Mr. Chan Tat, Eddie
Vice-Chairman	Mr. Chan Sui Po
General Secretary	Miss Young Wan Yin, Betty
Financial Secretary	Mr. Ting Kar Wai
External Affairs Secretary	Mr. Ng Wing Chung
Social Secretary	Mr. Tsoi Ting Kwok, Peter
Sports Secretary	Mr. Koo Ping Kong, Kenny

During the session, 2 Extraordinary General Meetings, 6 Council Meetings and 4 Emergency Council Meetings were held.

In addition to the various traditional activities and functions, we witnessed a few more undertakings this year which included the Medic Concert, talk on Medical Ethics by Prof. McFadzean, forum on Second Medical School, the Mobile Exhibition on Family Planning, the Anti-smoking campaign and the "General Health and Common Diseases" Exhibition.

The following is a brief account of the events during the past year.

I. STUDENT WELFARE

1. Faculty-Student Relationship

The Dean's Undergraduate committee continued to serve as an effective channel through which students can discuss with the Dean problems concerning students affairs.

2. Student Representation

Students were represented in the Faculty Review Committee, the Medical Library Committee and the Sing Tao Fat Choy and Vincent Woo Loan Fund Selection Committee.

3. Elixir Loan Fund

The Elixir Loan Fund Board meeting was held on 22nd Jan. 1974 in the Dean's Office. 16 applicants were successful and a total amount of HK$20,250 was allocated. The distribution was as follows:

HK$ 700	to	1 applicant
HK$1000	to	9 applicants
HK$1500	to	3 applicants
HK$2000	to	3 applicants

In order to facilitate the management of the Elixir Loan Fund, amendments on the administrative procedures and the details of the application forms were proposed by Dr. S. C. Tso, chairman of the Board meeting. After consultation with the legal advisor, Mr. P. C. Woo, for legal practicability, the amendments were adopted and made effective by the Council at the 3rd Council Meeting.

4. Medic Canteen

(a) In view of the rising cost of food and wages, the Council decided to allow an increase in the price of meals in March, 1974.

(b) On 8th April, 1974, Mr. Tsui, the caterer, asked for termination of the contract. From open application for the vacancy, the Council decided to grant the catering service to Mr. Lee Kam Wing who began his service on 8th May, 1974.

(c) In April, the Vice-Chairman represented the Medical Society in the catering committee of the University Council to discuss the possibility of a central catering system for all canteens under University administration. No final decision has yet been made.

(d) The University agreed to provide the Canteen with a brand new set of furniture which was put to use in May, 1974.

(e) On 1st October, 1974, Mr. Lee Kam Wing requested termination of the contract on catering service. After open application, Mr. Li Chark, the present caterer, was accept-

ed and a contract effective over a period of one year starting from 1st Nov. 1974 was signed.

(f) The Canteen was closed on 1st, 2nd and 3rd of November, 1974 in order to make alterations for the new service.

(g) The Canteen was inspected by Dr. Bard, the Director of the University Health Service to ensure the hygienic condition of the kitchen and by the members of the Catering Committee of the University Council to review the present condition of the various canteens.

5. **Common Room and Medical Society Office**

(a) A survey on the possibility of installing a colour TV was carried out. Most students living in the Medical Students' Centre were unwilling to pay $1.00 per month for the installation of a colour TV.

(b) A box for keeping table tennis balls was fixed in the Common Room and one ball per week was put in for about 20 weeks.

(c) A set of cooking utensils was bought and locked in the pantry. It is available for borrowing by all medical students.

(d) A telephone and a telephone booth were intalled in the Common Room.

(e) 50 letters had been sent to local publishers asking for complimentary copies of periodicals, and we are still waiting for replies from many. Copies of various periodicals were regularly placed in the Common Room including Newsweek, Medical Progress, Scala, Jena Review, Asian Medical Journal, Spectrum, Asian Hotel and Tourism, 明報月刊，今日世界 and 攝影畫報. Some were donated by USIS.

(f) The Medical Society received the courteous donation of a portable TV and a radio set from Prof. McFadzean. These were put in the Common Room of the New Clinical Building.

(g) To facilitate the work of the Executive Committee and the Standing Committees, some furniture and fixtures were added in the Medical Society Office, namely, a notice board, a blackboard, a desk, a letter box and an emergency portable notice board.

6. **Co-op**

Exercise books, paper, pens, badges, etc. were on sale in the co-op.

7. **Medical Fraternity Committee**

The committee have organized a series of activities to try to help the freshmen to familiarize themselves with other medical students and to provide some help to them in their studies.

(a) Freshmen Welcome Day. This was held on 29th Aug. 1974. The day's programme included distribution of information pamphlets, allocation of tutors, round-the-campus-tour, demonstration of microscopes and skeletons, display of books and a tea party.

(b) Second hand book sale was organized on 31st Aug. 1974 and the respons from the freshmen was overwhelming.

(c) Introductory lectures on 9th Sept. 1974 were delivered by Prof. Gray, Dr. Samuel Chan and Prof. Lisowski of the 3 pre-clinical departments.

(d) Fraternity Camp was held at the Caritas Youth Centre, Cheung Chau from 19th to 20th Sept. 1974. This proved to be very successful.

(e) Fraternity Nite. This was held on 25th Sept. 1974 at Loke Yew Hall. This was organized with the aim of promoting friendship and understanding between freshmen and senior students and included drama, debate and various performance by the students.

(f) Friendly match. A football match was arranged between the Faculty team and the Freshmen team.

II. SOCIAL ACTIVITIES

1. Christmas Carolling

The carolling was organized on 23rd Dec., 1973 at the Sandy Bay Convalescent Hospital and the Duchess of Kent Children's Orthopaedic Hospital and Convalescent Home, and was attended by about 40 society members. Gifts donated by the students were distributed to the children.

2. Social Gathering

A social gathering was organized on 26th Jan., 1974 in the Men's Common Room and about 250 persons were present on that evening. Guests were invited from St. Mary's Canossian College, Maryknoll Sisters' School, Sacred Heart Canossian College (Commercial Section), Ying Wah Girls' School and St. Paul's Secondary School (Commercial Section).

3. Farewell Party for Dr. Langenberg

A farewell party for Dr. Langenberg was held on 25th May, 1974 in the Men's Common Room. It was attended by about 100 students. A souvenir was presented to Dr. Langenberg.

4. Annual Ball

The Annual Ball was held on 15th June, 1974 at the Sheraton Hotel and about 100 couples attended this accasion. Patrons for the occasion were Prof. A. Yau and Mr. P. C.

Woo. Valuable prizes for the Raffle Draw included a colour TV donated by Mr. Henry Fok and an air-ticket donated by CP Air. A profit of about $6,000 was netted for the Elixir Loan Fund.

5. **Medic Nite**

This year the Medic Nite was held on 24th Oct., 1974 at the Loke Yew Hall and was attended by about 450 students. Dr. Wong Kwok On and Dr. Frederick Ong were judges for the inter-year drama competition of which the final year came first and the fourth year runner-up. Prizes were presented by Dr. S. C. Tso to the winners of the inter-faculty and inter-year sports events and the Medic Nite Drama Competition. Light refreshment was served.

III. CULTURAL AND ACADEMIC ACTIVITIES

1. **Inter-faculty Debate**

Although we were unable to win, the speakers Mr. Siu King Fan, Mr. Chan Pui Wing and Mr. Timothy Poon have done a good job.

2. **Inter-faculty Drama Competition**

We participated in this competition which was held on 14th Jan., 1974 at the Loke Yew Hall. The director for the play was Mr. Leung Lap Chi.

3. **Music Festival H.K.U.S.U.**

Many students in our faculty participated in the Music Festival organized by H.K.U.S.U. in Feb., 1974 and the Medic Choir conducted by Mr. Wong Ka Hing came third in the inter-faculty choir competition and our faculty came second in the overall competition.

4. **Forum on "Second Medical School"**

In view of the hot argument on shortage of doctors in Hong Kong and the setting up a second medical school to produce more doctors, the Medical Society successfully held two forums on this matter. The first one was held on 6th March, 1974 in the Physiology Lecture Theatre. During this discussion, opinions and comments were voiced by members of staff and students. Speakers included Dr. S. C. Tso, Dr. K. C. Lam, Dr. J. C. C. Huang, Prof. Lisowski, Mr. So Ping Cham and Mr. Au Tak Jor. The second forum was held on 8th March, 1974 in the Underground Lecture theatre, New Clinical Building. This occasion was attended by about 200 medical students, members of staff and also students from the Chinese University. Guest speakers included Dr. L. K. Ding, Dr. Peter Lee and Dr. M. H. Hwang.

5. **Talk on Medical Ethics by Prof. McFadzean**

Before Prof. McFadzean left Hong Kong for Scotland in April, 1974 the Medical Society has invited him to give a talk on Medical Ethics. This talk was well attended by about 400 medical students and members of staff. A Souvenir was presented to Prof. McFadzean at the end of the talk.

6. **Inter-year Debate**

Adjudicators for the debates were Dr. Paul Yue, Dr. C. H. Chan-Teoh, Dr. J. C. C. Huang, and Prof. Roberts. First year was the champion with third year being the runner-up.

7. **Medic Concert**

This was held on 21st Sept., 1974 at Loke Yew Hall and was well attended by about 500 students. This was one of the "non-traditional" activities organized by the Medical Society with the aim of promoting music among medical students. Since we also hoped to improve the staff-student relationship, we have also invited some members of staff to participate in the concert and guest performers included Dr. H. C. Liu and Dr. M. L. Ng. The patron for the concert was Prof. A. Yau.

8. **Bridge Tournament**

The inter-year Bridge Tournament was held on 13th Oct. 1974. The winner was third year with fourth year as runner-up.

9. **Talk by Dr. J. S. Horn**

A talk was given by Dr. J. S. Horn, a traumatologist of Birmingham Hospital, on "My 15 years in Modern China" at the Hong Kong Polytechnic Keswick Hall. The talk was sponsored by Medical Society, H.K.U.S.U., China Study Group, H.K.U.S.U., H.K.C.U.S.U., and H.K.P.S.U.

10. **Film Shows**

Several academic films from Ciba-Geigy Co. and entertaining films from the Students' Union were borrowed from time to time and were shown in the Medical Students' Centre.

11. **Activities organized by the Standing Committee on Health**

(a) Visit to the Town Office of SARDA and its Women Treatment Centre.
About 30 students participated in the visit to the Society for the Aid and Rehabilitation of Drug Addicts on 22nd Jan., 1974.

(b) Visits to the Family Planning Association. 2 visits were organized to the Headquarter of the FPA. About 20 students participated in the voluntary work in the clinics of FPA.

(c) Blood donation. 57 students donated blood on 26th April, 1974 in the Physiology Laboratory.

(d) Outdoor Camp. About 35 students took part in the camp held at the Queen Elizabeth II Youth Centre, Lantao Island from 20th to 21st April, 1974.

(e) Film Show. Films on vasectomy and Drug Abuse problem in Hong Kong were shown on 30th April, 1974.

(f) Discussion on Abortion. The discussion was arranged immediately after a film show on "Abortion: A Woman's Decision" on 31st May, 1974. Dr. Osmund and Father Deignan were present as guest speakers.

12. **Open Day, H.K.U.S.U.**

The Open Day organized by the H.K.U.S.U. was held on 16th and 17th November, 1974 and our faculty has played a very active role. The various exhibits shown in the Medic Centre included Surface Anatomy, demonstration of some physiological functions of the body, common biochemical tests of urine, effect of drugs on the heart, pathology specimens and slides. Blood pressure, blood group, electrocardiogram and nervous system examination were also performed. Most attractive of all was a slide show called "The Making of a Doctor" which described very vividly the life of a medical student. On the whole, the Open Day was a success and more than 10,000 guests had visited the Medic Centre.

13. **Presidential Address**

The Presidential Address was given by Dr. S. C. Tso on 18th November, 1974 in the Anatomy Lecture Theatre and the title was "Red Cell and the Hormones: A Study in Controversy". About 200 students and members of staff attend. After the talk, Dr. Tso presented souvenirs to all councillors, winner of the Inter-year drama competition and winner of the Bridge Tournament.

IV. SPORTS

1. Interfaculty competition

The medical students again showed their ability in sports by retaining the Championship Omega Rose Bowl for another year (1973-74), bringing to a total of six consecutive years.

Out of the 12 events we were:

Champion	in	Athletics
		Lacrosse
		Softball
		Badminton
		Soccer
1st runner-up	in	Hockey
		Squash
		Volleyball

This year (1974-75) we are off with a very good start and captured the Men's overall champion in the inter-faculty Aquatic Meet. In other games, we are still unbeaten in all the matches we have played so far.

2. Inter-year Competitions

The Champion Shield for Intrafaculty Sports Competition went to 4th year (1973-74) and the Prof. Gibson's Cup for Intrafaculty Swimming Competition went to 2nd year (1974-75).

The results were as follows.

(a) Inter-year Games (held in May and June, 1974)

		CHAMPION	RUNNER-UP
MEN'S	FOOTBALL	2nd	3rd
	LACROSSE	4th	3rd
	HOCKEY	4th	3rd
	BASKETBALL	1st	2nd
	VOLLEYBALL	1st	3rd
	SQUASH	4th	3rd
	TABLE TENNIS	1st	2nd
	BADMINTON	4th	1st
	TENNIS	4th	3rd
	TUG OF WAR	4th	2nd
	CROSS COUNTRY RUN	2nd	3rd

LADIES'	NETBALL	2nd	3rd
	BADMINTON	2nd	3rd
	TABLE TENNIS	3rd	2nd

OVERALL CHAMPION: 4th year (1973-74)

OVERALL RUNNER-UP: 2nd year (1973-74)

(b) Inter-year Swimming (held on 14th Oct., 1974)

Overall Champion: 2nd year (1974-75) 120 points

Overall Runner-up: 3rd year (1974-75) 100 points

Sportsman of the year: Mr. Chan Ping Kong, Leo (3rd year)

Sportswoman of the year: Miss Yung York Mui, Karen (3rd year)

V. PUBLICATION

1. Medic Handbook

The Society Handbook was published and issued to medical students in Feb., 1974.

2. Elixir

The Elixir 1973 was printed and distributed to students in Dec., 1973. The 1974 issue will be available in December, 1974.

3. Caduceus

The Society newspaper was published monthly and distributed to medical students, medical practitioners and medical schools abroad. A fund raising film show was organized by the Caduceus Editorial Board on 5th May, 1974 at the Lee Theatre.

VI. EXTERNAL AFFAIRS

1. Exchange Activities

(a) We had received altogether 11 IFMSA exchange application forms in the last year. 9 of them were accepted by the Faculty to do their elective clerkships in different departments. There were about 40 other elective students who were accepted through direct applications to the Faculty Secretary. A pamphlet was issued to provide general information to foreign medical students who were interested to come to Hong Kong.

(b) This year two of our society members took part in the IFMSA exchange programme and spent two months in Japan. This was the first time in recent years that we have out-going students to participate in the programme officially.

(c) A talk and slide-show on Holland was given by a Dutch exchange student, Mr. Karel W. Schuit, on 25th April, 1974.

(d) Arrangements for a mutual exchange programme between our Society and the Medical Society, University of Singapore has been undergoing. A definite agreement has not yet been reached.

2. **Relations with IFMSA**

(a) The First International Interdisciplinary Student Seminar on Population Dynamics and Family Planning (IISS-PDFP) was held from 25 July to 1 Aug., 1974 in Lagos, Nigeria.

Two students from our society were selected through an essay competition to take part in the seminar.

(b) A National Population Officer (NPO) was appointed to maintain liaison with the Standing Committee on Population Activities (SCOPA) which was set up during the IISS-PDFP.

(c) Because of financial difficulties, we were unable to send any representative to attend the 23rd IFMSA General Assembly held in Haifa, Israel.

(d) It was decided by the Council that the External Affairs Secretary should hold the post of IFMSA Liaison Officer simultaneously.

3. **Relation with ARMSA**

(a) Mr. Richard Rawson, the President of ARMSA 1973-74, visited the Medical Society on 23rd March, 1974. During an informal discussion, views and opinions on the future role of ARMSA were exchanged between our guest and members of the Executive Committee.

(b) On behalf of ARMSA, the Medical Society had contacted the People's Republic of China through the Hsin Hwa News Agency to invite her to join ARMSA. China declined the invitation owing to the reason that a national medical student association has not been formed in the country.

(c) The 8th ARMSA General Assembly was held in Kuala Lumpur from 25th to 31st August, 1974, followed by a Workshop on Asian Medical Education from 1st to 4th Sept. We were represented by 2 delegates and 1 official observer in these meetings.

(d) A sum of $400.00 was collected from the members of the society and sent to the Bangladesh Medical Students' Association (BMSA) in response to the aid appeals for the flood victims.

4. **Study Tour**

We had organized a study tour to Singapore in late September, 1974. 8 students participated in the tour. They were warmly welcomed by the Department of Social Medicine and Public Health and the Medical Society, University of Singapore.

5. **Medical Students' Travel Fund**

The setting up of this fund was proposed for the purpose of providing financial assistance to official reresentatives of the Society to attend meetings abroad and also for other students who intend to take part in exchange programmes or study tours. The relevant documents had been drafted and awaits for the the final approval by the Medical Students' Council.

VII. PROJECTS

1. **Mobile Exhibition on Family Planning**

Since the World Health Organization of the United Nations had declared 1974 to be the World Population Year, suggestion of a mobile exhibition in the New Territories on Family Planning was made. Advice and assistance were sought from the Family Planning Association. The project was authorized by the Council to be carried out by members of the Standing Committee on Health.

2. **Anti-smoking Campaign**

The Church of Jesus Christ of latter day Saints invited the Medical Society to participate in their Health Missionery Programme. The Medical Students' Council agreed to have a joint campaign on anti-smoking which was held on 13th July, 1974 at Mei Foo Sun Chuen. This project was headed by Mr. Chan Sui Po. Films, slides and demonstrations were shown during the campaign.

3. **"General Health and Common Diseaes" Exhibition**

This exhibition organized by the Standing Committee on Health was held at the City Hall Exhibition Hall from 13th to 16th September, 1974. The content of the exhibition included 6 topics, namely cardiovascular diseases, mental illnesses, child care, personal and community hygiene, drug abuse and Obstetrics and Gynaecology. This large scale exhibition mobilized a large number of medical students and secondary schools were also invited to participate. Much advice and assistance have been obtained from members of staff in various departments without whose help the project could not have met with such success.

VIII. MISCELLANEOUS

1. Investigation on shortage of doctors in Hong Kong

An ad hoc committee was set up as a follow-up of the forums on "Second Medical School", to investigate into the problem of shortage of doctors in Hong Kong. Members of the committee included Mr. Chan Tat, Mr. Au Tak Jor, Miss Cheung Suk Yee, Mr. Chow Wing Cho and Mr. So Ping Cham. A report was submitted to the Medical Students' Council and also published in the Caduceus.

2. Constitution Revision

A 7-men working party was appointed by the Medical Students' Council to look into the loopholes of the constitution of the Medical Society and draft the necessary amendments. Members of this Constitution Revision Committee included: Mr. Chan Tat, Mr. Chan Chor Kwong, Mr. Lao Tzu Hsi, Miss Anna Lok, Mr. Mak Kan Hing, Mr. So Ping Cham and Mr. Yeung Kwok Wai. After 4 committee meetings, the amendments were drafted and submitted to the Council and were adopted at the 2nd Extraordinary General Meeting.

In conclusion, the Medical Society is very much indebted to our President Dr. S. C. Tso, our Vice-President Dr. K. H. Lee, our Hon. Treasurer Dr. C. P. K. Cheng, the Associate Members' Representative Dr. D. Yu and also the Dean of the Faculty Prof. J. B. Gibson for their valuable advice, guidance and encouragement throughout the year.

(Sd.) Betty Young
General Secretary
Medical Society

18th November, 1974.

SNAPSHOTS

A welcome party for the students from Chinese University

Discussion with the students

Elixir Editorial Board at work

Anatomy 1974

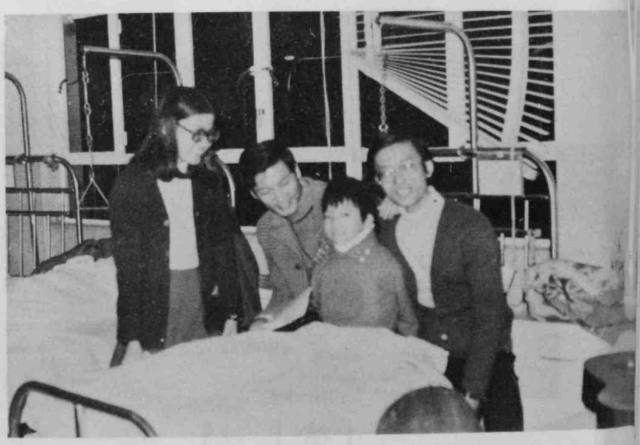
A visit to the abattoir

「猪」 門 怨

anyone for 豬雜

The President of Medical Society speaking in the Annual Ball.

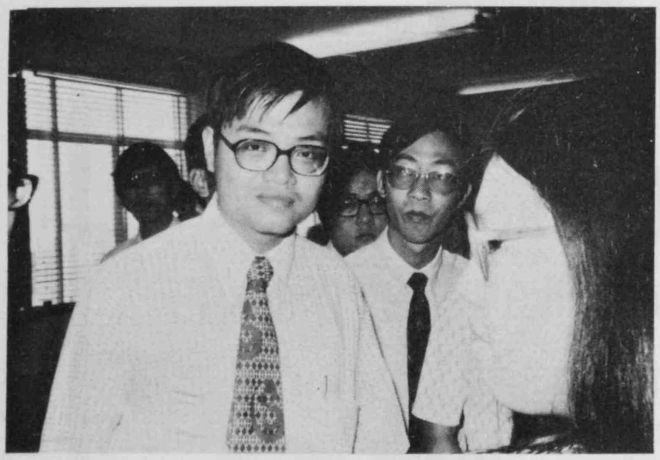
Christmas Carolling



Our Choir, which came third.

Farewell Party for Dr. A. Van Langenberg

Dr. Van Langenberg — our beloved warden



Dear Dr, don't look so sad!

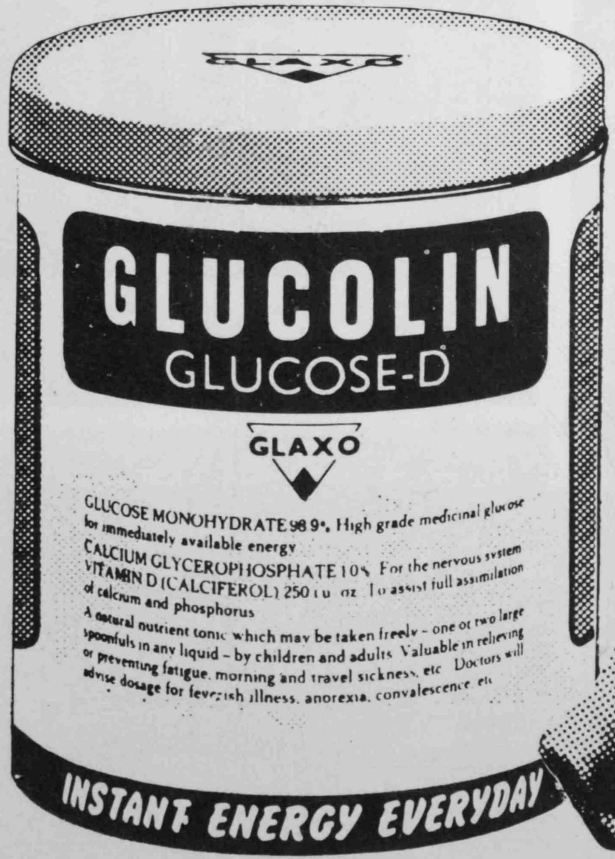
Everybody say cheese!

The last tutorial

A very large class!

Glucolin brings you back

Glucolin with calcium and Vitamin D restores lost energy instantly.



ORBITUARY

THE EDITORIAL BOARD
WISHES TO EXPRESS
THE DEEPEST REGRET
FOR
THE DEATH OF
PROFESSOR A. J. S. McFADZEAN,
EMERITUS PROFESSOR OF MEDICINE,
ON 29th NOVEMBER, 1974.

The Old Man of the Mountain

This article is taken from a past issue of Caduceus in memory of the late Professor A. J. S. McFadzean

TIME: ONE FINE SATURDAY MORNING IN APRIL

PLACE: PROFESSOR McFADZEAN'S OFFICE

. . . . It's about a new column in the Caduceus, sir, we wish to talk to you about, sir.

. . . . Calling me "sir" once is enough . . . . you've paid tribute to my appointment. You don't know me . . . . pay respect only to those who earn it, not to the position they hold . . . .

. . . . Yes, sir. We plan to feature a few VIP's around, sir.

. . . . What do you mean? . . . . because I am the old man of the Faculty? Age is not synonymous with either wisdom or experience.

. . . . Personalities of your stature, sir. (must resort to the use of explicit flattery sometimes!)

. . . . Rubbish! Few people in their life-time become of real stature . . . . you would need to perch me on a mountain . . . . the old man on the mountain . . . .

. . . . (Mountain? One can't be really sure it isn't a volvano.)

. . . . You've heard the usual tales about me . . . . most of them are apocryphal . . . .

. . . . Yes, sir, and we hope to find out the truth . . . .

REVAMP THE CURRICULUM AND NO DEGREE EXAM. (FOR THE AVERAGE STUDENT)

. . . . Any room for improvement in the Medical Faculty, sir?

. . . . Of course . . . . Reformation of a curriculum which is hopelessly outmoded and, even worse, hopelessly overloaded . . . . Partial abolition of degree examinations . . . . they were designed by the devil . . . . Replacement by continuous assessment . . . . The average student would pass and would not sit degree examinations. Students who failed would sit the degree examinations which we now know. Good students would sit examinations entirely different from that of the failures in continuous assessment. The radical reformer in this Faculty would need to acquire a machine-gun and ensure that his finger was on the trigger. It has been contended, for over 50 years, that if attempt be made to combine the educational with the vocational . . . . failures in both objectives. We do it here to a deplorable extent. However, over the years, the system has worked well enough . . . . The high quality of our graduates and, especially, of our past graduates are sources of great pride to me and I am sure to others . . . .

. . . . Wouldn't such a scheme of continuous assessment permits grounds for biased judgment and encourages favouritism, sir?

. . . . Yes, one cannot be blind to that danger but I believe it would be offset . . . . Difficulties may be greater in some Departments than in others.

SOCRATES, SLAVES AND STUPID STUDENTS . . . .

. . . . I can only speak for the Department of Medicine. Undergraduates do not receive a vocational training but there is a vocational content for the principles of medicine can be learned at the bedside, employing, as models, patients and their diseases. Basically we expect students to learn to acquire data from patients and consequently he must have the skill properly to examine patients . . . . to reason especially . . . . to apply, whenever possible, the knowledge gleaned in the Pre-clinical and Paraclinical Departments . . . . By and large students are stupid . . . . Instead of going to the bedside as often as possible they, slavishly, workship authority . . . . whether it be chalk, talk or the

printed word. Socrates taught that authority should be questioned, no matter in what guise it presented itself. Incidentally, in Medicine, the best method of teaching is the Socratic method .... does not matter whether teacher or student assumes the role of Socrates.

.... But sir, Socrates never barked at his students, did he?

.... I don't bark, for barking dogs don't bite. I snarl and bite, if the snarl produces no results. You know little of Socrates .... he suffered not fools gladly ....

Grab them by the scruff of the neck and throw them over, sir?

AN INCREASING CROP OF MEDIOCRE STUDENTS?

....As was anticipated, a progressive increase in intake has resulted in an increase in the major mass, the average and below average student. There has been no increase in the number of good students. Occasionally we have had vintage years but such have become decidely uncommon. Matriculation results are not necessarily reliable but at least their use is equitable and, in my view, the best yardstick we have. Headmasters' reports, as in the United Kingdom, vary widely in reliability. Interviews have proved useless. They are far too brief to be of value and the applicants tend to say what they think the interviewers want them to say. An entrance examination is anathema to me. ....

CLINICAL PRACTICE WILL BE

.... Osler said, "as is a man's Pathology so is his clinical practice. It would be truer today to say "as is a man's Biochemistry and Physiology" .... and this applies also to Pathology and Microbiology which are clinical subjects.

.... A case of "the early bird catches the worm", sir?

.... Yes.

"YOUR HAIR, DOC."

....They say you strongly object to clinical students wearing their hair long. Yet one really see little correlation between a mere out-growth from the cranial region and the level of academic competence. Are medical students not entitled to some measure of personal freedom, too, sir?

.... As usual you see issues from but one point of view and have the temerity to judge. No, it is not a personal foible. Have you ever thought of it from the patient's point of view? In the Aphorisms of Hippocrates you will find: "A physician shall be sober in his habit". The word "habit" (not habits) refers to his appearance, his dress and his manner. When a student enters the clinical years and comes into contact with patients, he must abide by the long established customs of his profession. The patients in this hospital are, by and large, highly conservative. Surely you can imagine, for example, the reactions of anxious, conservative, Chinese parents with a desperately ill child were that child to be attended by a long-haired "with it" doctor clad in the modern equivalent of Jacob's cloak of many colours.

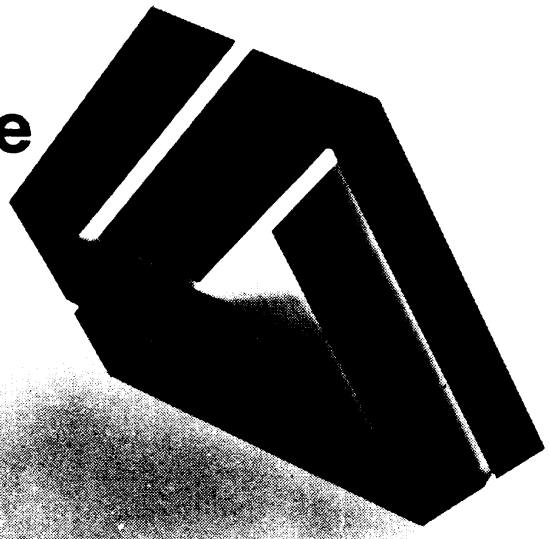
....Outwith the wards and the Department I would never dream of interfering with a student's liberty provided he does not bring the dignity of the profession which he has chosen to enter into disrepute.

LAME DOGS OVER STILES

.... Which of your achievement has given you greatest pleasure, sir?

.... "Siritis" seems an incurable disease in your case. I can best answer that in the words of my idol in Medicine, Patrick Manson, the Father of Medical Education in Hong Kong when asked the same question: — "Helping lame dogs over stiles" but I would add, commonly such have to be grabbed by the scruff of the neck and thrown over.

from Upjohn
a new Gram-positive oral antibiotic...
Dalacin C



a single 150 mg dose of new Dalacin C provides serum levels well in excess of the minimum *in-vitro* bactericidal concentrations for sensitive staphylococci, streptococci, and pneumococci

---

clinically demonstrated efficacy in a wide variety of infections, including respiratory infections, skin and soft tissue infections, osteomyelitis and bacteræmia

---

90% absorption even when taken with food

---

peak serum levels in 45 minutes (fasting)

---

serum levels in excess of minimum inhibitory concentrations for most common Gram-positive pathogens maintained for at least six hours with a single dose

---

generally well tolerated

---

effective against penicillinase-producing staphylococci

Supplied:

150 mg Capsules: Each capsule contains clindamycin hydrochloride hydrate equivalent to 150 mg clindamycin base, in bottles of 100.

Flavoured Granules: When reconstituted each 5 ml (teaspoonful) contains clindamycin hydrochloride hydrate equivalent to 75 mg clindamycin base, in 80 ml bottles.

(Not all forms and sizes are available in all areas.)

PRODUCT OF
Upjohn
ANTIBIOTIC RESEARCH

7312 TRADEMARK: DALACIN C FEE 5269.17

Drug Index

DEPARTMENT OF ORTHOPAEDIC SURGERY

(Left to Right)

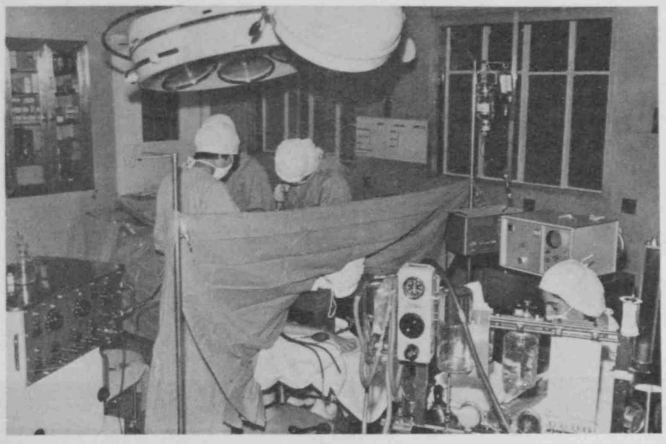
Back Row: Dr. H. M. Chan, Dr. K. M. Fong, Dr. K. K. Wong, Dr. G. Ma, Dr. K. Ho, Dr. C. Y. Wong.

Middle Row: Dr. D. Lee, Dr. V. Seal, Dr. K. M. Poon, Dr. S. Y. Chun, Dr. C. Y. Ho, Dr. D. Fang, Dr. S. Fountain, Dr. S. P. Chow.

Front Row: Dr. A. Dwyer, Dr. T. Loy, Prof. A. Yau, Prof. A. R. Hodgson, Dr. J. O'Brien, Dr. J. C. Y. Leong, Dr. L. Hsu.

SOME ASDECTS OF

These photographs are taken
The E.B. would like to thank
Dept. of Orthopedic Surgery



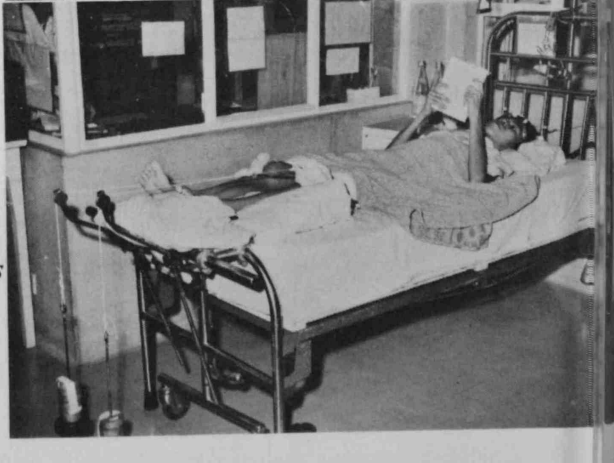
In the O.T.

Below Knee Amputee on the right side note the prosthesis

Patient suffering from genetic scoliosis on halo-pelvic distraction

The Physiotherapy Department

Time for recreation



This patient with congenital scoliosis has been put on Halo-femoral Traction

ORTHOPAEDIC SURGERY

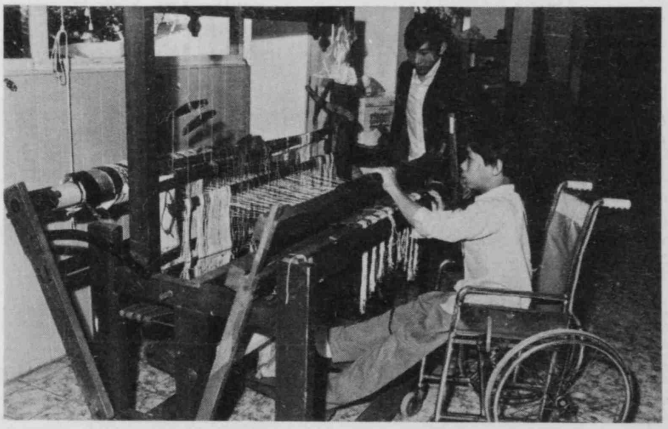
at the DOK COH

Mr. James Ho, AIIP,

for these photographs

General view of the ward

Pool Therapy



Occupational Therapy Department

This Patient suffers from polio and scoliosis with right side deformed flail and a short leg. She now walks with bilateral crutches and right long-leg caliper and wears a plaster body cast

Patient on Anderson Leg-lengthening Apparatus for the short right leg secondary to polio

Up till September, 1951, the orthopaedic patients in Hong Kong were reated by bone setters, general practitioners and general surgeons, so, when Professor A. R. Hodgson joined the University Deartment of Surgery as a Senior Lecturer in September, 1951, his objectives were to establish Orthopaedic Surgery in the Colony as well as the Section of Orthopaedic Surgery in the University. The Section grew in size and importance until 1961 when the Chair of Orthopaedic Surgery was created and he was invited to fill this position as Professor and Head of the new Department.

One of the biggest orthopaedic problems here at that time for him to tackle was the treatment of tuberculosis of the spine and hip. There was such an enormous number of these cases that conservative treatment was out of the question because of the shortage of beds, so he and Professor F. E. Stock of the Department of Surgery devised an operation for removal of the disease from the spine, through an anterior approach, and fusion of the resultant defect in the spine. They treated as many as 500 of these patients in a year and gradually resolved the problem so that now the few cases still being so treated comprise quite a number of patients from Macau and mainland China.

Also during those early years, and in relationship with his work on tuberculosis of the spine and hip, he helped to form the Society for Rehabilitation and the Society for the Relief of Disabled Children. He has served as Chairman on the Committee of the latter Society since its inception, when they started with a small convalescent home for disabled children which grew from the original fifty beds to a hundred beds and has now become a fuly equipped children's orthopaedic hospital named the Duchess of Kent Children's Orthopaedic Hospital. This is staffed by the Orthopaedic Surgeons in the University Department of Orthopaedic Surgery, with the assistance of visiting Orthopaedic Surgeons from various parts of the world who come to exchange knowledge and methods of treating the orthopaedic conditions which we have here in Hong Kong. Two of the Interns from the Government Orthopaedic Department are also assigned to work there.

Since the etablishment of the Department it has grown in size from a staff of Professor and a Senior Lecturer to the present complement of two Professors and four Lecturers, details of whom are given below.

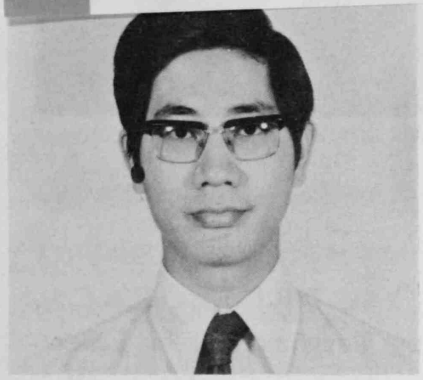
Professor A. R. Hodgson, O.B.E., F.R.C.S.E., F.A.C.S., F.R.A.C.S., graduated from the University of Edinburgh and returned there to take his Fellowship. As already stated, he inaugurated the Section of Orthopaedics within the Department of Surgery in 1951 and later became the first Professor of Orthopaedic Surgery. His hobbies are sailing and golf. He specialises in spinal surgery and is a world authority on the treatment of tuberculosis of the spine, cervical spondylosis and low back pain. His most recent research interests have been the correction of severe kyphosis and scoliosis and the use of metal implants and bone grafts in anterior spinal fusion operations.

Professor Arthur C. M. C. Yau, F.R.C.S.E., F.A.C.S., graduated from the University of Hong Kong and took his Fellowship at the University of Edinburgh. He joined the Department as a Senior Lecturer on 1st January, 1967, and was awarded a Personal Chair on 1st July, 1972. At present he is Acting Dean of the Faculty of Medicine. He plays golf and likes to fish. He specialises in spinal surgery and has been involved in a considerable amount of research in the correction of severe kyphosis and scoliosis, the incidence and pathogenesis of osteoarthritis in Chinese hip joints, and osteoarticular knee joint transplant in animals.

Dr. John P. O'Brien, F.R.C.S.E., graduated from the University of Sydney and took his Fellowship at the University of Edinburgh. He joined the Department in January, 1968. His hobbies and personal interests are: parachuting, classical guitar, collecting ancient books and maps, squash, rackets, swimming, and Chinese, Irish and Australian jokes and teaching H.K.U. students. He specialises in the investigation and treatment of spinal deformities, spinal growth and development and paralytic disorders in children. He is currently working on a thesis on the clinical, mechanical and anatomical aspects of halo pelvic traction and the prevention and treatment of paralytic pelvic obliquity.

Dr. Louis C. S. Hsu, M.B., B.S., graduated from the University of Hong Kong and joined the Department on 1st July, 1971. He plays tennis and he specialises in paediatric orthopaedics, especially deformities of the ankle and foot in children.

Prof S P Chow
1974



Dr. S. P. Chow, F.R.C.S.E., graduated from the University of Hong Kong and took his Fellowship at the University of Edinburgh. He joined the Department on 1st April, 1973. His hobbies are table tennis and Chinese painting. He specialises in general orthopaedics and is currently reviewing the results of anterior spinal fusion operations performed in this Department.

Dr. John C. Y. Leong, F.R.C.S., graduated from the University of Hong Kong and took his Fellowship in Edinburgh and England. He joined the Department in 1966 and specialises in adult general orthopaedics. His hobbies are golf, tennis and bridge. He has done research on the effect of hormones in bone growth, and his current research interests are ankylosing spondylitis, and osteomalacia in the elderly.

Dr J C Y Leong
1974

The Duchess of Kent Children's Orthopaedic Hospital

HORMONES AND THE RED CELL: A STUDY IN CONTROVERSY *

S. C. Tso

HUMORAL CONTROL OF ERYTHROPOIESIS

Physiological observations had for long identified hypoxia to be a basic stimulus for red cell production, although the mechanism involved had remained unsettled. 70 years ago, Carnot and Deflandre obtained plasma samples from rabbits 20 hours after they were artificially bled and injected these into normal rabbits. (1) They were able to show in the recipients a rise in the peripheral red cell count and an increase in erythroid activity in the marrow. The result suggested a humoral mechanism. However as the experiment was rather crude and later attempts in other laboratories failed to reproduce the results, it became, if not discredited, at least temporarily ignored. The next few decades saw the emergence of protagonists for the nervous control of erythropoiesis, mainly based on the studies of European and Japanese workers, which showed that the marrow was richly supplied by nerves, that experimental lesions in certain parts of the brain resulted in an increase in erythropoiesis and that transection of the cervical spinal cord abolished the erythraemic response to hypoxia. As to be expected all these observations were open to alternative interpretations and the neural school was not widely accepted. (2) The critical experiment was finally done by Reissmann (3) who, using the parabiotic rats, demonstrated unequivocally that the erythropoietic stimulus was mediated not by the nervous system but by a humoral factor. He exposed one of a pair of the parabion to 7.6% oxygen producing an arterial oxygen tension of 63 mm Hg. The other member breathed room air and had an arterial oxygen tension of 97 mm Hg. Not only erythrocytosis but also increased marrow erythroid activity was demonstrated in both animals. Later Grunter & coworkers were able to confirm the findings earlier obtained by Carnot & Deflandre by using repeated administrations rather than a single injection of anaemic rabbit plasma. (2)

Despite these findings, controversy was still rife regarding the exact nature of this erythropoietic factor. Based on the well-known observation that hypophysectomy was followed by the development of anaemia, a group of workers in California fed sheep pituitary extract to hypophysectomised rats and were able to show an increase in circulating haematocrit and haemoglobin. (4) Because they observed, as to be expected, no stimulation of growth or of the target organs, they concluded that the erythropoietic effect was due to a substance distinct from the known pituitary trophic hormones. However hypophysectomised animals can still respond to hypoxic stimulation by increased erythropoiesis though subnormally. (5)

The issue remained confused until Jacobson's group in Chicago and other workers carried out more work on the hypophysectomised and the hypertransfused plethoric rodents and demonstrated a difference between these two situations. While the former responded to pituitary-dependent hormones such as thyroxine (6) the latter did not. (7) Further experiments with hypertransfused mice led to the hypothesis that there was an inverse relationship between tissue oxygen supply and erythropoietic activity which was mediated through a specific hormone. (8) Thus the concept of a distinct hormone, erythropoietin, came into existence. This was further amplified by work

* Presidential Address, 18th November, 1974.

in many laboratories so that over the next decade or so not only the physiological control but the immunological characterisation (9) and physio-chemical properties (10, 11) of this humoral substance gradually came to light.

In this period new conflicts were seen in the erythropoietin field. The first was a series of observations which challenged the concept that erythropoietin was the sole erythropoietic hormone. For a long time, erythropoietin has not been demonstrated in the circulation in the normal, state, when erythropoiesis is constantly taking place to replace the daily senescence of red cells. This challenge was earlier on unsatisfactorily answered by the suggestion that the normal level too low to be detected by the relatively insensitive bioassay method in existence. (12, 13) Later various methods were developed for the concentration of erythropoietin in the urine and using these techniques normal persons were found to have definite amounts of erythropoietin in their urine. (14, 15) With the introduction of immunoassay, a definite though low level of circulating erythropoietin can be measured in normal animals and humans. (16)

THE UNITARIAN CONCEPT

It was also difficult on the basis of this unitarian concept to explain the replenishment of normal red cell volume after minor losses of blood where tissue hypoxia is not expected to develop. Similarly it is difficult to explain the maintenance of an increased rate of erythropoiesis, sometimes many times that of the normal, in the compensated haemolytic states where the circulating red cell volumes are normal or very close to normal. It is true that such a normal or near normal red cell volume is achieved only because erythropoiesis is maintained at a high level, but the absence of tissue hypoxia in such a state would suggest that an alternative control other than the hypoxia-erythropoietin axis may be involved. (17) The proponents of the unitarian school performed experiments and drew their conclusions from experiments of others to explain this anomaly. Erslev produced chronic compensated haemolysis in rabbits and studied the effect of erythropoietin on the marrow cells of these animals in vitro. (18) He found that a standard of erythropoietin elicited a greater erythropoietic response in the explanted marrow cells of such rabbits than in those from controls or acutely bled animals. He argued that the result indicated an increase in the erythropoietic stem-cells in animals with compensated haemolysis, so that a normal level of erythropoietin would maintain an increased amount of erythropoiesis. Not only is there alternative explanation of his findings, but even if one accepts his interpretation, the issue of how the stem-cell pool is kept increased remains unanswered. An experiment had been performed in human hereditary spherocytosis by Stohlman. (17) He replaced 40% of a patient's blood, volume for volume, by blood from a normal compatible donor and found that erythropoiesis was then markedly reduced. This would have argued against the unitarian thesis and for the possibility of a dualistic control. A defender of the unitarian concept argued that the erythrocytes in hereditary spherocytosis were possibly defective either in the transport or delivery of oxygen to tissues. The exchange transfusion then would improve tissue oxygenation leading to a reduced erythropoietin production. Although it might be difficult to measure tissue oxygen tension, this interpretation was not supported by functional studies of the spherocytic red cells.

Lastly, according to the unitarian concept plethora was thought to cause suppression of erythropoiesis because tissue oxygen supply was supranormal and this constituted a negative feedback to erythropoietin production. Actual measurement of oxygen delivery had been done in rabbits and it was found that oxygen transport was in fact reduced at high haematocrit levels due to an increased viscosity of the blood. (19) Yet erythropoiesis was suppressed.

Therefore the balance of evidence appears to be against the unitarian hypothesis. Several alternative suggestions were made. Arising from the anomaly of compensated haemolytic states, it might be logical to suppose that products obtained from haemolysed red cells might act as a stimulant to erythropoiesis. Experiments showed that haemolysates of red cells stimulated erythropoiesis in animals of the same species. (20, 21) Though this may appear an attractive theory to explain the normal state of homeostasis, the situation of the compensated haemolysis and the effect of exchange transfusion in spherocytosis, it does not explain the increased erythropoiesis induced by small blood lossed where the number of red cells haemolysed per day from senescence is reduced. Furthermore it can be questioned if the amount and nature of haemolysates used in these experiments are ever encountered in natural situations. Stohlman instead postulated that normal red cells contained a certain inhibitory factor which increased in concentration with increasing cell age. (17) Thus the increased erythropoiesis seen in very mild anaemia induced by small amounts of blood loss and in states of compensated haemolysis could be explained by a reduction of this hypothetical factor whereas the decreased erythropoiesis encountered in plethora by an increase of the factor. This theory is based on that of "contract" inhibition that seems to apply in the control of cell proliferation in other organs and tissues. Later work on hypertransfused animals demonstrated the presence of an inhibitory factor in their plasma. (22, 23) Similarly plasma inhibitor was found in plethoric altitude dwellers when they were brought down to sea level. (24) Though the nature of this plasma inhibitor was obscure, studies of human urine showed the presence of an inhibitor or inhibitors both in pathological and in the normal states. (25, 26) It would appear that the postulation of a dual control, in the form of a regulated production of erythropoietin and inhibitor best explains the experimental and clinical observations. More recently a mechanistic viewpoint had been raised based on anatomical observations. (27) In the plethoric state possibly through the production of an elevated pressure in the marrow sinusoids it was found that the physical migration of maturing red cells from the cords into sinusoidal lumens was impaired. Although this was an interesting observation and offered a fresh insight into the so-called marrow-blood barrier, it will not yet be a potential contender for a place in the present controversy.

SITE OF ERYTHROPOIETIN PRODUCTION

The next controversy centres around the site of erythropoietin production. An extensive literature of experimental and clinical studies suggests strongly that the kidney is the organ concerned with this function. Earlier experiments in rodents (28) and dogs (29) showed that erythropoiesis was dependent on the intact kidneys as bilateral nephrectomy was invariably followed by cessation of erythropoiesis whereas ureteric ligation producting comparable uraemia

was not. In later experiments using parabiotic rats, it was shown that exposure of the nephrectomised partner to hypoxia did not eliminate an erythropoietic response, thus suggesting an extrarenal source of erythropoietin. (30) In man bilateral nephrectomy does not result in a total suppression of erythropoiesis and erythropoietin has been demonstrated in the plasma of anephric men. (31-32) That the extrarenal erythropoietin is similar to that found in the intact organism has been substantiated by immunological studies. (34) Thus earlier controversy surrounding the role of the kidney in erythropoietin production appears to be best resolved by conceding the possibility of a species difference. While the kidneys may be the sole source of erythropoietin in dogs, they are the major organs involved in rodents and in man they, at most, play an important role.

Though the role of the kidney in erythropoietin production seems to be partly clarified, the intrarenal localisation of this function is much less certain. Poisoning the rats' renal tubules with mercury bichloride obviated the normal erythropoietin response to hypoxia. (35) This suggested the tubules as the site of erythropoietin production. In such experiments however secondary effects on other parts of the kidney could not be excluded. Experiments by some Japanese workers focussed attention on the juxtaglomerular apparatus. (36) They showed that in rats the granularity of the juxtaglomerular apparatus was increased in anaemic states induced by bleeding or haemolysis when an increased erythropoiesis occurred. Conversely granularity decreased in plethora when erythropoiesis decreased. This apparent correlation between the degree of granularity of the juxtaglomerular apparatus and the erythropoietic activity was considered as evidence that this structure was the seat of erythropoietin production. However the fallacy of this conclusion is obvious when it is pointed out that the changes in the granularity may in fact be related to alterations in renal blood flow or vascular volume which either stimulates or depresses renin production as the case may be. (37) The relationship to erythropoietin production was therefore fortuitous. This arena was not left vacant for too long as an antibody to erythropoietin was soon produced and used for histological localization of erythropoietin in the kidney by the immunofluorescence technique. Two such studies have been carried out on frozen sections of sheep kidney and in both fluorescence was seen in the glomeruli. (38, 39) Neither the juxtaglomerular apparatus nor tubular cells were seen to fluoresce. However the localisation was somewhat different in the two studies which could have been attributed to difference in the materials and the method. Until the purified hormone is available and unless the critical experiment was performed, using kidneys from plethoric animals as negative controls, these findings cannot be considered conclusive. The more direct approach of obtaining erythropoietin from homogenates of different parts of the kidneys is not feasible for reasons to be mentioned. And this leads us to the next field of contention.

ERYTHROPOIETIN PRECURSOR

Even in the early days of the study of erythropoietin many attempts had been made to recover it from different tissues as a means of locating the site or sites of production. Most of these were unsuccessful and others gave equivocal results. While some studies (40, 41) suggested that tissue inhibitors were responsible for the negative findings other studies yielded results that

were consistent with the production of a precursor of erythropoietin. (42, 43) For instance while no erythropoietin was found in the homogenate of hypoxic kidneys, its incubation with serum produced erythropoietic activity. An impressive amount of work has since been carried out in a single laboratory in New York by Gordon and his coworkers to elucidate this precursor substance. (44, 45) The properties of this substance, now called erythrogenin, are summarised in Table I. This led Gordon to postulate that erythropoietin is derived from the enzymatic activation of a plasma protein by erythrogenin. This theory not only explained their experimental results but is also attractive as it forms a good analogy to the state of affairs which obtain in the renin-angiotensin system. While credit must truly be given to Gordon and his associates for gathering the information, it need not automatically follow that the theory propounded by him is correct. The most difficult stumbling block in this hypothesis is in its application to man in whom, as mentioned before, the kidneys do not appear to be indispensable for erythropoietin elaboration. Furthermore although the technique for obtaining erythrogenin is not too difficult, efforts by other laboratories to produce it had not been uniformly successful.

ENDOCRINE INFLUENCE ON ERYTHROPOIESIS

Moving away from erythropoietin for a moment, perhaps not for long, as one will soon see, one may consider the action of other hormones on erythropoiesis. In this field there appears to be a fair consensus of opinion. (46) For instance nearly all observations validify the concept that the calorigenic hormones such as growth hormone and the thyroid hormones stimulate erythropoietin production through an increase in tissue oxygen consumption, their efforts being markedly reduced in plethoric animals. In regard to vasoconstrictive hormones like noradrenaline, angiotensin and vasopressin, their erythropoietic effect is believed to be due to the stimulation of erythropoietin production resulting from a lowering of renal blood flow and hence renal hypoxia.

The third category of hormones are the sex steroids which have been found to influence erythropoiesis in a different way and about which controversy is still present. Androgens stimulate erythropoiesis not only in the castrated male but also in the normal animals of either sex as well as in plethoric animals. A large volume of work in experimental animals and in human beings showed that administration of androgens resulted in an increased production of erythropoietin. (47) Gordon and his associates went on to show that androgens increased the amount of erythrogenin in the kidneys. (44) The difficulty in accepting this as the only action of androgens arose because a large number of clinical studies showed a beneficial effect of testosterone and other androgenic steroids in aplastic anaemia. (47) The erythropoietin level in these patients are already very high and although androgen therapy does cause a further rise in erythropoietin production (48), it is difficult to attribute the response in the aplastic marrow to this additional amount. However in a strain of mice with congenital anaemia due to a hereditary effect in the marrow stem-cells, in which the level of circulating erythropoietin is high, it was found that an erythropoietic response could be elicited with a massive but not a small does of erythropoietin. When androgen was administered over a period of time, an elevation of red cell volume was observed without any demonstrable improvement in the stem-cell function. (49) To extrapolate this observation to the clinical situation appears unsatisfactory not only because of the species

difference but because the murine disease is not comparable to human aplastic anaemia in various ways. Thus an alternative explanation for the effect of androgens was looked for, namely a possible direct one on the stem-cell itself. Several in vitro studies were carried out with testosterone on the marrow cells and the results were initially conflicting. Subsequently in vivo experiments demonstrated that testerosterone and other androgenic compounds increased the number of stem-cells going into cell cycle. (50) Furthermore 5 B-H metabolites of testosterone were found to stimulate haem synthesis in bone marrow erythroblasts in vitro. (51) Thus a direct effect on the stem-cells or on the process of differentiation appears possible and this will better explain the therapeutic effectiveness of androgen and related steroids in aplastic anaemia.

Since 'Yin' is the classic opposite of 'Yang', then it is not unexpected that the female sex hormones may have an influence on erythropoiesis opposite to that of androgens. Such an effect was looked for and was found. However a difference in opinion was held regarding the mechanism of its erythropoietic inhibition. Work from several centres showed that, in rodents, oestrogens did not inhibit erythropoietin production, did not annul the effect of exogenous erythropoietin, but suppressed the erythropoietic response to hypoxia when given within 24 hours of the exposure. (52, 53) These findings had been interpreted by some as evidence of a direct action on the stem-cell and by others as that for impaired elaboration of erythropoietin. As an additional evidence for their hypothesis of erythrogenin action, Gordon's group supported the latter interpretation with further work. They showed that while oestrogen did not impair erythrogenin production, it reduced the erythropoietin produced following exposure to hypoxia and reduced the ability of the serum to yield erythropoietin when incubated with erythrogenin. They concluded that oestrogens suppressed the production of the precursor protein with which erythrogenin was supposed to react. (44) In Gordon's experiment, however, the dose of oestrogen used was large, some 1000 times the daily endogenous production for the animals. Until more comparable studies are carried out, this controversial issue will remain unsettled. In the human, perhaps for practical reasons, the many other positive actions rather than this negative aspect of oestrogen have received more attention. The position of oestrogen in erythropoiesis remains unclear. Perhaps the association between pregnancy and either the occurrence or the clinical deterioration of aplastic anaemia (54) would be in favour of a stem-cell action of the oestrogenic steroids.

ENDOCRINE INFLUENCE ON RED CELL METABOLISM

Up to this point attention has been given to the influence of hormones on erythropoiesis. The metabolism of the mature red cell is in a way limited because it is an incomplete and a dying cell. It is therefore not unexpected that hormone action on the mature red cell is less well studied. Nevertheless it cannot be denied that the oxygen-carrying function of the red cell is an important one and this in turn is dependent on glucose metabolism. One important feature which distinguishes the red cell from many other cell is the presence of large amounts of the metabolite 2,3-diphosphoglycerate (2,3-DPG). This organic phosphorus compound is of basic importance in determining the degree of affinity between haemoglobin and oxygen: an increase in 2,3-DPG decreases the affinity thus favouring the release of oxygen to tissues and a decrease in 2,3-DPG has the reverse effect. (55) It has been observed that in hypophysectomised monkeys

and in patients with hypopituitarism not only was there a mild anaemia, as to be expected, but the red cell 2,3-DPG levels were also found to be low. (56) Administration of growth hormone or growth hormone an thyroxine together resulted in a rise in the red cell 2,3-DPG and the circulating red cell levels. Subsequent studies on hyperthyroid patients as well as in triiodothyronine-treated volunteers also showed a rise in oxygen consumption, an increase in red-cell 2,3-DPG level and a decreased haemoglobin-oxygen affinity. (57) On the surface of these observations the obvious conclusion would be that these calorigenic hormones increase tissue demand of oxygen resulting in the adaptise rise of 2,3-DPG in the red cells. This would mean that the action of these hormones is an indirect one. In view of the well-known action of thyroxine in glucose metabolism in other cells, attempts were made to find out if a direct action also exists for the red cell. In experiments using either intact red cells (58) or haemoglobin-free lysates, (59) the in vitro incubation of thyroxine was found to increase 2,3-DPG production. It remains to be determined whether the direct action demonstrated in vitro contributes to the rise of 2,3-DPG observed in vivo.

The other hormone which has been studied in this respect is testosterone. It has been mentioned previously that testosterone has a stimulatory effect on erythropoietin production which is demonstrable even in the plethoric animal. The mechanism of action is therefore unlikely to be due to a calorigenic effect. It is therefore surprising to find that androgens also increase erythrocyte 2,3-DPG in man (60) and in experimental animals (61) hand in hand with a rise in circulating red cell volume. Furthermore a similar 2,3-DPG augmenting effect can be demonstrated in vitro. (61) These results would require a revision of the existing concept of androgen action on erythropoiesis.

CONCLUSION

It seems that in the fields I have chosen review, more work has given rise to more confusion and bred more controversy. I hope that I am not misunderstood as preaching pessimism about the future of biological science. There is a positive aspect of the whole dissertation, which is to illustrate through studying these problems how conflicts did arise. I feel the explanations may be summarised in three broad categories. First the ideal and perfectly controlled experiment is a rarity and often the critical experiment for proving or disproving a certain theory has not been done or is yet unavailable. In this sense the existence of controversy is a tantalising challenge that gives researchers the constant impetus to research for the truth. Controversy has been referred to as the "yeast which keeps science in lively fermentation". Secondly results in an otherwise good experiment have been too readily applied across the species barrier. Perhaps even the most faithful follower of Darwin will admit that what is true of the ape need not always be applicable to the Homo sapiens. Lastly controversy is precipitated not by the experimental findings themselves but by their interpretations. After all, men of science are also human and are liable to indulge in the perhaps reasonable vanity of offering a part of their mind to posterity. Hence elaborate or aesthetically pleasing theories and hypotheses are put forward, and to support them compatible data contributed to by others are selected. Findings that do not fit into the scheme tend not to be mentioned and are allowed to fall into oblivion. As time goes on certain hypotheses may themselves be accepted as semi-fact and dissenters are frowned upon as creators of confusion in an otherwise orderly scene. This last error is often perpetuated by none other than the teachers in the field. In an attempt to make things simple, in order to help understanding of a subject, dogmatic expositions are resorted to and opposing views are not properly aired. Perhaps, as a teacher, one can take refuge in the sentiment of Oscar Wilde, himself a controversial personality, when he said, "Education is an admirable thing, but it is well to remember from time to time that nothing that is worth knowing can be taught".

TABLE I

SUMMARY OF PROPERTIES OF ERYTHROGENIN

LOCALISATION	Confined to kidneys
	Light mitochondrial fraction of cortical and medullary tissues
	Recoverable from tissue culture
BIOCHEMISTRY	Immunologically distinct from erythropoietin
	Reacts ENZYMATICALLY with plasma protein to form erythropoietin
PHYSIOLOGY	Action not species specific
	Increased recovery following
	(a) hypoxia
	(b) cobalt
	(c) androgen
	Decreased recovery following
	(a) hyperoxia
	(b) plethora

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6 hours	2.50 mcg/ml	0.16 mcg/ml

In vitro success when penicillin failed[5]

Of 45 gonococcal strains isolated from patients in whom penicillin failed:

- all 45 strains where sensitive to Minocycline at the low minimal inhibitory concentrations of 0.125-1.0 mcg/ml
- Minocycline was more effective *in vitro* in concentrations lower than either tetracycline or doxycycline

Hong Kong Medical Association Prize Presentation Ceremony

In 1970 the Hong Kong Medical Association established a prize at the University of Hong Kong, to be awarded for the most original essay on any subject within the curriculum of the Faculty of Medicine or on clinical observations and/or research. Competition for the prize is open to undergraduates in the Faculty of Medicine and medical graduates serving a compulsory period of pre-registration employment in a resident medical capacity. The purpose of the Association in establishing this prize is to encourage research among medical students and interns.

At a prize presentation ceremony held on July 3, 1974 in the University of Hong Kong, the President of the Hong Kong Medical Association, Dr. Peter C. Y. Lee, presented the prize in the form of a cheque for $4,000 to a third year medical student, Mr. Chan Suk Hung, for his essay entitled 'The effect of long-term administration of Tu Chung (Eucommia Ulmoides Oliver) to normal and hypertensive rats'. The prize was awarded for the first time.

Also present at the ceremony were Dr. R. L. Huang, Vice-Chancellor; Professor A. M. C. Yau, Acting Dean of the Faculty of Medicine; members of teaching staff of the Faculty of Medicine; and members of the Hong Kong Medical Association. A cocktail reception was given by the Vice-Chancellor before the ceremony.

The H. K. M. A. Prize Presentation Ceremony

The prize winner

Mr. Chan Suk Hung receiving the Prize from Dr. Peter Lee, President of the H.K.M.A.

Our V.C. Speaks

From the Left-Dr. S.C. Tso, Miss Margaret Li, Mr. S.H. Chan, Mr. Kevin Leung, Mr. S.P. Chan, Mr. Eddie Chan.

Mr. Chan chats with Dr. K.H. Lee In the centre is Mr. C.C. Liu, Information Officer

The effect of long-term administration of Tu Chung (Eucommia ulmoides Oliver) (杜仲) to normal and hypertensive rats

By CHAN SUK HUNG *

INTRODUCTION

Eucommia ulmoides Oliver has been used in China for several thousand years for many purposes. Among its action, it was reported that both the ethanol and water extracts of the herb were effective in causing hypotension in anesthetized dogs, cats, rabbits, rats and quinea-pigs[2]. The hypotensive effect has been reported to result from the direct action of the extract on vascular smooth muscle[1].

The extract, when given orally to mild hypertensive patients had an antihypertensive action with symptomatic relief in most patients[2]. In this paper, the effect of long-term administration of an extract of Eucommia on blood pressure and plasma volume of normal and cortisone-induced hypertensive conscious rats was studied.

MATERIALS AND METHODS

The bark of Tu Chung which came from China was supplied by local herbal stores. The dried bark was ground into fine powder and extracted with 95% ethanol using the method of Chan et. al.[1]. After filtration, the filtrate was exaporated to dryness over a water bath at 60°C. The residue was then dissolved in normal saline to a concentration of 100 mg of residue in 1 ml of the final solution, adjusted to a pH of 7.0, and was used for subcutaneous injections in chronic experiments.

Thirty-five adult male albino rats (Wistar strain) weighing between 150-200 gm were divided into 2 main groups: a normal group of 15 rats and an experimentally induced hypertensive group of 20 rats. For the induction of mild hypertension 2.5 mg/day of cortisoneacetate suspension was injected subcutaneously[5]. All the animals received liberal amounts of rat chow and water. Body weight and indirect blood pressure recorded from the caudal artery with a pneumatic pressure transducer were measured daily throughout the experiment which lasts for a period of 6 weeks. The rats in the 2 groups were further subdivided into groups of 5 rats and the regimen for drug administration was as shown (Table I). Rats in group 1 served as control for normal rats and those in group 4 served as control for the hypertensive rats. Two weeks after the administration of cortisone-acetate to induce hypertension, Tu Chung extract, 100 mg/kg, was injected subcutaneously daily to both the normal rats (in groups 2 and 3) and hypertensive rats (in groups 6 and 7). The rats in groups 2 and 6 received Tu Chung injection for 4 weeks whereas those in groups 3 and 7 only received the extract for 2 weeks in order to see the effect on blood pressure on stopping the extract administration.

At the end of 6 weeks, the rats were anesthetized with urethane 1.2 gm/kg intraperitoneally. The external jugular vein was cannulated for the injection of T-1824 and other drugs while the carotid artery was cannulated and fitted with a 3-way stopcock for withdrawal of blood samples and for measurement of blood pressure with a statham pressure transducer. Plasma volume was measured, with a modification for the size of the animal, with T-1824 using the technique of Chinard[3]. A ten-minute plasma sample after the injection of T-1824 was used for the estimation of plasma volume. After the measurement of plasma volume, the effect of adrenaline 2.5 gm/kg on blood pressure was studied.

RESULTS

The changes in blood pressure of the rats in the normal and hypertensive group were as

* Mr. Chan, a III Year Medical Student, submitted this article to the Hong Kong Medical Association and won the HKMA Prize of HK$4,000.

shown in Fig. 1 and Fig. 2. With the injection of cortisone-acetate, the blood pressure increased slowly from a control value of 110 mm Hg to a value of 140 mm Hg after 10 days and remained elevated between a pressure of 140 and 150 mm Hg. Even after the cortisone-acetate injection was stopped at the end of 4 weeks (group 5) the blood pressure remained elevated around 150 mm Hg. Daily injection of Tu Chung to both normal and hypertensive rats decreased the blood pressure after 5-7 days of administration with the decrease more marked in hypertensive rats. In both the normal and hypertensive rats the blood pressure was kept around 100-105 mm Hg during Tu Chung administration (groups 2 and 3, groups 6 and 7). After the injections of Tu Chung was stopped in groups 3 and 7, the blood pressure returned to the normal value of 100 mm Hg after 1-2 days in the normal rat and to the hypertensive value of 150 mm Hg after 8 to 9 days.

The plasma volume of the rats at the end of 6 weeks were shown in Table I. There was a significant increase in plasma volume in the cortisone-treated rats (group 4) but in rats where cortisone treatment was stopped (group 5), the plasma volume was no different from that of the normal. Tu Chung administration did not affect the plasma volume in normal rats but that of the cortisone-treated rats was decreased to the normal value. After injections of Tu Chung was stopped in cortisone-treated rats, the plasma volume increased to the controlled hypertensive value.

The percentage increase in the mean blood pressure in the various groups of rats after the injection of adrenaline 2.5 /kg was shown in Table I. Rats that received cortisone-acetate treatment throughout the experiment were more sensitive to the -action of adrenaline as the percentage increase in mean pressure was higher than that of the normal (group 4). This increase in sensitivity to the -action of adrenaline was not seen in rats where cortisone treatment was stopped 4 weeks after the start of experiment (group 5) and in hypertensive rats receiving Tu Chung (group 6).

DISCUSSION

In agreement with previously published data, injection of 2.5 mg cortisone-acetate daily in rats produced hypertension (5). The mechanisms by which the hypertension is produced is not known but it was suggested that salt and water retention and sensitization of arterioles to the pressor effect of catecholamines may play a part (4). However, Knowlton et. al.[5] found no disturbance in serum electrolyte concentration. These data might be explained by assuming that the plasma volume and plasma electrolyte increased equally. Our data show that there is an increase in plasma volume with the injection of cortisone-acetate, but the increase in plasma volume is not directly related to hypertension. After injections of cortisone-acetate were stopped hypertension persisted long after the plasma volume had return to the control value. A possible explanation of this finding is that as a consequence of the elevated plasma volume and hypertension the baroreceptors were set at a higher level so that when the plasma volume returned to normal, the baroreceptors respond by causing vasoconstriction thus maintaining the hypertension. After a period of time in which the plasma volume is normal the baroreceptors gradually readjust to the reduced plasma volume.

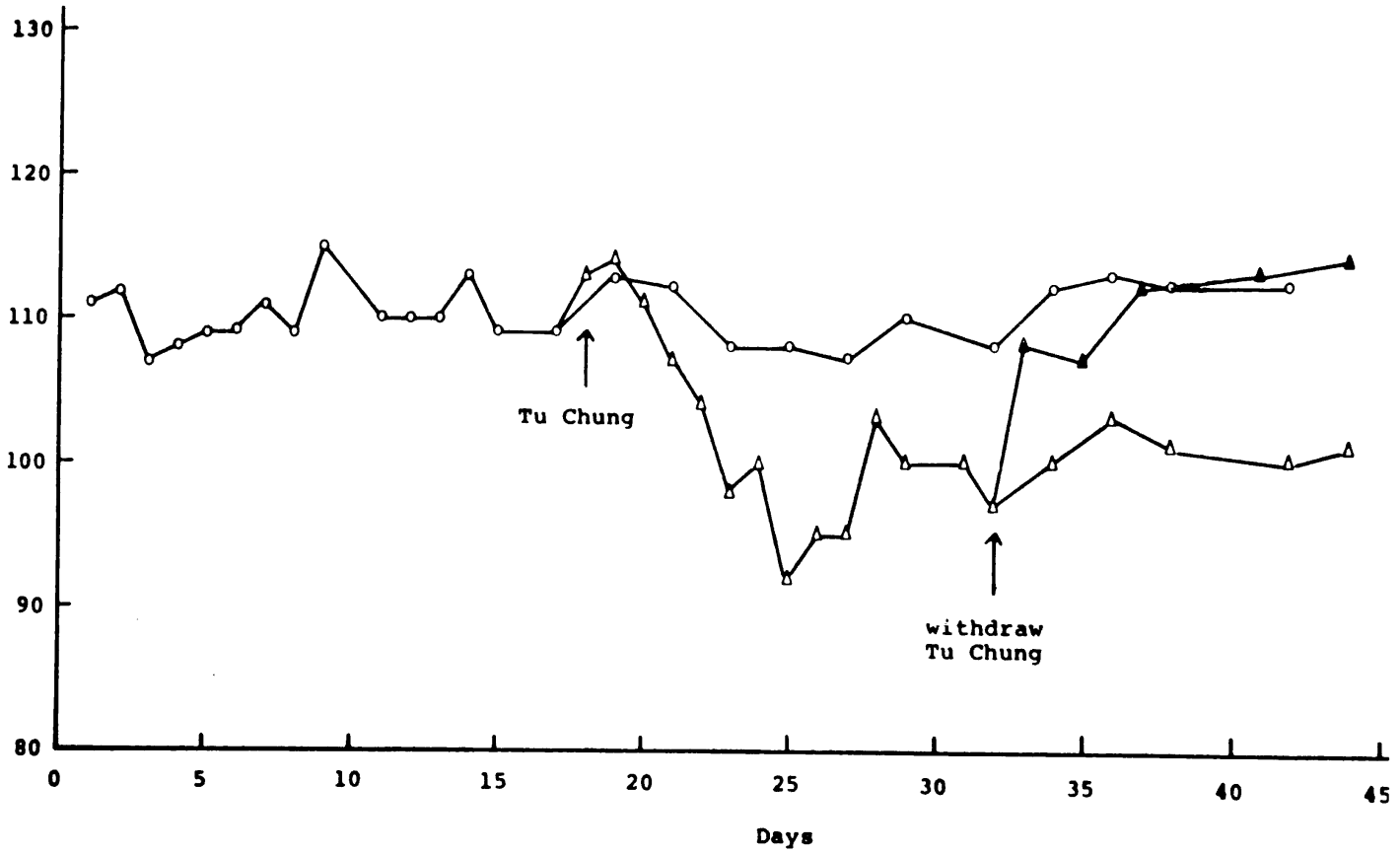
The expanded plasma volume and hypertension was reduced by Tu Chung perhaps by a direct action on renal excretion or indirectly by improving renal circulation with an increase in glomerular-filtration rate. Related to this mechanism of action is the report by Chan et. al.[1] that Tu Chung has a peripheral dilating effect on acute studies on rats. The present study also show the possibility that Tu Chung may act by decreasing the sensitivity of the arterioles to the pressor effect of catecholamines. The present data expand the work of Chan et. al. by demonstrating that chronic hypertension induced by cortisone-acetate in rats is significantly reduced by Tu Chung.

Table 1 Schedule of Cortisone-acetate and Tu Chung administration, their plasma volumne and pressor response to adrenaline after 6 weeks in different groups of rats.

Group	0-14 days	15-28 days	29-42 days	Plasma vol. % Bd. Wt.	% increase in mean pressure after adrenaline	
1	54%		Control		4.4	0.29
2	64%	Normal	EU	EU	4.6	0.48
3	59%	Normal	EU	Withdraw EU	4.3	0.30
4	73%		Cortisone-acetate		5.4	0.06
5	49%	CA	CA	Withdraw CA	4.7	0.31
6	52%	CA	CA + EU	CA + EU	4.2	0.16
7	73%	CA	CA + EU	CA only	5.3	0.10

Key EU = Tu Chung Extract
CA = Cortisone-acetate

Note There are 5 rats in each group

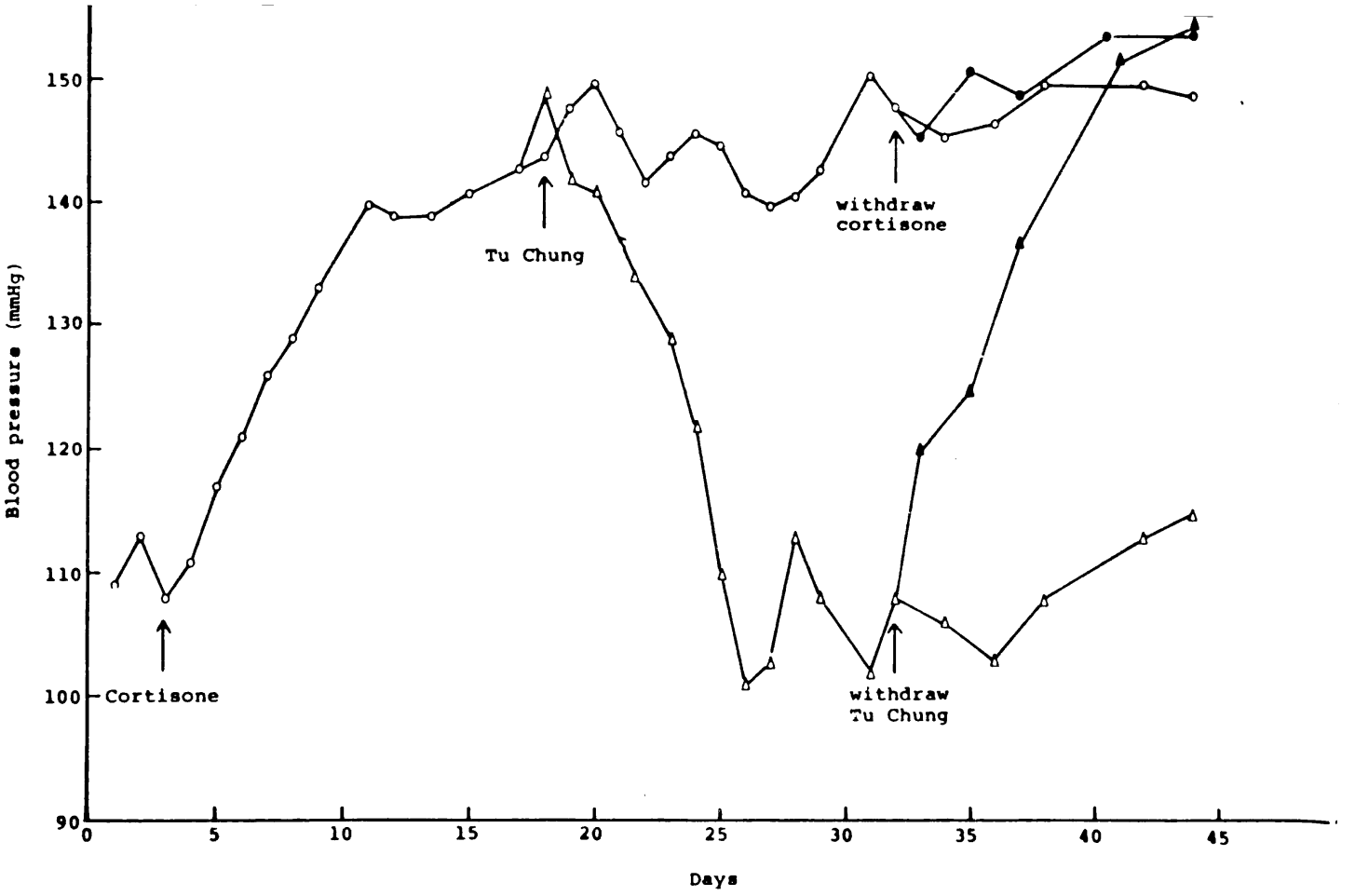


Graph 1 Changes in blood pressure of normal rats to administration of Tu Chung Extract

○ Normal rats

△ Rats receiving Tu Chung Extract

▲ Tu Chung Extract administration withdrawn after 2 weeks



Graph 2 Changes in blood pressure of hypertensive rats to administration of Tu Chung Extract

- ○ Rats receiving cortisone-acetate
- ● Cortisone-acetate administration withdrawn after 4 weeks
- △ Rats receiving Tu Chung Extract
- ▲ Tu Chung Extract administration withdrawn after 2 weeks

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ACKNOWLEDGEMENT

I would like to thank Professor M.B. Roberts, Head of Pharmacology Department and Dr. H. P. Sheung for their advice during the project. I would also like to thank Mr. Nelson Kwok for his technical assistance.

A STUDY OF THE AGEING CHANGES OF AORTAE IN CHINESE

By
LEUNG KWOK SUI,
LEUNG MING KEUNG,
NG WING CHUNG.

III Year Medical Students, University of Hong Kong.

INTRODUCTION:

Atherosclerosis is the most common precipitating cause of myocardial infarction which accounts for the highest mortality in adults in Western countries. That Oriental people are less susceptible to atherosclerosis than Westerners is well documented (McGill, 1968) and the factors causing this difference are multiple, e.g. diet, endocrine and physical habits. The fact that atherosclerosis never occurs in newborn, is rare in young adults and is frequent in old people indicates that ageing is also an important factor.

The basis pathology of atherosclerosis is destruction of the structural components of arteries with deposition of plasma materials. Balo and Ilona (1966) demonstrated a high concentration of blood elastase in atherosclerotic patients anl implied that a change of the substrate of the enzyme, i.e. the elastic fibre, an important component of the arteries, may be of prime importance in the initiation of atherosclerosis. Changes in other tissue components of arteries such as ground substance of mucopolysaccharides and collagen are invariable in atherosclerosis and might also be important in initiating the lesion but studies on this aspect are not familiar in the literature. Recently, Lyon and Preuto (1973) reported a new histological staining technique with which different structural components of artery can be demonstrated in a single section. This provides a useful tool in the study of the ageing change of aorta with special reference to atheroma formation and forms the basis of the present study.

MATERIALS AND METHODS:

A total of 49 aortae were obtained at autopsy from Chinese patients who died of diseases other than cardiovascular system. All autopsies were carried out in the Department of Pathology, University of Hong Kong from July to September, 1973 inclusive.

After all organs were removed **en bloc** from the body, the whole length of the aorta was dissected out and opened. Gross changes were recorded with special reference to the extent of atheroma. Particular attention was paid at the levels of aortic arch, thoracic and abdominal segments, renal arteries and bifurcations. As our preliminary study showed that the most frequent sites of atheromatous changes occurred in the abdominal bifurcations, blocks were constantly taken from that area for microscopic study. A total of 43 sections were studied; the remaining 6 were not available because they were kept by the Department of Pathology for other purposes. Tissue blocks were fixed in 10% buffered formalin, embedded in paraffin and cut at 8/u.

For routine histology, sections were stained with haematoxylin and eosin (H & E). For demonstration of different structural components, Alcian blue-silver impregnation (Lyon and Preuto, 1973) was used, in which the elastic fibres stained dark brown, collagen golden yellow and mucopolysaccharides blue. All samples were studied and graded by two of us independently. The grading criteria which we adopted in the present study were arbitrary and as follows:

MACROSCOPIC GRADING:

1. Grade 0 : smooth intima. No atheroma or thrombus seen (o).

2. Grade I : early atheromatous changes : with fatty streaks or less than three atheromatous plaques in any of the segments (+).

3. Grade II : moderate atheromatous changes: with more than three plaques in any of the segments (++).

4. Grade III : severe atheromatous changes : with over three atheromatous plaques plus calcification and ulceration (+++).

MICROSCOPIC GRADING:

1. Elastic fibres: different degrees of damage to the elastica were arbitrarily graded.

   Grade 0 : intact, no evidence of damage or degeneration (o).

   Grade I : superficial fragmentation close to the intima (+).

   Grade II : fragmentation involving about half of the media (++).

   Grade III : fragmentation extents to involve the whole layer of media (+++).

2. Cholesterol: the presence of cholesterol was judged by the characteristic crystal clefts in the sections.

   Grade 0 : no cholesterol deposit.

   Grade I : intimal deposit only (+).

   Grade II : deposit in the intima and media (++).

3. Collagen and mucopolysaccharides were qualitatively studied in relation to the elastica damage and atheromatous plaque.

RESULTS:

(A) Gross appearance of atheroma:

Of the 49 cases studied, the age and sex distribution is set in Table I and the occurrence of atheroma is shown in Table II. Atheroma was not seen in patients below 30 years old in either sex but occurred in both male and female patients with increasing age. Between 30 to 60 years old, atheroma was found in the whole length of the aorta with a slight predominance in renal arteries and at the bifurcation. Those patients over 60 years old had a sharp increase in atheromatous plaques which were distributed all along the aorta. Table III shows that advanced atheromatous changes occurred in the old age groups particularly at the bifurcation. Though there were marked calcification and ulceration, arterial occlusion by atheroma plaques or thrombi was not seen in any of the patients.

(B) Elastica damage:

The age and sex distribution of the specimens studied microscopically was shown in Table IV. The results of histological survey are grouped in Table V from which it is clear that the aortic elastic tissue was intact in nearly all cases below the age of 30 (Fig. I). Grade II changes with fragmentation involving half of the media was detected in one of the female patient between 21-30 years old in which no atheroma was seen grossly (Fig. 2).

All cases over 60 years old showed elastica fragmentation. The younger age group showed this change to a less severe degree.

Attention was paid to the relationship between elastic damage and atherosclerosis. Table VI shows their incidence of simultaneous occurrence.

It is clear that the two lesions do not necessarily go together. Four cases of severe elastic damage occurred without any sign of atheromatous change.

Table I: Age and Sex Distribution of 49 Autopsies.

Age	Male	Female	Total
Between 1 — 30	7	8	15
Between 30 — 60	9	5	14
Above 60 Years	12	8	20

Table II: Incidence of Occurence of Atheroma in Male and Female.

Age (Years) / Sex	60 Male	60 Female	30 — 60 Male	30 — 60 Female	30 Male	30 Female
Number	12	8	9	5	7	8
Arch and Thoracic	8 (67%)	6 (75%)	2 (18%)	2 (40%)	0	0
Renal	9 (75%)	5 (63%)	3 (27%)	1 (20%)	0	0
Bifurcation	10 (83%)	6 (75%)	3 (27%)	2 (40%)	0	0

Table III: Degree of Athermatous Change With Age.

	Age	60	30 — 60	30
Arch and Thoracic Part	Grade I	25%	14%	0
	,, II	25%	7%	0
	,, III	20%	7%	0
	Total	70%	28%	0
Renal	Grade I	20%	7%	0
	,, II	30%	21%	0
	,, III	20%	0%	0
	Total	70%	28%	0
Bifurcation	Grade I	20%	7%	0
	,, II	10%	14%	0
	,, III	50%	14%	0
	Total	80%	35%	0

(C) **Cholesterol deposit:**

The distinguishing feature of atherosclerosis is the presence of demonstrable lipid in the lesions. The occurrence of cholesterol cleft is shown in Table V and Fig. 3.

(D) **Ground substance and collagen:**

Acid mucopolysaccharides occur as acellular pools in between the elastic lamina. There was considerable variation in quantity even in undamaged aortae. A greater quantity was present in or close to the intima in normal aorta (Fig. I). Fragmentation of the elastica were always associated with the local accumulation of acid mucopolysaccharide (Fig. 4). Local accumulation of mucopolysaccharide was present also in atheroma (Fig. 3).

Collagen is stained golden yellow to golden brown by Alcian blue-silver impregnation technique. Fibrillar substances, collagen and reticulin, combined with acid mucopolysaccharide fill the spaces between the elastic fibres. Increase in collagen was seen within and adjacent to all atheromatous plaques, over which intimal thickening was prominent.

COMMENT:

The manifestation of atherosclerosis in Chinese follows the general pattern as described for other races, but it occurs at a later age. The early manifestation in the form of fatty streaks is minimal in young adults, in contrast to the high incidence described by other investigators of the International Academy of Pathology (1968). There is no distinct sex difference in atherosclerosis of the aorta among Chinese of over 60 years old (Table II) and in contrast to classical beliefs, a slight female predominence was found. The relative lack of a sex difference in raised atherosclerotic plaque of the aorta and the excess of fatty streaks in the aorta of women have also been noted by other investigators (Reports from American Association of Pathologists and Bacteriologists and the International Academy of Pathology). If the female hormones have any protective effect against atherosclerosis, this effect probably manifests more on the coronary artery thus leading to a lower incidence of coronary heart disease in premenopausal female and not in the appearance of fatty streaks or atheroma in aorta.

In the present materials, the abdominal aorta was found to be more susceptible to atherosclerosis and this is in keeping with the study of Duff and McMillan (1951). The fact that the human abdominal aorta, unlike other parts of the aorta, has no vasa-vasorum in the media is probably responsible for the segmental susceptibility to atherosclerosis. Though atherosclerotic change is rare in the younger age groups, it increases with age and reaches a high percentage beyond 60 years old (Table V). As atherosclerotic lesions vary greatly among individuals in our study, it is probable that the association of age with atherosclerosis is due to continued exposure to etiological insults rather than to ageing as an intrinsic process in the arteries.

Histological studies showed that local accumulation of acid mucopolysaccharides represents an early sign of break-up of the elastic media (Fig. 4). Breaking up of the elastica is not essential for atherosclerosis (Fig. 3) though it may occur hand in hand (Table VI). Fragmentation of the elastica occurs in all cases beyond the fifth decade but it appears earlier and severer in female patients (Table V). The association of damage to the aortic wall of any type with accumulation of acid mucopolysaccharides has been described (Braunstein, 1960; Wagn **et al.,** 1973), but their relationship is not very definite in our study with the combined alcian blue-silver impregnation technique (Fig. 3). Perhaps more sophisticated staining technique should be employed to differentiate different components of acid mucopolysaccharides in the aorta so as to achieve a better result. Zugibe (1963) also found that no apparent relationship exists between lipid and acid mucopolysaccharides in this study on coronary artery, aorta and cerebral arteries.

All microphotographs were taken from sections stained with combined alcian blue-silver impregnation technique, x 200.

Fig. 1. A healthy abdominal aorta showing thin and intact elastica. The intima is coated with a layer of acid mucopolysaccharides (Blue colour).

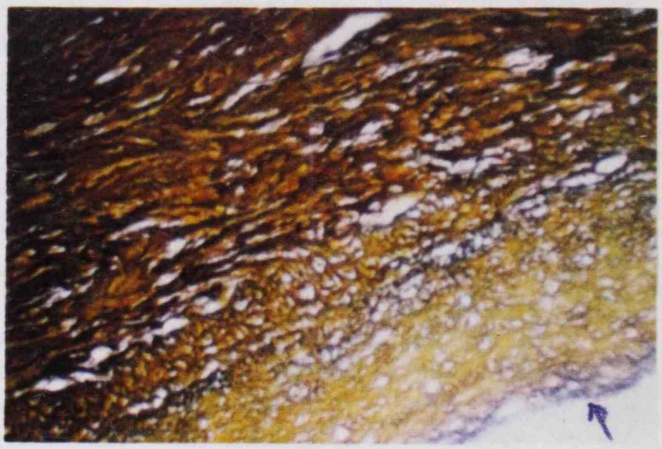

Fig. 2. Fragmentation of elastica next to thickened intima (Arrow). No atheroma is present.

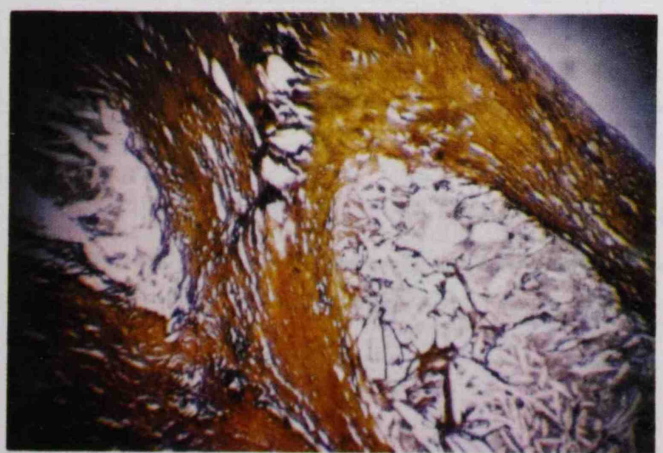

Fig. 3. The pale area is part of an atheroma with characteristic cholesterol clefts. There is associated fragmentation of elastica and accumulation of acid mucopolysaccharides (Faint blue colour).

Fig. 4. Accumulation of acid mucopolysaccharide (Pale blue spaces) in association with slight fragmentation of elastica.

Table VI: Relationship Between Elastica Damage and Atherosclerosis.

Degree of Atheroma Lesion	Degree of Elastica Damage 0	I	II	III
0	13	3	4	4
I	0	1	2	0
II	0	1	1	4
III	0	0	2	8

Table V: Elastica Damage and Cholesterol Deposit in the Abdominal Aorta.

Age (Years)	Cholesterol Deposit				Elastic Fibres Changes			
	Male		Male		Female		Female	
	Grade	No.	Grade	No	Grade	No.	Grade	No.
1 — 30	0	7	0	6	0	7	0	5
	+	0	+	0	+	0	+	2
	++	0	++	1	++	0	++	0
	+++	0	+++	0				
30 — 60	0	1	0	0	0	3	0	3
	+	2	+	3	+	4	+	1
	++	0	++	0	++	0	++	1
	+++	4	+++	2				
60	0	0	0	0	0	0	0	1
	+	0	+	0	+	6	+	4
	++	6	++	1	++	4	++	2
	+++	4	+++	6				

Table IV: Age and Sex Distribution of 43 Cases Studied Microscopically.

Age	Male	Female	Total
Between 1 — 30 Years	7	7	14
Between 30 — 60 Years	7	5	12
Above 60 Years of age	10	7	17

The small number of cases and the lack of certain age groups in the present study prevent us to draw a definite conclusion about the pattern of atherosclerosis in Chinese, but we feel that a histochemical study of mucopolysaccharides in a larger number of samples with good control remains a suitable method in the study of ageing changes in aorta.

SUMMARY:

Forty-nine aortae obtained from Hong Kong Chinese of different age groups autopsied at the Pathology Department, University of Hong Kong were studied macroscopically and microscopically using combined alcian blue-silver impregnation method. Degeneration of the elastica was studied in connection with accumulation of cholesterol and acid mucopolysaccharides. The pattern of atherosclerosis seen was qualitatively comparable with data described for other races. The classical concept about the sex difference in atherosclerosis in young adult was not apparent in the aortae studied.

ACKNOWLEDGMENT:

Thanks are due to Professor J. B. Gibson for his permission of using the facilities in the Pathology Department, to Dr S. T. Chou of Department of Pathology for his suggestion of this study and to Professor K.K. Cheng for initiating our interests in research work. We gratefully acknowledge Mr Y. S. Wong and his colleagues in the Histopathology Laboratory of Pathology Department for their technical advice. This study was supported by the Bank of America Research Project through the recommendation of Mr P.M. Whyte, Dean of Students and the Students' Union, University of Hong Kong.

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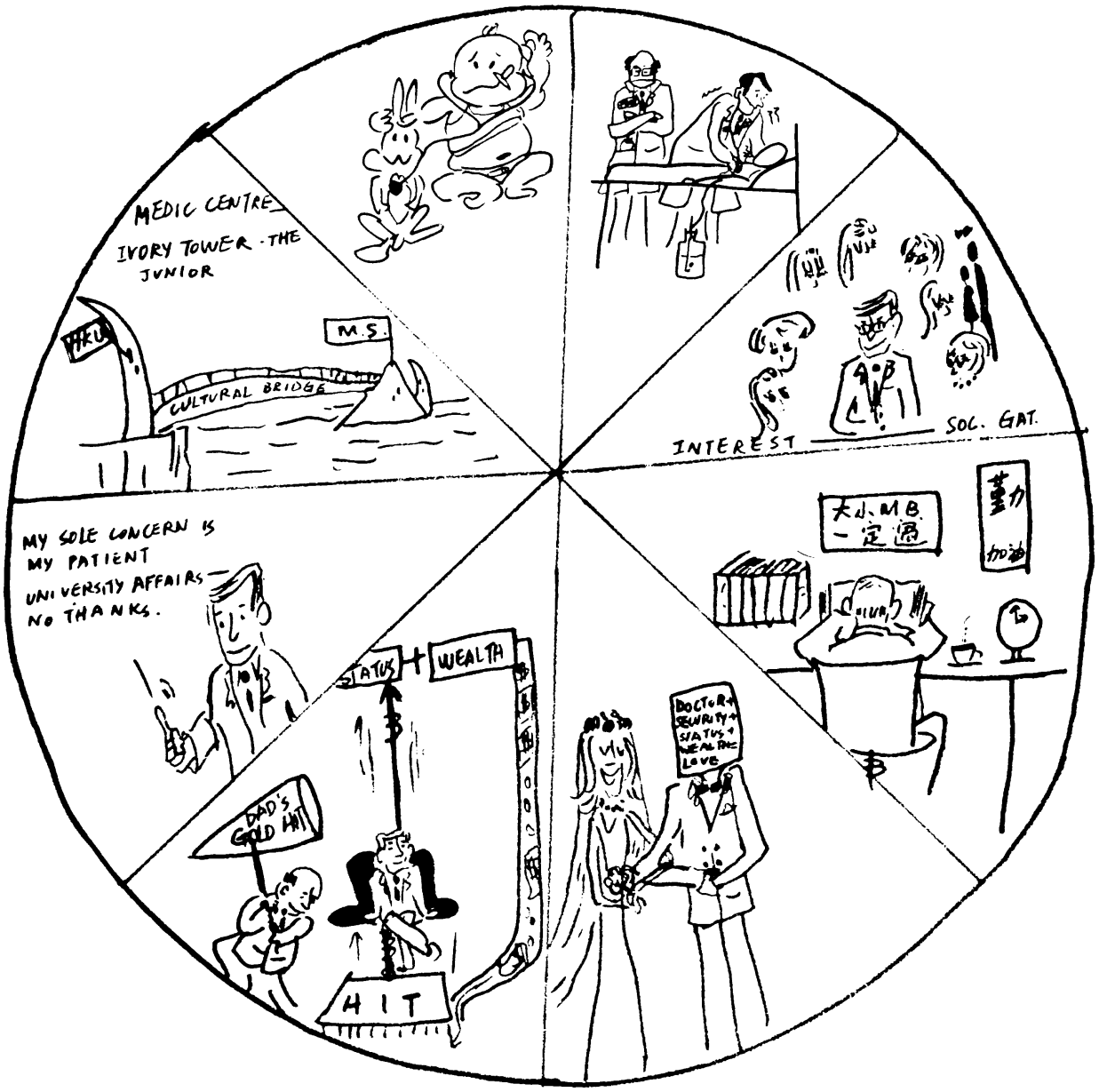
GENERAL IMPRESSION OF A M. S.



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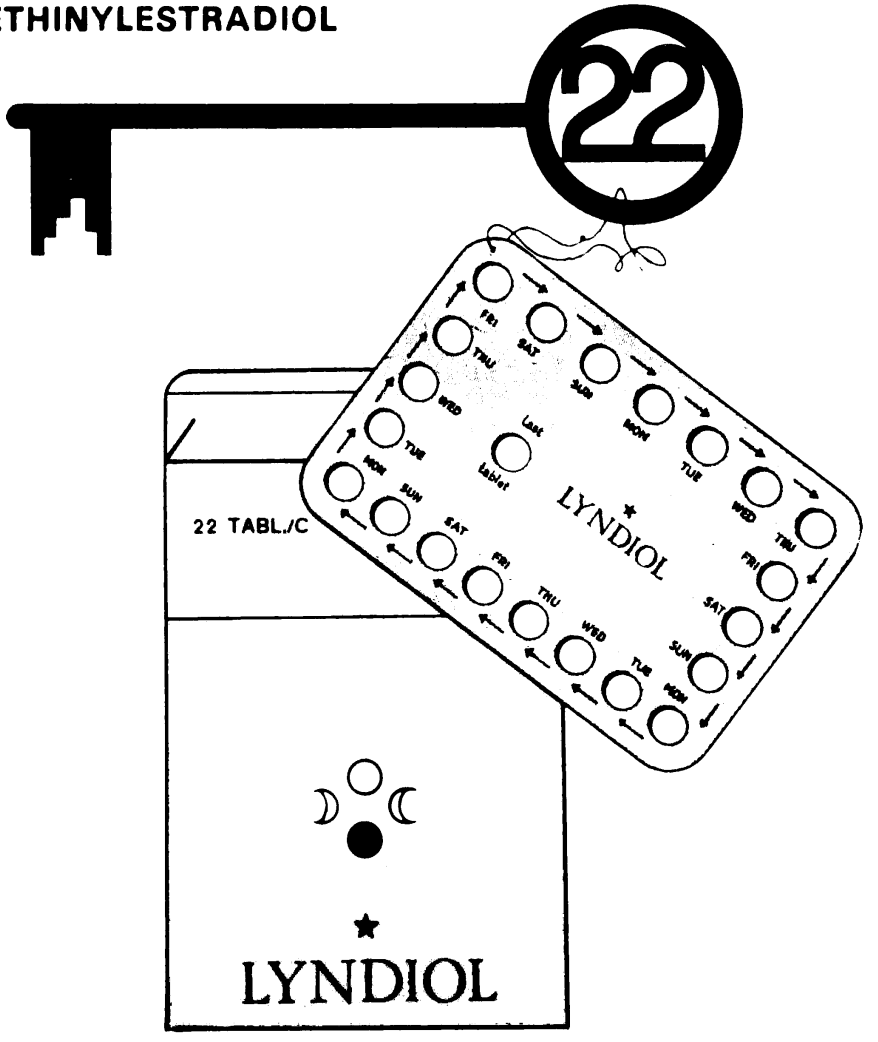

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POPULATION PROBLEMS OF HONG KONG

NG WING CHUNG

Hong Kong, a British colony with an area of 400 sq. miles and very limited natural resources, has a population of over 4 million. Moreover, over 80 per cent of this population concentrate in a city district of less than 15 sq. miles. The average population density is 10,000 persons per sq. mile but in some areas this figure reaches over 270,000 persons per sq. mile, which is the highest in the world.[1] Thus the population problems of Hong Kong can be said to be an amplified version of that faces the world. Besides, because of the peculiar geographical situation and historical background, Hong Kong also has unique problems of her own. Some of them have been solved, at least partially, while others have remained untouched. The following discussion may serve to reflect some of the facets of the current world population scene and bring out issues for the reference of other nations which share the same problems at present or will encounter them in future.

A look into the population statistics in the past twenty-five years reveal that there were sudden growth spurts, for example in 1950, 1957-58, and 1962. The increase in population during each spurt had out-balanced the difference between the gross birth-rate and gross death-rate of that period. This is due to the immigrants from mainland China. It was estimated that in the single year of 1962, one hundred and thirty-five thousand people crossed the Chinese border and entered Hong Kong, both legally and illegally. The number of net immigrants during the period 1966-68 was approximately 40,000 per annum.[2]

In the past, Hong Kong had served as a shelter-place for the Chinese people in the mainland. Whenever there was political instability in China, people rushed to the colony to seek for security. After the crisis, these refugees largely flowed back to the mainland. Examples were the Tai Ping Rebellion and the Sino-Japese war in the early forties.

Since the year 1949 when the Peoples' Republic was set up in China, this flow of population has essentially become a one-way traffic. More and more Chinese come to Hong Kong and although a large number later left for other nations such as Taiwan and U.S.A., a considerable residue remained in the colony.

This immigration bears great significance upon the population of Hong Kong in the last twenty years. The earlier free flow had given rise to sudden waves of pressure upon the community, and the later irreversible flow, together with the high birth-rate and low death-rate, blowed up the population balloon. It presented special difficulties to the government social plans, because there is no way to predict the volume of net immigration. Also the immigrants were mostly of the age groups with high fertility and their coming to Hong Kong is therefore more than a simple increase in the population. Because of their different ways of living and ideology, some of them often find it difficult to incorporate into the capitalistic society of Hong Kong and present as a social problem.

Fortunately, since the year 1968, the control at the Chinese border have been tightened and the incoming immigrants greatly dropped in number. The rate at present is estimated to be less than 10,000 per annum.[3] However, it still remain as a constant threat

1. (i) 1971 H.K. population and housing census, main report; 3.5.
   (ii) 香港家庭計劃會回顧與前瞻——林貝聿嘉
2. Country Profile, November 1969: the International Institute for the study of human reproduction, Columbia University (prepared by HKFPA).
3. 香港經濟——范叔欽著，第一章。

This Essay was presented by Mr. Ng Wing Chung, III year Medicine, in the First International Interdisciplinary Student Seminar on Population Dynamics & Family Planning held from 25th July to 1st August, 1974 in Lagos, Nigeria.

to Hong Kong which had already reached closely the maximum level of population that it can support. In July 1974 alone, 660 "illegal' immigrants were recorded and it is estimated that for 1 recorded, there are 3 who were not discovered by the police.

The reason to bring up the point is not to discuss the politics behind nor to blame anybody, but to emphasize that we need the co-operation and mutual understanding between nations to deal with the population problems that mankind as a whole have to face. It also reminds us that the problem consists not only of the absolute increase in world population. The distribution and flow also plays a part. Situations similar to that mentioned above occurred in U.K. and India during the Uganda crisis and East Pakistan War respectively.

Since nearly every nation in the world now feels the burden of its own population, any sudden flow from one nation to another will disturb the critical equilibrium that exists. This may create friction between the nations concerned and ultimately lead to war, which will undoubtedly solve the problem in the sense that it decreases the population in both nations, but this is not the way that we like it to be done.

The micro-distribution of population within the colony is also a problem. As mentioned above, a great proportion of the total population concentrates in the metropolitan areas that are situated mainly along the coast of the excellent harbour, which is nature's gift to Hong Kong. Such a development is understandable from the historical view-point that Hong Kong first developed as a entre-pot for China. Most of the early inhabitants earned their living through the various trades associated with shipping and therefore lived near the sea-front. As the main source of national income changed from entrepot trade to manufactory industry, the first factories are built near the centres of population to absorb the labour. The demand in labour attracted people from the rural areas and a vicious cycle developed. In the last ten years, resettlement areas and satellitic towns has been built at the out-skirts of the urban areas. As a result, the density of population had ceased to grow in the metropolitan areas, or even decreased slightly.[4] However, the figures remains the world's highest. The limited success of the dissemination of population is partly due to lack of long-term planning and partly due to insufficient mass transport media between the rural and urban areas so that people are reluctant to move into these satellite towns. (This will be discussed later)

The other factor, besides immigration, that contribute to the huge population is of course the birth-rate that far exceeds the death-rate. The gross birth-rate in Hong Kong has always been high. It reached the maximum of 3.7% in 1956 and was maintained above 3.5% until 1961 when the practice of family planning began to spread. It is only recently that the birth rate of Hong Kong has dropped below 2%, which is considered as the dividing lone between high and low birth rates.[5]

The birth rate in the coming few years is expected to rise a little because of the age-group distribution of the population. A greater proportion of the population will be in the fertile and suitable for marriage age-group in the next 10 years.

over 88% of the population in Hong Kong are Chinese. It is traditional Chinese believe that a large family is a happier one and increase in number of the household means increase in wealth of the family. This tradition originated in the peasant society of old China, in which manual labour was the chief source of energy in farming. The children were given minimal education or none at all and began to work in the fields from early childhood. When they grew up, they were responsible to maintain the living of their parents. The idea persisted in the early industrial society of Hong Kong, only that the children worked in

4. Table 4. H.K. 1971 population and housing census, main report.

5. Hong Kong Statistics 1947-1967.

the factories. The scene began to change after the laws to protect children labourer were laid down and the parents started to realise the value of education in a modern society. However, remnants of the old tradition still remains in the mind of some people, especially the older generation. About 12 per cent of the population still think that children were necessary as security against old age.[6] It was also shown that the 'Chiu Chau' people, who came from rural areas around Canton, usually prefer larger families than people that came from the urban areas of Canton, probably because of the reason stated above.[7]

Another Chinese tradition that is responsible for the high birth rate is the high status of males in the society. According to the old Chinese system of inheritance, only sons were considered as rightful heir to the fortune of their father. Men usually enjoyed a greater power than women both in the community and in the family. Daughters-in-law was a source of man-power to the family. Thus parents felt that they were at a loss if they did not have at least one son to perpetuate the family line. It is not rare to see that a couple only consider family planning after the birth of their first son, no matter how many daughters they had already. This concept had deeply rooted in the minds of most Chinese and presented as a great obstacle to the control of population. 12.9 per cent of the population felt that children, especially sons, were valuable as they must perpectuate the family line.[8]

Following the urbanization and industrialization of Hong Kong, the above traditions gave way to ignorance as the chief barrier to family planning. It was found that women above the age of 35 in Hong Kong are much more reluctant to accept family planning than women in younger age groups. These women are those who received relatively little education and are not much affected by the socio-economic changes in the society.[9] Since the fertility in this age group is still high, they are the main target group of the present family planning programme.

Ignorance also gives rise to the misconception about the side-effects and harmful consequences of contraceptive measures. These mis-conceptions are the main excuses given by those women who refused to practise family planning. Ignorance on the part of the husband also plays a part as the second most frequent excuse given is objection by husbands, who might think that family planning is solely the job of their wives and are less concerned with their children. Their ignorance also hinders the wide-spread use of vasectomy as a means of contraception, since quite a number of them confused vasectomy with sterilization and believe that it will lead to impotence.

The main weapon to beat ignorance is by education and propaganda. These are done most effectively through the mass media such as newspaper, radio and television. A survey showed that these media are not fully utilised, especially television, to spread the correct attitude towards family planning.[10] Most of the advertisements are motivative and seldom touch on the methods of contraception, probably in order to avoid embarassment. The public often depend on newspapers to gain knowledge on the methods and often a single article on the harmful effects of contraception would produce much misunderstanding.

It is expected that with the gradual rise in education level among the population, the situation will improve.

It was said that this innert attitude in the past years was due to the influence of the Catholic Church on the government.

The policy of the Hong Kong government should be responsible for a large part of the

6. The impact of industrialization on fertility in Hong Kong — by C. Y. Choi and K. C. Chan: Social Research Centre, the Chinese University of H.K.

7. Table 4.5.2., H.K. Population and housing census 1971 main report.

8, 9, 10. The impact of industrialization on fertility in Hong Kong. (see 6.)

population problem. The attitude of the government has been neither pro-natalistic or anti-natalistic and that family planning has always been regarded as something best left to the individual couples. Her tax, housing and abortion policies though revised on several occasions, have never been designed to create the demand for birth control. For example, the income tax is so designed that little had taken into consideration to encourage family planning.

Family planning work in Hong Kong is almost solely the effort of the Hong Kong Family Planning Association (HKFPA), which is a voluntary body subsidised by various local and international benevolent organisations. It is true that 40 per cent of the annual budget of the FPA is provided by the government. However, in spite of the support, it is unlikely that the target figure of 136,339 patient of PFA by 1976 can be achieved unless family planning is incorporated into the government health service.[11] At present many of the clinics which are held in government mother-child health (MCH) centres are overcrowded but no extension of service hour is possible because the MCH programme is itself pressed for space. Furthermore, it is unlikely that overseas agencies which have been supporting the FPA will continue to take such an interest in Hong Kong population research or supply funds to cover continuous expansion.

It was announced by the government at the end of 1972 that the Medical and Health Department would soon participate directly in family planning but the lines of development are still not yet known and no action had been taken so far. The effect of direct participation of the government in family planning is difficult to predict at this stage, as the result may not be any improvement[12], but at least it indicates that the government is more concerned with the matter and is generally welcomed. It remains the immediate urgency for the public to press the government to take an aggressive stand and positive moves such as a national family planning programme.

Due to the success of FPA, the growth of population by excessive births had largely been checked and the threat of further increase is somewhat reduced. The more important problems that face Hong Kong are the various social effects that result from the huge population.

Of most concern to medical students is the question of medical and health service. To provide adequate medical care is not an easy task, especially in a society like Hong Kong which cannot be said to have good social welfare system. The number of hospital beds to population ratio at present is at most 4.25 beds per 1,000 and in 1982, even after all the proposed plans are carried out satisfactorily, the ratio will only increase to 5.5.[13] This ratio is relatively low compared to the degree of development of Hong Kong. Besides, there is a deficiency of mental beds. There is also an acute demand for medical personnel, both doctors and nurses, especially in the government service. The population growth has outbalanced the source of supply and the potential shortfall for doctors in 1982 was estimated to be 374 or 27% of the forecast need.[14] This has given rise recently to heated controversies over the necessity of a second medical school in the colony.

Housing is still one of the greatest task for the government to tackle. The housing aims for Hong Kong laid down by the Hong Kong Housing board are that each family should have self-contained accommodation with a minimum of 35 sq. ft. of living space for each adult. The 1971 census revealed that in many districts, the situation is far below this ideal. In fact, over-crowding is a very common phenomenon

11. Studies in family planning Vol. 4 No. 5:—The population council May 1973.
12. The role of governmental, international and voluntary agencies in population dynamics and family planning. — by Professor S. S. Ratnam. First Asian regional seminar on population overgrowth.
13, 14. Report of the Medical Development Advisory Committee 1973 Chapter 2, Chapter 6.

in Hong Kong and is felt by the majority of the population. About one-third of the living quarters are in non-self-contained domestic units in resettlement blocks, simple stone structure, in residential structure of non-durable material and in premises not used for domestic purpose.[15] The earlier resettlement areas have been proved to be a temporary solution to the problem and unsatisfactory for living. Re-construction of these resettlement areas had started but the involvement will be huge because the inhabitants have to move to other areas during the re-construction period and a large sum of money has to be spent. According to the law of supply and demand, the rent of houses went up sky high and is a heavy burden on the average family.

Education is another knot to be untied. With the industrialization of Hong Kong, the demand for educated labour of a high quality had made the government to provide education to more children. Compulsory free primary school education was enforced recently and illiteracy was said to be erradicated. For higher education above primary school level, the competition is very keen. Only 50% of the candidates that sit for the SSEE 1974 were given places in government or subsidised secondary schools. The ratio of university places to the population is 1 to 800. As a result, many of the secondary school students seek for higher education overseas leading to a 'brain drain' of considerable severity that may hamper the development of the society. The total number of children from 5 to 6 years of age not at school was reported as 172,577 in 1971.[16] This indicates there is still a long way to go to achieve the aim of providing education for all children of suitable age.

With the recent economic depression and oil crisis, the industry of Hong Kong also suffered. Many factories closed and the number of unemployment greatly increased. The immense population of Hong Kong in the past had supplied ample labour-force to the manufacturing industry and in fact the chief wealth in **Adams' words.** The improvement in technology demands quality rather than quantity of the labour and the population gradually out-grows the opportunity for employment. The number of unemployed persons in 1971 was 72,058 and this figure is expected to be much higher this year.[17]

An indicator of the social problems is the crime-rate especially juvenille delinquency which rose to a peak in recent years in Hong Kong. Various methods had been proposed to suppress the crime and to punish the criminals, including harsher laws and a more powerful police force. Actually, the root of this deterioration in social order lies in the poor housing conditions, overcrowing, poverty, lack of education and various sociological factors that stem out from the population problem.

As mentioned earlier, mass transportation in the colony is an acute problem to be solved. The roads are always congested and the traffic is a mess during the rush-hours. It is just a 'natural' phenomenon in a city with such a tightly packed population and roads so badly constructed. The older part of the town was not designed to accommodate such a huge population. Even in the newly built areas it makes one doubts whether city-planning ever exists. The buses and trams are always full and before the cross-harbour tunnel was constructed, cars had to wait for hours to cross from one side of the harbour to the other. The condition of the traffic can be described as supra-saturated by the population. An underground railway system seems to be the only way out but it is still on papers and itwill be at least 5 years before the tubes are partially in use.

Attention has recently been focused on the effect of the population on the environment. Air-pollution is severe since the industrial areas are in close approximation to the domestic residential areas, especially in Hung Hom district near the airport where the height of the chimneys of the factories are not allowed

15, 16. 63: 1971 H.K. population and housing census, main report.

to exceed 200 ft. Noise pollution has reached a dangerous level around the airport and near the various construction sites. The laws that are meant for conserving the environment are seldom enforced and to some people pollution is 'the sigh of prosperity'. In a survey done recently, most of the streams in the New Territories were found to be polluted to such a degree that was unsuitable for natural lives of any form to live in.

To the above problems one may add the problems of water-supply, food-supply and others which are of a more chronic nature and had been relieved partially or totally.

Behind all these presenting symptoms is the basic pathology of population. There are other pre-disposing factors and the medicine so far given by the government is only meant for palliative treatment. Radical cure can only be achieved by eradication of the cause through family planning on one hand, plus long-term active therapy of the symptoms on the other. This, however, require the doctoring skill of a long-sighted, determined government and the assistance of a social-conscious public, both of which are absent in Hong Kong at the moment.

EXTRACT

Hong Kong has the highest population density in the world. It shares the population problems of the world and at the same time has that of its own. The problems can be divided into two folds: those concerned with the causes and prevention of the growth of the population and those resulted from the already existing immense population. In the first category are immigration from China, the unequal distribution between urban and rural areas, the Chinese traditional attitudes, the inert attitude of the government and other barriers to the acceptance of family planning. The second category includes various social problems such as inadequate medical and health services, poor housing conditions, education problems, juvenile delinquency, unemployment, traffic congestion and adverse effects on the environment. The solution lies in a long-term comprehensive population policy of the government with the co-operation of the public.

REPASE

by

Dr Sarah Israel

The E.B. thanks the International Planned Parenthood Federation for permission to reprint this poem.

From East and West and North and South,
We came to Gammarth's shore

To talk about the kind of things
We'd thought about before.

From Pakistan and Chile,
Tunisia, USA

From Egypt, Denmark, Uruguay,
Korea and UK,

From Mexico and Sweden,
Jordan, Malaysia,

Colombia and Haiti,
and sunny India.

Our friends from IPPF worked
like busy honey bees

To make our stay profitable
as also full of ease.

The bright blue skies and sunny warmth
of Gammarth's lovely bay

Combined with all the sunny smiles
to make a pleasant stay.

We started well with our dear Ottar's
glowing words of beauty,

While Thorsten cheerfully took up
our Convener's place and duty.

We talked about the How and When
by Whom, and What to say

On educating boys and girls
for family life today.

We discussed the possibility
of starting pilot studies,

And interpersonal relationships
with relatives and buddies.

The emotional involvement of
the target population,

And the fear of having sex without
the fear of procreation.

We talked of aids and manuals
TV and publication,

Mass media and programming,
Research and Documentation.

Maturity in all aspects—
emotional and physical,

And country needs of different kinds,
both social and cultural.

Sexology, Psychology,
the current ways of dating,

Anatomy, Biology,
and different modes of mating.

Criteria for selection of
the teachers of the nation,

And whether to call it Sex or
Population Education.

Should birth control be taught in schools
and smaller family size,

The values, codes, behaviour,
and problems that arise.

Opposition from the Left
and also from the Right,

We talked about these all the day
and dreamt of them at night.

Sanctuary's skeleton
gave rise to distillation

Of Draftings Number 1, 2, 3,
with final compilation

Of views from East, West, North and South
REPASE for every Nation,

'RESPONSIBLE PARENTHOOD AND
SEX EDUCATION

AN INTERVIEW WITH PROFESSOR M. J. COLBOURNE

Many of us are already well acquainted with Professor M. J. Colbourne, as he has been working for the past year, as Reader of the Department of Social and Preventive Medicine. With the retirement of Professor P. H. Teng, he has recently been appointed to the Chair of the Department.

Though he has been here for only one year, Professor Colbourne is by no means a stranger to Hong Kong. During the past twenty years, his work has been closely tied up iwth health problems in this part of the world. In 1956, he went to Sarawak as the adviser of WHO to the Malaria Programme. His headquarters then were in the WHO office in Manila, so that he frequently passed through Hong Kong and stayed for a few days here on his way between Manila and his post in the field. Later on, as advisor on Malaria in the WHO regional office, he came here on duty to discuss with the Government the problems of Malaria in Hong Kong. Malaria has, of course, never been a serious problem in Hong Kong, but some cases have been reported in the New Territories. He first came into actual contact with the students of Hong Kong, when, as the Professor of Social and Preventive Medicine in Singapore, he came here as the external examiner. After that, he went back to London to do more consultationship for WHO. On his way to and from Manila, he often visited Professor Teng whom he came to know very well. Anxious to leave his department in good hands, Professor Teng, some time before his own retirement, asked Professor Colbourne if he would be interested in applying for the Chair in the Department. As he had enjoyed doing similar work in Singapore, he decided to come to Hong Kong and accept the offer to succeed Professor Teng.

Apart from being a specialist in Malaria, Professor Colbourne is also interested in other aspects of medicine. He started off as a general duty doctor, doing general work in hospitals

in Africa, which included clinical medicine and a certain amount of emergency surgery. At the same time, he was also responsible for dealing with communicable diseases in that area. His work there led him to the conclusion that it would be very worthwhile devoting his time to the prevention and control of communicable diseases. Among the many such diseases, he specialized in malaria control and erradication campaigns. Later, in Singapore, he was interested in regaining contact with clinical medicine which he did while doing medico-social case teaching.

One is interested of course to hear what our new Professor has to say about medical students in Hong Kong.

He admitted, quite frankly, that he has found them more difficult to communicate with than their counterparts in Singapore. The language problem, he believes, may be partly responsible for this difficulty in communication. In Hong Kong, the language most commonly used when medical students talk to each other

is Chinese. Though he knows a bit of Chinese, it is quite inadequate for him to participate in to-and-fro conversation. Whereas in Singapore, which has so many nationalities, English is much more frequently a language of communication, so that he could communicate readily with the students both at the teaching level and the more informal social level. The other reason is that in Singapore, the curriculum of Social Medicine included certain medicosocial case-work in which he could go with small groups of students to visit patients in their homes. In this way, he was able to get to know better the students' attitude and what their problems were. With the help of Dr. Ng, he is planning, by next year, to incorporate such medicosocial case-work into our curriculum. This will allow the teachers to have more direct contact with small groups of students so that exchange of ideas may be more readily achieved.

On the whole, the students of Hong Kong have impressed him as being very hard-working as far as studying goes. They are also successful, by and large, to make the very best use they can of the information that they have picked up. However, he feels that many of them tend to stick somewhat too narrowly to the passing of examinations, the attainment of a degree and not taking enough interest in the other things that go on in the University and in the community, which are certainly all very important with regard to the subject of community medicine. He was pleased with the recent exhibition on 'Health and Diseases' put up by the Medical Society as this has shown that some students at least are prepared to look at the broader aspect of medicine outside the narrow curriculum. He advocates also a more open teacher-student relationship whereby students can feel free to disagree or argue with their teachers so that both may benefit in their pursuit for the truth.

According to Professor Colbourne, the medical school of Hong Kong enjoys a good reputation of maintaining a high standard of medical education. It is therefore the duty of the medical students to uphold this reputation by proving themselves to be well-educated doctors when they graduate. To this end, they should engage themselves in broader reading, reading the newspapers more seriously and taking more to heart the things that go on in the world, for they are going to work in a community which is problem-ridden and in which they will be regarded as leaders. A university should be a place where different points of view are intelligently discussed, whatever the faulty. Inspite of being rather short-staffed, the Department of Social and Preventive Medicine is ready to assist students in this aspect of their education. It is up to the students therefore to take the initiative in approaching their teachers for more personal teaching, discussion or advice.

The Department of Social and Preventive Medicine, now to be rechristianed as the Department of Community Medicine, is a relatively young member of the Medical Faculty of Hong Kong University. We hope that, under the excellent guidance of its new Professor, it may succeed in arousing more interest in this important branch of medicine.

* *

A pretty young girl went to America to study medicine. She returned 3 years later with a handsome young man. Her boyfriend, astonished, asked,

"Aren't you going to get your M.D.?"

"Sure," replied the exalted girl, "I got him real quick!"

* * *

A doctor requested a patient to bring in a 24-hour urine specimen. The patient appeared the next day without the specimen and explained,

"I couldn't hold it that long."

* * *

Doctor to a patient hospitalised for quite some time,

"And how are we this morning?"

The patient said, "Judging by the way I feel and the way you look, I'd say that we are both in trouble."

A STUDY TOUR TO SINGAPORE AND KUALA LUMPUR

In May, the External Affairs Secretary, Mr. W. C. Ng, initiated the idea of a Study Tour to Singapore. After consultations with Prof. M. J. Colbourne, the former Prof. of Community Medicine in Singapore, the object of the tour was decided to be Social Medicine. Thus application was opened only to students of Third Year, who have attended lectures and field visits for that subject. Prof. Colbourne, in order to arouse more interest, organized an Essay Competition, the theme of which was on Community Medicine and Health Problems. Two $1,000 prices, donated by Prof. Colbourne, were awarded to the two best entries to subsidize the travelling expenses of the winners. Five students set out on 21st September for a private tour of Bangkok first, before being joined by 3 other students in Singapore on 23rd September. They spent four days each in Singapore and Kuala Lumpur. Their visits were arranged by the Dept. of Social Medicine and Public Health, University of Singapore and the Medical Society, University of Malaya. They received the warmest hospitality from the medical students of the above universities. They returned on 1st October, just in time for the new clerkship assignments.

The two price-winning essays and the report are presented in the following text.

WE WENT, WE SAW. WE LEANED

LEUNG YUM KWONG
LEUNG MING KUENG

INTRODUCTION: Too Eager Fellows

Five members of the class were so keen in Social and Preventive Medicine that after their Surgery Senior Clerkship test on the 20th Sept. 1974, they flew off to visit Bangkok, to be joined later by three others who were just off their Medicine Senior Clerkship test on the 23rd. The eight of us carried out an eight day study tour in Singapore and Kualar Lumpa under the assistance of the Medical Society of the University of Singapore, and the Medical Society of the University of Malaya.

OUR NEW FRIEND IN BANGKOK

No connection was made with the University in Bangkok before the trip, but the group was fortunate enough to get a very good guide in Bangkok. This fellow found his living by picking up passenger from the airport to the city in his own car. He needed to pay 10% of his earning to the policeman on duty in the airport. (We got to have sympathy for the police in Bangkok because they are the 'low-income' group of the city). We told our guide that we were students and wanted to see the social aspects of Bangkok. He immediately offered to drive us around at a charge which was reasonably low. In the following days, he even returned to us what was paid to him as commissions by the tourist centres we visited. (The commission sometimes amount to 40% of what we officially paid).

We ate in the side-street stalls for most of our meals to see the actual life of the people. We also visited the house of our guide to see the living environment. Our friend belonged to the low-income group. He told us that he was staying in the slum part of the city, but it turned out to be a neat wooden hut which is much cleaner and tidier than any compartment in the resettlement area in Hong Kong.

WHAT BANGKOK IS FAMOUS FOR

Bangkok is not only a world-famous temple-city, she is also famous for her 'red-light' business. So, off we went to see the problems of social hygiene by visiting the bar and the massage parlour. (Unfortunately, or fortunate enough, none of us have visited such places in Hong Kong so that no comparision could be make). In the bar, the people there approached us patiently several times and finally we had to declare definitely that we came, not to do things, but to see. We visited two massage places and had a short chattering with the men-in-charge. Massage girls were kept in windows (like animals, oh dear!), awaiting to be selected and picked up by their customers. Pure massage might be done in the massage rooms but they might be taken out for "follow Up". One of us had the courage of being bathed and massaged, finding himself, happily, to be cleaner than before. (The rest of us had no confidence to try it once for a life?)

A MEDICAL STUDENT IN BANGKOK

Two of us met a gentleman in Bangkok who was also studying medicine. So willing to entertain his Hong Kong friends, he made a special offer despite the fact that he was facing a test the following day. "I can bring you to see special shows and go for a massage at a local price tonight", he smiled. We rejected this special offer partly because we didn't want to disturb his study, and partly because we were not intending to add any further experience about shows or massage. (Already bored?)

SHE AND HE, HE OR SHE

Our study of Social Medical in Singapore began 2 hours after landing. This time, the whole study group were anxious to know what was happening in Bugis Street. The whole street was occupied by food-houses and their tables and the she-him stood by along the side of the road. What a man-made beatuy! Modern Surgery and Medicine had given them what Nature did not mean them to be! A beautiful lady you will say if they walk beyond Bugis Street, only to recognise their "plus" or "arrow" when they begin to vibrate their vocal cords.

POOR PROFESESOR

We were greeted by Professor Phoon in his department of Preventive and Community Medicine on the third day of our visit in Singapore.

"Our department is one of the largest in the Faculty of Medicine. We have post-graduate studies in Public Health and Industrial Health and frequently it is the tops of the class who join these studies. Our department has more than ten staff members . . ."

"But our department of Social and Preventive Medicine has only two staff-members!" one of us interrupted.

"Oh! Poor Colbourne!" Dr. Yik exclaimed. (He is a lecturer of the Department in Singapore, and a former student of Professor Colbourne. It was he who arranged the study tour for us.)

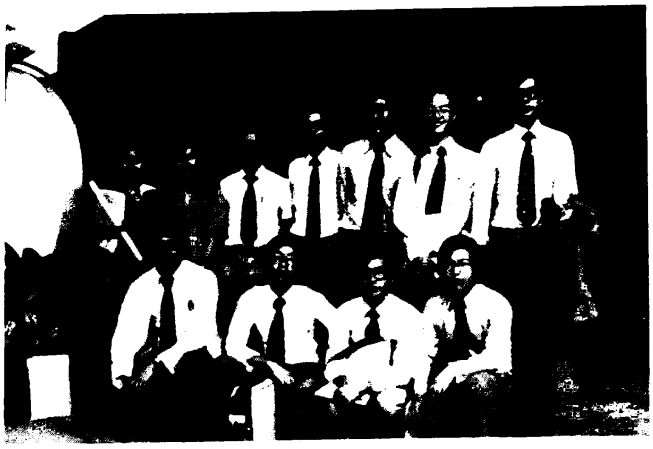
LESS CLEAN THAN WE THOUGHT

Singapore is said to be the cleanest city in South East Asia. They had a similar "Keep the City Clean" campaign before ours. Indeed we had to learn from them in our campaign. So we expected every Singapore street to be clean and tidy. But, according to what we have observed during our limited time, some of the streets are not at all too clean, especially those near the markets.

FAMILY PLANNING FOR HOUSING

Singapore is also famous for its family planning programme and housing scheme. There are a thousand and one ways for them to make you follow their family planning once you settle in Singapore. You can suggest any possible method of not giving birth to a baby, and probably they already have it — only to stop short at giving prizes or medals to families with no children!

The housing scheme there really deserves its praise. Each family unit has at least twice as much space as the one we have in Hong Kong. People either pay a reasonable rent or buy their own houses from the Government in instalments spread over a long period. Lots of such housing estates are under construction now.



LEARNED LITTLE, LEARN MUCH

Our 96 hours in Singapore has been a valuable time for us. We gained much in Family Planning, Industrial Health and drug problems.

"I learned more in Social Medicine in Singapore in the 4 days than the whole year-course in Hong Kong!" one of us told Professor Colbourne. (Probably you have been taking French leave too often, but why?)

THE GREAT ESCAPE

The bus service in Kuala Lumpur and Bangkok were equally bad. People never queue; they fight their way onto the bus which would move off at any moment. During the rush hours, those lucky ones who got on the bus last would find half of their bodies outside it while it was moving. One of us was brave enough to test his adaptability to such a condition in Kuala Lumpur. He managed to set one foot on a crowded bus when it started to move. Then he fell down on the ground, with the rear wheel of the bus rolling towards him. Luckily, his reflexes were intact enough as to pick him up before it was too late.

BATTLE AHEAD

If nine of you were challenged on the street by four strong men asking for money, would you surrender? Such an unexpected incident happened to us in the country-side in Kuala Lumpur while we were waiting for a bus. Our guide, a medical student from the

University of Kuala Lumpur, said that he had never met such a thing before in Malaya. I did not know how well medical students in Hong Kong could fight, but we were at the advantage of 9:4, and also with no lady in our group. After a short bargain, we cautiously moved away from the bus-stop. Seeing this, the gang also disappeared. (Both sides were frightened?)

A SLEEPLESS NIGHT IN THE OPEN AIR

It happened that the plane which was scheduled to bring us back to Hong Kong had engine trouble so that out flight was postponed until the next evening. As we were holding student tickets, we were not entitled to have free meals and lodging. After some arrangements, the airline offered us either to have free lodging in the YMCA in the city or have free meals in the airport. We chose the latter and spent over 30 hours in the airport in Kuala Lumpur. (Don't imagine th2at it is like the Kai Tak. In fact, we got to stay in the open air at night). Thus our extra day was spent sitting, eating, reading and playing cards in the restaurant. We had little fun, however, for "a tortoise's heart had become an arrow".

THE END OF US

The plane took us back to Hong Kong on the 3rd October at 1:15 a.m. One of us claimed that he had lost six pounds within a matter of ten days. (That will be a significant finding in the wards!) Others were only half-awake during their ward-round on the same day. However all of us feel that we did enjoy and learn a lot in this study tour. (And we spent a lot too!).

ACKNOWLEDGEMENT

The Study Group would like to thank Prof. Phoon and Dr. Yik of the Department of Social Medicine and Public Health, University of Singapore, for making the various arrangements for their visits in Singapore; and the Medical Societies for the University of Singapore and University of Malaya for their hospitality.

Last, but not the least, they are also grateful to Prof. Colbourne for his technical and generous financial assistance.

ABORTION—A CONTINUING CONTROVERSY IN HONG KONG: ITS SOCIAL IMPLICATIONS

LEUNG YUM KWONG

INTRODUCTION

Birth control has become a popular subject in this World Population Year, and amongst the varicus methods of birth control, help for the couple who cannot have children lies at one extreme, while at the other extreme lies ABORTION, the age old last resort of a woman who does not want a child but has become pregnant anyway.

Obstetrically and legally, abortion denotes the termination of pregnancy before the 28th week of gestation. Methods of dealing with unwanted pregnancy has been practised for thousands of years in all recorded civilizations, yet in today's world the legal status of abortion remains chaotic and confused. Taiwan prohibits abortion completely, but in United Kingdom, abortion is legal on medical, eugenic and social grounds since 1967, and in Singapore, legalization (1969) is also extended to juridical grounds. In Hong Kong, a certain limited step was done in this issue in 1972.

The aim of the present essay is to review the situation of abortion in Hong Kong and to discuss the social aspects of abortion.

ABORTION: HONG KONG SITUATION

Prior to 1972, the Offences against the Person Ordinance prohibited the mother or any person attempting to procure miscarriage by whatever means, and for whatever reasons. This Ordinance was amended in March 1972 for a trial period of 2 years, (now extended for another 2 years till 31st March, 1976), allowing for legal termination of pregnancy for therpeutic reasons, thus:

[1]A person shall not be guilty of an offence when a pregnancy is terminated by a medical practitioner if two medical practitioners are of the opinion, formed in good faith, that the continuance of the pregnancy would involve risk to the life of the pregnant woman or of injury to the physical or mental health of the pregnant woman, greater than if the pregnancy were terminated. Account may also be taken of the pregnant woman's actual or reasonably foreseeable environment. Any treatment for the termination of pregnancy must be carried out in a hospital or clinic maintained by the Crown or declared by the Director of Medical & Health Services. (11 hospitals have thus been declared as permitted hospitals.)

[2]This Legislation, however, does not intend to legalize abortion in any general way. [1]"Anything done with intent to procure the miscarriage of a woman is unlawfully done unless authorized by virture of the provision of this section (of the amended Ordinance)". The purpose remains, therefore, limited — to do no more than defining the terms under which doctors could undertake a therapeutic termination in certain specific circumstances, thus affording more protection to doctors involved.

In spite of its limitations, the amended ordinance was met with objections from the public, especially from the religious people. Thus they set up the Society for the Protection of Human Rights in 1973, trying to prevent the killing of an innocent life by providing medical and financial assistance to the unmarried mother-to-be or the pregnant mother who thinks of abortion to solve her social or economic problems. They also provide shelter for the pregnant woman so that she can give birth to her child without ever being known that she has been pregnant before. The child, if not wanted by her mother, is sent to the Govt' Social Welfare Services for adoption. So far some 25 lives have been saved.

[2]Almost within the same period of time, a total of 184 pregnancies were, on the other hand, terminated under the amended ordinance in 1973. The grounds for these terminations are not available for ethical reasons, but [3]one source discloses that for a certain series 90% were for social or economic reasons, while the rest were due to concommittent medical indications. There had been no cases in which the life of the mother was risked.

ABORTION: SOCIAL ASPECTS

Today our world is getting smaller and smaller for our ever expanding population, and this in a way is the most serious and threatening social implication of unwanted pregnancies. Already more than half of the world's population is starving or suffering from malnutrition, and unwanted pregnancies are something we can no longer afford. Our main concern has to be with the born rather than the unborn. Indeed induced abortion, whether legal of illegal, has played a considerable part in the control of births. [4]As a matter of fact, illegal abortion has made a major contribution to the recent decline of birth rates in both Singapore and Hong Kong.

[4]Current statistics show that the majority of abortions are performed on married woman, and about 65-90% of the subjects are in the age group of 20-39. Underlying patterns of fecundity, sexual activity, family formation and family building probably explain the concentration of abortions in this age span. [4]Over 69-90% of women who seek abortion already have a family of 2 or more children and they simply feel that they cannot face the psychological, social or economic impact of another child. Thus it is quite clear that the principal motivation for induced abortion is socioeconomic in nature. Statistical data in Hong Kong cannot be obtained because the great majority are performed clandestively, but the [4]data from Singapore where abortion is legal, illustrate these.

PERCENTAGE OF LEGAL ABORTION IN SINGAPORE

% distribution of legal abortion by age of woman at termination

	19 or less	20-29	30-39	40 or more
1970	1.8	27.7	53.7	16.8
1971	2.9	32.5	52.0	13.6
1972	2.7	33.7	51.5	12.1

% distribution of legal abortion by prior birth

	0	1	2	3	4	5 or more
1970	0.5	2.7	7.4	11.5	19.5	53.4
1971	0.5	3.2	9.9	19.1	18.0	49.3
1972	1.1	4.7	15.6	19.8	18.6	40.2

A striking fact about abortion is that despite the sordid, unsanitary and dangerous conditions under which it is generally performed, it continues to flourish everywhere. Women will get abortions if they want them. In Singapore where it is allowed legally, [4]3500 abortions have been done in 1972, giving an abortion rate of 1.6 per 1000 total population. In Hong Kong accurate data on the incidence of abortion are difficult to obtain, but the [5]7000 admissions to government and government-assisted hospitals because of complications arising from illegal and unspecified abortions (which also include natural abortions) in the same year do throw some light to the total incidence of abortions performed. Illegal as it is, this figure gives an abortion rate of almost 2 per 1000 total population, discounting already those (the majority, obviously) performed clandestively and successfully.

In a country where abortions are prohibited by law, women, finding themselves pregnant against their will, are ready to go to almost any lengths, to avoid carrying the pregnancy to completion. Rich women will travel to a foreign country for legal abortion (for example London and Japan) or get one locally under acceptable, medical and hygienic conditions. But poor women — the ones who can least afford another child — will eventually seek help from back-street quacks whose methods may be highly dangerous to the life and health of the mother. The after-effects of illegal abortion are in fact one of the leading causes of maternal admissions to hospitals. The following [5]Hong Kong data of 1972-73 show that almost one third of the admissions of pregnant women are due to complications of abortion.

To declare abortion illegal simply drives the business underground, thus making matters even worse than before. To dig up every case of illegal abortion again is not at all a simple process — [5]only less than 10 raids of abortion-lists were done in 1972 in Hong Kong. Legalization lessens the number of illegal abortions, and thus subsequently reduces the maternal death rate.

Looking at the problem of unwanted pregnancy in another aspect, the child born to a woman who was refused abortion is at a disadvantage when compared with the child

NO OF DISCHARGE FROM GOV'T & GOV'T — ASSISTED HOSPITALS RESULTING FROM COMPLICATIONS OF PREGNANCY 1972 — 73

	Gov't & Gov't Assisted Hospital: discharges	death
Abortion induced for legal indication	81	—
Other and unspecified abortion	6972	3
Toxaemia of pregnancy and puerperium	701	4
Haemorrhage of pregnancy and childbirth	2040	4
Sepsis of childbirth & puerperium	16	—
Other complication of pregnancy, childbirth and puerperium	14558	5

born to n other who never sought a termination during pregnancy. The unwanted child is usually a hated child and will be treated cruelly. This can take the form of over-protection, inattention, destructiveness, abandonment, child — battering or even murder. (Quite recently a tragedy has happened in Hong Kong: an unmarried mother threw her baby into the street from the top of a building because of severe psychological disturbances.) Ultimately, of course, society suffers as well: hated children tend to become hate-filled adults who are then even more destructive to their own children. [6]A study made in 1966 of Swedish children born when their mothers were refused the abortions they had requested showed that, in comparison with wanted children, these unwanted children, as they grew up, were more often apprehanded for drunkenness or anti-social or criminal behaviour, and that they needed more psychiatric care. Moreover, the females in the study group married earlier and had children earlier. How does society gain by increasing the number of unwanted children? By accepting the unwanted children, we are deliberately increasing inadequacy, hostility and destructiveness within the very society we are living. It is, therefore, unwise, in this respect, to permit an unwanted children to be born.

It is true that adoption instead of abortion may be a method of solving all the problems of an unwanted child, but too often the child given up for adoption finally has to face the fate of being settled in an orphanage, children's home or foster home rather than a family where he belongs. The unfortunate child is born to be without a family, and born to live a miserable life, left to be brought up disturbed and distorted.

On the other hand, the distortion to the mother-to-be, cannot be overlooked. This is especially more sericus in the unmarried but pregnant teenage who has to choose between abortion, forced marriage or adoption. To carry a pregnancy to completion in the very young may well interrupt the whole long term and emoticnal development of the young mother. Marriage following unwanted teenage pregnancy has a poor outlook: [7]further education is usually curtailed for the mother and often for the father as well and divorce is 3-4 times as common as among couples who marry and conceive under twenty. Abortion very often becomes the most satisfactory way out for the pregnant but unmarried.

CONCLUSION

Considering the realistics of human nature and the difficult circumstances under which many families must struggle to bring up their individual, we have to agree that abortion is, at best, a necessary evil. Despite laws that prohibit or permit abortion, abortion has always been and will always be one of the options in family planning. However, we have also to admit that abortion, legal or otherwise, is not a constructive method of family planning. On simply practical grounds, if children are to be prevented, it should preferably be controlled by one of the many reliable contraceptive methods, which carry none of the dangers of death or sterility or other complications. It is advisable for every woman who has an induced abortion to receive appropriate contraceptive advice. Now let us concentrate our energies and resources on family planning and education, because, in any case, pregnancy is better prevented than cured!

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COMMUNITY THERAPY IN MENTAL ILLNESS

MAK KAN HING

INTRODUCTION

The importance of mental illness lies not in being a major cause of death itself, but the morbidity results. In 1972, there were about 100,000 attendances at psychiatric outpatient clinics, of whom over 4,000 were admitted to the only mental hospital in Hong Kong — the Castle Peak Hospital. The respective figures in 1974 were 80,900 and 3,370. This shows that the load of the Mental Health Services in Hong Kong is on the increase and this increase will be further accelerated by the growing strain and stress in social strife. Economic instability and environmental disturbances brought about by the uncontrolled development of the community are the underlying pathology. The problem encountered in these years will be one on the prevention, treatment and rehabilitation of mental illness, a problem being regarded as a symptom of a sick society.

THE WAY WE ARE FOLLOWING — THE BRITISH TREND IN COMMUNITY THERAPY

Hong Kong is still young and it is quite a burden in handling with her present situation of mental health. In England, the country where mental health services have developed to solve her own problem, and from which the services in Hong Kong take shape, has the services being brought up with social services. Patients are not locked and confined to a mental hospital unnecessarily. With better knowledge of mental disorder and the greater effectiveness of physical methods of treatment, it is now possible to decentralise psychiatric patients from hospital. The aim at present is to attempt to use hospital admission in mental disorder mainly for investigation and early treatment and to carry out chronic treatment and rehabilitation within the community. To reduce prejudice and stigmata attached to a psychiatric patient, a step taken is to replace an isolated mental hospital by a special mental health unit in a general hospital. Admission therefore would not be so obvious and self-evident. Community mental health services are arranged for the treatment and rehabilitation of the patient to be undertaken while he is living at home — maintaining contact and interaction with his surroundings. Local authorities are responsible for developing widespread community social services for the mentally disordered as well as undertaking preventive care and after care work and arranging for the compulsory admission of patient when this is necessary. Day hospitals have been developed for the mental patient who still requires more supervision than is possible in the community services. Attendance of these day hospital has grown from 484,000 in 1962 to 1,426,000 in 1968, which reflects the increasing role of partial hospitalisation in Mental Health services. To these patients, the community remains to be a place for them to re-learn skills and to adapt to normal life. As Dr. Y. F. Ho has put it, 'The goal is to assist the disturbed individual in mobilising his own resources to cope with his problem more adequately and to lead a healthier way of life.'

Community care is only possible if greatly extended treatment and rehabilitation are made available in each area — hostels, training centres, special workshops, occupational therapy, job-placement services and after-care services designed to help and support the patient. In Great Britain, there are Disablement Resettlement Officers of Employment and Productivity Department, specially trained employment officers, responsible for finding employment for all handicapped people, including those with mental disorders. Sheltered employment are provided by Local Authorities and are mainly used by the mental subnormal, but the mentally ill also attends. It satisfies the patient's dignity and gives them a social status. This encourages great improvement in behaviour and outlook of the employed.

They feel that they have been taken a great step forward by showing that they can take up a useful occupation. Hostels, the function of which being quite similar to that of half-way houses run by voluntary agencies in Hong Kong — that is to smoothen the abrupt transition from hospital environment to the community commonly experienced by the chronically hospitalised, are also erected by Local Authorities. They are resting place for those who are able to go to a neighbouring workshop. After a period of rehabilitation, it is hoped that the residents are better orientated to the social and economic activity in the community and can board out in lodging.

Legislation related to the admission of the patient, the Mental Health Ordinance of Hong Kong modelled on the Mental Health Act of United Kingdom 1959 hopes to place more custodial care in the community. Informal admission, that is, admission on the same basis as medical and surgical patients, occupies more than 80% of mental hospital admission in England. In Hong Kong, however, about half of the admissions was compulsory. In practice, the admission and detention of voluntary patients are almost, though not exactly informal as they have to sign a form to be admitted and must give notice of discharge. Informal admission practises now only in the psychiatric unit of Kowloon Hospital. This form will soon dominate the field so as to eliminate the last difference and uncertainty that might arise among the patient and his relatives.

PRESENT SITUATION IN HONG KONG

Hong Kong is equipped with four types of psychiatric services:

1. Psychiatric Hospital: located at Castle Peak, being the only hospital for the full-time care of all types of psychiatric patients. Open-door policy is practised in all wards but one for patients involved in court proceedings. Eight wards are entirely open, the patients housed being convalescent and receiving attention in preparation for discharge.

2. Psychiatric Unit: Located in Kowloon Hospital, provides comprehensive psychiatric services in a general hospital setting. Patients were subjected to an intensive treatment programme.

3. Psychiatric Centres: One on each side of the harbour, provides treatment for both out and day-patients, including follow-up cases from the Castle Peak Hospital.

4. Psychiatric clinics such as Queen Elizabeth Hospital Clinic and many other Sunday Psychiatric Clinics which accept out-patients and follow-up cases.

As there is an increasing tendency to treat patients in psychiatric outpatients' centres and day hospitals rather than to admit them to Castle Peak, the stigmatised hospital, the roles of psychiatric centres and Sunday clinics are of growing importance. In addition, Castle Peak Hospital also functions as a night hospital for some patients returning for treatment and rehabilitation after work. Some travelled daily to Tsuen Wan, Sham Tseng, and San Hui to work in factories. Others went to the adjacent New Life Rehabilitation Farm each week. Besides the Farm, the Association also provides a variety of social and vocational rehabilitation services including a 19-bed half-way house for men, a 202-bed halfway house for women, a hostel for 40 who work in nearby factories and a sheltered workshop for selected discharge patients from the Castle Peak Hospital. The Mental Health Association runs a half-way hostel for short-stay discharged patients from the Mental Hospital. These voluntary agencies have taken over quite a large part in rehabilitating and after-care of patients, however government's direct intervention appears lacking at present.

The special political and economical make-up of the community render the population specially susceptible to mental stress and strain. Every year about 3,000 new cases are reported. The growth of facilities, though quite a step forward since 1949, still falls

behind. Staff recruitment seems to be worse. The doctor-patient ratio for psychiatry is 1/137 compared with 1/12 for medicine and 1/8.5 for surgery. It is indeed grave to accept that "the supply of psychiatric-trained doctors being an uncertain factor, but should not be allowed to outweigh the pressing need for a psychiatric hospital, the third after Castle Peak Hospital and Princess Margaret Hospital to be built as recommended in the Report of the Medical Development Advisory Committee 1973. Psychiatric wing of the Princess Margaret Hospital will be completed by 1976, but because of a shortage of staff, only 2/3 of the present psychiatric unit in Kowloon Hospital is operating. More personnel trained in this field will be needed in the psychiatric units of new general hospitals to be built at Shatin and Tsun Wan. How should we satisfy this tremendous and everlasting demand?

In Hong Kong, very few doctors and nurses like to involve themselves in mental health services. There is a prevalent unwillingness to do mental health work. Many people still feel that working with mental patients means low status, and frequently running the risk of being beaten or scolded by patients. With the expanse of community therapy, the load on hospital beds is eased, that on the staff progresses. How are we going to educate the people, and how to change people's attitude towards mental illness? China appears to be solving the problems altogether.

CHINESE EXPERIENCE

China does not emphasise the importance of building more treatment facilities and training more workers. Rather, they have given full recognition to the significance of the entire social dimension with which treatment and prevention are related. While from 1949 to 1959, new treatment facilities had been established in 62 localities distributed in 21 provinces and cities and that the total number of psychiatric beds had increased 14 times, this is not the only way out. Resources of the community are fully utilised, so that many patients can remain in the home and receive treatment rather than being institutionalised. The directive of extending medical services to rural areas means that the majority of patients can obtain treatment locally. The dissemination of medical knowledge including those related to mental illness to the masses removes to a large extent the prejudice and stigmata, and the aura of mysteriousness that has been traditionally associated with psychiatry. Mental patients are viewed largely as victims of the problems of society left over from the past. Being a mental patient in no way absolves a person of his responsibilities and right as a socialist citizen. The previously sluggish and lifeless patients are organised and actively take part in transforming the hospital into a family-like institution, so that they can lead a normal life. They are organised into small groups to foster mutual concern and comradeship. Self-regulation and self-reliance are encouraged. Criticism and self-criticism of unwanted attitudes are highly esteemed. Emphasis has been placed on education through participation in group discussions, vocational training, recreational activities and productive labor. Psychotherapy, referring to as tan hsin' (heart to heart talks) are conducted by psychiatric personnel and patients either individually, or in groups. They are encouraged to understand the causes of their own illness and not only co-operate with the staff but also participate actively in the curative process. Doctors are in fact only guides to the patient how he can tackle his own problem. Excessive use of drugs and psychosurgery is not advocated — being depicted as treating the illness, but not the person. Occupation is considered to be an approach to correct the problem of thought and to grasp a right political attitude of life. Arrangements are made with local factories or other productive units to provide patients with opportunities for productive labor.

COMMUNITY THERAPY — PRESENT AND FUTURE

Mental illness is inflicted onto the patient by society. It is the responsibility of society

to see that the socially disturbed gets recovered. Very often, it is the diseased environment that has precipitated mental illness, remains unchanged and ccuses the relapse of the illness. What the community should do is to care for the rehabilitants, and not to isolate nor to discriminate them. They should be helped to regain their self-confidence, mobility, and skill. The correct attitude of the public towards mental illness is the main factor contributing to the success of community therapy. Hospital is too-isolated, tco stable and too safe a place for a mentally disturbed. Community is the place he ultimately learns to adapt. After-care seems to be more thorough n China. A doctor would visit the patient's place of work and make sure that the patient returns to a job which is suitable for his mental health. After discharge, besides regular followup, the doctor in-charge, or the head nurse makes a house call to check on the patient's progress, to provide whatever guidance is required and to impress upon members of the patient's family and neighbourhood the importance of their role in contributory to his lasting recovery. Commodity and not hospital can give real treatment to mental diseases. Open door policy and integration of mental health services into general medical services are only the initial steps in keeping along with the modern trend.

It is essential to educate the people what exactly mental illness is. Like medical and surgical diseases, it may relapse. However, does this chance of relapse warrant the requestration and discrimination of these patients? Full recognition of the responsibility of society and of the right of being a healthy citizen of a mental patient is the pre-requisite to the success of tertiary prevention aiming at reduction of disability of mental disorder which has not been terminated or arrested, and secondary prevention aiming at avoidance of complications and chronicity or social breakdown associated with the illness, not to mention the primary prevention. It is a long way to go and a harsh task encountered by different departments of the government as a whole to reduce or eliminate environmental and social hazards, the pathology of community that has led to the prevalence of mental illness.

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* * * *

A female patient came in complaining of abdominal pain. The doctor discovered she was pregnant and asked her husband,

"How long has this been going on?"

He replied, "Well, it all started one cold night last March, when I couldn't sleep. . . . ."

"How would you investigate a d.u.?" asked the doctor.

"Barium enema." Replied the student.

"That," said the doctor, "will take hell of a lot of Barium."

AN INTERVIEW WITH PROF. HOBBS.* 8th FEBRUARY, 1974

1. Prof. Hobbs, could you please tell us what's the purpose of your present visit to Hong Kong?

The purpose of my present visit is as a guest of the Inter-Universities Council to consult all interested people and to advise on the establishment of an Immunology Unit within the University of Hong Kong. This has been planned by your own Faculty of Medicine, to be instituted, we hope, in the next quadrenium.

2. What will be the chief aims of this Immunology Unit?

I think it's going to have 3 roles. One is the co-ordination of the undergraduate education in immunology, both throughout the preclinical and clinical years, and there's a tremendous amount of good will from the other departments concerned to make this a success. So I hope this will end up with your being taught. The second role is to be responsible for the laboratory investigation of patients or as we sometimes call it, the hospital service commitment. And I believe in this because it's only by running a hospital service that you know what the students will need when they become doctors. The third role will be to act as an established base for immunological research at the laboratory level. Here we hope the unit will operate with other departments interested in immunology.

3. What do you think is the prospect of doing research on immunology in Hong Kong, taking into consideration the establishment of this new unit?

I think the facilities that may be provided will be adequate to get a small programme going. But if the programme is to expand, may be we'll need the support of other sources. I think the prospects are good. There are some very interesting problems unique to Hong Kong — cholangiocarcinoma, NPC and choriocarcinoma and primary hepatoma, all have a very high prevalence compared with other areas and there must be something here that accounts for this and

* Dept. of Chemical Pathology, Westminister Medical School, University of London.

immunology is one of the lines of investigation that should be used. This I think could make attractive research, but in the end it will depend on who runs the unit for you.

4. What lines of interest are you presently engaged in?

Our department of course has to be responsible for both chemical pathology and immunology, and because the Westminster Hospital for a long time has attracted a special interest in cancer patients, my own interests tend to be on the material that is available. Therefore we have an extensive programme in tumour immunology, in malignant melanoma and on malignant neuroblastoma and we also have a programme on hormone-dependence in breast cancer and in other tumours. I'm also continuing the interest I have in monoclonal protein disorders. The Medical Research Council's third trial and the trial on macroglobulinaemia are continuing.

5. Regarding your last lecture, we've all agreed that it's been a very interesting lecture, and most informative too. In that lecture, you told us about immunodeficiency disorders and some of these are actually iatrogenic in origin. How far jutsified do you think is the use of immunosuppressive drugs, radiotherapy and that sort of thing?

Ordinary radiotherapy and chemotherapy, even the quadriple chemotherapy that is now being used do not in themselves generate much in the way of immunological deficiency in a patient who has established good secondary reactions. Secondary responses are very difficult to delete. The people who run the risk of induced immunological deficiency are patients such as those with renal transplanation where you are walking a very difficult tight-rope. But if you were the patient you would have to choose between trying to hang on to your kidney or running the risk of getting a pneumocystic pneumonia. I think while you're reasonably well you'll prefer hanging on to your kidney. This is especially so in HONG KONG where they seem to be having difficulties in getting kidneys. In Britain as the supply of kidney increases there will be less reluctance to abandon immunosuppressive therapy because they will just let go the kidney and put in another one. I think this is one way out. Actually I hope in the future they'll find another way of keeping the kidney in place such as inducing tolerance. At the moment immuno-suppressive therapy is the best and it has established itself as useful despite the risks. I would add that in the field of childhood diseases like nephrotic syndrome, it is only the life-threatening disease that I would treat with immunosuppressive drugs because of the risks that would otherwise occur. In other words they should not be used lightly. They should only be used where I think the patient would otherwise die.

6. About immunotherapy, say, as applied to cancer and so on, how useful do you think it is in practical application?

I think it is too early to answer that question. I can say, I think, honestly, that the use of immunotherapy in a large established tumour has been pretty disappointing. But this use of immunotherapy on a prophylactic basis for tiny amount of residual tumour may be the most promising line yet to be developed.

7. One last question. This is about autoimmune diseases — because quite a number of diseases, whose etiology previously thought to be unknown, are now suggested to have an autoimmune basis. Could you please tell us something about this?

Autoimmune diseases are really the problem of others. I would fall in with the argument that on the whole the patient's cells which become the object of autoimmune attack have probably expressed a change in antigen on their surfaces. In that respect the attack made upon them is because of this induced change. This may be because viruses have programmed the cells or it may be just the result of somatic mutation. I'm not over keen on the idea that a rogue clone of lymphocytes turn around and attack the normal tissues. We have many patients with rogue clones of lymphocytes in myelomatosis and lymphosarcoma and indeed autoimmune attack is not common in these conditions. Furthermore if such rogue clones were to produce auto-antibodies we would expect them to be monoclonal and there are only two diseases where this occurs. One is chronic cold haemagglutinin disease and the other is lican-myxoedematosis. Otherwise, in thyroid, adrenal, parathyroid, rheumatoid diseases, it is unusual to find the monoclonal antibodies.

8. Professor, is this your first visit to Hong Kong?

This is my first visit to Hong Kong and if all the people here are as nice as they have been to me this time, you can be sure I'll come back.

9. We'll look forward to seeing you again. Thank you very much, Professor.

Ivory-Tower-Keepers' Quotations

With only a week left before the Biochemistry Comprehensive Examination, on the billboard of the second-year students somebody wrote, "What is the treatment for hypobiochemia?"

Within an hour the answer appeared, it read: "Daily ingestion of Lehninger extract + B.B.B. complex, minimum dosage: 100 pages/day.

Repeated treatment to be taken for seven days, starting **Today!** !"

* * * *

The proposed treatment for hypobiochemia didn't seem to satisfy everybody. Someone remarked:

"B. :矯,

B.B. :妙,

B.B.B. :吃不消!"

* * * *

A **Primitive Streak** in embryology is a groove formed on the surface of the ectoderm of a 3-week old embryo.

A 'primitive treak' in life is a nude baby crawling on the floor.

* * * *

The professor from a clinical department, when delivering a 8.30 a.m. lecture on a Saturday morning in place of his wife, a lecturer in the same department, talked about the negative response of 18-month old babies.

"When you tell them to do something, they deliberately do the opposite."

"The same thing goes with women," said the professor, "that's the reason why I am here this morning."

* * * *

A pop fan campaigning for the chair of the Students' Union put up this slogan:

"I've gotta get a message to you,
What the U needs now is LOVE,
I surely know how to love them.
VOTE FOR ME!"

* * * *

In a lecture on 'Nutrition' delivered to a group of medical students, the lecturer talked about weight-reduction.

"You should prescribe a diet with calorie intake limited to 1800 kcal/day," said the lecturer, "and if this has no effect, further reduce it to 1200-1500 kcal/day."

"If the patient still does not lose weight," she added, "you may diagnose this as: 'The prescription was not followed.'"

* * * *

A lecturer from the Department of Psychology stressed on the unreliability of examination results. To illustrate his point, he quoted the following example:

"A student was able to secure a copy of the marking scheme just before a written examination. He smuggled the piece of paper into the examination hall and transferred the model answer word for word onto the answer book.

Three examiners marked his answer afterwards and, though unaware of the scandal, two of them failed him and the other one gave him a marginal pass."

PROSTITUTES, "AMATEURS" AND THE PROBLEM OF VENEREAL DISEASES.

WONG KWOK ON

It has been said that prostitution is as old as civilisation but the question whether it should be legalised is still being vigorously discussed. Some argue that legalised or not, prostitution will continue to exist, but by legalising it, the authorities can exert some control whereby the spread of venereal diseases (V.D.) may be prevented. Let us now have a look at how effective the control of prostitutes is in the prevention of V.D.

Some degree of control of prostitutes has been practised for varying periods in different countries. The actual methods used vary but the principle is the same. In essence, the prostitutes are required to be medically examined at regular intervals, usually once a week. If signs of V.D. are found, she will be forbidden to carry on business until the disease has been cured. There is no doubt that a lot of V.D. can be discovered in this way, but the method is far from full-proof. For example, gonorrhoea, the commonest V.D. in Hong Kong, has a very short incubation period, usually 2 or 3 days, which means that a girl who has been found free of gonorrhoea today could acquire and spread the disease to many clients in a few days before her next examination is due. To give another example, the early stage of syphilis in a woman is difficult to diagnose and the blood test may be negative in the first few weeks of the disease, during which time the disease could spread quickly. Moreover, the voluntary co-operation of the prostitutes is absolutely essential, if the regular examinations are to give reliable results. Self treatment with a few tablets of antibiotics or a vaginal douche performed before attending the clinic can invalidate many of the tests for V.D.

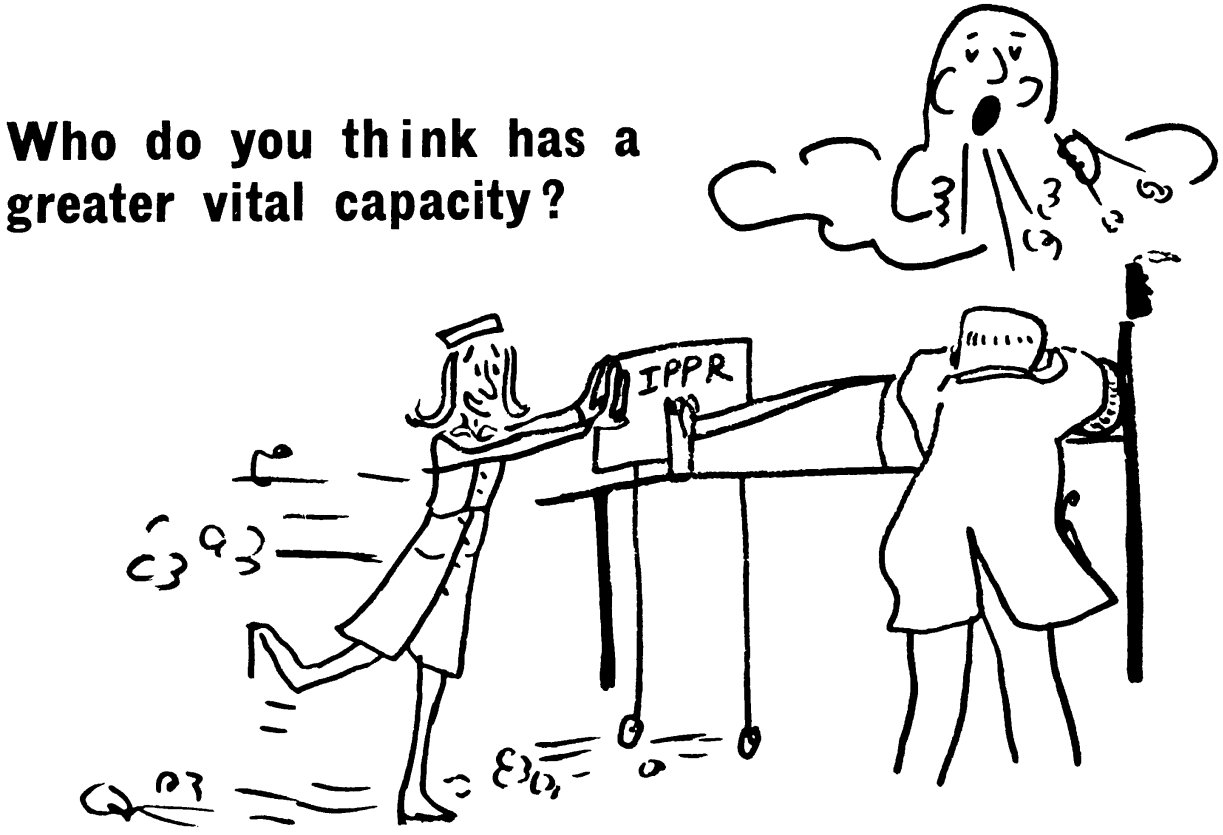
It is very difficult, if not impossible, to assess the success or otherwise of this method of control of V.D. Reliable Statistics are seldom available and, in many cases, not very relevant, because there are so many factors which can influence the incidence of V.D. in a community. In many parts of the world, prostitution has gradually become less and less important as a means of spread of V.D., a lot of which are nowadays spread through the medium of the so-called "amateurs". Unlike the professional prostitutes who work for money, these "amateurs" are people, both male and female, who are promiscuous because they like to be. In the past, promiscuity was tolerated in the male only, but this unfair situation has, to a large extent, been corrected, and now promiscuity is just as common in women as in men — a perfectly natural development in the fight for the equality of the sexes. These "amateurs" are much more efficient than the prostitutes in the spread of V.D. The reason is that the prostitutes and the men who frequent them have at least some fear of V.D., which in many cases prompts them to seek medical advice. The "amateurs", on the other hand, usually have a false sense of security, and the V.D. they may have acquired remains undiagnosed and thus spreads unchecked.

The role the 'amateurs" play as a means of transmission of V.D. varies in different countries. In some western countries, they have already become the most important factor in the spread of V.D. However, in most parts of Asia including Hong Kong, prostitution is still responsible in the majority of cases, although there are already signs that the "amateurs" are playing an increasingly greater part. Some people have advocated the reviving of traditional moral standards by education as a means of fighting the spread of V.D. However, I believe that a much more effective way is health education to the general public concerning the danger of V.D.

Most V.D. can now be treated effectively with antibiotics. When penicillin became generally available for the treatment of syphills more than 25 years ago, many thought that the medical profession could at last bring this terrible scourge of mankind under control, and some venereologists even feared that they might soon become redundant. However, the events or the past quarter of a century have proved that antibiotics, although effective in treatment, cannot solve the problem of the spread of V.D. It is to be hoped that research workers will soon come up with a more effective weapon, perhaps a vaccine. It is a fact that many infectious diseases, e.g., small pox, polio-myelitis, have been effectively controlled by vaccines. It is, therefore, not impossible that an effective vaccine or vaccins would be the ultimate answer to the problem of V.D. control. Should such a vaccine become available, those who indulge in promiscuous intercourse would be free of the fear of V.D., just as they had been of pregnancy when contraceptive pills were introduced. The day might also come when health officials at international airports would be checking the passengers for V.D. vaccination certificates in addition to those of small pox and cholera!

ACKNOWLEDGEMENT

I am grateful to Dr. the Hon. G. H. Choa, C.B.E., J.P., M.D., F.R.C.P., D.T.M. & H., Director of Medical & Health Services, Hong Kong, for permision to publish this editorial.



THE BEAUTY OF HEALING ART

PHILIP C. F. CHAN (Dept. of Anatomy)

Some law-abiding tax-payers think that doctors and nurses can really unscramble the egg. They are crazy. Whoever 'just out of their minds' must be nuts, potatoes, vegetables. Healers are of 3 types: superior ones deal with nationalism; mediocre with democracy; inferior with socialism. In order of their priority, I'd recommend Dr. Sun Yat Sen, Dr. Henry Kissinger, and Dr. V. G. Patience. Medical doctors are of only 2 types: those who practice with their brains and those with their tongues. Those with an amateurish manner are mostly immature in their career. Though doctors' errors are the will of God, their faults are covered with dust; rich men's with money; our's with love! Men doctored out of a classical text are no better than any one who doctors himself by common-sense and experience, for medicine, being a conjectural art of intellectual strain, has its place in the whole stream of life, not just on its 'banks'. The very term 'Armchair Medicine' was coined by those who act without thinking on those who just think without acting. Some doctors don't know the drugs they use, nor their 'prices'. They merely stamp out prescriptions until the patient either dies or is cured by nature . . . they 'charge' you no matter whether they kill you or the disease does, right? In fact, they prescribe drugs, of which they know little, to cure diseases, of which they know less, in human beings of whom they know practically nothing. Indeed, they should re-learn their Anatomy. Nobody should get married if he hasn't finished dissecting at least one woman! Of course, a half doctor near is better than a whole one far far away. Remember, your conscience is your best healer; prayer and bed are you best drugs! It's absolutely unnecessary and perhaps hazardous in medicine to be too clever. The best practitioner cures sometimes, relieves often, but reassures always. He is, in fact, someone with the reporter-preacher-researcher prerequisites all in one. Some say English doctors may kill you, the French let you die, the Chinese try you out with herbs, and the Americans see your inside for a 'constant practice.'. Indeed, one doctor makes work for another.

"I had a sore arm the other day. I walked into Dr. Lee's clinic and said, 'Doc, it hurts when I do this.' He told me not to do it. I took his advice but it's still aching me all over!"

"Have you had that before?"

"Yes, I have."

"Then you're only having it again this time. Don't worry!"

True, medicine is not for the medical-men only, but for the men in the street. 'The art of medicine,' remarked Voltaire, 'consists of amusing the patient while nature cures the disease.'

"Look, sonny, what must we do before we go to heaven?"

"I guess we must die!"

"True, but what must we actually do before we die?"

"Of course we must get sick and send for you Doc.!"

"You exactly, only a common-sensed guesser!"

Western doctors didn't believe in acupuncture in the past because they would rather stick you with the bills. No doubt, some doctors are too money-oriented: they're even thought of vitamin M.

"Oh, Dr. Lee, I heard you've got a fathead just admitted. What did you operate on him for?"

"8000 bucks!"

"No, I mean what did he have?"

"I've just told you, 8000 dollars!"

Believe it or not, doctors and lawyers are quite similar. The only difference is that lawyers merely rob you, but doctors also kill you just 'to save the trouble', yours and his!

"Oh honey dear, Dr. Lee gave me only six months to live, but I told him I couldn't pay the bill."

"Then what did he do?"

"Well, he gave me another six months to live!"

The fact that your patient got well after seeing you doesn't prove that your diagnosis was 100% correct. Often a smart mother and a sharp nurse make a much better diagnosis than a Mongolian doctor. Beware of old barbars and young doctors. If you want to enjoy your medical pursuit, be students all your life, and the patient is your best textbook. You might learn more about the illness from the way he tells the history than from the story itself in a classical sense. To talk of diseases is a sort of Arabian Night's entertainment.

Every disease, being the necessary tax on ill pleasure, is a medical speciality in itself. The history of diseases is the whole story of medicine. Complete freedom from diseases is quite abnormal. To study the phenomena of disease without reference books is to sail on an uncharted sea, whilst the reverse is not to go to sea at all!

Too much ahead of progress is not acceptable. For instance, we simply can't treat today's patients with tomorrow's drugs. Anyone trying to victimize the public should be drastically penalized. Up to now, still no panacea is applicable to leukeumia. Occidental medical practice demands a paramount emphasis on personal tidiness aside from an over-whelming circumlocation during morning rounds or office consultations. No wonder most head sisters and matrons demand strict asepsis with just a glance. Moreover, with the advent of computerized 'nurse', patient care is perfected one step beyond. It saves time to save life and is phenomenally accurate. Absolutely fantastic! I personally advocate all clinical wards should be innoculated with a homely sense of cosy relaxation. If possible, put off your white gown rotating in Paediatrics. Never quote or invent terminology to mislead you patients. Quite offten, the 'mental garbage' of a doctor can shock the hell out of a patient to make hell out of heaven! (Greek is not for us, but is to most of us!) I don't see why modern scientists, instead of describing in pure English simply what they can see, often prefer to use Latin or Greek for what they can't. At the end, the teaching hospital turns out merely a scrub of interns, a giggle of nurses, a cash of dermatologists, a pule of proctologists, a colony of bacteriologists, ophthalmologists.

A good researcher is one who seems to be too scientific to say anything in words. Having a 'right' angle of looking at things will enable him to see through almost anything. A thought is still original though you have uttered it a thousand times. Be inquisitive! Always teach their tongue to say "I don't know". The assseciate professors are perfect gentlemen who want to 'bore' you with classic, talk you into sleep, and raise questions while you expect him to answer yours! If not for them, medicine may be much easier. In fact, talks and speeches are just like 'babies' — easy to conceive but pretty hard to 'deliver'. The study of the causes of anything should be preceded by a thorough study of things caused. Anyone may do research for the fun of doing it, but he surely can't expect a definite fund just for fun! You can study to earn you M.D.-Ph.D., but you can't earn the Nobel Prize just by studying. Research has a human right-duty relationship with only aims but no reasons. "Ask not what your country can do for you", remarked the late President John F. Kennedy, "but what you can do for your country". Remember what the Bible said, 'Seek and ye shall find'. Curiosity is holy, having its own reason to exist.

Men without conscience and doctors without Ethics are death of the soul. And Medical Ethics is the religious science of human bondage! Any sort of operation is just like law-suit, only a matter of luck — chances are fifty-fifty. In fact, luck is a shadow of chance. Though surgery admits no bygone clinicians, success

is only when God works through you. The boxer knocks off a tooth and you as a dentist extract one, both present a hell of a picture. Medical staff should never appear to be crest-fallen despite a constant abortive setback of indiscernable etiology. This line of 'business' works like heart muscle contraction — 'All or None'.

To ensure oneself from getting hurt is to insure oneself against ill-health. Prevention insures oneself against ill-health. Prevention is not just better than cure, but much cheaper too! The climate of Southern California makes the sick well and the well sick, the old young and the young old. Yes, fresh air does impoverish the doctor. Never waste your health to get your wealth, then spend it to gain you health again. No doubt, an apple a day does take the smiling doctor's bread away, but what is the sum to make him come? Health, being a state of mind, is a gift from God. Don't lose it. To be the picture of health, keep in a good frame of mind. God can take care of your soul forever, but you, your body. One sure way to keep your 'ticker' ticking is not to continually overwind it. Say aloud you're well, and all is well with you. But don't tell others how you are getting on. Nobody wants to know. All that we see and seem to see is but a dream within the heaven of another dream. So don't tell me what you dreamt about last night, for I too have been reading Freud. Try your best to stay away from doctors and tranquilizers, and to mingle with nature as much as possible. Obviously, the beauty of health, like the beauty of religious science, is what makes you feel euphorically that you're now in the best time of the year, in the prime of your life.

It's absolutely useless to treat the dead or to advise an old man. The proper study of Geriatrics begins with Pediatrics. Pediatricians eat because children don't. Old people cry because geriatricians won't. Tranquillity is the old man's milk. Medical staff should learn that there are moments when it's better to leave a patient alone, because sympathy, not pity, would only make matters worse. Nature's vicious kill-cure cycle creats nothing but a few sparks in the course of evolution. A pretty innocent cutie is an accident of nature, but a charming elderly dame is indeed a work of art! So a lady of 'certain age' means she's certainly aged — there are only 18 and 80, no other choices. Doctors are dealing with living men as a whole, not cadavers or specimens. Case-history-taking, as an art of talking, is a matter of the individual. Sometimes your former professor becomes your patient. But don't panic! Just advise him, or I should say remind him to take his medicine like a man — cats don't, but then he doesn't have nine lives! To call a drug 'quite safe' is like dieting, only to wish to die more slowly. Those living 'medically' will live quite miserably and die early for autopsy. There is no love so sincere as the love of food. What makes your cup of tea may not be my type of music. To a man with an empty stomach, food is God. Kitchen physic is the best physic to keep your physique physically fit in accordance with the laws of Biophysics. So tell me what you eat and I'll tell you what you are. True, 'lighter supper makes longer life'. The only sure way to keep your health is to eat what you don't want, drink what you don't like, and do what you'd rather not. By examining the tongue of the patient, Chinese doctors can check out the diseases of the body; philosophers, the diseases of the mind. A neurotic is one who builds a castle in the air; a psychotic lives in it; a psychiatrist collects the rent; a neurologist is your mind's obstetrician. God always forgives you your sins via confession, but your Autonomic Nervous System won't. Passive optimism is only a philosophical attitude — the digitalis of failure! Only a normal person has a sound mind in a sound body.

Oh, my sweet Lord! Our Almighty Jesus!
One science only one genius can fit,

So vast is Healing Art, so narrow the human wit.

Ah, men! Behold, believe and beware,
Medicine is just like a lady fair.

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NEGLIGENCE AND THE MEDICAL PROFESSION

By V. YEUNG (Law IV)

It seems to me that most of our "doctors-to-be" regard negligence as something which only happens in the United Kingdom or America rather than something which might happen to they themselves when they are in practice.[1] This is partly due to the overwhelming self-confidence of the local doctors and partly due to the unawareness of self-right of the people in Hong Kong. We seldom have cases where a doctor is sued for negligence in executing his duty despite the fact that it is aware that there is some mistake on the part of the doctor.

This situation, I hope, will not continue long. If a person suffers as a result of another's mistake, it is just appropriate that he should be compensated. As a responsible medical practitioner, a doctor should see to this as well even if it might be detrimental to he himself or to his follow-colleagues.

This article aims at a very brief discussion of the tortious liability of a doctor in carelessly executing his duty, i.e. negligence.

Tortious liability is independent of contractual relationship. Thus, the fact that the patient or his next to kin signs an agreement to the effect that he agrees to the proposed operation or other forms of treatment does not exempt a doctor's liability if he has been negligent.

Negligence as civil liability is the breaching of a duty to take care which results in damage to the plaintiff. Its ingredients are (a) a legal duty on a party towards the other to exercise care in his conduct as falls within the scope of his duty, (b) breach of that duty, (c) consequential damage to the other party.

When is a party said to have owed a legal duty to take care towards the other? This has been firmly established in the case **Donoghue v. Stevenson**[2] where Lord Atkin said,

"You must take reasonable care to avoid acts or omissions which you can reasonably foresee would be likely to injure your neighbours. Who, then in law, is my neighbour? The answer seems to be — persons who are so closely and directly affected by my act that I ought reasonably to have them in contemplation as being so affected when I am directing my mind to the acts or omissions which are called in question."

In the medical profession, patients clearly falls within the definition of neighbour in this text. Medical men owe a duty in tort towards their patients, whether there is any contract with the patient or not.[3] They should take reasonable care to avoid acts or omissions which, they can reasonably foresee, would be likely to injure their patients. If they fail to observe this, they might be liable.

Whether the care that has been taken is or is not reasonable is a question the answer to which must vary with circumstances. There are cases where negligence can be established without much difficulty. In **Dryden v. Surrey C.C.**[4], a surgeon has been held to be negligent for leaving a wad of surgical gauze in a patient's body after an operation. In **Hocking v. Bell**[5], a surgeon was liable for leaving a portion of a drainage tube in the site of the operation and in **Collins v. Hertfordshire C.C.**[6] for not checking to see whether the solution to be used as an anaesthetic was what he had ordered and not something else.

But in most cases, the question of whether reasonable care has been taken can only be decided after a elaborated examination of each individual case. In **Roe v. Minister of Heath**[7] where R. was, in 1947, a patient in a hospital and Dr. G., an anaesthetist, administered a spinal anaesthetic to him in preparation for a minor operation. The anaesthetic was contained in a glass ampoule which had been kept before use in a solution of phenol and unfor-

tunately some of the phenol had made its way through an "invisible crack" into the ampoule. It thus contaminated the anaesthetic, with the result that R. became permanently paralysed from the waist down. Dr. G. was aware of the consequences of injecting phenol, and he therefore subjected the ampoule to a visual examination before administering the anaesthetic, but he was not aware of the possibility of invisible cracks. Had he been aware of this possibility, the danger to R. would have been eliminated by adding a powerful colouring agent to the phenol so that contamination of the anaesthetic could have been observed. It was held that he was not negligent in not causing the phenol to be coloured because the risk of invisible cracks had not been drawn to the attention of the profession until 1951 and "care has to be exercised to ensure that conduct in 1947 is only judged in the light of knowledge which then was or ought reasonably to have been possessed. In this connection the then-existing state of medical literature must be held in mind.[8]

Thus in a situation which involves the use of some special skill or competence, the test is the standard of the ordinary skilled man exercising and professing to have that special skill. A man need not possess the highest expert skill. It is sufficient if he exercises the ordinary skill of an ordinary competent man exercising that particular act.

In the case of a medical man, negligence means failure to act in accordance with the standards of reasonably competent medical men "at the time".

Trouble may still arise in situations where there may be one or more perfectly proper standards. This is quite common with the medical profession. If a doctor follows one common method in making diagnosis and ignores the rest, is he liable for negligence in any way? This point was settled in the case **Bolam v. Friern Hospital Management Committee**[9] where Mr. Justice McNair said, "I myself would prefer to put it in this way, that he is not guilty of negligence if he has acted in accordance with a practice accepted as proper by a responsible body of medical men skilled in that particular art." The fact that there was a body of competent professional opinion which might adopt a different technique does not affect this. In **Hunter v. Hanley**[10] Lord President Clyde said, "In the realm of diagnosis and treatment there is ample scope for genuine difference of opinion and one man clearly is not negligent merely because his conclusion differs from that of other professional men nor because he has displayed less skill or knowledge than other would have shown. The true test for establishing negligence in diagnosis or treatment on the part of a doctor is whether he has been proved to be guilty of such failure as no doctor of ordinary skill would be guilty of, if acting with ordinary care."

To establish negligence, it must be proved, (a) there is a normal practice applicable to the case, (b) the defendant has not adopted it and, (c) the course he took is one which no professional man of ordinary skill would have taken had he been taking ordinary care.

No doctor is an expert in every medical field. Thus there may be situations where a doctor is confronted with a case which he knows is beyond his skill. Clearly he cannot refuse to provide treatment to the patient. But if he does, he might be held liable for negligence when he is doing something he knows to be beyond his ability. In such a situation the most appropriate step a doctor should take is either to call in a more skilful person or to order the removal of the patient to a hospital where skilled treatment is available. When a consultant has thus taken over the responsibility for the treatment of a case, it is a defence to the competent practioner that he acted on the specific instructions given to him by such consultant. In **Junor v. McNichol**[11], the House of Lords held that a house surgeon was not liable for the treatment of a child, who had to have an arm amputated because he was not given sufficient penicillin, since the prescribed treatment was being given under the instructions of a responsible consultant.

The medical profession is an area where an exhaustive examination of its problems relating to negligence is quite impossible in view of its being such a highly skilled profession and the ever improving methods of treatment in this field. It is difficult even for a qualified lawyer to be sure in what circumstances is a doctor said to be negligent. All I can say is that every doctor must exercise his utmost care in executing his duty as a member of such a respectable profession, not only for the benefit of the public at large, but for his own interest as well because any mistake he made may result in a great financial loss and a heavy blow to his professional status.

FOOTNOTES

1. This is the impression the writer has as a result of his acquaintance with a number of medical students.
2. [1932] A.C. 562.
3. Pippin v. Sheppard (1822) 11 Price 400.
4. [1936] 2 ALL.E.R. 525.
4. [1948] W.N. 21.
6. [1947] K.B. 598.
7. [1954] 2 Q.B. 66
8. Winfield and Jolowicz on Tort. P. 64.
9. [1958] 1 W.L.R. 582.
10. [1955] S.L.T. 213.
11. The Times, March 26, 1959.

EXAMINATION JOKES

DR. JOHN LEUNG

I

Professor of Anatomy (to the students): Never get tonguetied in the oral examination. Keep talking. You might get some vital hints from the examiner. So, go to the extent of saying, "The weather is fine", or "I like your tie".

Later on in the same class. . . .

Professor (to a female student): What is this nerve ?

Student (blushing): Er . . . . I . . . . I like your tie.

II

A student was taking his oral examination in operative surgery. In front of him was shown a set of urethral bougie, size 3 to 15.

Examiner: If I had urethral stricture, what would you do?

Student : I would dilate the stricture with bougie.

Examiner: Good. What size would you use?

Student : (forgetting the usual size range, and not being able to grasp a hint from the table) . . . . . er . . . . . size 47.

* * * *

In a viva, a certain candidate was asked by the External Examiner the significance of a straight skin crease running right across the palm. The highly strung student hesitated and stammered,

"Such condition is found in Mongols, sir?"

The gentleman frowned, looked at his own palm and finally thundered,

Examiner: Good Lord! I won't like to have such a bougie on me, would you?

Student : No.

Examiner: Why?

Student : I haven't got a stricture.

III

Examiner: For inoperable carcinoma of prostrate, what can you give?

Student : Stilboestrol.

Examiner: What dosage?

Student : (Having forgotten the dosage, but not giving up) Do you refer to the preparation in oil or in water?

Examiner: (A bit weak in this part of Pharmocology, but not being in the mood to show it) . . In oil, of course.

Student : (Seizing his obvious chance of escape) Sir, this is the first time I have heard of stilboestrol being prepared in oil.

Examiner: . . . . . .

* * * *

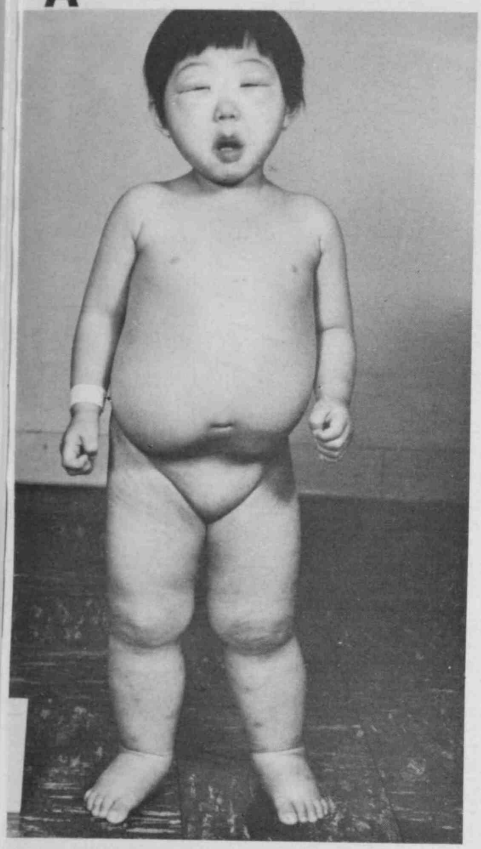
"Look here, you, I've got the same sort of skin crease myself!" The poor fellow was taken a back but then his eyes twinkled and he nursed,

"Well, sir, they say that it is also found in very intelligent individuals!"

SPOT DIAGNOSIS

Thanks are given to the Departments of Medicine and Paediatrics for their kindness in lending the photographs.

A



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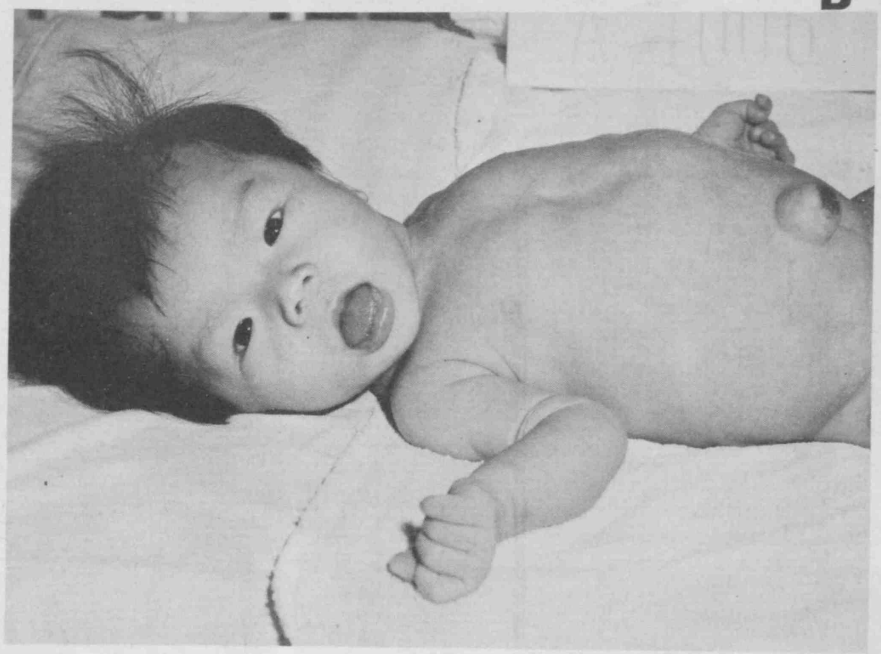
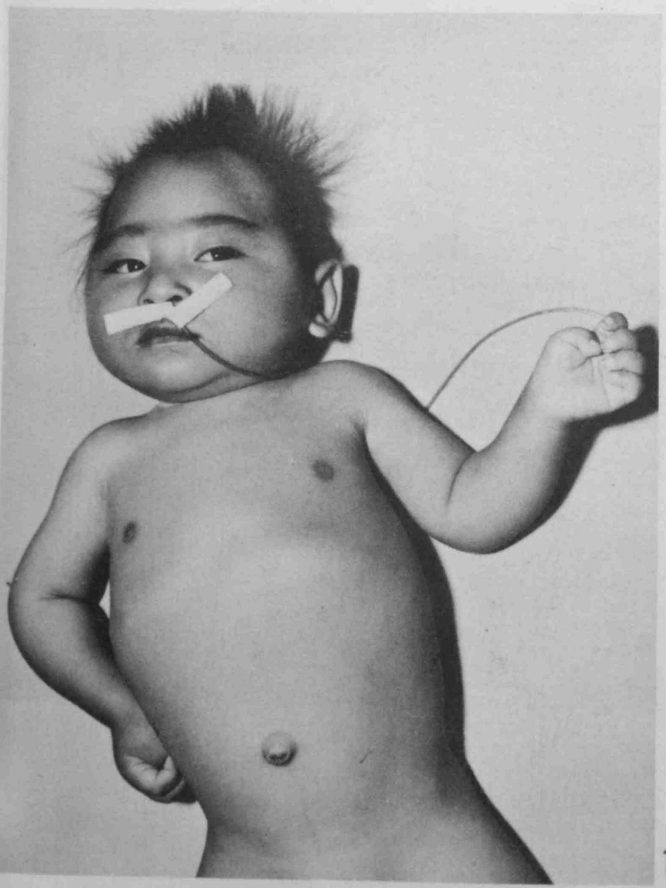
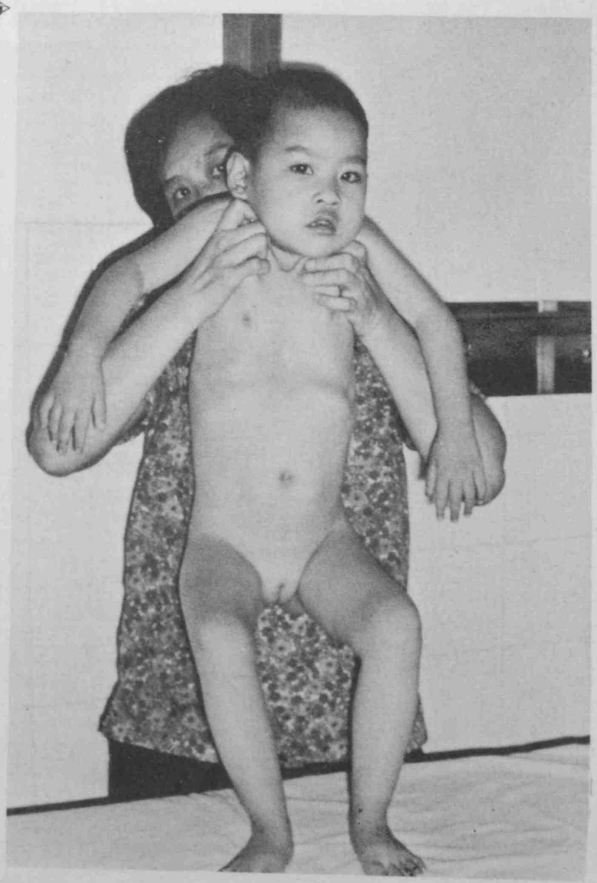


This 4 year old girl cannot stand unsupported.





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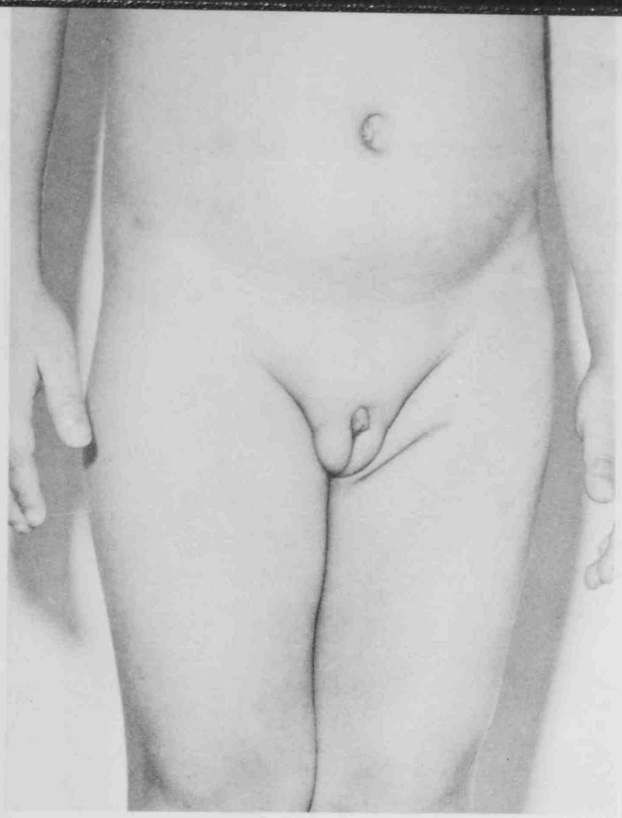

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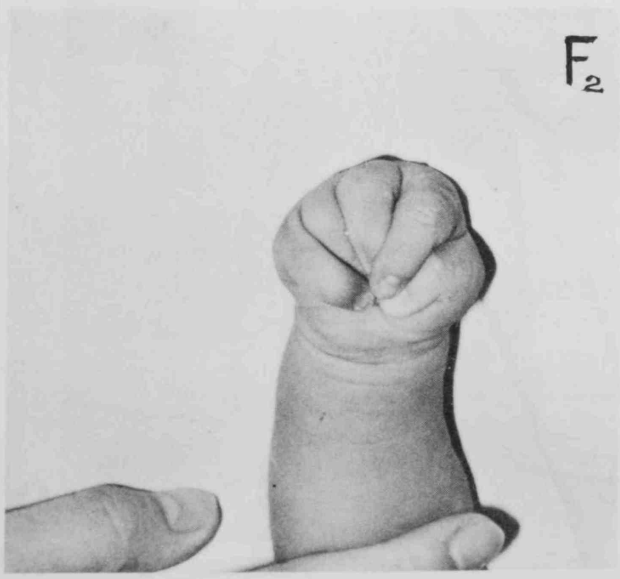

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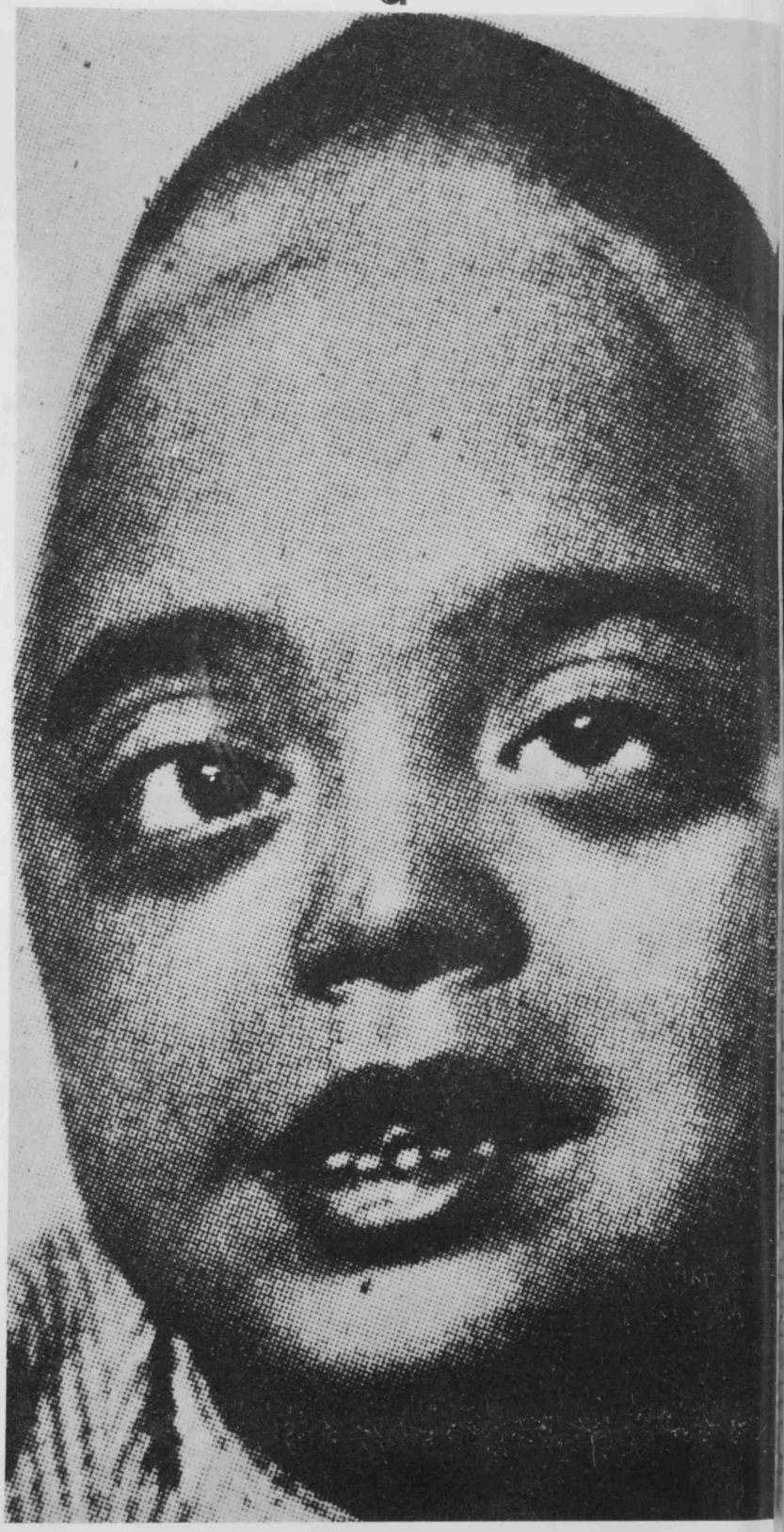

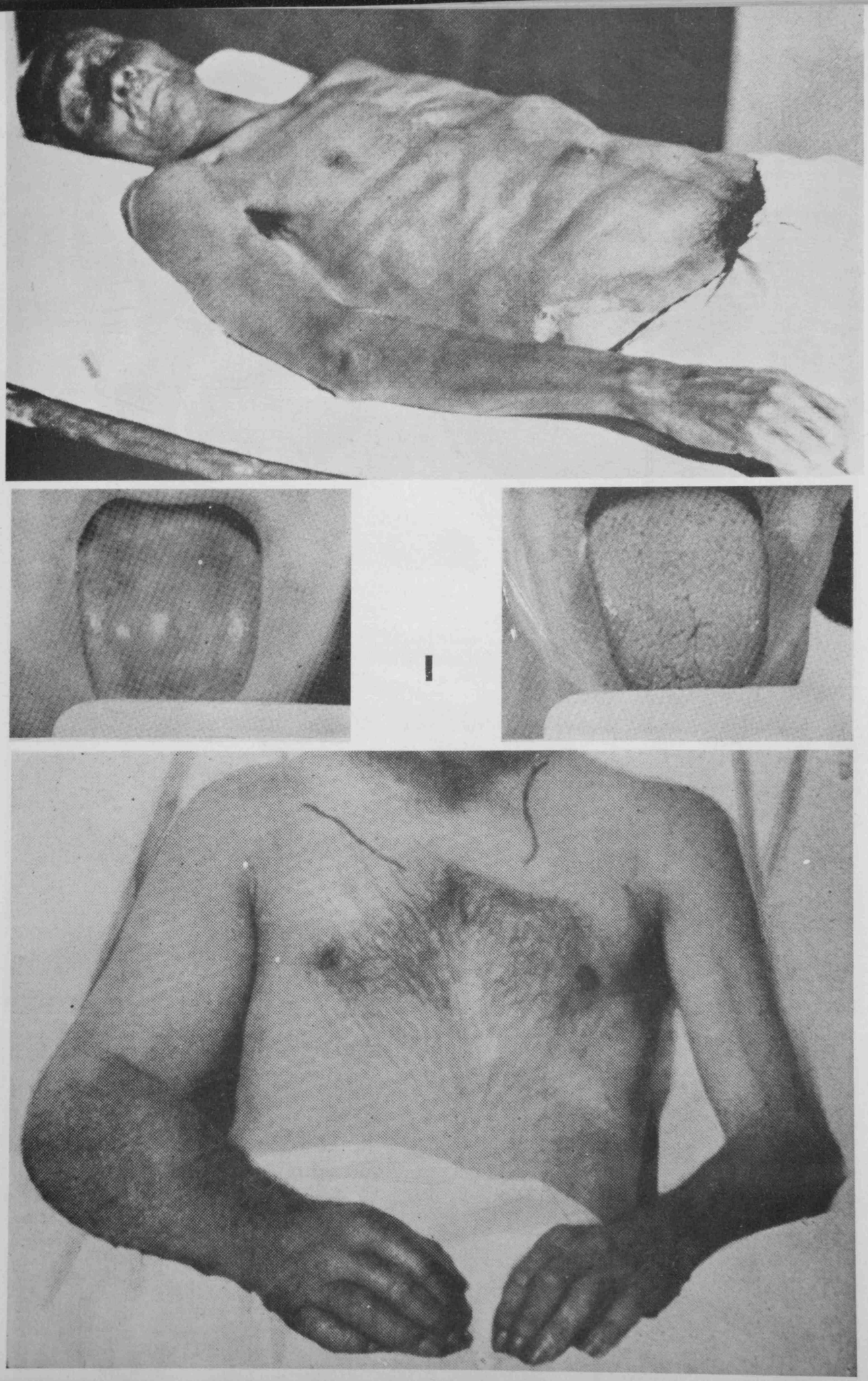
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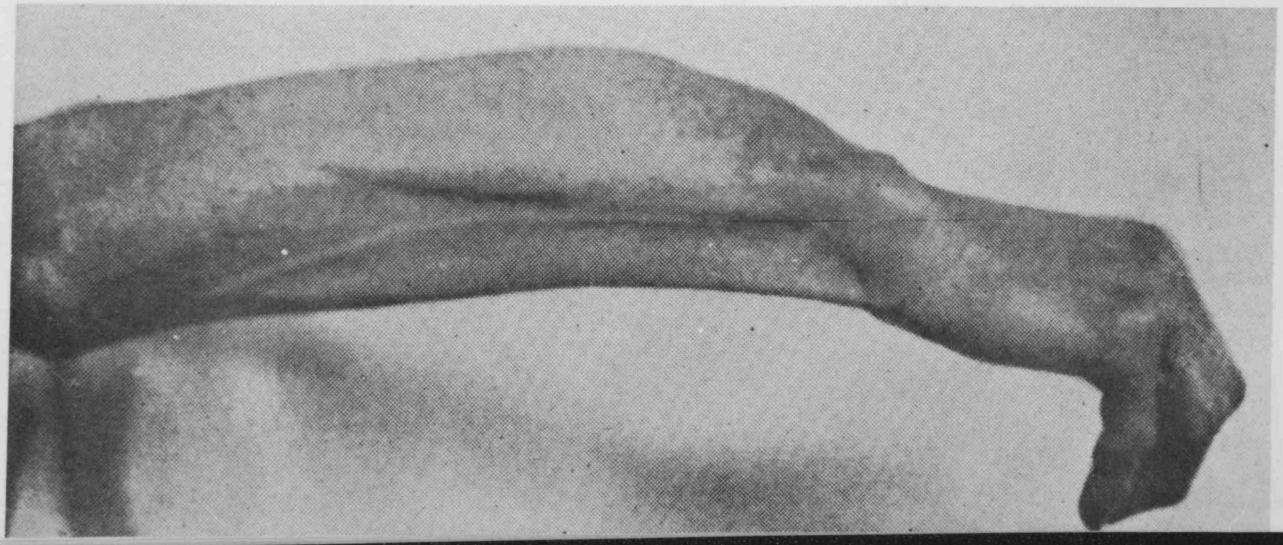
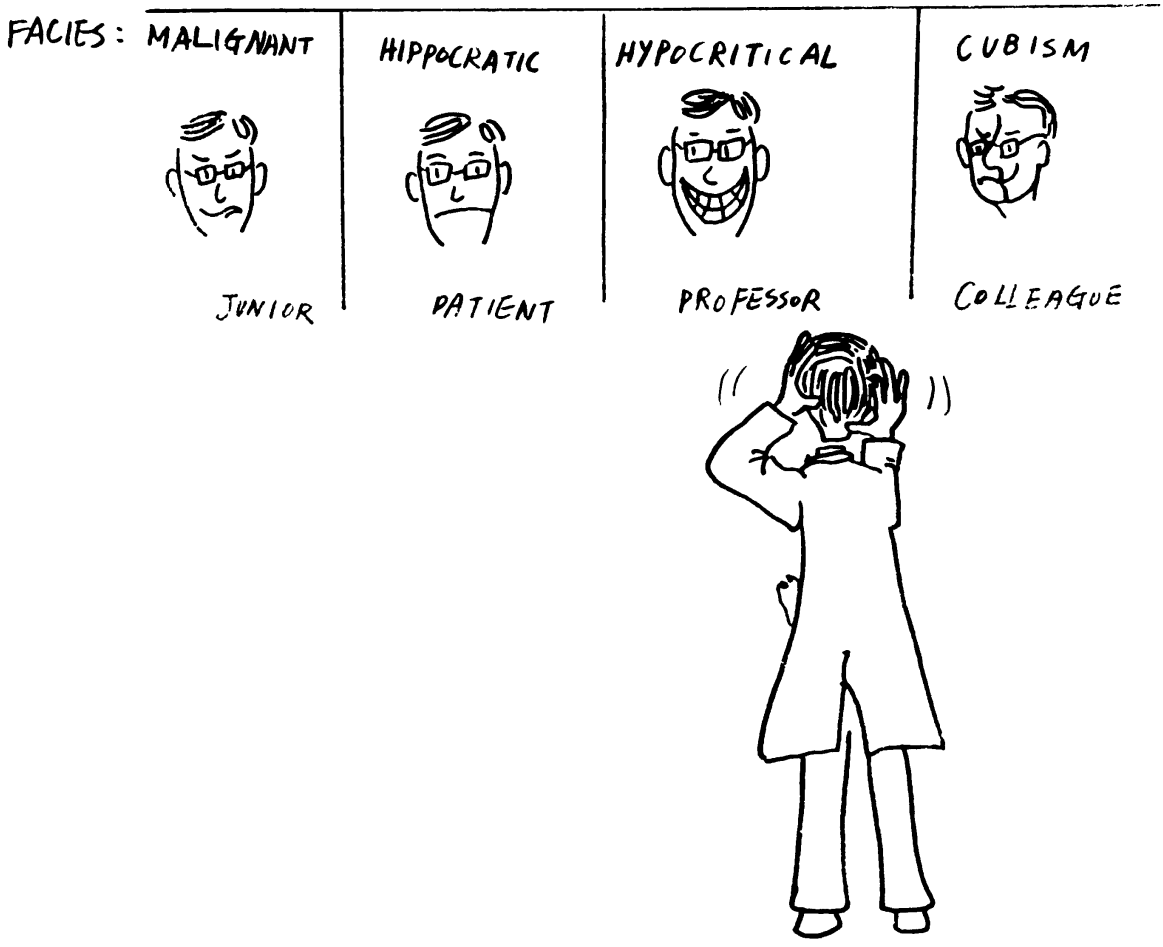




SPOT DIAGNOSIS

Answers:

A. Nephrotic Syndrome
B. Cretinism
C. Werdnig-Hoffman Disease
D. Microcephaly
E. Ambiguous genitalia — this patient has hypospadias and testes inside the scrotum. Buccal smear shows XY pattern.
F. Pierre-Robin syndrome — note the Trisomy hands, small chin, tube feeding.
G. Steeple Head (Turicephaly).
H. Ladder pattern in intestinal obstruction.
I. Vitamine B_{12} deficiency — note the regeneration of lingual papillae following B_{12} therapy on the right picture as compared to the left one before treatment.
J. Malignant exophthalmos.
K. Paget's disease.
L. Oedema of right arm in mediastinal tumour.

A LETTER TO MY FIRST LOVE

(The writer of this letter studied at Berkeley. He has loved much and suffered much, and he sincerely believes that love is still the answer to the contemporary human predicament. —Editor—)

My Dear Suzanne,

I still remember how ten years ago I walked into Morrison Library and asked you for Felix Greene's A Curtain of Ignorance. And ever since then I frequently visited your library. It was the place where I found relaxation and where I nourished my secret hopes and yearnings. I listened to Handel's Messiah and Schubert's The Winter Journey. Here I read Edgar Snow's Red Star Over China as well as his other works, like Journey to the Beginning. I also read The Sword and the Scalpel, the biography of Norman Bethune. I still remember his aphorism that "Creation is not, and has never been, of a genteel gesture. It is rude, violent and revolutionary." Thus it was no accident that he became a witness as well as a participant in the creation of Modern China. How can I forget his encounter with Chairman Mao at Yenan in 1937? He was so excited after the meeting that he stayed up all night and typed out the interview lest the event might slip from his memory. After the first half hour of conversation, he received an overwhelming impression of the communist leader as "a man of deep culture, a poet who could express himself in sharp political terms, a complex individual in whom a thousand different facets are so smoothly geared that he thought and spoke with the utmost simplicity." He then finished by saying, "I now know why Mao impresses everyone who meets him the way he does. He is a giant. He is one of the great men of our world."

As I thus dreamed about Modern China, about the beauty of Peking, Yenan and Changsha and being fascinated by the personality of Chairman Mao, I did not know that you were already interested in me. One evening, while I was sitting in a corner and secretively reading Robert Payne's Portrait of a Revolutionary: Mao Tse-tung, I suddenly looked up and found you turn your back and walk away. It was this sign that prompted me to call you and talk with you.

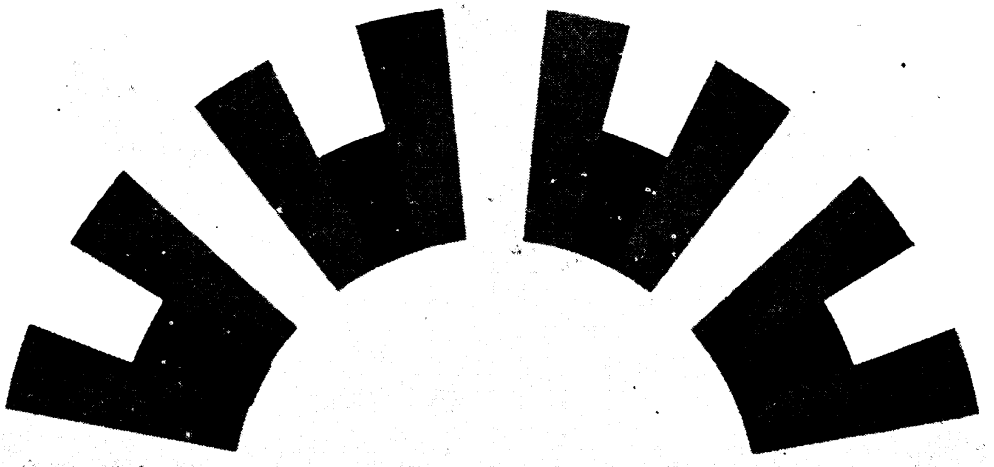
On October 16, China exploded her first atomic bomb. Like other Chinese students at Berkeley, I was very excited. Then came the Free Speech Movement which changed the course of my life. Professor Ely warned me against taking part in the movement because I had a good chance of winning a Nobel Prize if I remained at Berkeley. Professor Corcoran was irked that I was so obsessed with politics and he said, "You could still have got interested in mathematical philosophy and become one of the brilliant logicians of the world." I played with the ideas behind the basic theme of Free Speech Movement for some time. Then I decided to participate, though not without your encouragement — I was convinced that racial discrimination was wrong.

The rest of the story you were familiar. I had to leave Berkeley, and you did cry. But I have some good news for you. I have succeeded in visiting Peking. It is as beautiful as I read in the books at Morrison Library. At West Lake, Hangchow, a Chinese girl taught me the song To-day — "A million tomorrows shall all pass away, ere I forget all the joy that is mine today." It was truly memorable.

I have come to another important decision — I am coming back to Berkeley, so that I may be able to walk into Morrison Library again.

Your friend,

Moth Man.



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CIBA

THE OPEN DAY

On the 16th and 17th November, the Medical Students' Centre, along with other faculties and residential halls of the University, were open to the public. This was the third open day since 1968. A central committee, chaired by Mr. Chan Sui Po, was set up to organize the 'show' here. More than 400 medical students, mainly from the 2nd and 4th years, were mobilized. Our programmes included a slide show titled — 'The Making of a Doctor', various exhibition on many of the subjects in our curriculum, including surface anatomy, radiology, introduction and experiments on Physiology, Biochemical and Pharmacological tests, display of pathological specimens, clinical tests and physical examination in neurology, measurement of blood pressure, blood group and ECG. Also there were displays and pamphlets about the history of the medical faculty and society.

A conservative estimation revealed that at least 17,000 people visited the Medical Centre, many of them were parents and secondary school students; and a large portion came in busloads. Strange to say, many have heard about our Faculty but did not know its whereabout and some experienced difficulty in finding the place. Receptionists were chosen to show the visitors around for a general introduction while more detailed information was provided by the demonstrators in the various sections.

It was apparent that the visitors were very interested in the displays, especially the laboratory tests. The slide show was also well-acclaimed. Encouraging and rewarding comments were received. Many actually said that it was the first time that they could really understand and appreciate the life of a medical student, and not without sympathy. Some visitors lingered on even after the closing hour. Most of the visitors, being so impressed, requested for other similar occasions in the future.

On the whole, our Open Day was a success; and, although dog-tired, we were happy and satisfied in that we had at least put up a good performance, achieved some understanding and opened up communication with the public, from whom we have been isolated for so long.

The following abstracts from our reporters' notebooks review some other aspects of the Open Day:

— The Open Day was a memorable day for the medics. Our workers received much tributes from our visitors. They all agreed

Busloads of visitors with expectations.

The entrance, where several receptionists were giving out pamphlets.

A young lady studying the circulatory system.

In the anatomy department, where so many visitors were interested in surface anatomy, or . . . . ?

The visitors don't seem to be attracted by the kidney.

Hypo — or Hypertension?

Visitors burrying the head into a certain pharmacological test.

A fellow student smiling at his own achievements.

The end of a most beneficial visit ? ! ?

that the displays in the Medic Centre were much more appealing than those in the Main Campus, and they were also glad to see that Chinese terms were employed as far as possible.

— Our reception system was perhaps the most outstanding feature in the whole campus. Fellow-students from the main campus also admitted that our system was very successful, and could stimulate the interest of the visitors.

— Surface and Radiological Anatomy was the most popular section in the 2-day period. The main reason for this is that the public do not have much opportunity to see so many X-ray films. But as a matter-of-fact, the demonstrators on duty in this section had really done a remarkable job. The sections on physiology, pathology and the clinical tests were also very much appreciated.

— To show our respect for the dead bodies, the dissection room and the museum were not opened this year. This was quite disappointing for some of our visitors who came just for the cadavars.

— A secondary school student disclosed that he was really fascinated by the displays here, and had decided to take up medicine in the future. He pointed out that the displays in the main campus were quite disappointing.

— Many demonstrators learned from experience in the 'General Health and Common Diseases' exhibition held in the City Hall that people at the back of the crowd might not hear what they say. Therefore during the open day, they all tried to use the loudest voice. As a result they had to employ soft-drinks and pastilles to keep their voices going during the 2-day opening period.

— Very unfortunately and disgracefully, some of our guests noticed that many medical students looked pale and thin. This was understandable since our second-year schoolmates had just battled through their Second Physiology Comprehensive examination the day before the Open Day. Here, we must express our most sincere thanks for their unselfish support throughout the Open Day.

REPORT

ON THE EXHIBITION

GENERAL HEALTH AND COMMON DISEASES

On the 14th to 16th September, 1974, the Health Committee organized an exhibition in the City Hall. The aims were:—

(1) to introduce medical knowledge on common diseases and general health to the public and to clarify misconceptions in this field,

(2) to promote understanding between the medical students and the public.

(3) to promote co-operation among our students.

The topics presented were personal and community hygiene, cardiovascular diseases, child care, mental illness, drug abuse, obstetrics and gynaecology, including vineral disease and family planning.

Besides medical students, students from 8 secondary schools also participated. On the whole, the Exhibition was a success, with an estimated 17,000 visitors during the 3 days. About two-third of the visitors were secondary school students. Remarks from them were encouraging.

The Elixir, in an attempt to evaluate this exhibition and assess the reaction of the public, interviewed 269 visitors. The results are presented in in the following text. This is by no means a full-scale survey and, unlike the one performed by the Caduceus, we used no questionnaire. Instead, 6 students were assigned the task of talking to the visitors individually. In order to obtain information from every age group and both sexes, our sampling was selective and did not represent the true ratio of the ages and sexes of the visitors.

The Editorial Board would like to thank the Caduceus Editorial Board for the advice and help given.

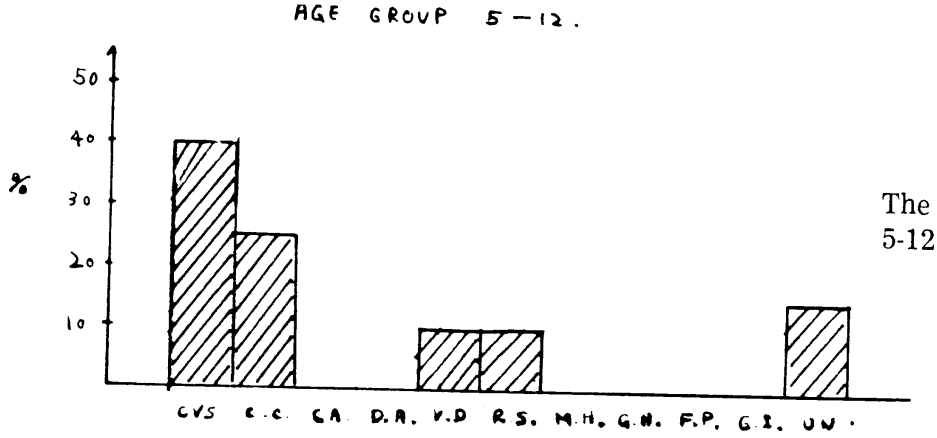
Table I

Age group	% of total in group		% of male in group to total male	% of female in group to total female	% of group in total
	Female	Male			
5 — 12	78%	22%	5%	2%	3%
13 — 18	69%	31%	26%	13%	20%
19 — 24	62%	38%	38%	26%	32%
25 — 40	50%	50%	19%	26%	32%
41 — 60	31%	69%	9%	23%	16%
Over 60	17%	83%	3%	15%	9%

Table II. The proportion of visitors in each age group who show interest in the various sections. This table shows the variation in taste in the different age groups.

Group Age	% of visitors in this age group to total no. of visitors	Cardio-vascular diseases	Cancer	Respiration	Child Care	Mental Health	Venereal diseases	Drug abuse	Hygiene	Digestion	Family Planning	Unspecified	None
5 — 12	3%	40%	0	10%	25% (all female)	0	10%	0	0	0	0	15%	0
13 — 18	20%	24%	10%	5%	12% (all female)	14%	3%	3%	0	0	3%	25%	1.5%
19 — 24	32%	28%	8%	6%	12% (of which 85% female 15% male)	6%	7%	8%	2%	0	2%	18%	2%
25 — 40	20%	9%	3.5%	5.5%	11% (of which 67% female 33% male)	3.5%	2%	2%	9%	6%	3.5%	34%	0
41 — 60	16%	32%	4%	9%	4% (all female)	7%	0	2.5%	4%	0	0	34%	0
Over 60	9%	24%	20%	15%	3.5% (not much female)	3.5%	3%	0	4%	4%	2%	20%	0

NB: A graphical representation of results of this table is given on the next page. Some remarks on the results are made and are presented on the page after next.



Age Group 5-12

The most popular sections in age group 5-12:

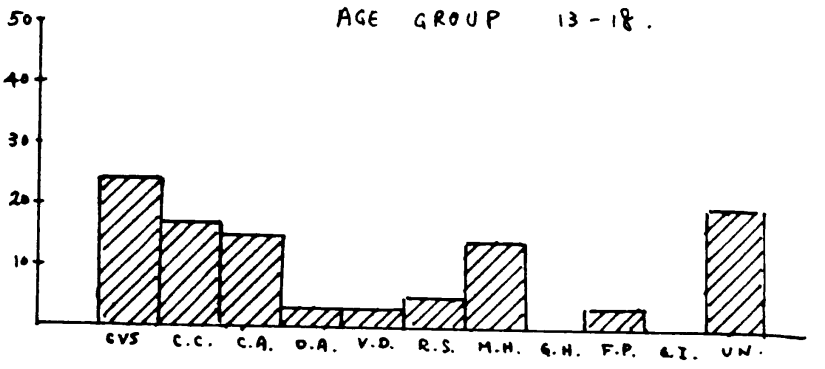
1. Cardiovascular Diseases
2. Child Care
3. Respiration & Venereal Disease.

* * * *

Age Group 13-18

The most popular sections in age group 13-18:

1. Cardiovascular Diseases
2. Mental Health
3. Child Care



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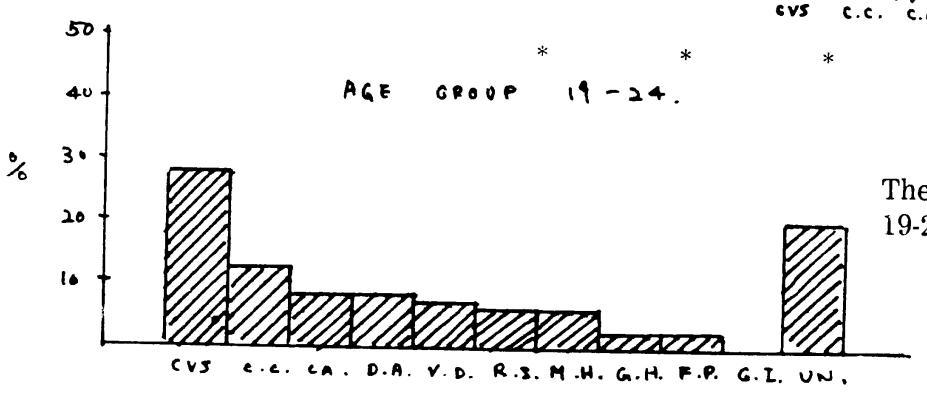


Age Group 19-24

The most popular sections in age group 19-24:

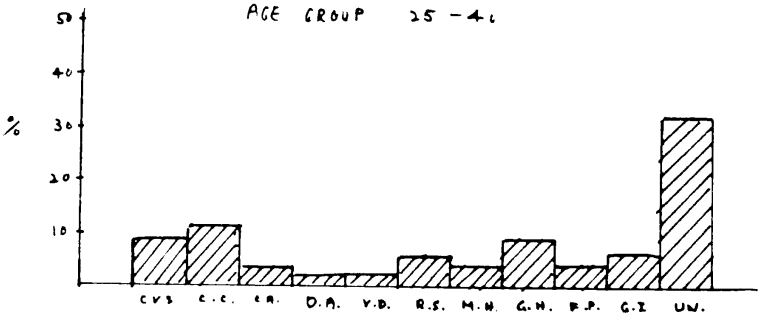
1. Cardiovascular Diseases
2. Child Care
3. Cancer & Drug Abuse.

* * * *

Age Group 25-40

The most popular sections in age group 25-40:

1. Child care
2. Cardiovascular Diseases & General Hygiene
3. Digestion & Respiration.



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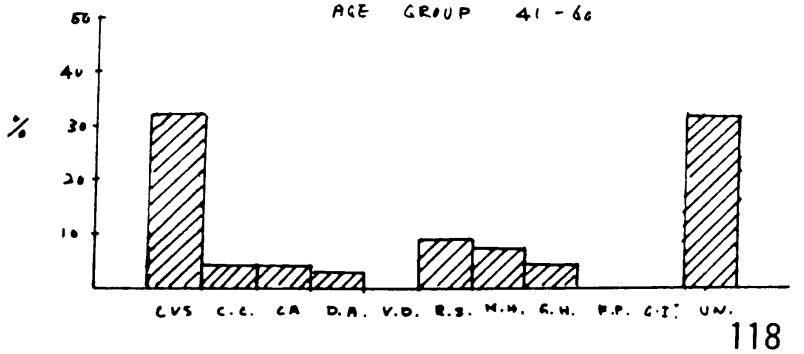
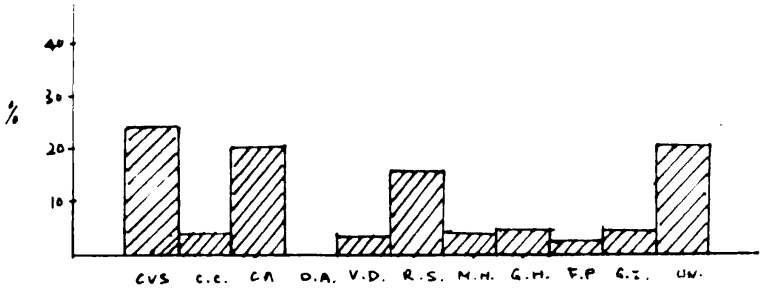


Age Group 41-60

The most popular sections in age group 41-60:

1. Cardiovascular Diseases
2. Respiration
3. Mental Health.



AGE OVER 60

The most popular sections in over 60 age group:

1. Cardiovascular Diseases
2. Cancer
3. Respiratory Diseases.

KEY:

CVS	Cardiovascular Diseases	DA	Drug Abuse	GH	General Hygiene
CC	Child Care	VD	Venereal Disease	FP	Family Planning
CA	Cancer	RS	Respiratory System	GI	Gastrointestinal Tract
		MH	Mental Health	UN	Others and Unspecified

SOME REMARKS ON THE RESULTS PRESENTED IN TABLE - II:

1. The questions of cancer and family planning seem to have become widely publicized and not much audience showed particular interest in these topics. However, the section on cancer seemed more appealing to people over 60 years of age probably because of the relation of cancer with old age.
2. Teenagers are more interested in V.D. than the grownups. May be it is a chance for them to acquire sex education which they are deprived of in school.
3. The section on Cardiovascular System might not necessarily be more successful than the other sections, its popularity was due largely to the Blood Pressure tests and blood grouping.
4. The section on Child Care and Childhood Psycholcgy was more appealing to visitors of the 5-12 age group. These visitors are all children and it is natural for members of this age-group to show more concern in topics about themselves. However, girls were more eager to know something in this field than the boys.
5. Only the males in the 19-24 and 25-40 age-groups showed more interest in Child Care. Males from other age-groups are totally indifferent. Child Care is the most popular section for visitors of the 25-40 age-group. This is understandable since people from 25-40 years of age constitute the most productive group in the population.
6. Visitors of over 60 years of age paid much attention to diseases that usually come with old age. Cardiovascular diseases, cancer and respiratory diseases were the most popular sections.
7. The only visitors who showed no interest in any of the sections were from the 13-18 and 19-24 groups. These were the students from the higher forms and other post-secondary schools. Possibly they have already learned a lot from their schools and the content of this exhibition was not up to their expectations.

Table III: % of visitors who has visited previous Med. Soc. exhibitions.

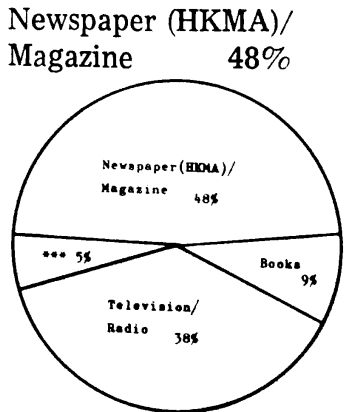
(These figures only apply to the group of visitors whom we have interviewed and can by no means be the case for the total audience.)

Yes	25%
No	75%

(The EB was unable to obtain information on attendance in exhibitions organized by other bodies. A comparison is therefore impossible.)

Figure A: The relative contributions of the various media in conveying basic knowledge in in health and diseases.

(These data were taken from the non-student group)



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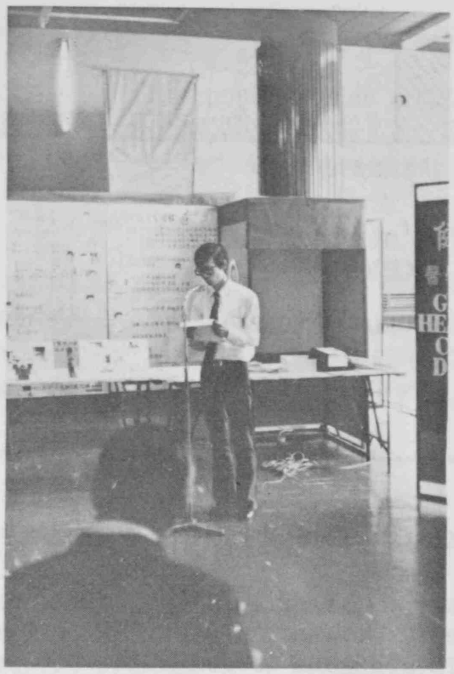
Mm . . ., next time . . .



The Chairman's speech.

Trimming off a little fat.

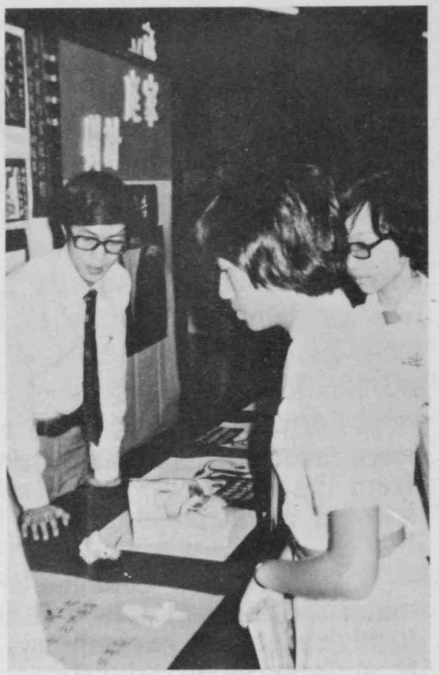
"OH! It hurts!"

Who's telling who?

Fruitless effort?

Sir Albert Rodrigues addressing the audience.

"I've gotta get a message to you."



Planning ahead for the future?

SNAPSHOTS

from

THE EXHIBITION

Those enchanting eyes ! !

Showing the patrons around — "So you see . . ."

No wonder her B.P. is going up.

WHAT DO PEOPLE SAY

ABOUT OUR EXHIBITION . . . . .

The remarks that we received from the audience were encouraging. Most of the comments were favourable and our workers managed to give our visitors a good impression. The response from the public was good and the visitors all agreed that the exhibition to a certain degree did succeed in introducing some basic knowledge in health and diseases.

There are complaints that varied from the superficiality of treatment and exhibiting materials that had appeared in previous exhibitions (particularly those concerning V.D. and cancer), to high-sounding explanations and difficulty in understanding. Such variation was probably due to differences in educational background and age. But this was only an indication that our exhibition was 'in the middle of the road'.

One thing that must be aware of is that some members of the medical profession who happened to have visited our exhibition pointed out that there were misconceptions in material presented and some students were confused with certain types of diseases. It was recommended that senior students should assume a more active role in some of the sections. They also suggested that topics that are of public interest (e.g. mental diseases, cardiovascular disorders) should be given more detailed and intensive treatment in separate exhibitions. A medical practitioner remarked that the section on drug abuse was a marvellous attempt, for knowledge of the correct use of drugs was so essential and yet so little known to the public.

Unsystematic lay-out was a frequent accusation. Many people complained that they did not know which was the route to follow and there was no direction given. There were not enough programmes for all the visitors. Nearly all agreed that publicity was not enough but at the same time there were complaints on the crowdiness and chaos in the exhibition hall. Also, the closing time was too early (6.00 p.m.) and it was a pity that many working people could not come. The exhibition period was undoubtedly too short and there were frequent requests that the duration be extended for a couple of days. (However, it is the regulation of the Hall to close any exhibition at 6.00 p.m. each day and the Urban Council usually let the Hall for a few days only during Summer.)

We received much valuable advice from our visitors. The more extensive use of drawings, instruments, specimens and photographs was recommended. It seemed that most people did not like lengthy written explanations. The inclusion of the original English terms was also suggested. Quite a number of people said that they could not hear the students and they recommended the use of loudspeakers. Many visitors hoped that there would be more clinical tests included in future exhibitions.

To end our report, there are some information for the future Health Committee: Exhibitions of this type are very much welcomed by the public and many people are looking forward to having many more exhibitions like this in the future. The audience is more interested in the prevention rather than the causes of diseases. This should be taken into consideration in preparing for another exhibition.

* * * *

A REPORT FROM OUR SPORTS SECRETARY

It has been five years since the Omega Rose Bowl (Interfaculty Sports Competition) stays in our Faculty and this year it is going to remain in our possession again. Somebody asks me how we can make it and the only answer I can give him is "Simply because we want it to stay with us and this is the desire of every student in the faculty!"

No doubt, the medical faculty is one of the faculties with the largest manpower but without the spirit, the co-operation and the brilliant skill in the games, there is no way we can achieve this honour six years in a row.

Let us look at the results this year (1973-74):

Champion	Softball
	Soccer
	Lacrosse
	Athletics
	Badminton
1st runners-up	Hockey
	Squash
	Volleyball

In the above mentioned, I must pay special tribute to the Soccer team because it has been seven to eight years (as recalled by one of the past students) since we last captured the Champion in this field. Though we do not have any distinctive players on our side we have a balanced team, well trained and have good fighting spirit in every one of our players. This is a good example of how we co-operate and strive towards the common goal — to be the unbeatable winner of the Omega Rose Bowl.

It seems that we dominate in field events mainly, but we did improve a lot in Basketball and Swimming, both clinching a third place this year. With constant practice I hope we can do even better in the years to come.

Here I must thank all the individual team captains for helping me to organize the teams and giving me advice every now and then. I must also thank all the players for playing their hearts out in each of the matches and the last but not the least I must thank all those who have come to support us. Without the help of any one of them, I do not think we will be able to achieve such high honour.

The Athletes, the Volleyball, Tennis, Hockey and Softball players are not only the best players in the interfaculty competition but they are also the cream of the University. This has been proved to be so during the Biennial Intravarsity Games help in August this year in Hong Kong. Over half of the University Team players in Softball and Hockey come from the Medical faculty and they did achieve a very good result in each of the games. This has been an honour not only to the players alone but to the Faculty as a whole.

No doubt, our traditional intrafaculty sports competition helps a lot to achieve the honour above mentioned. It not only gives us a chance to improve the skill of the new-comers by playing against the matured players but also gives us a good chance to locate the new-blood for the subsequent years. But to me, the most profitable result of the Interyear games is to give us, medical students of all four years a great occasion to gather together, play against each other and to know each other — an occasion so rare in our academic daily life. Though in some moments conflict breaks out but I am so happy to see that they all settle down and throughout this year's competition I can see that numerous friendship has been built up and the standard of each game is soaring up. I must make use of this opportunity to congratulate 4th year (1973-74) for winning the Intrafaculty Sports Competition and again be the owner of the Champion Shield.

The one year-old Champion Cup donated by Professor J. B. Gibson for Intrafaculty swimming competition goes to 2nd year (1974-75) this year after it has been shared by 1st and 2nd year (1973-74) — the co-champions last year.

I do not want to make anyone misunderstand that we only play to win. We never for one moment forget to be fair, generous, to be a good loser and a graceful winner. This can be proved by the numerous friends we have made both inside and outside the University.

Finally as a conclusion, I would like to quote the last sentence from the last year's Sports Reports as the last words — "KEEP UP THE GOOD WORK, MEDICS! ! !"

By KOO PING KONG

The Omega Rose Bowl

CLASS REPORT OF FIRST YEAR 1973-74

The setting up of a Class Constitution in May formally proclaimed our class as "Medic '78". We had our first get-together function at the Morrison House which demarcated the onset of the numerious activities held throughout the year.

It was in the Medic Nite that we came to know of the meaning of tradition as is used for the occasion. Nevertheless, we performed fully at our best though being interrupted throughout. As reaction to this, we had a forum on the 'Medic Nite' held and this was well participated by the class.

The closing of the term was highlighted by a camp at Wong Yei Chau where we spent three exhaustive days in games, canoeing and cycling. A similar camp, also of three days duration, was held in Cheung Chau in April.

A Christmas dancing party and a Folk-dance Nite held in March surely provided a swinging time for those present. But the "so-gat-philic" guys may be disappointed in that the former occasion was the singleton of the kind in the whole year.

In April, our photographers had their day when they went for a photo-trip with Miss Hong Kong 1973, Miss Elaine Sung, in the Peak Area.

Other intraclass activities included a table-tennis competition, a Chinese Chess and a Bridge tournament. Due to the Lunar New Year, the last function was poorly responded. The other two received satisfactory support from the class.

Though fresh in the interyear competitions, our class, in which good sportsmen and potential ones are plenty, managed to grasp the Men's Basketball, Volleyball and Table-tennis Championships besides our victory in the Swimming Gala.

Friendly matches were organised intermittently, basketball and volleyball being the favourite. Everyone, players and spectators, enjoyed the excitement and thrill.

Indeed, the year was one of joy and laughter interwoven with times of nerve-breaking tests. This is only the beginning, and a good beginning. We hope, in the four years yet to elapse, to have more fun, more excitement, more experience and . . . . more tests. But above all, we hope to share our comradeship to the fullness.

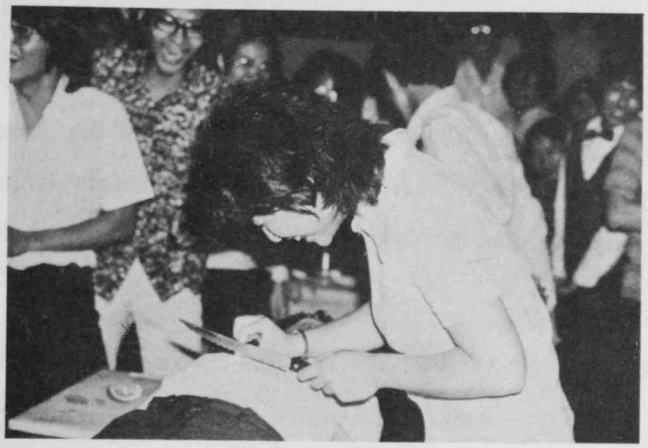
So cheer again:

"We've got a seven, 7

We've ot an eight, 8

What have we got?

78!"



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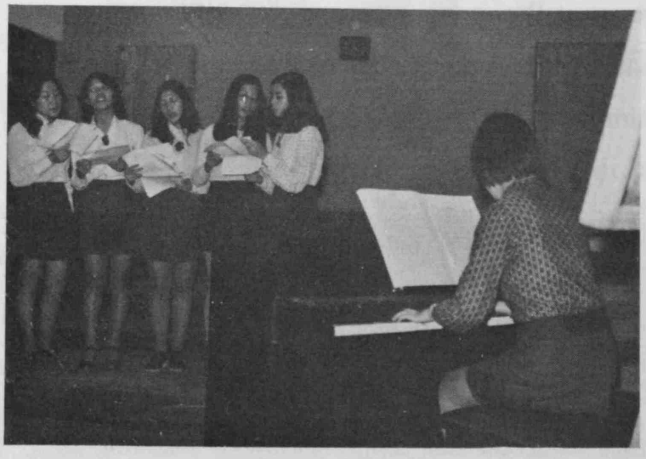


CLASS REPORT OF SECOND YEAR 1973-74

1973-74 has been a very eventful year for our Class.

The summer vacation was filled with activities which included a Folk Night, tea party, barbecue and sports training programmes.

In spite of the comprehensive tests, many activities were organized during the First Term. The Class Concert held in November at St. Louis' School was especially memorable for the high standard of the performances, both by guests and class members, and for the enthusiasm of the audience.

Our Class came first in the Medic Nite drama competition with a comedy on the life of the preclinical students, thanks to the talented actors of our Class, who put up a five-star performance.

A Christmas celebration party was held just befre we broke up for our first term holidays. It was well attended by over fifty class members and we are proud to say that the food we prepared ourselves was most appetizing.

The mounting pressure of the impending First M.B. examination put a stop to all class activities during the Second Term. Class attendances at the library rose to an all time high and even the Sports Centre regulars began to turn up. The examination itself, which was held from 25th February to 6th March, however, was quite uneventful.

The second term holidays which immediately followed provided the opportunity for class members to relax. A canoe camp at Tai Mong Chai was organized, but it was marred by heavy rain. Intraclass competitions in table-tennis, badminton and tennis were held and were participated by many class members.

With the commencement of the Third Term the Class entered competely new fields of studies, in which many find more interest than the three preclinical subjects. Activities were organized as in the past. A social gathering was held in April. A dinner party in honour of the preclinical staff was held on 2nd May at the Lo Fung Restaurant, Peak Tower. Guests included Professor Lisowski, Professor Boyde, Dr. Hwang and many other members of the three departments.

The feeling of the Class for sports has always been strong and it was not surprising we were co-champion with 1st Year at the first Swimming Gala organized by the Medical Society. The Class also excelled in the Intrafaculty competitions, coming first in soccer, cross-country relay, badminton (women) and netball.

The Class has produced many fine sportsmen and sportswomen. Our Ladies' Sports Captain, Miss Winnie Ngai, was elected Sportswoman of the Year (1972-73) of the Factulty of Medicine, and many class members represented the University in various sports activities.

With the memories of the past year still fresh in one's mind, a new academic year is about to start. It seems that 1977 is not so far away now!

CLASS REPORT OF THIRD YEAR 1973-74

The session 1973-74 saw a most fruitful and exciting year for our class.

Social activities were held very frequently, and served mainly as relaxant after bedside teachings, lectures and library studies. Social gatherings were indispensable, though always attracted only the same bunch of fellows. More enthusiastically attended were picnics, cycling tours, folk dance parties and tea time concerts. Eager campers found themselves accompanied by other classmates on an occasion to 黃宜州 . (WONG SOON CHAU)

Many took the opportunity to go abroad for sight-seeing during the summer vacation — Taiwan, Mainland China and the Phillipines were the favourites. Slide shows and introductory talks were held on the places visited. Those of us who stayed behind during the summer haunted the post-mortem examination room frequently and several of us found time to conduct a research entitled 'A study of the Aging Changes of Aortae in Chinese'.

Christmas was highlighted by a carnival held in the Lady Hotung Hall — indoor games, quiz, songs and dinner buffet were followed by a dancing party with guests invited from secondary schools.

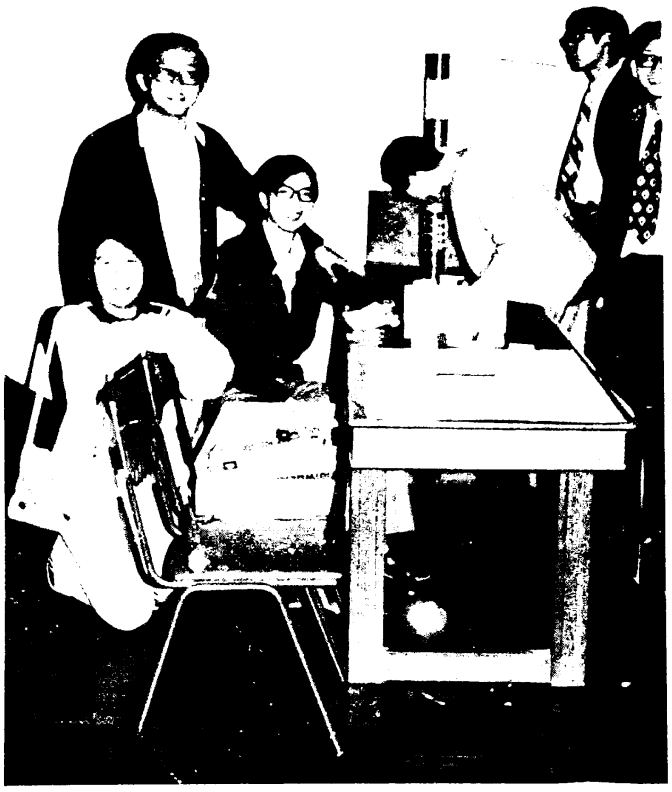
The class proved to be very socially conscious as reflected in the eager participation of the Anti-Cancer exhibition sponsored by the HKU Medical Society and staged on both sides of the harbour in Queen's College and Queen Elizabeth College respectively at the end of the summer. The occasion was well received by the public.

The festive annual class dinner was held after the 2nd M.B.,B.S. examination at the Kingsburg Restaurant. We were honoured by the presence of the professors and most of the teaching staff of the three paraclinical departments. Programmes of the evening included performances and games. All present had a most enjoyable evening.

Again we proved to be very conpetent sportsmen. Though unable to capture the Champion Shield, our players showed high spirit and sacred sportsmanship throughout the games. We managed to become the Second Runners-up.

The economic-orientated Class Committee was well received by the prompt order of stethoscopes and other equipment at a considerable discount for the class.

Last but not the least, the whole class has continued the effort of promoting better understanding and relationship with students of other years and all teaching departments. On the whole, all of us have strided forward in various aspects in the year. KEEP UP, CLASSMATES! !



CLASS REPORT OF FOURTH YEAR 1973-74

1973-74 proved to be a successful and enjoyable year for the fourth year Medical students. A variety of social and sports activities were held, including social gatherings, a visit to Hay Ling Chau, a night-trip from Wanchai to University Hall, cycling tour, several friendly interclass matches and a launch picnic to Clear Water Bay. About 30 members of our class shared the fun and hardship of the launch picnic. Many of our future doctors found themselves in an embarrassing state of nausea and/or vomiting. Some ladies and gentlemen were wise enough to leave the launch after reaching Clear Water Bay and to return home by a safer route. We would like to express our thanks to Doctor P.F. Teng and Sir Siu Kin Tang who generously subsidised the picnic.

Our class participated actively in the Medic Nite and we managed to gain the runners-up. Thanks are given to all actors and actresses as well as to Mr. Li Man Ki.

We were overwhelmed with joy when we saw our skilful sportsmen succeed in winning the Overall Championship of the interclass matches again. So we were able to get hold of the Shield donated by Dr. Frank Cheng.

Our class was split up into 5 speciality groups at the beginning of 1974. We are now in the Final year and the Final M.B. Examination is not far aawy. We have to work in order to prepare ourselves adequate enough to get through the examination.

Finally, we would like to wish every member of our class the best of luck and success in the coming Final M.B. Examination in 1975.


懷孕的母親
發育中的嬰兒...
需要常飲
利賓納
Ribena
醫生經常推薦的利賓納,是新鮮英國黑加侖子汁,含有豐富維他命C及多種天然益處,美味可口,爲懷孕時期的母親及發育中的嬰兒所必需,利賓納能增進母親健康,助長嬰兒發育.
請遵從醫生囑咐——常飲利賓納.
利賓納,現代最有益健康的天然飲品.
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EXTRACT FROM THE GAZETTE

PERSONALIA

Dr. (Mrs.) Huang Chan Shuk Tsz, Reader in Anatomy, and Dr. K. M. B. Chan, Lecturer, attended the third European Anatomical Congress held in Manchester from September 3 to 7, 1973.

Dr. P. Nandi, Lecturer in Surgery, attended a conference on chest diseases held in Bangkok from October 30 to November 6, 1973.

Dr. (Mrs.) Teoh-Chan Ching Haan, Senior Lecturer in Microbiology, and Dr. P. Y. Chau, Lecturer, attended the first international congress for bacteriology held in Jerusalem from September 2 to 7, 1973, and the eighth international congress for chemotherapy held in Athens from September 8 to 14, 1973. At the former, Dr. Chau presented a paper entitled 'A one-day selective migration procedure for detecting salmonellae in faeces'.

Dr. M. J. Colbourne, Reader in Preventive and Social Medicine, attended the platinum jubilee celebrations of the Haffkine Institute in Bombay, from January 14 to 16, 1974, and read a paper entitled 'Implementation of communicable diseases in Africa and Asia', to be published in *Progress in drug research.* He acted as external examiner for the Universiti Malaya from January 31 to February 9, 1974.

Professor J. B. Gibson attended the third regional seminar in education and training and the meeting of deans of medical schools organized by the WHO Regional Office for the Western Pacific, from February 11 to 25, 1974, in the University of New South Wales, Sydney.

Professor C. T. Huang, Dr. K. H. Lee, Senior Lecturer in Obstetrics and Gynaeco-logy, and P. C. K. Yue, Senior Lecturer in Surgery, attended the first symposium on gentamicin sponsored by the Schering Corporation, U.S.A., held in New Delhi on December 10, 1973. Dr. Yue presented a paper entitled 'Clinical experience with gentamicin in surgical patients'.

Professor G. B. Ong has been awarded the first Ismail Gold Medal by the Malaysian College of Surgeons. He visited Malaysia to receive the medal on March 29, 1974, and delivered the first oration. He has been elected a Fellow of the Royal Society of Edinburgh. At the invitation of the Royal College of Surgeons of England he delivered a Moynihan lecture entitled 'The inoperable carcinoma of the oesophagus' in April 1974.

Professor K. Singer has been appointed to the editorial boards of *Medical Progress* (Australia) and *Eastern Medicine* (United Kingdom). He has also been appointed corresponding editor of *TV in Psychiatry Newsletter* of the University of British Columbia.

Professor P. H. Teng acted as WHO consultant on drug abuse for the Malaysian Government from September 13 to November 4, 1973. He attended the seventh session of the council of the Federation of World Health Foundations in Geneva, from November 22to 23, 1973.

Dr. (Mrs.) Teoh-Chan Ching Haan, Senior Lecturer in Microbiology, has been elected a Member of the Royal College of Pathologists.

Dr. Marjorie Topley, post-doctoral Research Fellow in the Centre of Asian Studies, attended a conference on the comparative study of traditional and modern medicine in Chinese society, held in the Health Sciences Centre at the University of Washington, from February 4 to 6, 1974, and presented a paper entitled 'Western and Chinese medicine in Hong Kong: socio-cultural determinants of variation, interaction, and change'.

Dr. Susanna S. C. Wong, Lecturer in Biochemistry, attended the ninth International Congress of Biochemistry held in Stockholm from July 1 o 7, 1973.

Professor A. M. C. Yau attended the Western Pacific Orthopaedic Association meeting and delivered two lectures on the spine in August 1973. From October to November 1973 he was visiting professor at the Clinica Primenvera Orthopaedia in Mexico City, where he operated and delivered a series of lectures; he also visited the Universities of Vermont and Rochester, New York, and lectured in the departments of orthopaedic surgery in both; he was guest speaker at the second seminar on scoliosis held at the University of Cincinnati and the American Academy of Orthopaedic Surgeons programme on spinal deformities in children held in New York.

Dr. S. P. Chow, Lecturer in Orthopaedic Surgery, has been elected a Fellow of the Royal College of Surgeons of Edinburgh.

Professor A. R. Hodgson has been elected as Honorary Fellow of the Royal Australian College of Surgeons. He was Visiting Professor to the Fundacion Hospital Ortopedico Infantil and the Venezuelan Orthopaedic Association, Caracas, and conducted a post-graduate course on spinal surgery from May 15 to 21, 1974. He was also Visiting Professor to the section of orthopaedic surgery in the school of medicine at Yale University, where he gave the Carl Henze Memorial Lectures and participated in the residents' disputations from May 21 to 25, 1974. Professor Hodgson attended the meeting of the International Orthopaedic Association held at Geneva and Munich from May 26 to June 1, 1974, and the Royal Society of Medicine summer meeting from June 7 to 9, 1974.

Dr. M. C. Ip, Lecturer in Anatomy, attended a symposium on muscle spindles at the University of Durham from April 4 to 6, 1974.

Dr. S. K. Lam, Lecturer in Medicine, attended the sixty-eight annual general meeting of the Association of Physicians of Great Britain and Ireland held in Newcastle-upon-Tyne from April 19 to 20, 1974, and presented a paper entitled 'Evidence for the existence of two populations of duodenal ulcer'.

Dr. A. K. Y. Lee, Lecturer in Medicine, attended an international symposium on hepatitis organized by the Gastroenterological Society of Taiwan held in Taipei from March 23 to 24, 1974, and presented a paper entitled 'Hepatitis B antigen and auto-antibodies in chronic liver diseases in Hong Kong'. His visit was sponsored by the Roche Far East Research Foundation.

Dr. K. H. Lee, Senior Lecturer in Obstetrics and Gynaecology, has been appointed by His Excellency the Governor to be a member of the Medical Council of Hong Kong for a period of three years from May 7, 1974.

Dr. C. H. Leong, Senior Lecturer in Surgery, attended the twenty-seventh annual meeting of the Urological Society of Australasia held in Melbourne from March 3 to 13, 1974, and presented a paper entitled 'Gastrocystoplasty'. He presented a paper entitled 'The surgical treatment of genito-urinary tuberculosis' at the twentieth annual urological seminar held in Kansas City on April 8, 1974, and acted as visiting porfessor in the University of Missouri for two weeks after the seminar.

Professor F. P. Lisowski has been elected to the council of the International Association of Human Biology.

Professor A. J. S. McFadzean has been elected an Honorary Fellow of the Royal College of Surgeons of Edinburgh and the first Honorary Member of the Hong Kong Medical Association.

Dr. J. P. O'Brien, Lecturer in Orthopaedic Surgery, has been elevated to the active members' list of the Australian Orthopaedic Association.

Professor G. B. Ong acted as extenal examiner in Surgery in the final degree examination of the University of Malaya held from April 8 to 18, 1974, and as examiner in the final fellowship examination of the Royal Australasian College of Surgeons held in Sydney from May 17 to 28, 1974. He was elected corresponding fellow of the American Surgical Association.

Professor K. Singer presented a paper at a conference on strategies for mental health planning, organized by the University of British Columbia in Vancouver from May 1 to 3, 1974. He was elected corresponding fellow of the American Psychiatric Association.

Professor D. Todd has been elected a member of the Association of Physicians of Great Britain and Ireland, and re-elected a member of the Board of Directors of the Hong Kong Anti-Tuberculosis and Thoracic Diseases Association.

Dr. Rosie T. T. Young, Reader in Medicine, represented Hong Kong at a WHO conference on a multi-national study of vascular complications in diabetes mellitus, held in London from January 21 to 24, 1974. She also attended the 5th Asia and Oceana Congress of Endocrinology, held in Chandigarh, India, from January 27 to February 1, 1974, and presented a paper entitled 'A study of diabetes mellitus in Hong Kong'.

Dr. F. C. Y. Cheng, Senior Lecturer in Surgery, has been invited by the board of councillors of the Asian Zone of the International Society of Endoscopy to serve as a councillor representing Hong Kong.

Dr. S. Dai, Demonstrator in Pharmacology, attended the eighth Singapore-Malaysia Congress of Medicine held in Singapore from July 26 to 29, 1973, and presented a paper entitled 'A study of the experimental assessment of anti-ulcer agents'.

Dr. P. K. Das, Lecturer in Biochemistry, and Dr. (Miss) Lin Hsiang Ju, Senior Hospital Biochemist, attended and presented papers at the ninth International Congress of Biochemistry held in Stockholm from July 1 to 7, 1973. Dr. Das also attended and presented a paper at the twelfth international symposium on red cell structure and function held in Berlin from August 22 to 26, 1973. During his visit to the Groningen University he delivered a lecture entitled 'Role of cholinesterases on the effect of hexafluoronium on smooth muscle' in the Department of Pharmacology.

Dr. A. Koo, Lecturer in Physiology, attended a course on classical physiology with modern instrumentation at the Baylor College of Medicine, Texas Medical Centre, Houston, Texas, from July 9 to August 18, 1973.

Professor F. P. Lisowski has been invited to serve on the editorial board of the Annuals of Human Biology from June 1, 1973. He has also been nominated to be a member of the Scientific Subcommittee, World Health Foundation (Hong Kong) from June 23, 1973.

Professor K. Singer attended and presented papers at the second regional seminar on psychotropic medication held in Kuala Lumpur from April 23 to 28, 1973, and at the annual meeting of the American Psychiatric Association held in Hawaii from May 7 to 11, 1973. He also participated in a conference entitled 'Psychiatric education and the nations of the Pacific rim' at the University of British Columbia, and presented a paper.

Dr. S. C. Tso and Dr. R. Yu, Senior Lecturers, and Dr. J. Y. C. Pan, honorary Clinical Lecturer in Medicine, have been elected Fellows of the Royal College of Physicians, Edinburgh.

Dr. F. A. O'H. Ward, Senior Clinical Pathologist, has been appointed a member of the Government Medical and Health Department working party on blood transfusion services.

Professor A. Yau delivered three lectures on the spine for the first postgraduate course in orthopaedic surgery organized by the Philippine Orthopaedic Association and held in Manila from November 30 to December 2, 1972. He also lectured and operated on spinal deformities at the University of Kobe from June 18 to 22, 1973.

Dr. Rosie T. T. Young, Reader in Medicine, and Dr. D. C. Y. Yeung, Lecturer in Biochemistry, attended the eighth congress of the International Diabetes Federation held in Brussels from July 15 to 20, 1973.

Senate

External Examiners

The following have been appointed External Examiners:

Sir John Bruce, Professor Emeritus of Surgery, University of Edinburgh, in surgery for the Final Examination in December 1973.

Professor J. F. Goodwin, Professor of Cardiology at the Royal Postgraduate Medical School, University of London, in Medicine for the Final Examination in May 1975.

Professor R. B. Duthie, Nuffield Professor of Orthopaedic Surgery at the University of Oxford, in Surgery for the Final Examination in May 1975.

Professor H. C. McLaren, Professor of Obstetrics and Gynaecology at the University of Birmingham, in obstetrics and gynaecology for the year 1975.

Professor R. Mitchell, Professor of Child Health at the University of Dundee, in paediatrics, for the Final Examination in January 1974.

Professor M. J. Rand, Head of the Department of Pharmacology at the University of Melbourne, in pharmacology for three years from 1974 to 1976.

Professor D. R. Wilkie, Professor of Physiology in University College, University of London, in physiology for three years from 1975 to 1977.

Professor C. E. Oxnard, Department of Anatomy, University of Chicago, in anatomy for three years from 1975 to 1977.

Professor C. A. Braga, Department of Obstetrics and Gynaecology at the University of California Medical Centre, in obstetrics and gynaecology for the M.B., B.S. Final Examination in May 1974.

Council

Emeritus Professors:

The Council has resolved on the recommendation of the Senate that the title of Professor Emeritus be conferred upon the following, on their going into retirement on June 30, 1974:

Professor A. J. S. McFadzean (Medicine);

Professor P. H. Teng (Preventive Medicine).

Gifts and Grants:

Anonymous: $200,000 to establish the Li Koon Chun Surgical Travelling Fellowship; and $20,000 to establish the Mun Gold Medal and Prize in Psychiatry.

China Medical Board, Inc. of New York: US$30,000 for the purpose of establishing Medical Faculty Training Fellowships for the academic year 1973-74.

Mr. M. B. Lee: £1,000 a year for an annual M. B. Lee Visiting Professorship in orthopaedic surgery for a minimum of ten years.

Faculty of Medicine

Appointments:

Chan Tai Kwong, M.B., B.S. (Hong Kong), M.R.C.P. (Edinburgh and London), and Donald Yu Yu Chiu, M.B., B.S. (Hong Kong), M.R.C.P. (Edinburgh), Lecturers, appointed Senior Lecturers in Medicine from August 1 and September 1, 1973, respectively.

Kong Chi Tai, M.B., B.S. (Hong Kong), appointed temporary Lecturer in Psychiatry from September 1, 1973, to June 30, 1974.

Raquel Maria de Fonsecar Alves, Licentiate in Medicine and Surgery (Lisbon), appointed temporary Lecturer in Paediatrics from March 1 to September 14, 1974.

Vivian Chan Nap Yee, M. Sc., Ph. D. (London), D.I.C., appointed Lecturer in Non-clinical Biochemistry from October 1, 1974.

(Miss) Cheung Yuen Ming, B.Sc., (London), appointed Lecturer in Physiology from September 1, 1974.

Henrietta Ip Man Hing, M.B., Ch.B. (Liverpool), M.R.C.P., appointed Lecturer in Paediatric from March 1, 1974.

Rosamond Wong Ling Chui, M.B., B.S. (Hong Kong), M.R.C.O.G., appointed Lecturer in Obstetrics and Gynaecology from March 1, 1974.

David Todd, M.D. (Hong Kong), F.R.C.P. (Edinburgh), appointed to the Chair of Medicine from July 1, 1974.

Michael James Colbourne, M.B., Ch.B., F.R.C.P. (Edinburgh), D.T.M. & H., D.P.H. (London), F.F.C.M. (R.C.P.) (United Kingdom), Reader, appointed to the Chair of Preventive Medicine from July 1, 1974.

Rosie Young Tse-Tse, M.D. (Hong Kong), F.R.C.P. (London and Edinburgh), J.P., Reader, appointed to a personal chair in medicine from July 1, 1974.

Andrew James Cameron Buchanan, M.B., B.S. (Melbourne), M.R.A.C.P., appointed Lecturer in Paediatrics from May 13, 1974.

So Kong Fan, M.B. (South China Medical College) and Chan Wing Chung, M.B., B.S. (Hong Kong), appointed Clinical Pathologists in the Hospital Pathology Service from May 1, 1974 and July 1, 1974 respectively.

Alexander Leung Kwok Chu, M.B., B.S. (Hong Kong) and Robert Gerald Choa, M.B., B.S. (Newcastle upon Tyne), appointed temporary Lecturers in Surgery for one year from July 1, 1974 and September 1, 1974 respectively.

Stephen Ng Kam Cheung, M.B., B.S. (Hong Kong). appointed Lecturer in Preventive and Social Medicine from July 1, 1974.

Rebecca Wang Yu Ching, M.B., B.S. (Hong Kong) and Yeung Choi Kit, M.B., B.S. (Hong Kong), appointed Lecturers in Medicine from July 1, 1974.

Doris Edna Gray, B.A., M.Sc., Ph.D. (Western Ontario), F.R.I.C., appointed to a personal chair in biochemistry from September 1, 1973.

Alfred Au Man Cheuk, M.B. (National Defence Medical Centre, Taiwan), appointed Lecturer in Surgery from December 1, 1973.

Resignations:

Dr. T. K. C. King, Senior Lecturer in Medicine, from December 13, 1973.

Dr. K. Y. Wong, Lecturer in Paediatrics, from April 8, 1974.

Dr. D. W. K. Sue, Lecturer in Paediatrics, on January 2, 1974.

Dr. J. L. Taw, Lecturer in Surgery, on November 30, 1973.

Dr. K. T. Chan, Clinical Pathologist in the Hospital Pathology Service, from June 16, 1974.

Dr. L. C. T. Chang, Lecturer in Pharmacology, from July 23, 1974.

Dr. C. P. K. Cheng, Lecturer in Physiology, from June 30, 1974.

Dr. A. van Langenberg, Senior Lecturer in Surgery, from June 19, 1974.

Dr. M. G. P. McCabe, Senior Lecturer in Biochemistry, from May 12, 1974.

Dr. H. P. Sheng, Lecturer in Pharmacology, from October 14, 1974.

Visiting Professors:

Professor H. H. Eddey, B.Sc., M.B., B.S., F.R.C.S., F.R.A.C.S., F.A.C.S., Professor of Surgery at the University of Melbourne, appointed Visiting Professor in the Department of Surgery from December 16, 1973, to April 1, 1974.

Professor H. S. Goldsmith, M.D., Samuel D. Gross Professor of Surgery and Chairman of the Department of Surgery at Jefferson Medical College, Thomas Jefferson University, appointed Visiting Professor in Surgery from July 28 to August 17, 1974.

Honorary Visiting Lecturers:

Dr. H. Miller, M.B., B.S. (West Indies), F.R.C.S. (Canada), Thoracic Surgical Fellow at the Sunnybrook Hospital of the University of Toronto, appointed Honorary Visiting Lecturer in Surgery for a period of six months from June 30, 1974.

Professor H. D. Roeher, M.D., Associate Professor of Surgery at the University of Heidelberg, appointed Honorary Visiting Lecturer in Surgery during his visit to Hong Kong, for between three and four weeks.

Retirement:

Professor A. J. S. McFadzean, O.B.E., D. Sc., Professor of Medicine, from June 30, 1974.

Professor P. H. Teng, C.M.G., O.B.E., LL.D., Professor of Preventive Medicine, from June 30, 1974.

Prizes:

The following prizes have been awarded:

John Anderson Gold Medal: Miss Rebecca Wan Yu Ching and Mr. Chan Wing Chung.

Chan Kai Ming Prize: Mr. Yeung Choi Kit.

Li Shu Fan Medical Foundation Prize in Pharmacology: Mr. Raymond Wong Woon Sing.

C. P. Fong Gold Medal in Pathology: Miss Olivia Chow Kit Wun.

Dr. Mary Hui King Li Memorial Prize: Dr. Lee Sum Ping.

The Sir Patrick Manson Gold Medal has been awarded to Dr. Ho Hung Chiu.

Ng Li Hing Prize: Edmund Woo Kin Wai.

Li Shu Fan Medical Foundation Prize in Physiology: Edmund Woo Kin Wai.

Li Shu Fan Medical Foundation Prize in Biochemistry: Edmund Woo Kin Wai.

Ho Fook Prize: Edmund Woo Kin Wai.

Janet McClure Kilborn Prize: Anna Lok Suk Fong.

DORIS EDNA GRAY, B.A., M.Sc., Ph.D. (Western Ontario), F.R.I.C.

Dr. Doris Gray, Reader in Biochemistry, has been appointed to a personal chair in the Department of Biochemistry from September 1, 1973.

Born in Guelph, Ontario, Professor Gray was educated at the University of Western Ontario where she received the degrees of B.A. (general science) in 1949, M.Sc. (biochemistry) in 1951, and Ph.D. in 1953. She was elected a Fellow of the Royal Institute of Chemistry in 1963.

Professor Gray was previously a Baxter Research Fellow and a part-time lecturer in chemistry in St. Joseph's Hospital at the University of Western Ontario, before joining this University in 1953 as a Lecturer in Biochemistry. She was promoted to a senior lecturership in 1955 and a readership in 1966.

Professor Gray's research interest has been largely concerned with investingations into the biochemical role of alpha tocopherol, and studies on some active principles in Hong Kong's medicinal plants used by Chinese herbalists. She has published numerous papers on these subjects.

She has pursued an interest in statistics applied to biology since her post-graduate days, has published a booklet on the subject, and is currently engaged in a large volume on biostatistics. She has also published a laboratory manual on biochemistry for medical students.

MICHAEL JAMES COLBOURNE, M.B., Ch.B. (Edinburgh), F.R.C.P., D.T.M. & H., D.P.H., F.F.C.M. (R.C.P.)

Dr. M. J. Colbourne, Reader in Preventive and Social Medicine, has been appointed to the Chair of Preventive Medicine from July 1, 1974.

Professor Colbourne was educated at the University of Edinburgh, where he obtained the degrees of M.B., Ch.B. in 1942 and at the University of London, where he obtained the Diploma of Public Health in 1951. He was awarded the Diploma of Tropical Medicine and Health in 1949 and elected Fellow of the Royal College of Physicians of Edinburgh and of the Faculty of Community Medicine respectively in 1970 and 1972.

After holding appointments for nine years from 1947 as a medical officer and malariologist with the Gold Coast Government and for five years thereafter to 1961 as a World Health Organization malaria adviser in Sarawak and Manila, Professor Colbourne became senior lecturer in the London School of Hygiene and Tropical Medicine, a post he held until 1964 when he left the United Kingdom to be Professor and Head of the Department of Social Medicine and Public Health at the University of Singapore. Returning to the United Kingdom in 1969, he was appointed Reader in Tropical Hygiene at the University of London and served concurrently as the Assistant Director of the Ross Institute from 1970 to 1973. He was also editor of the Journal of Tropical Medicine and Hygiene from 1969 to 1972.

In 1973 Professor Colbourne was seconded to the University of Hong Kong as Reader in Preventive and Social Medicine.

Professor Colbourne's current research interests lie in the epidemiology and control of communicable disease, especially of malaria in the Western Pacific. He has published articles in many learned journals.

DAVID TODD, M.D. (Hong Kong), F.R.C.P.

Professor D. Todd has been appointed to the Chair of Medicine from July 1, 1974.

Professor Todd was born in Canton and educated at the University of Hong Kong, where he obtained the degrees of M.B., B.S. in 1952 and M.D. in 1958.

After graduation, Professor Todd worked as a house physician in the Queen Mary Hospital for one year. In 1953 he joined the University of Hong Kong as senior clinical assistant in the Department of Medicine and became an Assistant Lecturer in Medicine in 1955. From 1956 to 1958 he was Sino-British Fellowship Trust scholar at the Muirhead Department of Medicine, Royal Infirmary, Glasgow, Scotland. On his return to the University he was appointed Lecturer in Medicine in 1958, and promoted to a senior lectureship in 1964, and a readership in 1966. He was appointed to a personal chair in July 1972. Professor Todd has also carried out postgraduate work at the University College Hospital Medical School, London, and in various medical schools in the U.S.A., including those of the University of California at San Francisco, Harvard University, University of Michigan, and Washington University.

Professor Todd became a member of the Royal College of Physicians of Edinburgh in 1957 and a Fellow of the College in 1966. He is a member of the Association of Physicians of Great Britain and Ireland and Fellow of the International Society of Haematology, of which he is the local counsellor. He is also a member of the Board of Directors of the Hong Kong Anti-Tuberculosis and Thoracic Diseases Association and the St. James' Settlement, and has served on the Medical Council and councils of the Hong Kong Medical Association and Federation of Medical Societies of Hong Kong.

His current research interests are mainly in the field of haematology on which he has published many papers in the learned journals.

ROSIE YOUNG TSE-TSE, M.D. (Hong Kong), F.R.C.P., J.P.

Dr. Rosie T. T. Young, Reader in Medicine, has been appointed to a personal chair in medicine from July 1, 1974.

Professor Young was born in Hong Kong and educated at the University of Hong Kong, where she obtained the degrees of M.B., B.S. in 1953 and M.D. in 1959.

After working as a house physician and house obstetrician for a year, she joined the University as clinical assistant and became Assistant Lecturer in Medicine in 1957. From 1958 to 1959 she was Sino-British Research Fellow at the Muirhead Department of Medicine, Royal Infirmary, Glasgow, Scotland. She was appointed Lecturer in Medicine in 1962, promoted to a senior lectureship in 1967, and to a readership in 1969. Professor Young has also carried out research work at the Department of Biochemistry of Cambridge University, at the Royal Postgraduate Medical School, London, at the University of California Medical Centre, and at the University of Michigan Medical School.

Professor Young is a Fellow of the Royal Colleges of Physicians of London and Edinburgh. She is also a professional member of the American Diabetes Association.

Her main research interests are in endocrinology and metabolism.

勇敢的嘗試——記音樂晚會

嫩芽

聽說醫學會今年要首創「音樂晚會」，心情頓時覺得份外興奮，不是因爲我對音樂特有興趣，而是它意味着醫學會活動的又一個突破！

以往，班與班之間的隔膜，造成了同學之間的不快、不和，使同學們認識到互相尊重，携手一同探討學問、探討人生才是我們同學間應有的關係。這年以來，不論是醫學會，還是班會，都提出了要講團結，不但加强同學之間的團結，也加强師生之間的團結，而事實亦表示了在某些共同基礎上，同學之間及師生之間的友誼是逐步建立起來了。而這次音樂晚會就是一次成功的嘗試！

當天晚上，陸佑堂洋溢着輕快、歡樂的氣氛。觀衆達四百之多，其中有十多位老師和一部份港大其他學院的同學。台上節目一個緊跟一個，每個都贏來觀衆們熱烈的掌聲。最受歡迎的，莫如廖老師及黃同學的二部合唱了。回想平日上課的時候，誰會想到站在教台上的老師果然有如此美妙的歌喉，唱來別有風味。說起來，眞有點怪他們沒有滿足我們的要求——再來一首。這時不期然聯想到在我們老師之間，一定不乏音樂人才，只是我們這次疏忽了，沒有把他們「發掘」出來，否則如果邀得各系參加節目表演，那時台下一半席位都坐着老師，濟濟一堂地歡樂，場面一定更加熱鬧了！

其他項目亦相當豐富。由一位中大同學演奏的手風琴，活潑輕鬆的舞曲實使人坐不穩椅子，以身體打着拍子，而台後有位同學則毫無拘束地翩翩起舞。沉醉在舞曲的旋律當中。學生會歌詠組的八位同學穿起整齊的制服，以兩曲表達了對醫學院同學的關懷和支持。此外，本屆港大學生會音樂節的優勝者，亦毫不吝嗇地表演了他們的絕技——口琴、鋼琴、水準甚高，觀衆無不喝采。其他的民歌、樂器演奏都各具特色，醫學院歌詠組的大合唱亦演出了意想不到的成績。這許多節目都構成當晚多采多姿的氣氛。

這次舉辦之所以成功，除了是因爲它符合一般同學對活動方向的要求有所改變，還有賴各等籌辦及演出同學的努力及老師們的支持，眞的，同學們都期望着學生活動朝着正確的方向邁進！

開放日記趣

（1）醫學院於開放日期間所放影的幻燈片「一個醫生的成長」無可置疑是一個十分成功的製作。校長黃麗松博士本來預算了十分鐘寶貴時間去欣賞這套幻燈片，但結果黃校長已不惜再花多二十分鐘的時間，看畢全片後始願意離去，其吸引力，於此可見一斑。

（2）在短短的兩天內，由於人太多的緣故，也曾發生過若干意外。星期日早上，李樹芬樓外有一位市民不支暈倒，在場負責的醫科學生正想上前施以適當的救護，但却給正在當值的警務人員以「非正式醫生」爲理由，加以攔阻，並私自扶起遇事者，及蓋以毛氈。因爲此乃極之錯誤的急救措施，故一些醫科學生提出警告並謂若病人有什麼不良後果，這些警員要全權負責。擾攘一番之後，這些「關心市民」的警員才願意讓其他人上前協助，放棄他們「照顧市民」的權利，其後遇事者幸保平安。

（3）學生會在開放日期間會預備了多輛旅遊巴士，載遊人往各處不同地方。在醫學院這方面最後開出的一輛特備巴士在下午六時正離去，但在場的市民仍然十分擠逼，以至現場交通情況十分混亂，巴士站人頭湧湧，爭先恐後，幸而此時中華巴士公司突然派出多輛特別加班的巨型雙層巴士，轉瞬之間擠迫情況完全改善。巴士公司這種服務精神及權宜措施，在此值得一讚。

（4）在衆多的展覽及實驗中，最能够引起市民爭論的，就是色盲的圖片示範及測驗。在大約二十多幅彩色圖片中，每張都藏有一些數目字或動物的形像，能够準確地認出來的就是正常，相反的就表示有色盲的可能。其中一位市民把一幅圖片裏的「雞」說是「牛」，講解員便指出這位市民有色盲的可能，但他却堅持己見，硬要指雞爲牛，並與講解員爭論，令到當時的氣氛，尷尬而又可笑。

（5）在開放日這類公開性的文娛活動中，醫學院內當然又出現了一些「例牌」的場面，平時孤單獨處的醫科學生，很多都「還我本來面目」，帶着女友來「炫耀」一番；有些高班的同學，更加帶同妻眷齊齊駕臨，融融洽洽，濟濟一堂，此「情」此「景」，眞是羨煞旁人。

（6）平日在學院內最引起非議的醫學院餐廳，亦有新聞兩宗，其一乃是老板當日穿了一套黑色的禮服，令人耳目一新，據他所稱，此乃他於一九七〇年所訂製的一套新裝。其二是老板當日擬將午飯提高至三元正，但經辦事人員抗議後，仍然依回原價。但不料那天午飯很明顯地「縮了水」，比起平時的質與量都更差，並且臨時出售漢堡牛肉飽，難怪常言有道；「生意佬」密底算盤，生財有道。

※　※　※　※

人物

他，不能算老，據他自己的見解，六十歲以下的人，都算年青。但，他已經聲威震杏林有幾十年了，這位杏林覇王，其名確令圈外人如雷貫耳的。

他，那種威嚴，等閒人難望其脊，誰的課在十時上，會在八時便坐滿了人？誰的課從不會有人遲到？誰的課人人會正襟危坐，靜得如一湖死水？誰會像總統演說一樣，米高峰放滿前面？只要他紅潤的面向你一轉，你會從心中抖出來，跳其震震舞矣！

他，認爲女人最沒頭腦，最無邏輯，最愛幼想，對丈夫最壞——大概除了一位之外！所以，沒有一位女學生能逃過他的揶揄。不過，你有時候會見到一位紳士，小心的伴着一位風姿卓約的淑女上街，你抹抹眼鏡，那個就是他，而她就是那個例外！

他，你不會信是很受學生歡迎的吧？許多年來，他被看透了，藏在那銀髮紅面底下的，是個慈祥的好老師，他在學生的宴會中，那麼的溫和得要死？在考試中，他更是公認的學生救星，又那能不受愛戴呢？他平日的嚴格，都是要使學生有規律，有分寸，要做醫生，不能不這樣，所以人人都是口服心服，臣服于這位杏林覇王，難怪好多人都說醫學生是最滿足的一羣，很少惹事生非的，我們有個通情達理的頭頭嘛！

他，近日不知怎的，常有微恙，但這決不是老的象徵，因爲他還沒有六十歲。常常想，他病了誰敢去診斷，去開藥，他會說：「Who passed you medicine ? Go and get your money back!」嗎？

早日康寧！

•節自「啓思」三卷三期，爲送某君而錄•

素描

稚人

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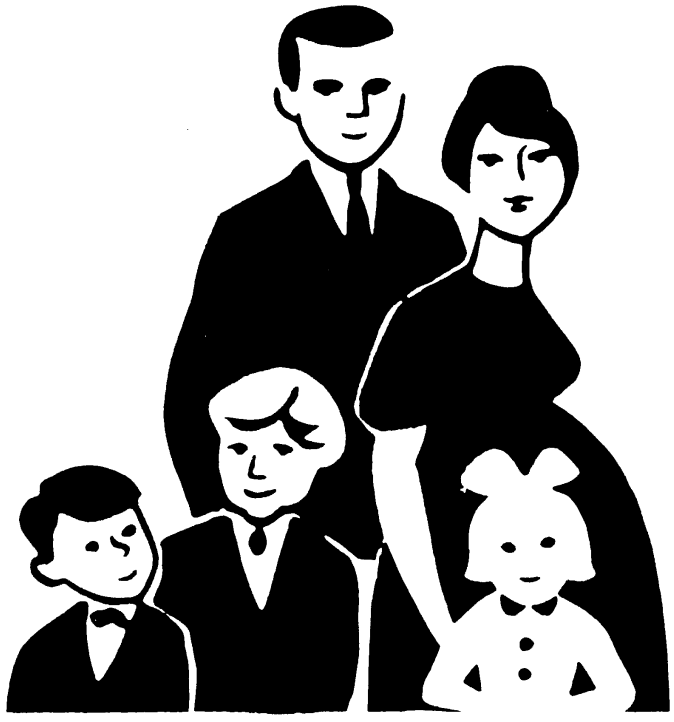

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哥兒我承認，因爲我覺得這樣沒有什麼不妥，周圍的環境也似乎告訴我「這是合理的，當時心中想望着一個美好的前景，舒適的房子，幾個佣人，汽車遊艇，好讓爸媽優悠地過活，而自己做個好醫生，聞名的醫生，有地位的醫生。我承認我是個中國人，並且愛中國，我很希望有一天能以自己所學貢獻給，我的國家、社會、人民。但從我認識到一班和我截然不同的人開始我改變了。如今回顧從前，都覺得可笑，看我以前是多麼的多麼幼稚，自大和缺乏經驗！

幾個月前我偶然有機會參加了一個社會探訪，是大學裏一些同學辦的，我第一次接觸到一些和我生活方式完全不同的人，他們困苦，受壓迫、終日勞碌，但卻沒有跳出那個勞苦圈子的希望，然而他們仍奮鬥下去。這使我開始問自己，爲什麼？而給我最深感受的是去參加這次探訪的同學，他們的心態，他們的學習精神，他們的認眞態度都使我覺得不知如何是好，因爲我就從來未曾認眞去思考這些問題，更從沒有考慮過自己的態度，但看見他們的做法我便開始懷疑自己和問自己很多的問題。事後我開始更多地和那些同學接觸，而自己漸漸去尋找一個新的學習態度和處事方法，從觀察和各種的參與裏我知道自己以前的想法是多麼錯誤，我發覺到空談服務社會，空談自己躊躇滿志，豈能眞正地發揮到我們應有的作用？自己乘着華的，陶醉於溫暖夢鄉的生活怎能叫我對社會起關心，對國家起愛護？更怎能爲社會作好日我裝備？我於是發覺我不能再將自己關在溫情自私的圍牆裏，我要從這死胡同裏跳出來，去關心我周圍的事物，才能使我們對那貧大羣衆有感情，有愛護。更不能再抱以前那高人一等的態度，因爲我也只是社會的一份子，服務和關心是我應有的責任，這樣才能使我眞正地和有效地去走我面前的路。

花芸，我變了，變得樸素，實在。兩年前的我和今天的我實在是兩個人，不得不佩服那冥冥中的主宰改變我的一切。也許你是個移民，不會對這不平社會和中國有多大感情，但你裏面還是有中國的血，所以我還是將我這特別的訊息與你分享，願我們還能成爲一對遠方關切的朋友，我們以往的一段還將是一段落，但我希望我們不會再被這段回憶阻礙我們成爲朋友。我在大學這幾年將會致力於發展自己和學習，願你在加拿大也過着愉快的生活，別了，我的朋友

祝好！

橋

×月×日

寄芷芸書

牆

芷芸：

鼓起很大的勇氣才能執筆寫這封信，我到底是個眞情易露的人，過去的一個暑假像是個噩夢，但醒來卻重新找到了自己，雖然我覺得離你很遠，不知道你的心情如何，但我眞的希望把一些經歷和你分享。

你如旋風似的從加拿大回港，轉眼間在我心裏捲起了很大的波濤，現在你走了，是那麼的急速，是那麼的出其不意。但這次『卻給我許多感受與啓發』。我就越發覺得人要不斷從痛苦失敗的經歷中磨練自己。去年我入了港大，你決定（也許是你父母決定）居留於加拿大，你在港的母親和弟弟都準備赴加……這些都使我很混亂，我知道我入港大是背棄了我們以前的約，就當時形勢及父母的阻撓我是無能爲力，但雖然如此，我仍堅信一點，就是一年後你會回港，那時再決定前路如何。從那時起我就天眞地渴望能在機場接你回港的一天，我們再可以一起在卜公碼頭看日落中的海港，在公園漫步談笑，在屋外花園裏盪鞦韆，在我起初就是天眞地等。

在大學的一年裏我遇到了許多冲激，我變了，我漸漸發覺到我並沒有好好地愛過你，以前的是自私的愛，是佔有式的愛，是不成熟的愛，不是愛！於是我靜悄悄地等，我比前更加渴望着再見你的一日，好叫我可以從頭做起。但事與願違。我到底還是天眞，沒想到你也變了，並且變得更多，在你出現於機場閘口時我才開始感覺到我美麗的幻想要消滅。那眼睛、那臉孔、和那說話的聲音與神態比前更美更甜，但卻再不是一年前在機場和我吻別的那一個比我更天眞更活潑的芷芸了。在你留港那短短的兩個月裏，我的痛苦實在難以形容，我相信你也有類似的痛苦，不同的是我們所抱的態度及目標有差別吧了。你臨回港前雖停止寫信給我，但我卻愚蠢到全沒有想到是怎麼回事，多麼可憐，多麼可笑！

但你那短暫的逗留更加逼使我去面對現實，去更加反省。雖然我仍盡了一切努力去重建我倆的感情，但私下裏已覺得我的努力終必歸於白費。我開始更發覺我們一年前的愛情是基於一些表面的感覺，和自我陶醉的幻想，而這些基礎要面對現實生活的各種考驗時，便不堪一擊！還記得我們在蜜霞滿天的時份倚欄而坐，面對那波平如鏡底海港的情景嗎？記得我們互相鼓勵要往加拿大一起讀書嗎？忙得我們那漂亮的計劃嗎？記得我們在松樹林中所應的約嗎？那棵松樹我想還在，但上面的字我希望它們已被風兩抹去。這些情景時常在我腦海中出現，而每次都像在指控我少年的無知。也許是社會的教育叫我倆跌進了這根治，但我的心提醒我對這些事的個人責任，所以我會盡力去重建一座我倆之間的橋，去的好地愛你！

可惜太遲了。你說的對，我們之間已被我們所受不同的文化教育所阻，一年的分首使你在思想及生活方式上起了變化，相對地港大的生活也使我變了很多，於是我們發覺大家離得很遠。更重要的，你是個移民，香港不再是你的家，而我在最少四五年之內會留在這裏，因爲我什麼都在香港，可以說我們參加一起的希望實際上是渺茫。我得要說我佩服你，可以理智地在這沉沒中自拔，也許是在外的生活培養了你那獨立思巧的能力和勇氣更要多謝你也給了我這份勇氣，雖然是苦不堪言，但我得要同意你那說話；「我們以前既然沒有眞正地愛過大家，而現今環境亦要我們分開，我們爲什麼要苛求大家維繫着一段沒有前境的感情呢？」這是冰硬的理智，是難得的慷慨，我們熱淚盈眶，但大家都明白這事實。

終於你走了。我還記得你最後那凝害的目光，親友們連聲道別，但我們只是很遠地相對無言，你那句「再見」帶着一些前路茫茫的感覺，使我愈發覺得空虛，一切似乎再歸年靜，淚乾了，心裏盡力去忘記這件事，不久又開學了。

一連串的宿舍活動，球賽，迎新加上繁重的功課，使我疲於奔命，但卻叫我少了胡思亂想。似乎忙碌的生活叫我心境平靜了許多。但我漸漸發覺了大學生活的眞諦。也許是我倆這事叫我去專心致意過大學生活。不經不覺一個學期了，這短暫的幾個月叫我更加改變，我有機會看到並接觸到一些肯爲他們的理想付出代價的同學。這對我來說是件大事，甚至是喜事，不得不告訴你。

兩年的大學生活叫我享受到很多大學生所有的權利，課可以不上，實驗可以不做，球賽卻一定要到，宿舍沒有約束的生活更使我陶醉於一個甜蜜的漩渦，更常自以爲不可一世，將來必定成爲社會棟樑。我中學時的生活你也知道是很貴族化，在這裏，尤其在宿舍我更變本加勵，人家說我公子

第一次武林大會後種種……

經過第一次武林大會一役後，衆人馬上整頓元氣；轉眼又是躊躇滿志，興緻勃勃地向前邁進了。

武林中有「狠」字訣。要達到仁心仁術，定要明白對比；弟子們需於地窖中觀看分屍，加深對武術失敗認識，而更悉心習武，使武術能更完美地運行於世，救人於危。

「狠」字中又包括把毒藥射入小動物身上，觀其反應，再給予解藥；萬一失手，只有向小動物說再見。

武功重胆大心小，細莫若對微菌的觀察，於是古往在黑暗中靜觀蚊蠅的功夫被改良，取代的是以顯微鏡來欣賞微菌、細胞。

第一次武林大會下來滿以爲可鬆一口氣，發覺大戰、小戰五、七天一次，眞是不勝其煩，但憑着耐心終於捱過了。

跟着展開一個新階段，衆人移師上瑪麗武館，開始了臨陣訓練，臨陣的表現與經驗是成正比的，師傅們的武功高深莫測，使大家敬畏十足。有些大師於教導時對弟子痛罵不惜，於是……。不過這是苦口婆心，弟子自當領會，因此也噤聲不語只希望監量把傅的精華吸收過來。

此時又開始了前往廣華武館研習「刀的學問」，大師們對各類兵器，暗器，蒙汗藥運用自如，使衆弟子羨慕不已。

爲弟子們津津樂道的「鬥獸場」設於西區，衆人在該處研習臨陣變化，解方諸類，「鬥獸場」只因該室之陳設而名之，其中實在只有驚無險。

武館設有部門接見百姓，聆聽其投訴，使衆弟子能通悉民間疾苦。由於弟子們過份熱心，往往使老老百姓煩擾不堪，而又莫明所以。但亦有些老百姓平素被武師冷落慣了，一旦看到這許多武林中人追問其疾苦，關切之情，溢於言表，自是樂不可支，便一股腦兒把在世以來諸事全盤托出，悶壞了衆弟子可不要怪老百姓啊！

另一種會見方式由弟子單獨面對老百姓，問悉其投訴後，使出平生所學，「望、聞、切」的功夫，苦思因由而作出判斷，再由大師加以指導，此種方式挑戰性濃厚，過程亦緊張刺激，但不失爲一重要訓練。

更有等「論戰會」，由三數位同門主持武術專題講解，把最新的招數依書直說，既要把握最精確的資料，又要應接師傅與同門的挑戰，眞是苦不堪言。

這就是第一次武林大會後的生涯，當其時，各家各派已歸納爲「踏實派」，因爲只有不辭勞苦，體會臨陣的種種，方能領略其中要訣，紙上談兵的年代已經過去了。

行得快，好世界！

伸得長，願以償！

「第一次武林大會記」

話說天下大勢靜久必有變，久變必趨靜。

「少林寺」位於沙宣道山下，該處地勢僻靜，臨海而面對瑪麗大武館，正是一臥虎藏龍之地。

在某次選拔賽中，一批英武少年男女如願地被挑中了來這裏研習武功。按「少林寺」規矩，凡少林門弟，需勤習五載，通過三次武林大會，合格後，方稱滿師，滿師後即可行俠江湖，「少林寺」招牌一打出，天下莫不欽佩，各武館自會爭相禮聘，此後濟世救人，打家劫舍，悉隨尊便。這批少年雖各懷目的而來到底、但一場師兄妹，在學期間，相處倒也十分融洽，大家朝夕勤習武功。

「少林寺」第一次武林大會向於農曆正月中旬舉行，大家早已傳說紛紜，當告示牌上貼出第一次大會的詳情時，大家立刻抖擻精神，各謀良策。

話說云云衆生中，有些朝夕埋身於藏書閣，熟讀各家各派經典，博覽羣書，苦練武功，該批乃正派高手也，對「武林大會」正是左盼右望，伺機一顯身手，日曆每劃去一天，心情便更愉快，對其他各家各派予以輕蔑態度，對「武林霸王」一位則虎視眈眈。

有等乃投機分子，奉「細書要讀，天書要熟」爲金科玉律；有等更是旁門左道、邪派中人，專集歷屆武林大會熱門題目而熟習，然後預備一衝而過。

有等是瀟洒派，一副「本人身經百戰而來，豈是等閒小輩？區區第一次武林大會，何足懼哉？」的模樣。

有等鼠胆派，以「武林大會萬歲」爲原則；顏如玉嗎？天下美女如雲，故掉之；銀兩嗎？來日方長，故棄之。一切武林大會後再作打算，有等雖不忍捨下心上人，但因武功與顏如玉不能兼顧，只好忍痛選擇其一。

其他各家各派，招式繁多，難作一一介紹，總之大家都期待着在第一次武林大會中一分高下。

望穿秋水，大會之期終於到了。第一個回合完畢，已倦得要命，可是還得繼續努力，準備下一回合，經過三個回合之後，心情實難形容；是悲是喜，各有不同。不過一向忙慣了，一旦鬆弛下來，很多人不知如何打發時間，正派中人是第一批相率回返藏書閣深造的。

有些則深明小艾慕英雄的心理，造訪顏如玉，此其時也；五行欠水，撲水此其時也；無座駕車，如何顯得英雄的威武？學車，此其時也！

有等以竹戰四方城爲我國國寶，焉能不學？於是少林門生休憩所內辟拍之聲，歷久不絕。

第一次武林大會出榜了，這消息一傳出，大家立刻趕至，不看尤可，一看之下可氣壞各英武少年，原來殺出一名嬌滴滴的女子爲霸主，另一霸主則是正派中人；瀟洒派、邪派、投機派中均有人掛彩，有些倒地不起；有些則要離開少林；回想兩年同門生活，不禁黯然神傷。

有等於今次鬱鬱不得志者，馬上寄望將來，以後尚有兩次武林大會，更有天下大會，絕不以失敗爲失敗，蓋誰勝誰敗，還待下回分解呢！此乃樂觀派也。

※　※　※

來說，國內的人工製成品價錢比較便宜；化學合成品如塑膠器具，菲林等眞是貴得驚人。舉例來說，塑膠拖鞋每對資二元多人民幣；但同樣貨色在香港的國貨公司只要一元多便可買到。總括來說，國內一般平民的生活是維持在一個最低限度的水平，一般工人工資每月約在人民幣三十至六十元左右；農民的收入比工人還要低。這收入是够過節儉的生活，但是想要過比較豐裕的生活則不是一般人所能够負擔得起。雖然如此，國內同胞們的健康看來並不比香港人差；尤其是小孩子們，大多數都是活潑非常。

鼓吹提高認識水平，努力建設祖國

在國內遊覽時，周圍都看到很多標語；綜合耳聞目見的資料，我感覺到國內政府正在提倡一般人，尤其是幹部們對事物的分析能力及更清楚地認識若干理論上的原則和事物的基本矛盾。例如有很多標語是叫人多看書，多辯論，從而使人們更直接，更深刻地認識到整個問題的中心，不致盲目附和及空談而至被人利用。另外一點是提倡自力更生及爲人民服務。他們更鼓吹爲公忘私和養成一種刻苦耐勞的精神。在宣傳這些要點時，除了使用標語外，他們更加利用其他方式如地方戲劇來表達，務求使一般人，尤其是文化程度不太高的人能有一個較深刻的印象。總括來說，現在國內宣傳的是對提高國民意識形態及建設國家具有積極性的推動作用。至於人們對這些號召的感受如何，基於客觀環境如時間等的限制，我還未能够清楚地看到。

一些難忘的交談

曾經和一些導遊同志談及國內的路線問題，他說現時主要是「政治掛帥」，發展經濟是次要；他們的論點是如果把政治弄好，經濟發展便不會十分困難；但假若只注重經濟發展而忽略了政治的話，就很容易被資本主義復辟或爲帝國主義及殖民地主義者所侵佔。當談到改善國內同胞的生活水平時，他指出現時國內人整體來說生活是清苦一點，但比較解放以前已經有所改善。同時由於外交的成功，禁運等限制的解除，與外國在平等互利，互通有冇等有利於建設的情形下，相信國內的工農業發展將會更加快速，人民的生活亦勢將會有進一步的改善。當談到歸屬的問題時，他們都指出香港是中國的地方，回到祖國懷抱祇是時間問題。至於思想上的分歧，亦將會採取同化的形式，慢慢進行。當談到現在海外居住的中國人能够替國家作出甚麼貢獻時，他們說海外的人應該利用他們個別的客觀環境，多認識國內的事物及制度，從而決定是否喜歡及適合國內的生活，至於青年們，尤其是學生，現在主要是把自己的知識學好，盡量充實自己，以便能够爲人們作出更大的貢獻。

中國的路向

總括來說，雖然是次旅行時間短，接觸的人與事均有其極限性，而所接觸的人其代表性亦未能加以肯定，但就所感受到而言，中國是一個充滿朝氣的國家，她對很多基本問題都能面對現實，設法加以解決：如農業方面，政府協助及鼓勵水利建設；大學教育方面，政府提供免費教育另加津貼給學生們以作零用；工業及建設方面，鼓吹自力更生，以減低對外國的倚賴性；辦事方面，不同階層的意見都會被考慮到；在意識形態方面，政府亦能够給予人們一個明確及崇高的工作目標，例如政府號召人民爲國家建設及提高人民生活而奮鬥，爲人民服務，支援世界上受壓迫的人民等等，這些都是正確的方向。美中不足的地方，國內一般人對國外事情缺乏一個完整的觀點。例如有些人說美國現在是一貧油國家，因爲她需要輸入石油而中國在這方面比美國强因爲她有石油可供輸出。這些似是而非的論點時有所聞。另外，國內有很多需用的東西呈現供不應求的情形，如食物，布，交通工具，塑料製品等等，這些情形都是極需改善的。

所謂知易行難，我相信每一個英明的政府都想使到其人民更能安居樂業，過更美好的生活；雖然在是次旅行中覺得國內有很多問題是未能合乎理想，但當自己體會到中國地大人多，加上各地人民風俗習慣之不同，要把所有中國人連結起來，把中國治理好，實在是一件十分困難的事。尤其是在外强虎視眈眈，存心不良的情形下，問題更變得複雜。在另一方面，我感覺到國內政府現行的方向是以大多數人民的長遠利益爲出發點，至於施行手段，與客觀形勢是分不開的。由於自己對國內的政策及人民對這些措施的感受認識尚淺，不能亂下評論。但願中國人民能同心協力，排除萬難，爲謀求更美好的明天而努力。

祖國遊

「幼稚」

「中國」這名稱對我來說既感陌生，又帶有點親切。所以感到陌生是因爲在這個暑期以前我從未曾親身去接觸過她。覺得對她有一份特別的親切感是因爲自己乃黑眼睛，黃皮膚的中國人。在很偶然的安排下，我意想不到地得到一個能親近她的機會——一次二十多天的國內旅行。我們的旅程是沿近海城市北上，然後往中部南下。路經城市計有廣州、杭州、上海、南京、北京、鄭州等地。交通工具包括飛機，火車及旅遊巴士等等。由於時間的限制，我們只能作走馬看花般的參觀。雖然如此，我仍然覺得這次旅行是十分有意義的，因爲我終於有機會看到我底美麗可愛的祖國，看到了居於不同地域的中國同胞，及親身體驗到國內的實況。這次旅程，沿途都有國內同志專責導遊，旅程中的節目安排得頗爲充實；雖然行程短暫，對國內一般情形總算能够得到一個簡略的概念。

風景、建設

在旅遊的過程中，我深深體會到「江山如此多嬌」這句話的妙處。中國的風景實在美得難以形容！我們所經過的城市，都各有其特色：杭州的水色山光，給人一種寧靜而清新的感覺；南京的中山陵則在靜中帶有一種雄偉的風格；北京的古代建築呈現出一片宏偉金碧輝煌的景象，總之，各地方風景都有其獨特風格，最難得的是從廣州乘飛機往杭州所作的鳥瞰，在那雪白的浮雲間，能覽祖國的名山，平原，大湖及水庫等美麗雄壯風景，眞是令人嘆爲觀止，難以忘懷。大建設方面：國內各地都有見到。這些大建設都是爲着解決一些基本問題而建的。例如爲解決用電及灌溉等問題而建的有「新安江水庫」，黃河水利工程等。新安江水庫除了調節河流，發揮防洪防旱外，還供應三省的用電。黃河水利工程對疏導該河之泥沙，促進灌溉及開發新耕地也起了積極的作用。軍事方面的建設有北京的地下鐵及防空地道等。運輸交通方面有長江大橋等。以上所列舉的只是曾經看到及比較龐大的工程。這些工程都有一個共同的特點，就是從設計到施工之全部過程，都是由國內依據「自力更生」的原則自己建造的。故此當參觀時看到以前被譏爲「東亞病夫」的中國人能做成國外專家認爲「無機」的工程（如長江大橋），心內有一種很特別的感覺。在城市建設方面，綠化的工夫做得頗爲成功，馬路旁都種有很整齊的大樹，林蔭蓋道，給人一種清新的感覺，整體來說，國內城市給我一個古舊的印象。新的建築物不多，屋宇多數是以前遺留下來的。拿廣州做一個例子，新大廈是有的，但爲數甚少。民居大多是二三層的舊建築物，有點像八九年前的西環。其他城市如上海，北京，南京等也不例外，舊建築物佔比例上的大多數，當然，各地的房屋，都帶有其地域性的特色。

人民生活

國內同胞的生活情況，就表面所見，可以說得上是十分清苦，但隨著地域的不同，人們的生活也有所差別，例如在上海居住的人生活似乎比鄭州爲佳；前者是一個工商業的大城市。在衣飾方面也呈現出地域性的差別；大致上來說，北京，上海，杭州等地比廣州，鄭州，南京等地爲好；但各地區的衣服都有一個共通點——樸素。國內一般平民所用的衣料，以棉質爲主；相信可能是人造纖維價錢太貴，非一般人能够負擔得起。在食物方面，國內的人相信都可以吃得飽，但若從質方面着眼，用香港人的標準來衡量，還是不大理想。像衣飾一樣，食物供應也有地區性的差異。大抵上蔬果的供應比較充足，價錢比香港便宜；在北京西瓜約合港幣四至五角一斤，蕃茄約一至二角一斤左右。住屋方面，國內的房租不太貴；如果在大工廠做事的話，通常都有宿舍供給。國內的公共交通工具頗爲缺乏，搭車並不是一件太容易的事，擠擁情形可能比香港更甚。一般

類，如何處理河豚肝臟及卵子的毒素，如何認識河豚體內所含毒素的季節性演變等。制度實施後，在飯館內吃河豚而中毒的事件很少了。近年來，在日本中河豚毒的人，大多數是吃了那些未合格的廚師或私人烹調的河豚。

三、河豚在其他各國的情形。

吃河豚的食品文化，祇見於日本和中國。但世界各地也有因誤吃河豚以致中毒的事情，在書籍中也有不少的記載，在這裏，略舉幾件來看看。

一九六六年 Diego de Landa 所寫的 Relacion de Las Cosas de Yucatan 一書中，述及 Maya 族人知道河豚可致人於死（註六），早期的西班牙傳教士在墨西哥和美國加利福尼亞一帶，也曾耳聞目睹河豚中毒的事情，例如 (History of Lower California) 中就有一段描述四名士兵在加利福尼亞灣捉獲一條河豚，烹後吃了魚肝以致中毒的過程。其中兩名士兵在吃後半小時便告死亡，一名士兵只咀嚼了魚肝而沒有吞咽，則一直昏迷到翌日，至於另外的一名，僅碰了碰它，結果也病了好幾天。

居住在 Baja California 的土人早已懂得到利用河豚的肝和肉以毒殺野貓和狗（註七）。Steinbeck和 Ricketts在一九四一年合著的(Sea of Cortez) 中，亦提及有一次當他們訪問該區時，想向一名小童購買一條河豚而遭他拒絕，因爲他說：「有人已給我一角錢買了這條河豚，用來毒殺一頭貓的。」

Captain James Cook 在一七七二至一七七五年期間作第二次環球航海的時候，便親身體驗到河豚中毒的情形。他對於中毒病徵，曾有描寫得很好的記載（註八）。「一七七四年九月八日的那天，一名船上的文員從新發現的 (New Caledonia) 土人手中買到了一條魚，我們覺得此魚很陌生，決定先描繪該魚的形狀，再煮來作晚餐，……幸虧我們花了很多時間描繪魚，到煮熟時，Mr. Forster（同船的一位生物學家）和我只嚐少許大約到了凌晨三、四點鐘的光景，我倆突覺得疲憊不堪，四肢麻木，手足好像被冷凝後再放在火堆上一般，我的知覺差不多全失，就算把一壺水或一根羽毛放在我手中，我也無法分辨得孰輕孰重，後來我倆經過一陣嘔吐和出汗，情形才覺好轉。第二天早上一看，發現有一頭豬因吃了魚的內臟而死去。不久，當地土人走上船來，看見此魚給懸着，便立刻向我們說該魚實在不可吃，而且說得令人十分戰慄……」後來，Forster 證實該魚是屬於斑魚類的河豚。

荷蘭軍艦船醫 Hellmuth 的臨床報告中，也有吃河豚中毒迅速致死的詳細病例（註九），因普通醫書很少記載河豚中毒的病徵，所以在本文之結尾，試將其中大意譯於後，以供參考：

「一八四五年九月四日，一名船上的水手頭目 Kleinhaus 和一名事務助手 Hausen 吃了一條由好望角 Simon's Bay 捉得的河豚，大約在他們吃後十分鐘，我便立刻要去診視他們——Kleinhaus 躺在甲板上，他要費盡氣力才可以支撐起來，他的臉發紅，眼睛發光，瞳孔收縮，咽肌抽搐，口角流出涎沫，咀嚼痙色發脹，滿額是汗，脈搏加速柔弱而沒有規律，病者感到極度不安和痛苦，但仍保持清醒……病情急劇起變化，病者覺得麻木，眼睛定注，呼吸困難，鼻孔擴大，面色蒼白，滿頭冷汗，咀唇青黑，知覺和脈搏漸漸消失，呼吸停止，這情況只維持了七分鐘，病者便死亡……」「至於 Hausen 的症狀和 Kleinhaus 的差不多。不過，他在未被施用催吐劑之前，已不斷地嘔吐……他仍清醒，還說經過二次嘔吐後覺得舒服了些……較後脈搏無力，又再嘔吐，兩臂痙攣，這時脈搏停止，發脹的舌頭由兩唇中伸了出來，他大約在 Kleinhaus 喪生後一分鐘死亡的。」

註一：Halstead, B.W. (1958) U.S. Pub. Health Report, 73:302. Lane, C.E. (1968) Ann. Rev. Pharmacol., 8:409-432.

註二：Halstead, B.W. (1967) Poisonous and venomous marine animals of the world, vol. 2, Chapter 7, pp. 679-902. Washington: U.S. Government Printing Office.

註三：同註二。

註四：Kaempfer E. (1906) The History of Japan (1690-1692), transl. by Scheuchzer, J., pp. 134-135. Glasgow: MacLehose.

註五：Kawabata, T. (1962) Fish as food, vol. 2, edit. by C. Borgetrom. New York and London: Academic Press.

註六：同註二。

註七：Phisalix, M. (1922) Animaux venimeux at venins, vol. 1, pp. 487-628, Paris: Masson et Cie.

註八：Beaglehole, J.C. (1961) The Journals of Captain Cook, vol. 2, Voyages of the Resolution and Adventure, 1772-1775, p 534.

註九：Richardson, J. (1861) J. Linnean Soc. (Lond.), Zool., 5:213.

河豚中毒史考

施靜雯　鄭國翹

河豚（粵人俗稱雞泡魚），是一種含有劇毒（Tetrodotoxin）的無鱗魚類，據說，一兩河豚魚的毒，可以毒死五萬六千人。早在摩西律法中經已明文勸止以色列人進食像河豚這類無鱗的毒魚，「水中可喫的，乃是這些。凡有翅有鱗的，都可以喫。凡無翅無鱗的，都不可喫，是與你們不潔淨。」（舊約申命記，十四：九—十），因爲河豚的肝臟和卵巢皆含有劇毒，誤食可以致死。根據法國考古學家 Claude Gaillard 的考證，在埃及公元前二七〇〇年的金字搭遺跡中，已有河豚的象形文字，古埃及歷史學家 Keimer（註一）亦證實古埃及人已知道河豚是屬於有毒魚類的一種。由此可見，人類對河豚含有毒素的認識，已非一朝一夕。

一、國人對河豚的認識與愛好。

中國人至少在兩千幾百年前已經認識河豚了。單是河豚一名，在中國古語中即有鮒，鯸，鮐，鮭，規魚，嘔魚等不同的稱呼。因它具有吸入空氣使腹部膨大的奇性，又名爲吹肚魚或氣泡魚。從書籍的記載來看，中國人對河豚有精徹認識。舉例來說，戰國時代的山海經有「鮭，食之殺人」。王充論衡中說「鮭魚殺人」。較後的本草經類別了河豚的功効可作補藥或毒藥，如分量用得適當的話，更可治療瘰癧症。隋巢元方在巢氏病源卷七，食鯸鮐魚中毒下更進一步的說明，河豚「肝及腹內子有大毒，不可食，食之往往致死。」李時珍在本草綱目卷四十四鱗部無鱗魚一節下，陳藏器述及河豚以「海中者大毒，江中者次之」。並說在南中國某些區域的河豚不一定會使人中毒死亡，但是有二種河豚「其色炎黑，有文點者名斑魚，毒最甚，或云，三月後則爲斑魚，不可食也。」這是由於「肝及子有大毒」，食後「入口爛舌，入腹爛腸，無藥可解。」

因此，前清官府曾經一度禁止售賣河豚，這可見於一七七一年東印度公司的瑞典籍醫生 Osbeck 的記載中，（註二）。曾提及當他第一次在珠江目睹一條河豚時，一位當地人士便（力便）力勸他必須將拿過河豚的手洗淨，還告訴他在中國境內是禁止將河豚混在其他魚類中出售的，違法者將受到處罰。

可是，由於河豚魚肉的佳美鮮味太吸引人，自古以來，有不少文人雅士作文章盛讚河豚，例如昭明文選選錄式思的吳都賦中便有「王鮪鰿鮐」一句，朱竹垞鷺鷥湖櫂歌謂「聽說河豚新入市，蔓蒿荻筍急須抬」。大詩人蘇東坡曾以稱讚的口吻說過，拼死吃河豚亦值得一試，不過，近年來在中國吃河豚已是比較稀有的事，今日的香港，只間中少數漁民，撈到河豚，有時烹食，以致間有中毒死亡的事情發生，香港近海中的河豚有九種，其中兩種俗名黃肚泡及花腰泡的毒性最劇，據說，最好吃的河豚却也是最有毒的河豚！

二、河豚在日本的情形。

日本人吃河豚有二百多年歷史。近數十年來，日本吃河豚的風尚更加普遍了，換句話說，在日本，「河豚料理」已成爲無人不知而雅俗共賞的食品了。河豚的售價較普通魚類爲高。日本人認爲河豚的鮮美佳味是特殊的，像日本名歌人一茶曾題下一句詩：「不解河豚味，安識富士美」，他比喻河豚的清淡樸素的美味如富士山的幽雅寂靜的美麗。因此，日本人認爲賞識河豚的味道是一種文化。但有人說最重要的還是因爲吃了河豚的人會產生一種有愉快感的淺度中毒反應，使他感覺欣快（Euphoria），温暖，舌尖和咀唇有輕微的痲木快感（註三），結果有上了癮的老饕，明知河豚有毒，還要冒着生命的危險去吃它，Kaempfer 著的（History of Japan）（註四）記載中「日本人喜愛吃一種名叫 Furube 的毒魚，荷蘭人稱這種魚作 Blazer，即吹氣魚的意思，因它能够將身體吹得像圓球一般，這是屬於有毒魚類的一種。凡吃了此魚的人，是難逃一死的。在日本海域裏捕獲這類的魚可分三種……」「……第二種名叫 Mobuku，也就是 Fuku，這是日本最美味的魚類，也是日本人最愛吃的。他們在未吃之先，必須將魚頭、骨、腸胃和內臟皆予清除而棄掉，用水小心清洗魚肉。可是仍有許多人爲喜愛吃這魚以致喪生的；也有些人因久病厭世或遭遇悲慘，亦常常會選擇這種魚來代替刀和套索而結束他們的生命。」

河豚中毒在日本是一個嚴重問題。據一九六二年 Kawabata 搜集得來的資料，（註五）在一九五六至一九五八年間，全日本有七百一十五人中河豚毒，其中有四百二十人死亡，死亡率高達百分之五十九。因此，日本政府立法管制售賣河豚。凡欲烹調河豚的廚師，必須經過國家很嚴格的考試，合格後才能執照烹製河豚賣給客人吃，否則便是違法，考試及格並不容易，每年有二百人應考，合格的不過三十多人。考試中要辨別分

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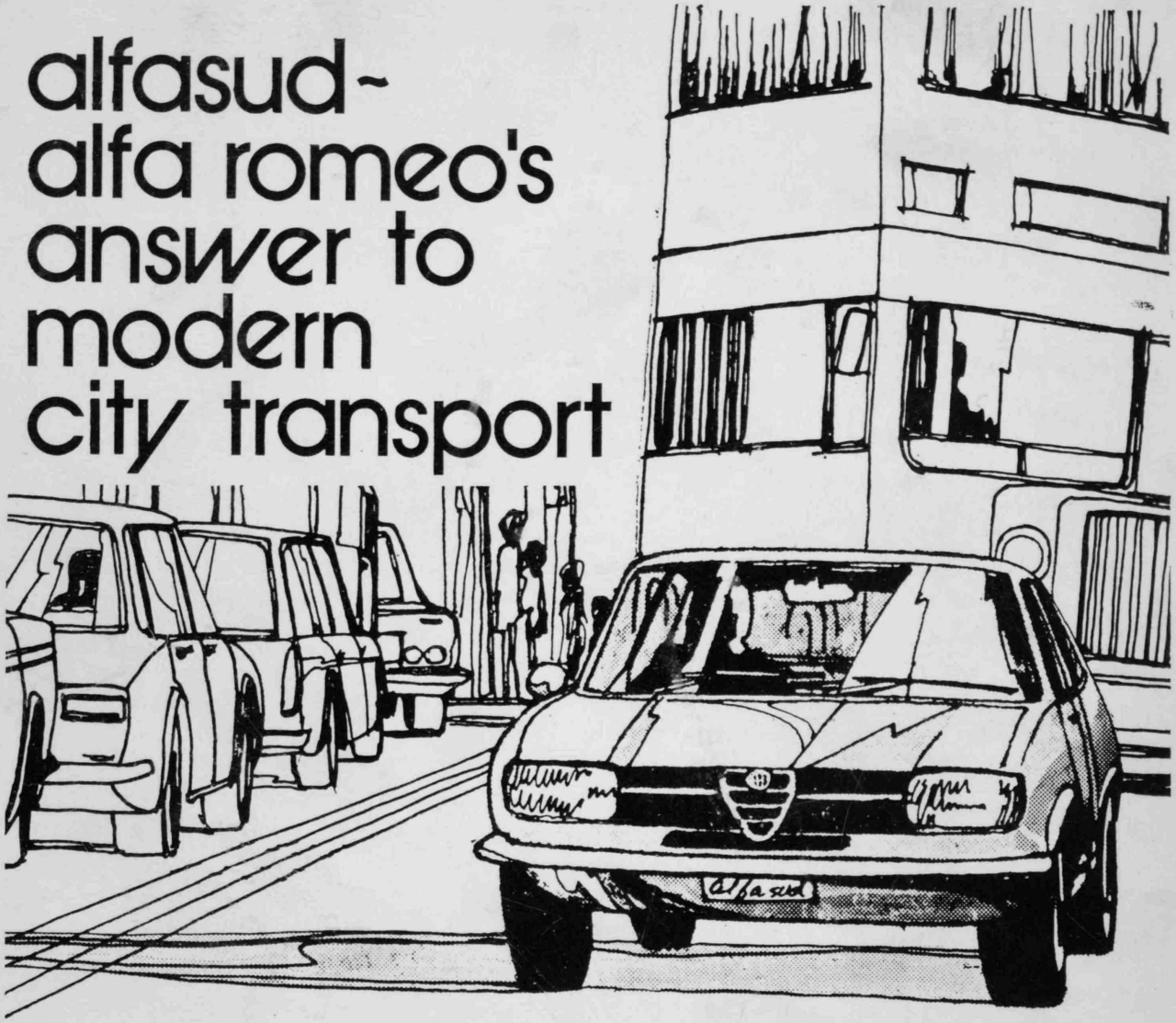

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