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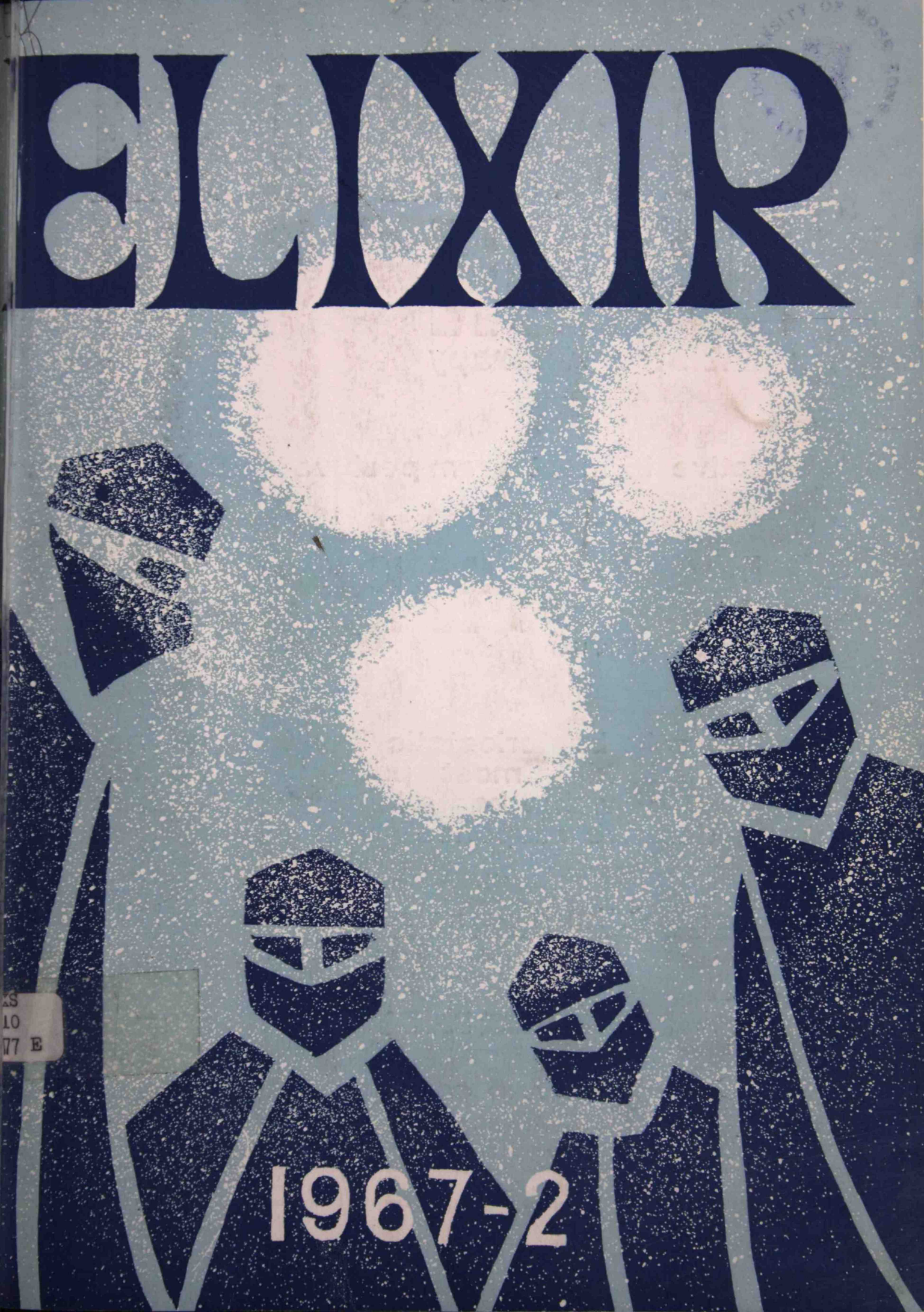

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Textbook of Medical Treatment, 9th ed., Sir Derrick Dunlop, Sir Stanley Davidson, and Stanley Alstead, ed. (Edinburgh, E. & S. Livingstone Ltd., 1964), p. 68.

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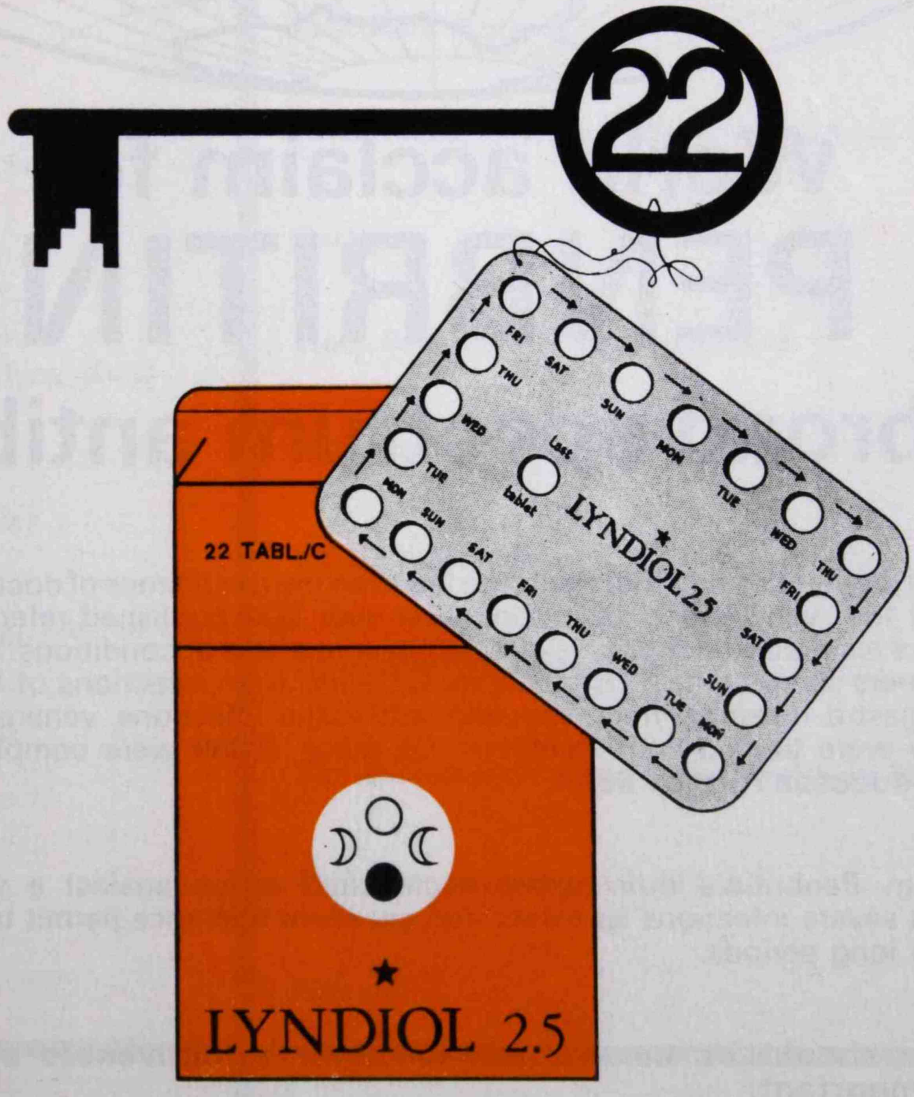

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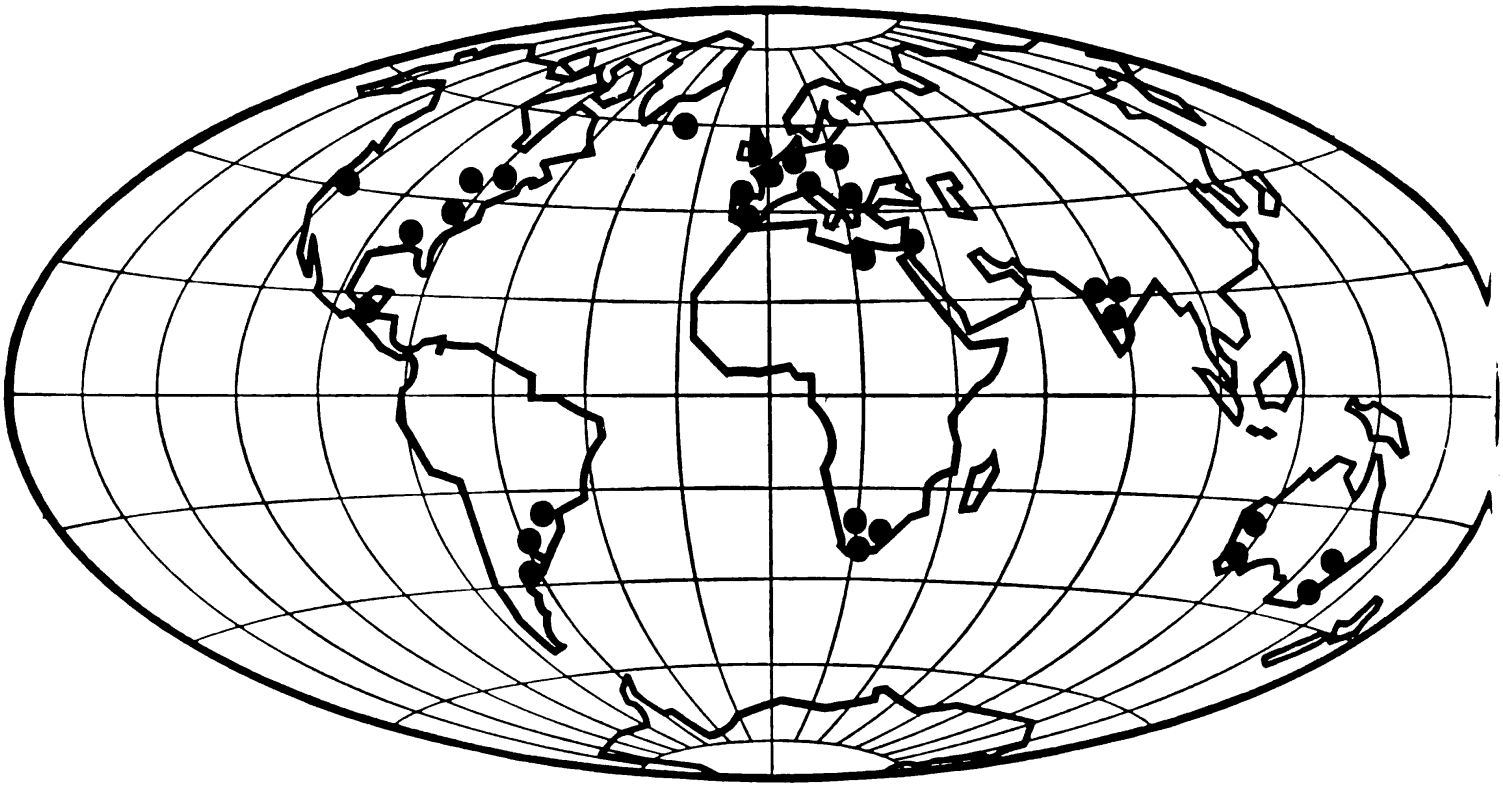

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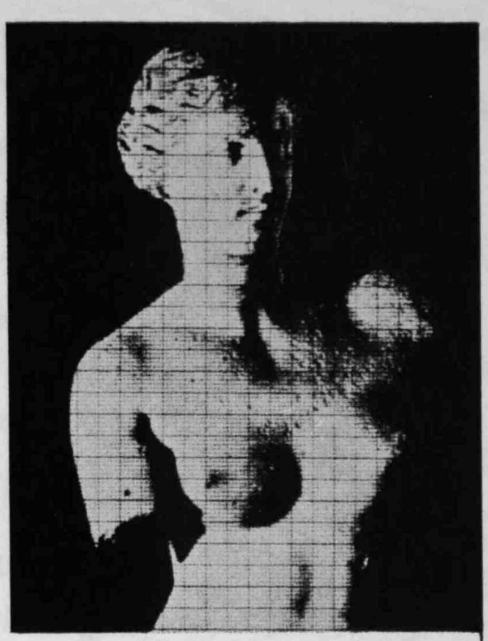

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Editorial

After a casual conversation with Dr. David Todd and Dr. Tso on the subject of the Medical Students of Today, one becomes aware of the consequence of an ever increasingly large student population: the instructors' inability to get acquainted with each and everyone of the students.

"Medical students of to-day are enjoying more courtesy, freedom and suffering less from dogmatism, autocrasy and shivering less under the yoke of tyranny . . . . . I guess the staff is all right for they really know what they are talking about. Still, I wish I had known them better," says a member of the Executive Committee of the Society.

"To emulate we must have contact with our preceptors" says Dr. Hsieh in the featuring article of this issue: Medical Students in Hong Kong. There should be more to a doctor than just the acquisition of knowledge in disease and cure. Could the magic touch lie in more frequent inspiration through every bit of concourse, example and contact with the instructors and the impact of their vividly alive personality and character on the students?

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MEDICAL STUDENTS IN HONG KONG

By Arnold C. L. Hsieh

A promise, given rashly and without much thought for the consequences, to "write something for Elixir" about medical students in Hong Kong wrecked what should have been a Merry Christmas. After re-reading the manuscript, I shall be surprised if I have a very Happy New Year either.

On the surface, I should be eminently qualified to profess and propound on matters concerning with medical students. Since joining the University as a Demonstrator (Grade II) in 1953 I have been closely associated with the Medical Society—having held all the offices open to faculty members, I am now on my second time round. Of the forty-two important functions held by the Society during the past fourteen years I have missed only seven (I was not in Hong Kong when the Annual Ball and Medical Night were held in 1956 and 1963; I was unable to attend the Barbecues of 1953 and 1962 and the Medical Night of 1960). It is true that I have always missed the annual launch picnic held by the second year students, but that is because I cannot swim. My curriculum vitae also includes such posts as Vice-President and then President of the Volley Ball Club, President of the Swimming Club (twice) and Adviser to the Folk Dance Club. More recently I have also been involved in the selection of students for entry into the medical faculty.

Fourteen years of experience certainly qualifies one to speak, but, alas, experience is not synonymous with ability. While the former can be passively acquired the latter must to be actively cultured. I was born with very little ability for deep observation and have done very little to cultivate it. Neither have I the ability to write clearly. Truth will out, if the reader decides, after reading this article, that I have said nothing it is not because I have nothing to say but because I have nothing to say it with.

Over the years I have heard, with increasing frequency, the phrase "medical students are not what they used to be". Meaning, of course, that they are getting worse. If the general quality of the students entering the senior classes has indeed been deteriorating the cause could be poor selection and/or poor weeding out at the first examination. As I have been closely involved in both these steps, it is clear that in opposing this view I have a very large axe to grind.

When one says that the quality of medical students, and presumably the quality of graduates, is deteriorating one is speaking in vague terms and not referring to their academic qualities. Academic quality is measurable and one would expect to see a reduction reflected in a gradual increase in failure rate. This has not occurred. Indeed, the failure rate has remained so steady that students have, quite erroneously, reached the conclusion that it is arbitrarily fixed. Results from the U.S. Medical College Admission Test indicate that there has been an increase over the past ten years in the intellectual ability of all students taking the test. In Hong Kong, the

pressure for secondary school places, the filtering processes of the school certificate and matriculation examinations and finally the competition for for places in the faculty must certainly ensure that the intellectual ability of students entering has shown a similar increase.

To say that present-day medical students do not show sufficient interest in extra-curricula activities is to speak from inexperience. Publication of Elixir and the raising of funds for the Elixir Loan Fund is entirely in the hands of members of the Medical Society and these functions have been carried out most successfully, with a minimum of fuss. The Presidency of the University Students' Union appears to have become the prerogative of medical students. The turn-out at sports and social events has always been good. (I may add, in parentheses, that over the past five years the quality of the singing on Medical Night has shown a definite improvement.) Further evidence, though perhaps less honourable, that the medical students does not confine himself to books can be found in his amazing ability to perform with grace the intrictate gyrations that have made the modern dance a spectator sport for his elders. The noise that emanates from the Medical Centre at night suggests that not all Senior Clerks spend their nights quietly waiting for emergencies. I may also add that the activities of the second year in the Common Room at Li Shu Fan may go unseen but are definitely not unheard.

What, then, is lacking in our present day students that has given rise to this feeling that they are in some mysterious way less suited than their predecessors for the most honourable of professions? Could it be that they lack that vague and undefinable quality one usually associates with the art of healing? If this is so then the fault lies not with the student but with the faculty.

One of the main objectives of unversity education is to stimulate the development in the student of curiosity and initiative which will make for him life-long habits of learning. Medicine is both a science and an art. The science of medicine can be taught but the art of medicine can only be learned and emulated. To learn one must have time for thought and experimentation; to emulate we must have contact with our preceptors. Over the last few years we have seen student numbers increase from a modest fifty to an almost unmanageable 120. Since 1960 departments of Biochemistry, Pharmacology, Microbiology, Orthopaedic Surgery and Paediatrics have been established—each new department demanding extra time and attention from the students. The introduction of regulations increasing the penalty for those failing examinations has further increased the burden of the present-day medical student. The expansion in student numbers and in curriculum together with increases in staff has reduced to insignificance the time that senior members of the faculty spend with students. Could it be that in giving the students more "science" the faculty is tending to ignore the "art" of medicine? Could this be why medical students are not what they used to be?

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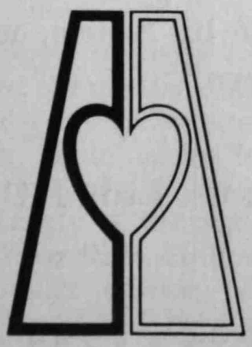

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UNDERGRADUATE STUDY IN MEDICINE IN AUSTRALIA AND HONG KONG

By Dr. C. S. Reed, M.B.B.S., F.R.A.C.P.

Leverhulme Lecturer in Medicine, University of Hong Kong
Fifth Year Tutor in Clinical Medicine, (Sydney Hospital)
University of Sydney.

It has been said that students are the same the world over—perhaps in many ways this generality is true. You are each in your own mind striving to share the adventure of education; in medicine this adventure imposes a heavy burden of responsibility, both to yourself and to your future patients. Your fellow man will be seeking your wisdom and your skills to aid him in overvoming the hazards of the illnesses which beset mankind. It is at this point that some divergence occurs between yourselves and your counterparts in Australia.

In large measure, the problems of community health have been solved in Australia. The bacterial epidemics are not seen, thus typhoid is almost unknown; tuberculosis is under good control; malaria, typhus and leprosy are medical curiosities. Progress is being made in the control of virus illnesses. It is important that credit is given for this state of affairs to those who are responsible—the medical research workers and field workers in the disciplines of public health and preventative medicine. Your are in frontier of the army pushing back the frontiers of these illnesses here in Hong Kong.

Because of these advances coupled with a static birthrate, our medical undergraduates in their clinical years are required to adopt their approach to an ageing community. The consequences of the diseases of degeneration fill many of the medical beds—cerebrovascular accidents, cardiovascular and peripheral vascular disease, degenerative vertebral disease and peripheral joint disease are all commonplace. Inherent in the understanding of these conditions is a sound need for knowledge of rehabilitation and social medicine.

In Australia, industrial automation, excellent living standards, a uniform working week of fourty hours and compulsory retirement are producing social consequences. It would be naive to suggest that these are the only factors involved but certainly they do contribute to the pathogenesis of psychosomatic illness, which is seen so frequently. It is believed that in general practice consultation, some seventy percent involve some element of psychoneurotic overlay. Bound to this problem are the medical consequences of increased leisure. Sports medicine is developing as an entity. Alcoholism and related illnesses are major social and medical problems. The affluent society of Australia I believe ranks third per capita ownership of motor vehicles, the road death and injury toll has been compared to that suffered by an army in the field, a heavy demand is placed upon resuscitation, blood bank, orthopaedic and rehabilitation staff.

Although over 6,000,000 of Australia's 11,000,000 population live in large seaboard cities, there is a vast inland to be served by medical practitioners. In many of the country towns the general practitioner must be skilled in many arts which in the cities may be more properly the province of a medical specialist. The undergraduate must have a full range of training and there is no question of becoming involved in specialist study as an undergraduate. Certainly further study at an advanced level may be undertaken as an undergraduate by completing a B.Sc. (Medicine) degree, this may aid in later post-graduate work.

Thus briefly I have endevoured to show that the picture of medicine seen by an Australian undergraduate may differ from that to which you are accustomed. How

is Australia providing for her future medical requirements? Let me take the University of Sydney as my example. The University of Sydney was founded in 1850. In 1965 there were 16,171 students enroled of whom 76% were full-time. There were 1942 students in the Faculty of Medicine, attending six major teaching hospitals for their clinical instruction, coupled with two major obstetric teaching hospitals and a paediatric teaching hospital. In 1964 there were 244 graduates in Medicine and 15 students attained B.Sc. (Med.) in that year. At the University of Hong Kong in 1964—1965, there were 2090 students, 90% full time. Enrolement in the Faculty of Medicine was 430. In 1963—1964 there were 68 graduates in medicine. In Hong Kong you are to serve a population of over 4,000,000 proper in an area of 398 square miles, in New South Wales the population is also a little over 4,000,000 but in an area of 309,433 square miles. Medical courses are also conducted by the Universities of Queensland, Tasmania; Western Australia; New South Wales, Adelaide, Melbourne and at the Monoah University. The graduates from all these universities are to serve a population of a little over 11,000,000 people. As you can imagine competition for top positions is very keen; but many small city hospitals and country areas remain understaffed.

The undergraduate course at the University of Sydney is six years in duration. The first clinical year is directed to learning clinical examination with formal lectures in psychiatry and public health. The second clinical year is the specialty year and the third clinical year is nearly fully devoted to medicine and surgery with emphasis on clinical clerking. In the final year the students meet together for formed lectures at the University only one morning each week; the remaining time is spent in the teaching hospitals. As you can see this is very similar to your own system, this is to be expected as both great universities are modelled upon the traditional lines of the Universities of the United Kingdom. I have been asked about the cost of undergraduate study at the University of Sydney; the figures to be quoted are those for 1965. The overall University Fees are $A 1592 with Hospital accommodation fees in fourth and fifth years totaling $A 131.52. There are in addition compulsory subscriptions to the Student Representative Council, the Union and the Sports Union of $A 134. In all this amounts to approximately $H.K.11,885. Many of our students are supported by Commonwealth Scholarships.

It is too early for me to draw conclusions about the standard of you all as undergraduates. You should be proud of the excellence of your clinical teachers and your teaching school as the standards are excellent. This is not only my opinion but also that of that august body, the General Medical Council of Great Britain whose duty it is to approve the standard and worth of a medical degree for registration in the United Kingdom. I feel your share in common with my students a reluctance to utilize the clinical material in the wards and place too great reliance upon the results of laboratory investigations.

Be proud of your medical school, strive to bring honour upon it by your own excellence, beware of accepting poorly considered opinion but be receptive to news ideas, digest and consider the evidence of your own eyes, ears and hands, fight always against the pitfalls of mediocrity.

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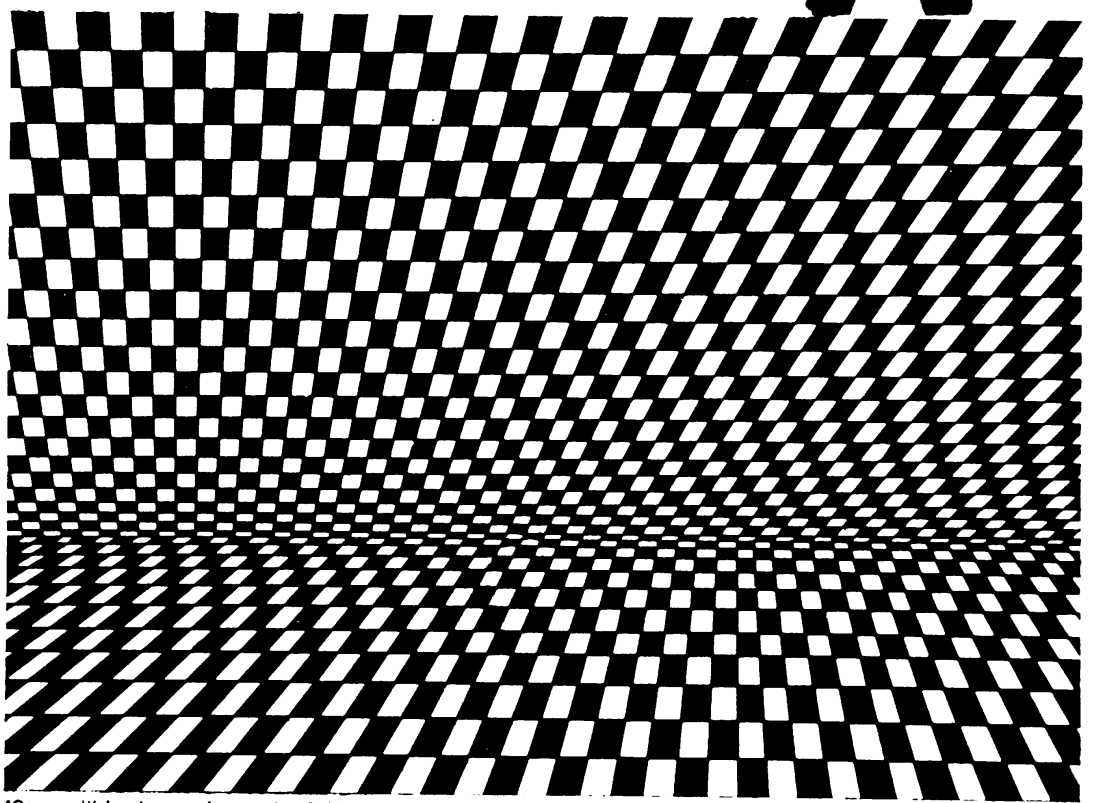

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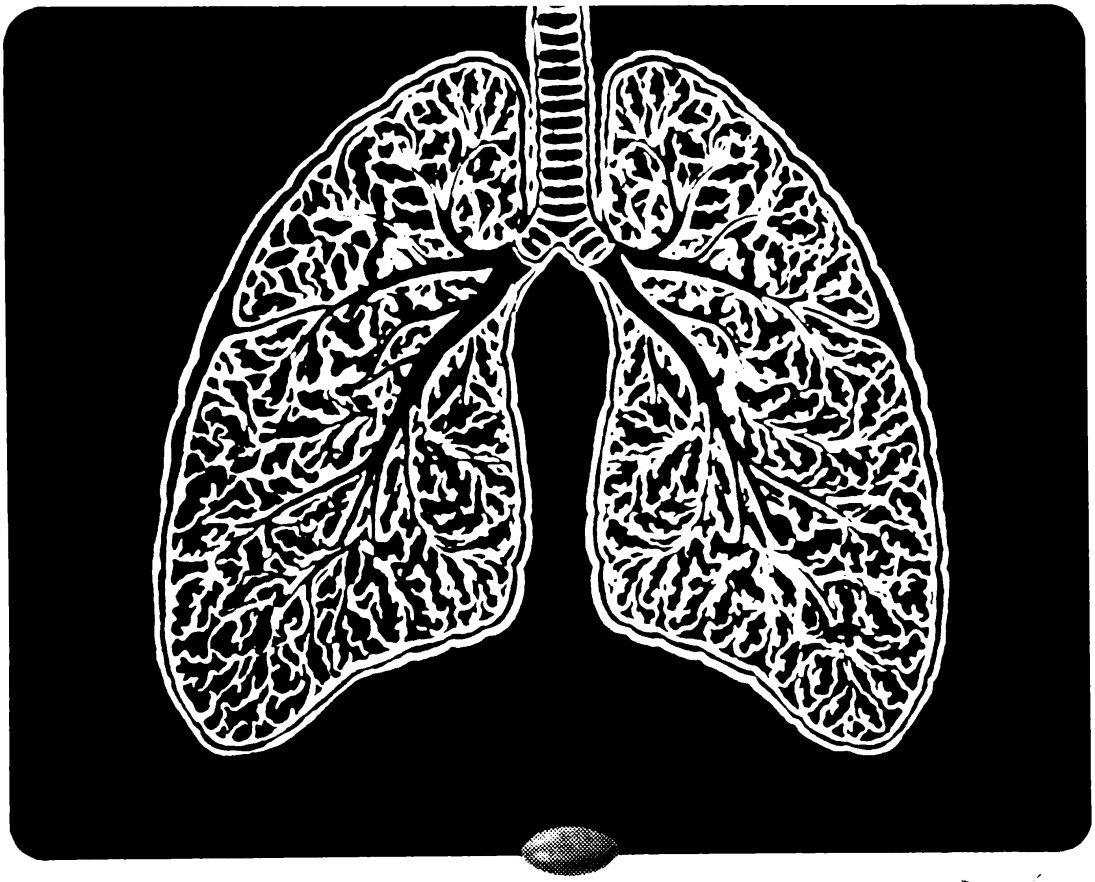

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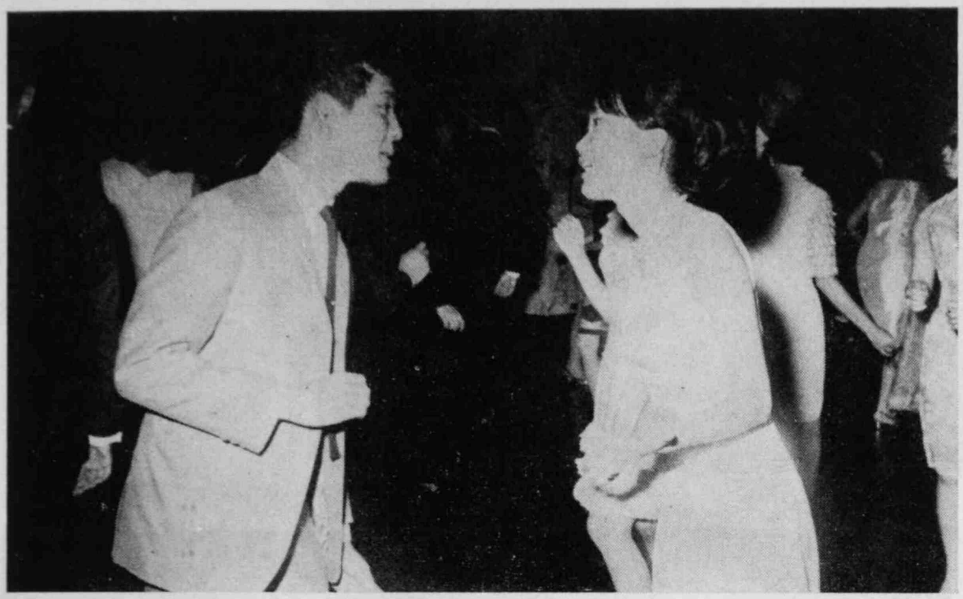
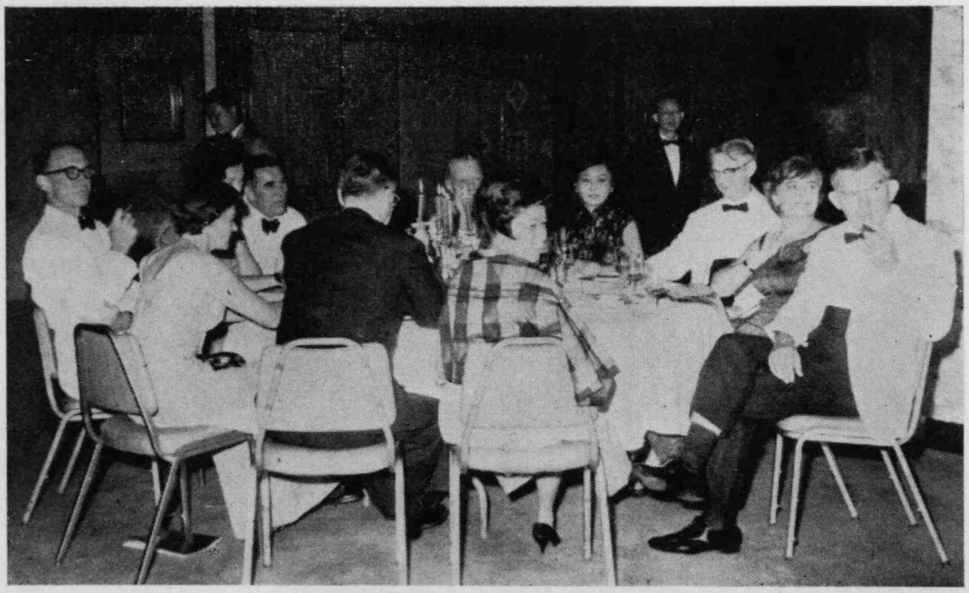


"小姐，你眞係靚！"

"對不起，儂聽不懂"



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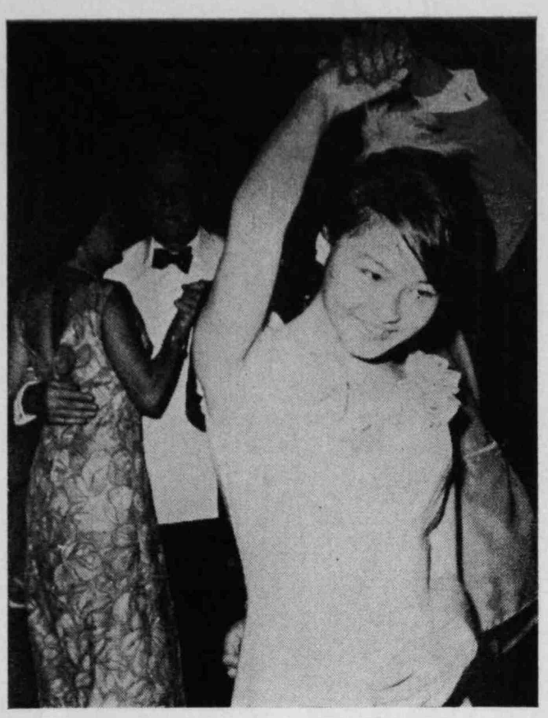

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寓言一則

從前有個好瘦弱嘅 Medical Student 叫做「阿里」，每次 THURSDAY CLINIC 都暈咗嘸度，敢個 Class Rep 就好嬲，但佢係個好人，就介紹佢食「老麥牌有格麥片」，於是佢成個都強壯晒，個「大老板」重將個女嫁俾佢添！

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虞美人（考試嘆）

官立夜中　・凌君・

考試日子何時了。分數知多少。小樓昨晚又通宵。課本不能回憶試場中。依稀印象總猶在。只是寫不來。書已讀過好多酬。祇是題目出得難將就。

（轉載自中國學生週報，特此致謝）

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I woo thee with tender love,

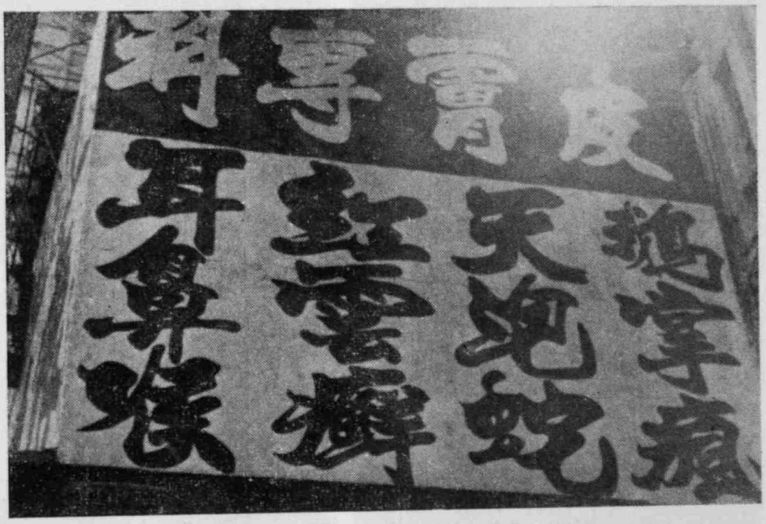
For thy face so fair bespeaks a dove.

For ugly ducklings to swans did turn.

Through old prescriptions from the magic urn.

E'en saddle noses admit of cure.

And moles and naevi are turned pure. . . . .

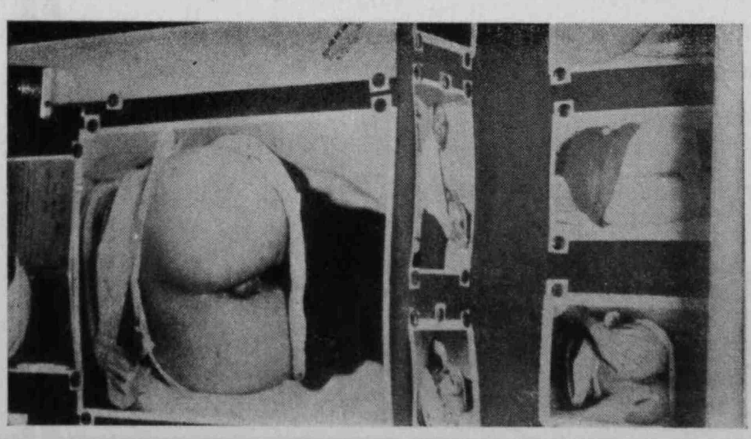


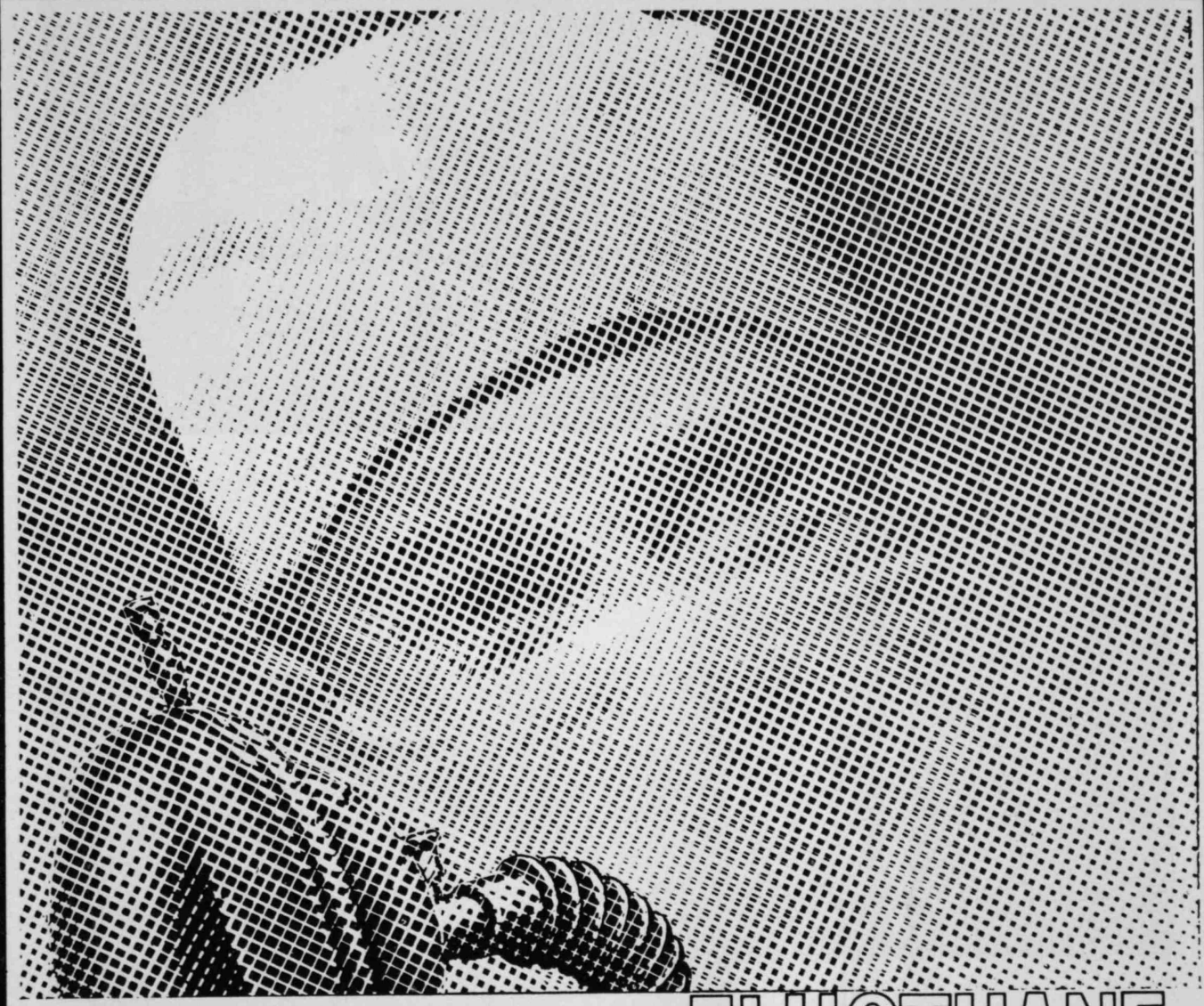
But ere the the years have gone seven,
Thou will itch all even
With spirochaetes and accumulatum;

So you search all through the land.

Till you find that friendly stand.

To shave thy bottom and thy groin.





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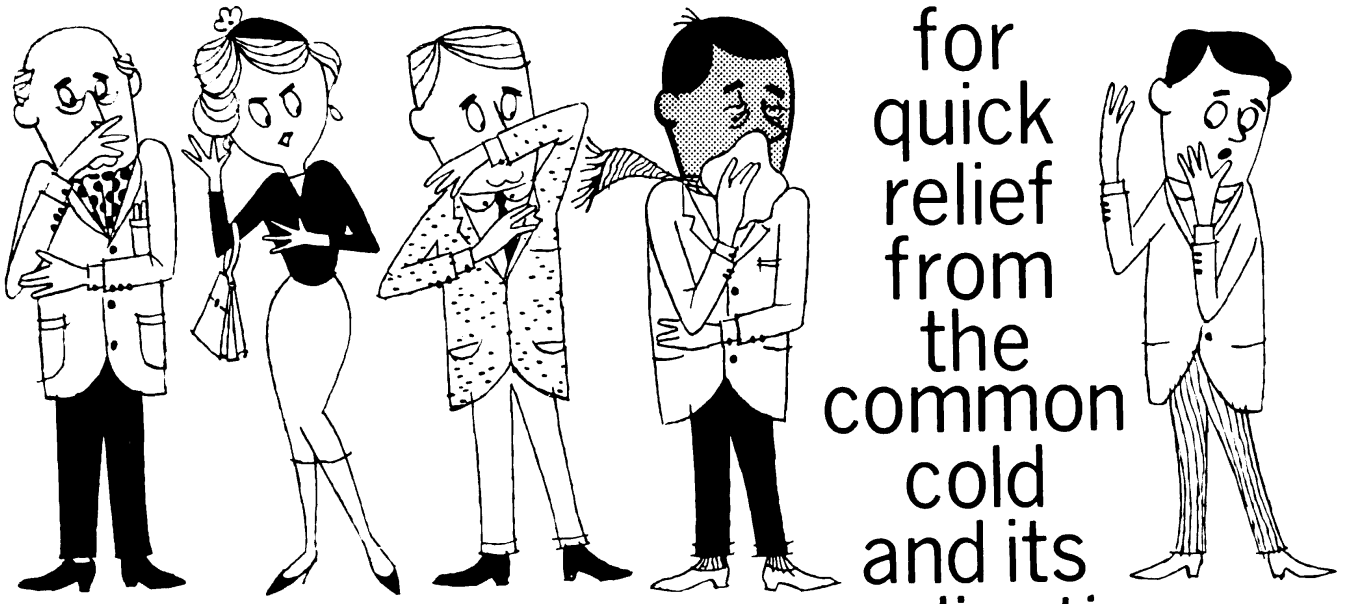

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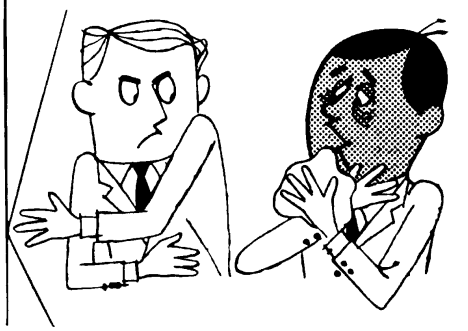

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Leonardo da Vinci—self-portratt,
in red chalk, c. 1510-1513,
National Library, Turin.

THE ANATOMICAL DRAWINGS OF LEONARDO DA VINCI (1452-1519)

by Jorge A. Taiana, M. D., Buenos Aires

"And you, who contemplate in these drawings the marvellous creations of nature . . . think that the structure of the body, which is so perfect in your eyes, is nothing in comparison with the soul that resides in it."

Leonardo da Vinci, truly a giant of the Renaissance, was a genius of many parts—artist, engineer, architect, and physicist. However, his studies of the biological disciplines as seen through the eyes of historians, occupy only a modest place in his career, and many regard his fragmentary writings on zoology and anatomy either as the explorations of an inquiring mind or as the necessary preliminaries of his artistic works.

One possible reason for this is that of the various creative activities of Leonardo, the anatomical, physiological, and pathological investigations were in all probability the least known at the time and in the next century.

Contemporary beliefs prohibited human dissection; those who wished to study anatomy had to do so in secret, often by night, and on the bodies of executed criminals.

Thus while Leonardo was immortalizing the Gioconda's smile in the soft sunshine of Florence, he was also furthering scientific progress in the twilight of improvised mortuaries.

In the eagerness for research that characterized the Renaissance, men such as Verocchio, Michelangelo, and Durer wielded the scalpel on the human body in the furtherance of their art. But the exceptional number of dissections carried out by Leonardo had a different objective.

This becomes apparent from a consideration of the range of his work in anatomy, physiology, and pathology; from the systematization of his studies; from the techniques he used, and from his book on anatomy.

Jorge A. Taiana, M.D., is Professor Emeritus of the Faculty of Medical Sciences of Buenos Aires, Argentina.

Dissections of children

Among his observations Leonardo noted the characteristics of the blood vessels seen in aged individuals and drew attention to the difference between their appearance and those of children and young adults.

Some of his dissections were done in the Santa Maria Nuove Hospital in Florence, the Hospital Maggiore in Milan, and the Hospital of the Santo Spirito in Rome. In 1517, towards the end of Leonardo's life, the cardinal of Aragon and his secretary, the canon of Amalfi, visited him at Cloux, near Amboise in France, and heard him describe what for those days was the remarkable total of 30 human dissections.

When Leonardo died, a certain Francisco Meliz was entrusted with his possessions, but on Melzi's death the manuscripts were dispersed. For three centuries they remained scattered and lost in obscurity in France, Germany, England, and Italy. Most of the anatomical writings were under lock and key in the Royal Library of Windsor Castle, England, until the appearance in 1898 in Paris of *'Dell Anatomie-Foglia A* published by T. Sabachnikoff and G. Piumati. In 1901 those in Book B were published in Turin.

Between 1911 and 1916 another series of drawings and anatomical writings, also originating from the Windsor Library, came to light and were reproduced with the title *Quaderni Anatomie* by Cristiana University, Oslo, under the editorship of

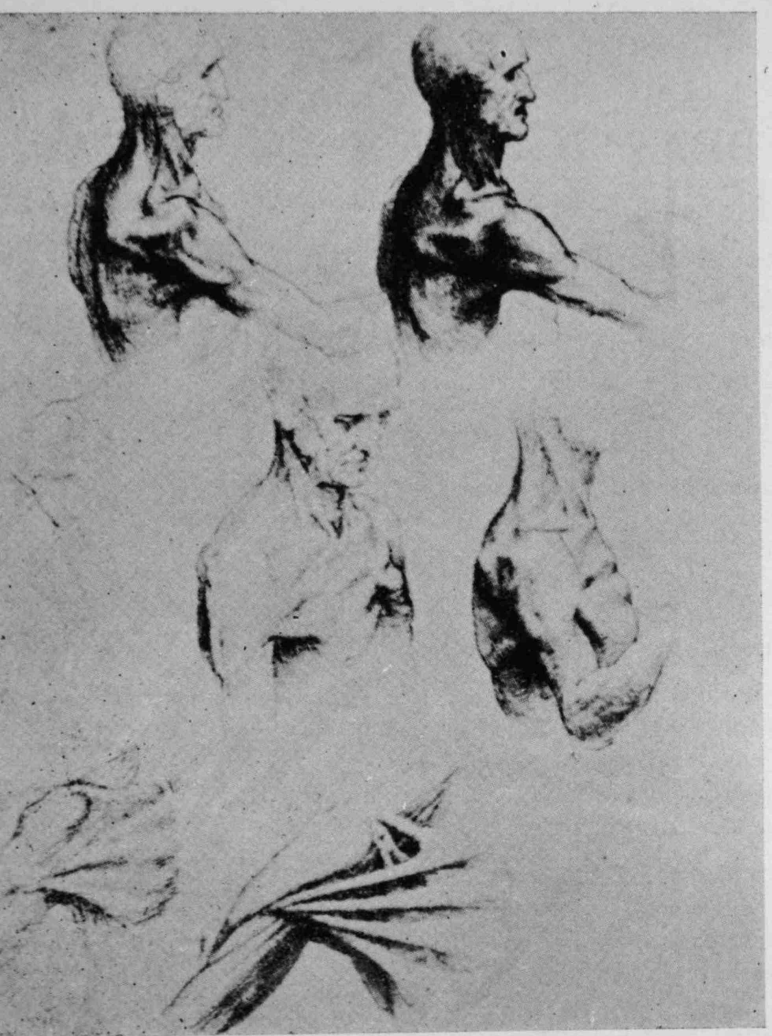

Fig. 1. Musculo-skeletal system. The pectoralis major muscle, the biceps, the deltoid and the two heads of the sternocleidomastoid muscle are clearly shown.

Ove C. L. Vangensten, H. Fohahn, and H. Hopstock. In 1930 Muller published the *Anatomical Sheets* belonging to the Castle of Weimar. This represents a small portion of the 120 chapters of a work that Leonardo planned to produce as a treatise on anatomy.

The drawings show that Leonardo's technique was to dissect off the skin and underlying layers until the muscle masses were revealed; he then identified the individual muscles and established their functions.

He used corrosive methods to demonstrate the arteries and veins as well as the skeleton stripped of muscles. He injected coloured substances into the interior of the vessels and introduced wax into the heart and brain to obtain models of the inside of the heart and of the cerebral ventricles.

He boiled soft organs—such as the eye—in egg white, which, wen solidified, enabled him to cut sections to show the structures in a life-like state.

Leonardo preceded Vesalius in showing that the veins usually accompany the arteries. He assumed the existence of the capillaries when he stated that arterial blood must pass through small vessels. And he formulated a partial conception of the circulation: "The blood of animals always moves from the sea of the heart and flows to the top of the head."

He observed how the blood passes from the left ventricle to the aorta and made diagrams of the haemodynamic turbulences in the neighbourhood of the aortic valve.

Thus Leonardo (and Servetus) contributed to William Harvey's discovery, a hundred years later, of the circulation of the blood.

Leonardo was the man who gave anatomy a systematic visual expression. All his observations and experiments were recorded in the form of drawings to which the written text was subordinate. *Musculo-skeletal system.* Leonardo studied the skull, the spinal column, the ribs, the sternum, and the limb bones of man. He disvovered the maxillary sinus, later called the antrum of Highmore; the nasolacrimal canal, and the curvatures of the spinal column, as well as the characteristics of the first two cervical vertebrae—atlas and axis—and the five vertebrae of the sacrum.

His drawings of the teeth show that he appreciated the characteristics of the incisors, the premolars, and the molars. He drew the articular surfaces, the ligaments and capsules of joints.

His drawings show how thorough was his dissection of the muscles (by planes) of the limbs, neck, thorax, and abdomen (Fig. 1).

Cardiovascular system. Leonardo described the veins of the upper and lower limbs, and made drawings of the aorta and its branches. The parallelism of the courses of the arteries and veins is apparent.

He recognized the presence of three cavities in the heart. The "auricle" receives the two venae cavae, the superior and the

inferior. The interventricular septum is shown with a series of dots that represent the "Galenic pores". He described both ventricles and noted that the left has a thicker wall and connects with the aorta. He mentioned the pericardium and elaborated the drawing by including the papillary muscles and the chordae tendinae.

Component parts of a machine

Leonardo isolated the cardiac chambers and separated them like the component parts of a machine. He studied individually the "auricle" and each of the ventricles. He sketched the auriculo-ventricular and ventriculo-aortic orifices to show the respective valvular structures with the valves closed, half-closed, and open. *Respiratory system.* Leonardo described the larynx and its importance for phonation. He recognized that the lungs expand and that they are situated above the diaphragm. *Alimentary system.* He made drawings of the alimentary tract that showed the caecum, the vermiform appendix, and the greater omentum.

Nervous system. Leonardo described the cerebrum, both externally and internally. He obtained models for the latter by injecting melted wax intraventricularly and by sectioning.

He demonstrated the four cerebral ventricles and the aqueduct of the midbrain which later became known as the aqueduct of Sylvius. He showed the spinal nerves, the structure of the brachial and lumbar plexuses and the cervical sympathetic nervous system.

He studied the eye—by inclusion in egg white, boiling, and sectioning, and by observation of the globe in its socket—together with the optic nerves, the optic chiasma, and the optic tracts. He regarded the optic and olfactory nerves as cerebral prolongations.

He drew the tongue and its frenulum, and clearly showed that he considered the former to be the site of the sense of taste.

Genito-urinary system. Leonardo made drawings of the kidneys, the ureters, the bladder, and the male and female reproductive organs. The uterus was shown with a single cavity. The foetus within the uterine cavity he showed in an oval shape covered by the amniotic membranes (Figs. 2).

Topographical anatomy. Before he dissected and analysed the various parts of the human body, he observed and drew them as a whole. His transverse sections of the limbs and their study represented the beginning of topographical anatomy *Physiology.* To his purely morphological observations he added others of a functional order. The muscles he replaced by cords, and the principal movements of the limbs he interpreted through the function of single muscles or of several muscles combined in groups. He related muscular action to geometrical diagrams of forces. *Pathology.* His drawings of dissections of

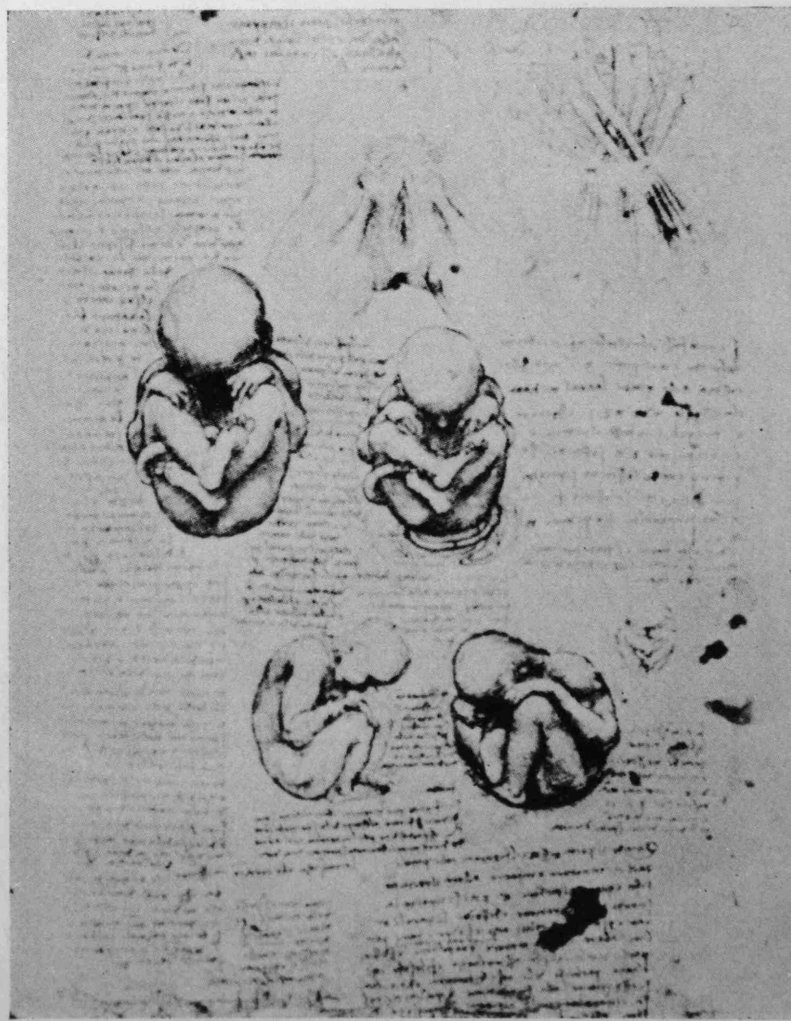

Fig. 2. Genito-urinary ststem. Drawings of the foetus showing it curved into an oval.

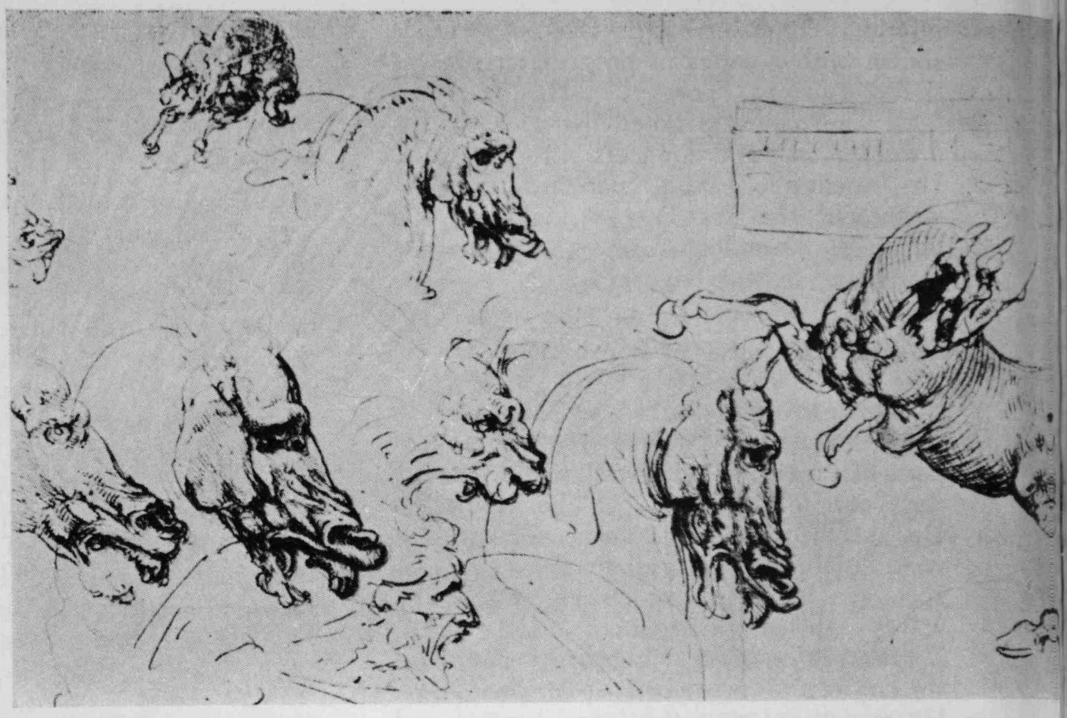

Fig. 4.

Facial expression. The forerunner of facial expression in an animal and, at the bottom, the face of a human being in a state of violent emotion. Reproduced by gracious permission of Her Majesty Queen Elizabeth II.

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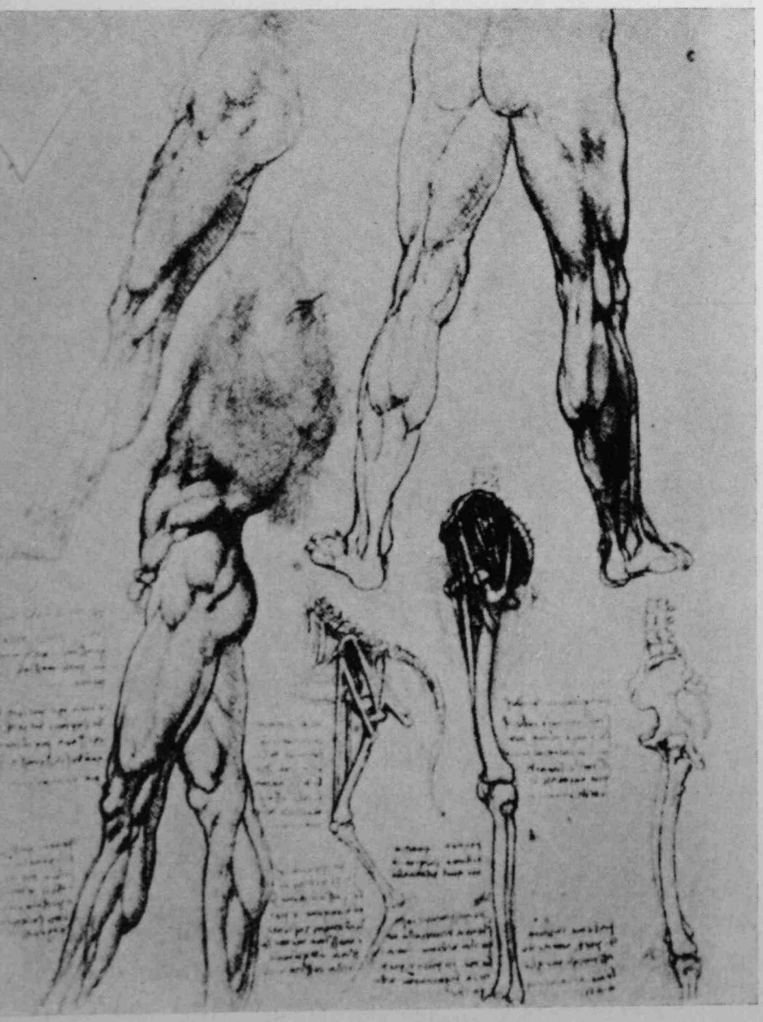
Fig. 3.

Comparative anatomy and physiology. Dissections of the hind limbs of animals compared with those of the lower limbs of human beings. The bony differences are notable.

↓



children and old people were proportioned so that he could observe the changes produced by advancing years in different anatomical structures, particularly in the blood vessels.

In Florence, about 1503, he investigated the cause of the sudden death of an old man with whom he had been talking some hours previously. This was perhaps the first anatomical examination of its kind.

Comparative anatomy and physiology. His drawings show how Leonardo's scientific curiosity extended to animals. Hogs, monkeys, horses, and plantigrades were observed and experimented upon. He found, for instance, that a probe stuck into the heart shows its contractions and that dissection of the lower limbs reveals bony and muscular characteristics distinct from those of human beings (Fig. 3).

As a last example, he observed that facial expression of which there is scarcely a trace in many animals attains its highest form in human beings (Fig. 4).

The influence of Leonardo on modern anatomical knowledge. Leonardo's work failed to affect the evolution of scientific thinking simply because succeeding generations had no access to it. While the drawings and writings of Leonardo were forgotten for many years, anatomical studies progressed

with Paracelsus, Vesalius, Paré, Servetus, Colombo, Cesalpino, Fabricius, and Harvey.

The man who stated, "We must begin with experience and by its intermediary discover reason", the man who praised . . . . "experience as the only master who never deceives", traversed the space of four centuries like lightning without thunder and now surprises us with the brilliance of his light.

Leonardo féared the destruction of his work and celebrated the sanctity of human life with a song of peace:

"And you, who contemplate in these drawings the marvellous creations of nature, if you consider it a crime to destroy my works, imagine how much more criminal it is to take a man's life; think that the structure of the body, which is so perfect in your eyes, is nothing in comparison with the soul that resides in it. Do not destroy this life by your wickedness."

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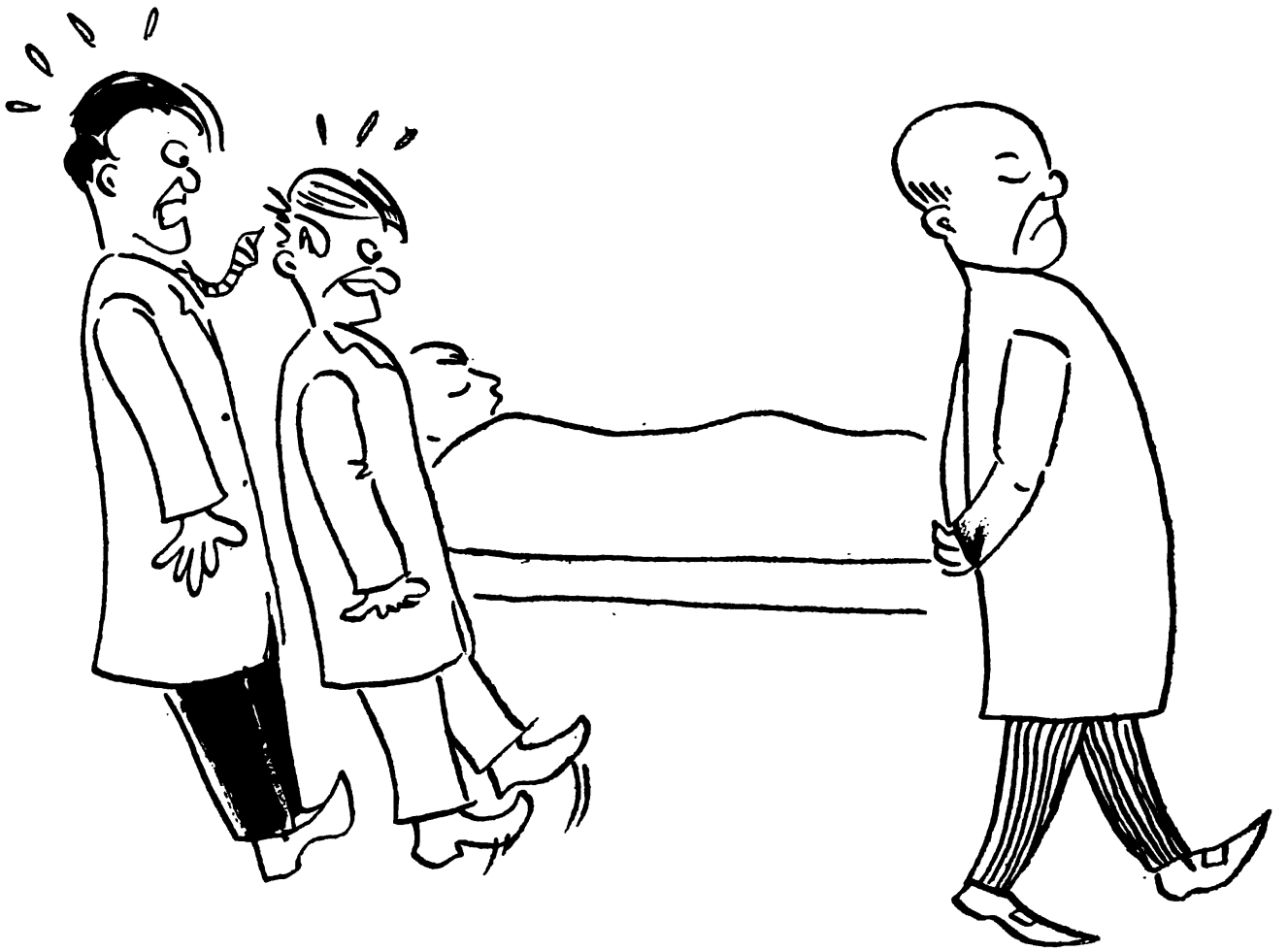
IF YOU ARE ABSENT-MINDED . . . . . .

You can paper your wall with your notes, or pages from your book, "for building up the atmosphere", you may explain. Then you can say to the patient, "Your diagnosis is at the back of my head and I can get it with a slight turn."

You may become a lecturer or professor. Then you would have all the medical students to remind you of things that are at your finger tips although not at your lips. If they do not now, you can always say.



"I won't tell you this. You go back and look it up and tell me in the next ward-round."

Avoid employing beautiful nurses. Or, better still, have a male nurse, you can obtain, in addition, a sense of security.

The immortal triad of 36 — 24 — 36 in always that distracting, and may aggrevate your absent-mindedness.

Too much work always makes the condition worse. So you should do a minimum of work, as many famous doctors do.

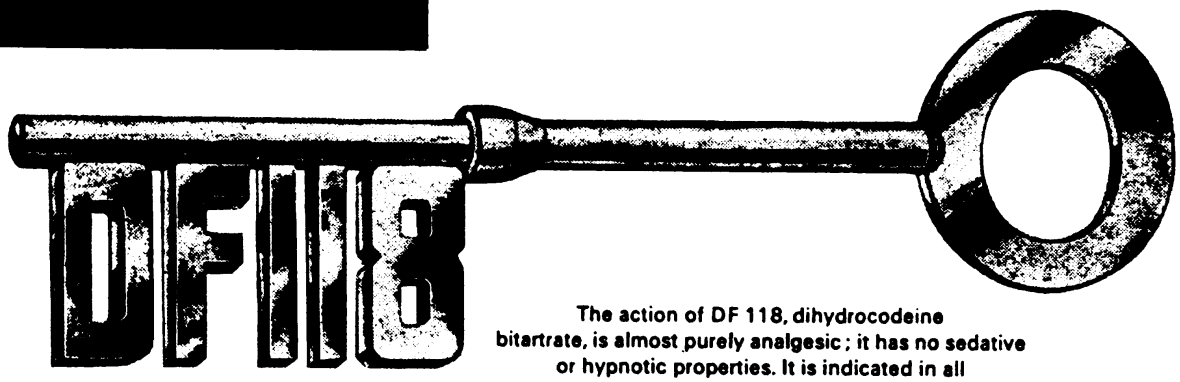
"To-day I shall see only one patient, See who is the lucky one."

But still your phone keeps ringing, for business.

"Morning, Doc. What is the address of your new patient. My business has flourished so much recently that I think we should become partners."

DF118

releases the patient
from severe pain...
without narcotics



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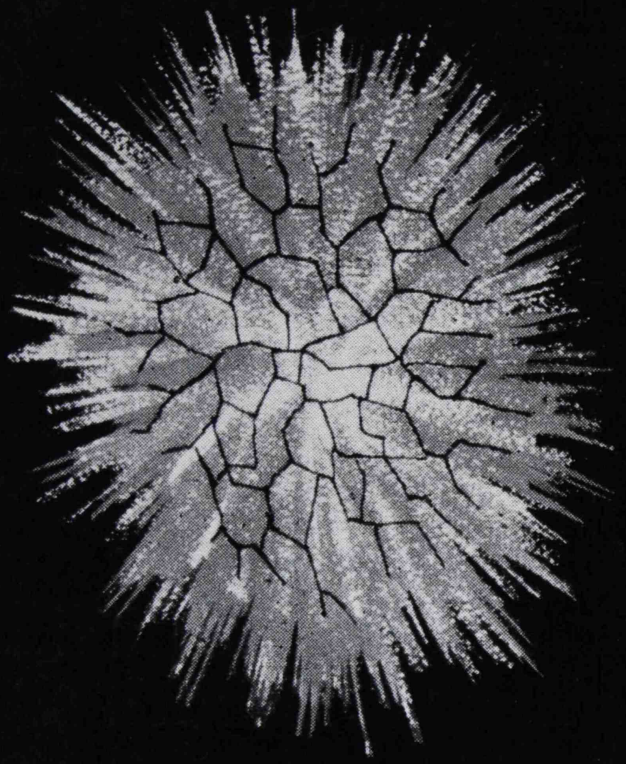
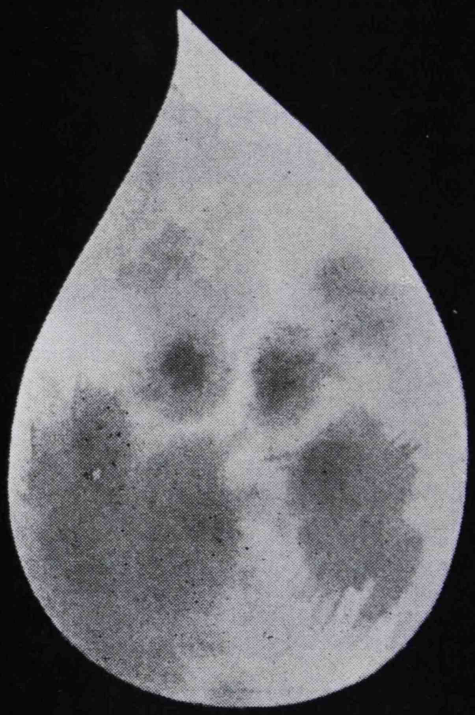


...or productive cough



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reliable anti-tussive, non-constipating, safe for adult or child.

with

PSEUDOEPHEDRINE

effective decongestant and bronchodilator less likely to produce cardiovascular or CNS side effects than ephedrine.

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HONG KONG UNIVERSITY MEDICAL SOCIETY

ANNUAL REPORT

Stephen Lau, Hon. Secretary,

Medical Society, Hong Kong University

(SESSION 1966 - 1967)

The present session began last November after a difficult labour of an Executive Committee. However, with the admirable comradeship and professional unity among the members, our Medical Society added to its glorious history another page of success.

With the recapturing of the Omega Cup, we are honoured to be able to say with confidence that medical students are not only academically fit, but also good at sports. As host to the ARMSA 2nd General Assembly, our Medical Society took a further step towards the co-operation and mutual assistance among medical students in South-East Asia; being President Country in the coming year, we will continue to advance in such direction. In the intra-faculty affairs, the negotiation with the University authority regarding the Canteen was most encouraging. The social functions were no less than those of the past, and special effort had been made to provide more academic and cultural activities, such as debate and symposium for the members.

The following is a summary of the events during the past year:

Students' Welfare

1. Canteen—Since the beginning of the Canteen in January, 1966, it was run on very poor terms. The small business, the long holidays and heavy expenditures were the problems any Caterer had to face. It was obvious that the Canteen could not be continued without subsidies and some changes in the system. Since March, 1967, many negotiations took place with the Dean, the Faculty Secretary, the Assistant Bursar and the Steward. It is happy that the University has agreed to subsidise $500 per month for the Canteen; besides, the kitchen equipments and utensils will be provided by the University, while the internal maintainance and repair will be taken care of by the Estate and Maintainance office. We thus can foresee the coming improvement in our Canteen. Indeed, with the introduction of a good self-service system and the enthusiastic support from our members, further success can be achieved.
2. Students' Common Room—It has been furnished and most often used by the 1st and 2nd year medical students. 5 tables, 27 chairs and 2 open arm-chairs have been borrowed from the Medical Faculty and the Estates and Maintenance Office. A card table, 4 easy chairs, a chest-billiard table, a magazine shed and some magazines were installed by our Medical Society.
3. Elixir Loan Fund—16 loans were given this year:

1 loan at $1200	$ 1,200.00
1 loan at $1100	1,100.00
6 loans at $1000 each . .	6,000.00
4 loans at $800 each . . .	3,200.00
4 loans at $500 each . . .	2,000.00
Total:	$12,500.00

Balance of the fund up to October, 1967—$10,600.00

In the past 3 years:

1963-64	2 loans of $1000 each
64-65	5 loans of $1000 each
65-66	10 loans of $1000 each

4. Freshmen Information Service—
This was set up during the freshmen resgistration day on September. Information was given to the freshmen together with the sale of second-hand books, microscopes and skeletons. The service ended with a guided tour of the Li Shu Fan Preclinical Building. The Society wishes to thank the third year students who devoted much time and energy to help their junior colleagues.
5. Guided tour for new clinical students—
Information sheets were distributed to the new clinical students, who were then shown around Queen Mary Hospital to get them orientated.
6. Miscellaneous
   a. British Medical Journal, Practitioners, were ordered at special concession rates for students.
   b. Past examination papers were printed and distributed.

c. Christmas cards. The new design of the Society X'mas cards met with great approval from students; they were sold at 20 cents each.

d. Society key rings, ties, car badges were sold to members.

e. Lockers at Queen Mary Hospital were rerarranged and keys rented to students at $1.00 each.

Lockers at students common room were arranged for 1st and 2nd year students.

Social Activities

1. Barbecue—the traditional medic BBQ was held at the Sports Centre on December 8, 1966. The occasion was nonoured by the presence of Prof. Field, her guest and Dr. Todd. About 200 members heartily roasted meat and sausages against the background music provided by the Mustargs and Mr. David Fang. The limbo contest and tombola brought the climax of the early winter evening, bringing the delightful meeting to a close with warmth and joy.

2. Christmas Party for the Sick Children—on December 23, it was most warmful to see the children smile as our carol echoed in the wards of Sandy Bay and Queen Mary Hosipital, while our gifts reached their little hands. The function was made possible by the generous donation from the medical students, and we are much indebted to our Santa Clauses Leung Ping Ki and Yu Wing Cheong as well as other members who came to share the X'mas with the sick children.

3. Med Hop—

   The barn dance, equivalent to last year's Starlight Dance, was held on January 7. It was honoured by the presence of Dr. & Mrs. Philip Mao and some 40 couples. Music played by the Rangers, and the Louis & his Combo flooded the Medical Students Centre with gaiety and fun.

4. Medical Ball—This was held on June 10th, at the Hilton Hotel. It was attended by over 100 people. The fashion show, sponsored by Wing On Company, performed by Hong Kong Model Academy, lightened up the evening. Mrs. Mac Fadzean was kind to draw the winning tickets for the Raffle. The first prize—a round trip ticket to Taipei—went to a final Medical Student. From the profit of the Ball, a total of $3000 was contributed to the Elixir Loan Fund.

5. The Launch Picnic—The discouraging typhoon on August 17th prevented us from launching with the ARMSA delegates. However, it was held successfully on September 5. For this, we owed much to the Winthrope Company who kindly sponsored the function.

6. Union Fete—Our society participated in the charity fund raising Union Fete on September 23. A Coconut Shy was built up in the Sports Centre, and proved the artistic talent of we medical students by winning the championship of the Stall Decoration Competition. To this, we are much indebted to the 2nd year students.

7. Medical Night & Celebration Dinner—The curtain closing function took the form of Celebration Night on October 24, at Loke Yew Hall. Over 250 staff and students came to share this enjoyable evening, which was rounded up by the presentation of sovenirs to our sportsmen. We would like to thank Winthrope Company who donated a shield to us for the best performance of the night; and also Prof. Field, Dr. Huang & Dr. Todd, whose generosity made this memorable evening possible.

Sports

Medical students have always been good at sports. This year, with the outstanding teamwork and sportsmenship of our members, we proved our champanionship among all faculties and was awarded the Omega Cup.

Out of ten inter-faculty games, we won the following:—

Namely, Men's: Badminton
Hockey
Tennis
Table Tennis.
Ladies: Hockey.

Results of the Braga Cup were:

	First	Second
Badminton	2nd yr.	3rd yr.
Basktball	5th yr.	2nd yr.
Football	2nd yr.	4th yr.
Volleyball	5th yr.	2nd yr.
Table Tennis (men)	4th yr.	2nd yr.
,, ,, (ladies)	3rd yr.	2nd yr.

Overall champion: 2nd yr.

The title Best Sportsman of the Year went to Mr. Louis Hsu, who was awarded the Kirk Memorial Cup.

Academic and Cultural Activities

1. Presidential Address—the presidential address entitles 'A developmental Study on the Chinese Child' was delivered by Prof. Field on April 20, at the Physiology lecture theatre. Over 250 staffs and students attended the meeting, which was preceded by taking of group photograph and light refreshment.

2. Symposium—a symposium on 'Postgraduate Careers in Medicine' was held on May 26, at the Physiology Lecture Theatre. We thank much Prof. MacFadzean, Dr. Gerald Choa, and Dr. Gutteres, who spoke on 'The Pursuit of

a University Academic Career', 'Opportunities in the Government Medical Service', and 'Introduction to Private Practice' respectively.

3. Debates—an interclass debate competition was introduced this year with the aim to promote mutual understanding among classes. Although the attendance of the debates was disappointing, those who did participate benefited the most.

   Medibate Cup was awarded to 1st year students. We were much indebted to Prof. Field, who kindly donated the Medibate Cup, and Prof. K. K. Cheng, Dr. Gray, Dr. C. A. Braga, Dr. Rosie Young and Dr. Majoree Lee, who sacrified much of their time to be our judges.

   In the interfaculty debate, we were runners-up this year.

4. Film Show—Lunch time film shows were organised in November, December January and October. Most of the shows were held around 12:30 p.m. in order to provide students a means to relax after lunch. They were proved to be worthwhile.

   The Society wishes to thank the Physiology Department who kindly allow us to use the lecture theatre and its projector in every occasion.

Publications

1. The Elixir—Through the unfailing spirit and deligent work of our editors, the first issue of Elixir was published in June, 1967. The second issue is expected to be out by December this year. From the 1st issue, approx. $5000.00 was contributed to the Elixir Loan Fund. The Society owes much to the Elixir Editors for the time and energy they have sacrificed.

2. Society Handbook—The Society handbooks with the revised lists of names, addresses, hostels and the Medical Society Constitution were printed and distributed to members free of charge in January, 1967.

External Relationships

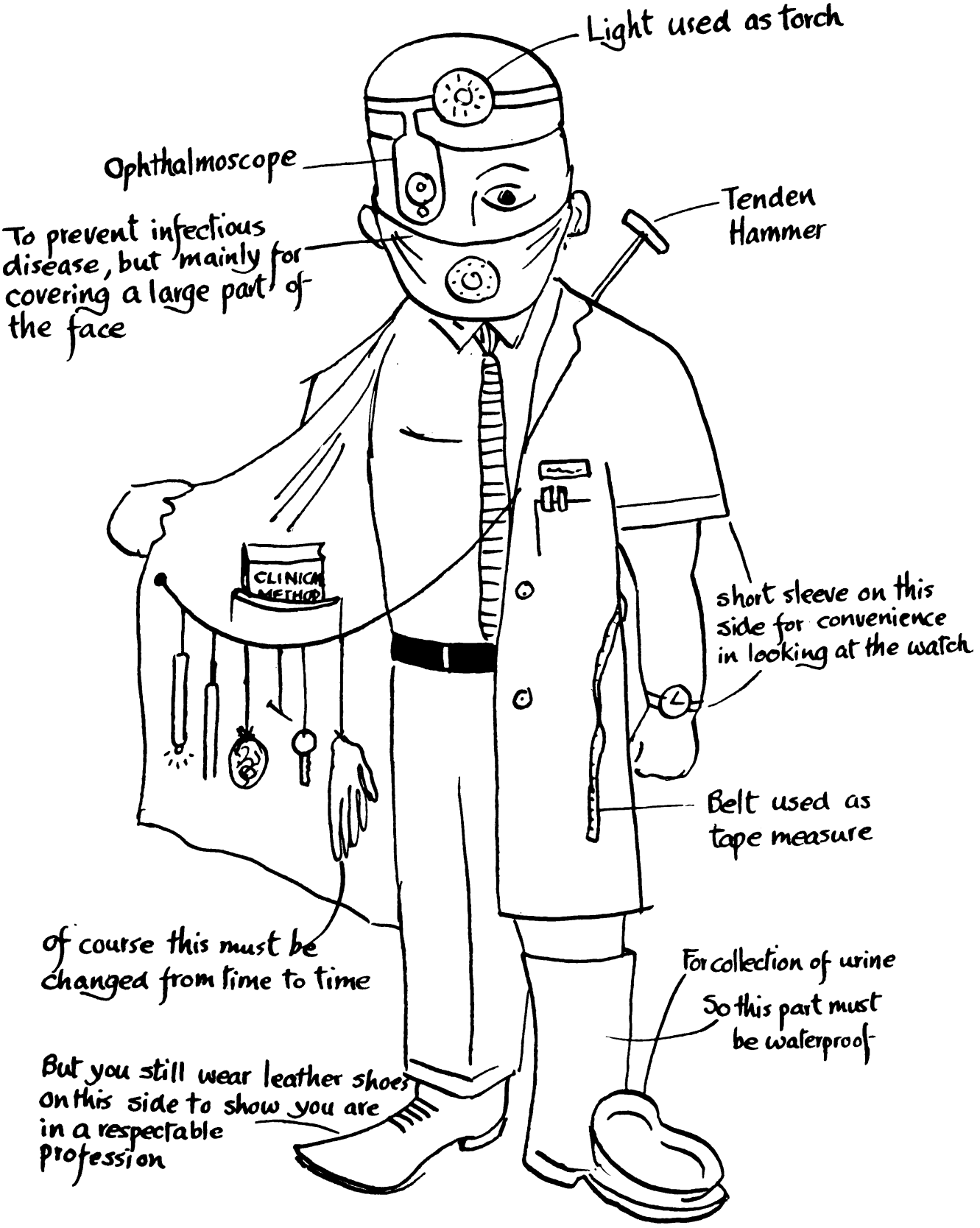
1. ARMSA second General Assembly—the first international student conference held in Hong Kong—took place in August 11 to 18th, terminated in great success. To this we owe very much indeed to Miss Christina Wang and Mr. Tang Nim Cho; the two membered organizing committee. Excellent work was done by them, although problems and obstacles were very many.

   By organizing and attending the conference, Hong Kong University Medical Society has taken a leading part in this international medical students association. In the conference, Mr. Woo Chi Pang was appointed President of ARMSA, and we were asked to continue our work on medical education and health, on which Mr. Peter Chang has laid down a concrete foundation last year.

2. Exchange Projects—Due to financial difficulties and the lack of an elective period in our medical curriculum, the exchange programmes in the past years were almost one way traffic. However, we were very much delighted to be host to medical students from Shiffield University, Guys Hospital. Sydney University, New York University, University of Malaysia, University of Singapore.

   Thanks are due to the Wardens of University Hall and St. John's College for the provision of lodging for the visitors during their stays in Hong Kong.

Throughout the year, the Hong Kong University Medical Society was very much indebted to Professor Field, our President, for her enthusiasm in our student affaires and her constant guidance; Dr. K. S. Lai, our Vice-President, for his valuable advice; Dr. C. T. Huang, our Hon. Treasurer for his understanding and patience; Dr. David Todd and the staff of Medical Faculty for their encouragement and generous support.



NEW COSTUME DESIGN FOR MED. STUDENTS

This hymn is specially dedicated to someone very special and dear:

To someone who flies across the rainbow

Carrying a trail of joy and laughter

Yet leaving a sweet but unfinished melody, ever to be fulfilled and ever be haunting. . . . .

Joy Is Like The Rain

I saw rain drops on my window,
Joy is like the rain
Laughter eases away my pain,
Joy is like the rain

I saw clouds upon a mountain,
Joy is like a cloud,
Sometimes white sometimes grey,
Always sun not far away,
Joy is like a cloud.

I saw Christ in wind and thunder,
Joy is like the rain.
Christ asleep within my boat,
Whipped by wind yet still afloat,
Joy is tried by storm.

I saw rain drops on the river,
Joy is like the rain.
Bit by bit the river grows,
Till all at once it overflows,
Joy is like the rain.

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Joy is like the rain.
Bit by bit the river grows,
Till all at once it overflows,
Joy is like the rain.

ROUNDABOUT

ALL BECAUSE OF MONEY

Hong Kong 17/6/67

In report to the University Court of University of Hong Kong, Professor E. K. Robinson, the Vice-Chancellor, said that it had been hoped to establish a Department of Psychiatry in the Medical Faculty at the University of Hong Kong in the 1967-68 triennium. But this project and five others, including the institution of a degree in Building Science, a Student Counselling Service, the purchase of an electronic microscope unit and a computer unit, and the establishment of a Research and Statistical Unit for University Administration, could not be undertaken, because of shortage of funds.

CIRCULAR LETTER TO DOCTORS FROM LEFTISTS

Hong Kong 18/7/67

The letter is signed by a "Norman Bethune Combat group of Hong Kong." Dr. Bethune, a Canadian surgeon, died while serving with the Chinese Communist Army during the Sino-Japanese War. The use of his name has become a favourite theme for Mr. Mao Tse-tung in propaganding the concept of "international brotherhood."

The letter said, "You are probably in good financial condition. Prepare yourself to contribute in the interest of our race and the fatherland."

Doctors are also approached by visitors on the same line. No violence has been reported, but some of the visitors threaten to prevent patients from consulting the doctors.

WOMAN IN COMA SIX MONTHS GIVES BIRTH

Boston, 21/7/67

A 36-years-old woman, who has been in a coma since January after suffering a cerebral vascular accident, and has since been fed by intravascular drip, yesterday gave birth to a healthy six-pound girl at the Massachusetts General Hospital. The delivery was normal.

NEW SEX STIMULANT FOR TEENAGERS

New Jersey, 12/8/67

Mr. Raymond Neff, public health co-ordinator for Cape May County, said that this little known drug is called "68", whilst the users call it "SJ" or sex juice. He said, "It sells because it is apparantly not illegal as LSD is, and is much cheaper. It induces wilder but shorter trips than LSD, the former's effect lasts only three to four hours followed by a deep sleep, while LSD's lasts eight to twelve hours. LSD is like being let out of a cage, while 68 is like being shot out of a gun."

THE SHADOW OF THE WALL

Berlin, 14/8/67

Petra Krause is five and lives in one-and-a-half rooms with her parents and five brothers and sisters near the Berlin wall. She has developed a psychiatric condition called "Wall Neurosis" which is also fast becoming evident among other children who live in the shadow of the wall. Together with 17 other children with the same complaint, Petra is now on a holiday in London seeking Psychiatric treatment.

BEWARE THE POPPING CHAMPAGNE CORKS

London 2/9/67

Drs. Desmond Archer and Nicholas Galloway, 2 British eye surgeons, reported in the Lancet that corks BLASTING FROM OPENING CHAMPAGNE bottles have produced nine cases of serious eye injury recently, three of which suffered permanent damage. Even waiters and waitresses have committed the arch error of

uncorking Champagne with the bottles held towards instead of away from themselves. They claim that a flying cork equals a mine or quarry blast, and can attain a velocity of thirty miles per hour and a height of forty feet.

FEMALE MENTALITY

Kuala Lumpur, 16/9/67

A survey of the sex and social behaviour of undergraduates at the University of Malaya is being carried out by a student committee. The physician working for the committee stated that some women students in the campus, when questioned, said that babies came from the umbilicus.

ANAESTHESIA AND ARCHITECTURE

London, 30/9/67

Sir Basil Spence, the architect, in a speech to medical students yesterday, said that a dentist gave him an injection to treat a tooth abscess. As he passed out under the effect of the anaesthetic, he conceived the idea for his design of the new Coventry Cathedral, which when finished, has been called by some "A prayer in stone", and by others as "an anaesthetic outrage."

DISFIGURATION CAUSED BY BEAUTY SURGERY

Tokyo, 24/11/67

This kind of cosmetic plastic surgery is not recognized by Japanese law as a medical science. Advertisements have lured Japanese women into having plastic surgery, and distress, disfiguration and breast disease have resulted from unsuccessful operations. A 26 years old housewife died from embolism after injection for augmentation mammoplasty. Thousands of Japanese women undergo these operations which last about half an hour each and cost as little as HK$12 to $16. This problem is now becoming a growing concern throughout Japan.

DEADLY ELIXIR

Chiquinquira, Colombia, 26/11/67

A deadly dose of arsenic, mysteriously mixed into bread dough, has cause a morbidity of 600 and a mortality of 80. National Police headquarters in Bogota reported that persons "were falling in the streets like flies" during the day. A public appeal is issued to all citizens to refrain from eating bread and drinking milk till health inspectors could trace all the poisoned loaves.

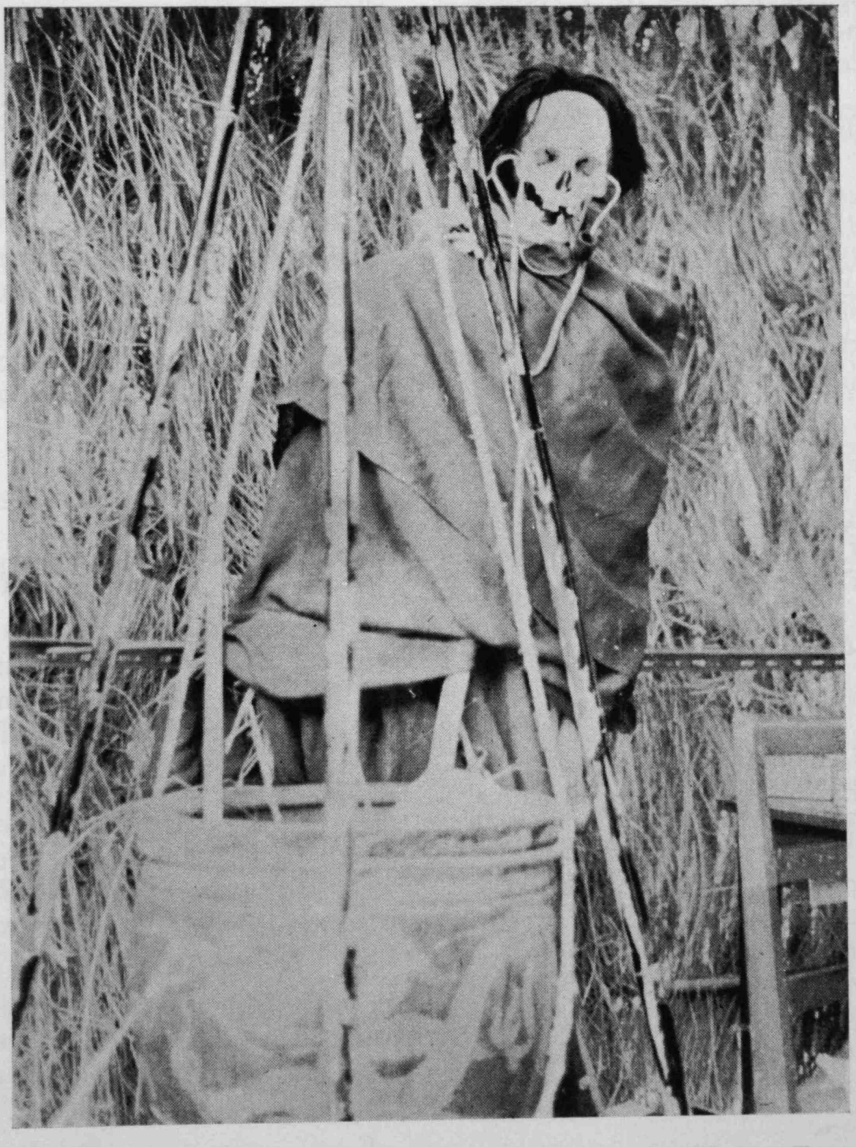
SMALLEST BABY EVER

London, 2/12/67

Tracy Hamlett, 3 months premature, was one of the smallest babies ever born in Britain: only a few inches long and weighing 16 oz. She was born in St. Mary's Hospital, Newport, Isle of Wright, and is now happily thriving.

COCONUT SHY

Designed by Mr. Lee Sum Ping



The shy that blushes its way to the top in the Union Fete

嬰孩心中的世界

秋葉

這個世界給我第一個印象就是殘忍、野蠻。在我降臨那一刻，雙眼便被那些比「阿拉伯的羅倫斯」裏的太陽還耀眼的燈光照得睜不開來，跟着便被提起、倒吊着，屁股還狠狠的捱了一記，痛得我哇哇大叫。「好了，又一個死不掉的」，我睜開眼，便看到一副魔鬼般的臉孔，露出一排黃澄澄的牙，作出一個暴虐行爲後底滿意的微笑，漸漸的在擴大，擴大……

那些大人們眞無聊，整天抱着我拋來拋去，這個捏一把，這個又 Bu Bu Jeet 的，有時對着我瞪起眉頭，或把舌頭伸出來擺上擺下，或把那張咀胡亂的擺動，大概是想引我笑了，可不知這究竟有什麽好笑呢？有時因爲被他們煩死了，或可憐他們這樣費勁，或恐怕他們老羞成怒打我一下，便勉强地笑一笑，他們却樂不可支，高興得見牙不見眼，看他們的舉動眞是滑稽可笑幼稚可憐。

不要以爲那些龐然大物很聰明，從我的觀察所得他們是最愚蠢的東西，他們說的話我都懂得，但我說的他們却一竅不通。每次我想要什麽，如果好聲好氣的告訴他們，他們都是莫明其妙似的，有時還傻傻的笑一下來掩飾他們的無知，眞氣人。到我急得大吵大鬧，他們才手忙脚亂的給我這樣，給我那樣。可是有一次，我看見他們在吃得津津有味，便叫他們給我一些，可是他們一些也不懂，我跟着便大喊大叫，於是再一次的令到他們手足無措，胡亂的給我玩得膩了的玩具和那淡而無味的牛奶，我還是不停地哭，直至面也紅了，嚇得他們以爲我有什麽不妥，便帶我看一個他們叫做醫生的人，嘩！那裏眞是人間地獄，對我這個手無寸鐵、軟弱無力、痛苦無告的人，簡直就是一個受難所。起初我以爲遇到救星，以爲醫生一定是懂得我說話的人，但是他給我的印象却是：醫生是最胡塗、殘忍的凉血動物，他不停的把我推左推右，又用一個冰冷的東西在身上左按右按，凍得我大叫大嚷他也毫不動容，跟着還不由分說的給我打了一針。我想醫生這兩個字一定是代表了胡塗、愚昧、殘忍，只有狗養的才會做這種慘無人道、滅絕人性的醫生的。回到家裏，大人們還强迫我飲下一些肴色水，這眞是難以下嚥，我吐了又吐，他們却餵了又餵，結果是吐了一半，吞了一半，這場禍刼我眞是割了腦也會記得，以後我再不會隨便叫喊，以免他們再一次的帶我到那個天殺的那裏。可是大人們却說：「哈，啤仔病後乖得多了。」唉！眞是天曉得。

出生後不久的一個晚上，我被包紮得結結實實的，手脚幾乎完全不能動彈，跟着還把一些冰凍的東西掛在我的頸上、手上，怪不舒服的，我急忙用手去扯開，大人們却說：「你們看啤仔多麽喜歡那些金錬、金鈪，他長大後一定賺很多錢的。」哼！眞氣人。跟着我便被送到一間很光亮的房子裏，那兒已經

堆滿了許多人，細看去，原來許多人都掛上金什麽的，難道他們不覺得難受難看嗎？難道這是一個金什麽的展覽會，連我這個小東西也參加？可是他們一看見我，便一蜂窩的擁上來，跟着又見到那些討厭的吧臉，那些黃牙的開合：啤仔眞趣緻眞乖眞聰明伶俐像爸爸一樣老實忠厚和藹可親謙恭有禮和媽媽一樣可愛清秀美麗動人聲音感人腑肺眉宇軒昂一表人材他日一定出人頭地是國家棟樑社會大杉討個漂亮的太太連棺材也特別大的。跟着又說：啤仔叫聲舅父舅母啦叫聲姨媽姑姐啦叫聲四姑八婆叫聲隔離二叔公二叔婆哥哥姐姐爹哋媽咪伯伯亞姨婆婆媽媽公公四嫲表哥表姐太公太婆王師奶陸先生孫姑娘二小姐啦，簡直把我弄得頭也昏了。跟着大家便圍在一起拚命的吃，彷彿這便是他們來這裏的目的，我又一次給他們冷落了。好，哭一會看看他們怎麽樣，於是又一大堆人圍了上來：乖乖不要哭今天是你的大日子啊乖乖不要哭哭大了口不好看哭場了肺長不大哭彎了手長不高哭正了腦袋便畫不出翳線漫畫寫不出翳線文章乖乖不要哭大了給啤仔多多吃的玩的給啤仔討個好老婆附送一個小的兩個三個四個夠未？哼！又是那一套，眞悶死人。我看見捉弄了他們，又想起上一次慘痛的經驗，便停止不哭了。啤仔眞乖眞聽話眞懂人意以後一定孝順父母對人和藹可親品學兼優，眞佩服這一羣人，有事沒事也可以說上大半天的。

有一次，一個和我差不多大小的小妮子隨着她的大人到我們家裏，她的頭髮紮上一個蝴蝶，咀唇塗得紅紅的，很可愛，眞想唱唱東尼的For The First Time，於是我便和她打開話匣子，談得興緻正濃，媽媽說：「啤仔，親親表妹吧。」這是我最近才學得的技術，不知獲得多少人的稱讚，媽媽要在姨媽面前表現我的聰明，我也樂於這樣做。於是便忙不迭的把臉湊過去。可是，「啪」的一聲，這妮子的氣力可眞不小，我的臉便結結實實的捱了一下，變成紅一片、白一片的，大人們這時却笑得腰也彎了。我眞不知如何是好。從此我得了一個教訓，要親一個人，一定要比出手的速度快。

一年快過去了，另外一個小東西又降臨這個家裏，這個小東西更得大人們的喜愛，因爲他一出世便能說「錢」這個字，大人們以爲這小東西將來一定非富則貴，光宗耀祖。我私下裏問問這個小東西，原來他一早便知道這個世界的人最愛這個「錢」字，爲了以後好過，他一出世便說出來。哼！好一個投機份子。

大人們的愚昧簡直是無可藥救，我盡了一年的努力也不能教他們學會我們的言語，沒辦法，爲了避免以前的誤會，以後還是說他們的言語吧。

後話

多年後，這嬰孩漸漸的長大了，他跟隨着社會的潮流，學習着大人們的言行，忘記了自己的語言。或許他已混忘了嬰孩時代那場禍刼，他還準備做一個小兒專科醫生。現在，讓我們一起誠心禱告，希望上帝能拯救那些處於水深火熱的形勢下却無人了解的嬰孩，阿門。

The symposium: As I Heard It
POST GRADUATE CAREER IN MEDICINE

Speakers were: PROFESSOR MCFADZEAN
DR. GERALD CHOA
DR. A. P. GUTERRES

This claims neither to be an accurate, factual, matter-of-fact presentation of what happened at the symposium nor does it pretend to be a recording in words of the proceedings for it has been said that the practice of medicine remains an art and the writer, being a student in "art" only looks with eontempt at what a tape-recorder is capable of doing and so, you may take the article *as you like it.*

With a booming and aggressive "Mr. Chairman, Sir. . " began our old veteran on POST-GRADUATE CAREER IN THE UNIVERSITY MEDICAL UNIT, while shovelling away the microphone with the back of his hand.

"You must be competent to be a teacher. Once you are admitted you would serve as Assiatant Lecurer for one year and then Trainee-Lecturer with a salary of £1950 per annum for three years . . . . "

Bang, bang, shrieked the rear-door and in barged a late comer who was greeted: Lad, you haven't come to the Clinical Years, have you!

"You would be given clinical awards amounting to £250 per annum for the first 5 years and then £500 afterwards. Study leaves would be given with expenses paid by the University. . . . .

It is not without reward for you would get a head of *grey hairs* and an increased proneness to *cardiovascular accident...*

In conclusion, his old chief in Surgery of Glasgow was quoted as saying: It was easy to practise hospital medicine but it wasn't easy to practise medicine outside.

* * *

It was evident from the start that Dr. Gerald Choa's POST - GRADUATE CAREER IN GOVERNMENT SERVICE would trun out to be a successful recruiting campaign for there were always vacancies in a multitude of services: the Medical Service with posts in general clinics, in prison hospitals and general out-patient department; the Health Service which included Industrial Health Services, School Health Services and Maternity and Child Health Clinics. The salary per month for Medical Officer amounted to $2435 with annual increment of $115 for the male and $1955 with increment of $130 for the female colleague.

The main thrill lies in the fact that there are always not enough men on the job.

* * *

"Preparation for Private Practice should begin long before graduation," began Dr. Guterres on his POST - GRADUATE CAREER IN PRIVATE PRACTICE.

"You are well advised to cultivate a social life with people from other Faculties and never gravitate with only medical students. . . . " But how true! No wonder many a prospective doctor is cultivating so friendly a relationship in the main campus library.

"There are three specialties which should be pursued by every General Practitioner, namely:

1) Diseases of Children —— and this includes the putting on of a napkin and the feeding of the client's first child.

2) E. N. T. —— where the painless removal of a hard ear-wax is not to be despised at.

3) Skin Diseases —— where the progress can be recognised as quickly by the patient as by the doctor.

Gee, as the saying goes, you can't always go be books, can you?

"As regards the monthly income of a General Practitioner, it varies: you may not be able to pay up your rent in your first few months but with 10 years standing, you would get about twice what the Government is offering you not to mention about the $10,000 per month after 30 years in the game. . . .

To be successful you must be kind and patient to your patient who is anxious, tired, scared and suffering with the exception that when you are established, rudeness is justified."

A FOURTH YEARER'S INSIGHT INTO THE SANCTUARY OF LEARNING— THE LECTURE THEATRE

CLASSIFICATION	CHARACTERISTICS	SIGNS	SITE & OCCASION
GRADE 0	Absolutely dull	Snoring from the audience	Slide Demonstration
GRADE 1	Flicker of Interest with assistance from fellow students in the form of jokes and/or candy	Persistent Yawning & occasional Snoring	At the Back Seats in a 3-4pm lecture in July
GRADE 11	Flicker of Interest without assistance	Hush-hush with secretive and appreciative nods	Revision Lectures just Before Exams
GRADE 111	Invigorating	Intent Faces but with a Dumb Look	Professor Clinic!

N.B.—Please to remember that a broad spectrum of presentation does exist between the two ends of the scale.

從歷史觀點看文化革命

·親民·

每一個國民都願看到自己的祖國繁榮富强，每一個國民也希望自己能夠生活在一塊美滿的樂土上。

然而，它們並不是不勞而獲的，那是要經過每一位國民的努力奮鬪，用自己的鮮血熱汗來爭取。

任何行動的誕生，是起源於某一信念，兩者互相扶持，並駕齊驅，正確的行動由堅强的理想所拖動，而理想也爲源源不絕的成果所鼓舞和滋養着。有理想而不訴諸行動祇是偉大的空中樓閣，有行動而不明所以由來却是可憐的盲目衝擊。

本文就筆者對東西方的自强運動作一個分析，並由此解釋及預料未來的中國所應完成的文化改革道路，以期達到一個完善富强的祖國。

（一）

西方的自强運動，起源於文藝復興和宗教改革。在此之前，歐洲大陸被歷史學者稱爲黑暗時期。當時教會整個地控制了人類的思想，絞殺了人類的智慧，任何稍爲違背了教會教義的，甚至認爲有危害其專制統治的，一概皆目爲異端邪說，受了教會的「異端裁判所」所摧害。漸漸，十三世紀的文藝復興，受了啓蒙大師彼得拉克、培根等影响，人身自由說漸漸盛行。十六世紀初馬丁露德竟冒着生命的危險，高舉起宗教改革的大纛，對存在的束縛着人類思想那不可侵犯的「神」進行了强烈的痛擊。由此以後的數百年，歐人的思想領域漸漸擴大，精神也逐漸地伸張，爲一個健全的社會舖下了一層穩固的地基。

然而，有了新的思想就使人類對其四周環境有更加深切的認識，對任何落後的社會體制也謀求改良。於是，十七世紀歐洲就發生了工業革命。新的技術及機器也順序而生，物質文明也日趨千里。

不久，社會上有識的人士却深深地體會到那阻塞着文明進步的就是統治社會的上層建築，那就是指存在當時歐洲的政治體制。於是，緊接着社會革命的就是民族及民主主義的澎漲，革命的洪流日益洶湧——理想、行動、流血、奮鬪、犧牲也就湊成了無數頁可歌可泣的樂章，新興的國家也就一個個地誕生了。

有了健全的文化、社會及政治的改革，那些新興國家，就像初升的旭日一樣，動用了其一切的資源人力，充實了自己的力量。更由於它們國內安定，倉庫廣實，民用富足，和因爲在國外列强彼此間的競爭，遂有軍事上謀求改革之舉。

由此可知，歐洲的自强運動，是從改革人類最基本、最深入的思想做起，逐次提升，漸漸地把每次的改革建築在前一次的改革後穩固的基礎之上，把範圍漸漸深入，漸漸加强。所以，歐洲近世紀的繁榮可說並非是偶然倖致的。

（二）

經過數百年的閉關自守的局面，落後自大的古老東方帝國終於被一股從西方來的風暴所襲擊。外國的力量不費什麼大的氣力就從容地啓開了那道莊嚴但却是腐朽的關防。

中國的各階層志士，一方面羨慕了人家强盛的外表，另一方面也有鑑於當時局勢的危機，遂有洋務運動、戊戌維新以及連接而來的自强運動。

洋務運動是由李鴻章、張之洞等人發動。他們以爲中國的積弱是由於武器落後、裝備不全，於是設立造船廠、水師學堂等及從國外購入各式火器。甲午一戰，這個以爲從軍事改革就可以進步的美夢完全被砸個粉碎。

戊戌政變時康有爲、梁啓超及六君子等則以爲戰爭的失敗及外患的相乘是因爲政制上不如人，於是他們提出憲法維新，妄想從上而下的一點一滴的政治改良來振興當時這個積弱的帝國。很明顯地，即使當時慈禧太后的反擊並沒有發生，即使他們順利地在制度的表面上完成他們的各項改革的主張，最後的失敗是可以預期的。

國父孫中山先生親眼看到了腐敗的社會的各項不合理措施，看到了走在他前面的歷次改革的澈底破產，也看到除非有一次從頭到尾的社會改革，除非把這個數千年來凌駕在人民頭上的帝王揪下來，把這個爛攤子朝庭粉碎，是無法有所作爲的。辛亥革命一爆發，兩個月內全中國各地紛紛反正，清帝不得已而遜位。

可是，是否把表面的政治和社會制度打破後，就是革命的最終目的，新中國的誕生呢？並不是。中國數千年來平民的一般觀念、腐敗的官常和若干所謂大儒的無理性、阻遏人類思想進步的教誨還是根深蒂固地佔據着一般人的心靈。一九一九年的五四運動，就是中國現代史的文化革命的先鋒。

然而，一個成功的開始却並非意味着一定有成功的成果。自民國以來，中國經歷了連續的苦難，軍閥割據，國共之爭，日寇入侵，及外國的窺伺乘機，它們固然使我們國家的完整受到無可補償的破壞摧殘，另一方面却給我們新的一代賣貴到無可復加的教訓，給了我們一套完整的生命理論，眞眞正正使我們從戰火的洗禮中獲得了鍛鍊人生的大好機會。這是一個極好的文化思想革命的實習場所！

很可惜，中國人民有若干的「傳統」思想，如個人主義，宗族主義等，却還是牢牢地存在人的心靈中的底層，故此，除非有一套完整的思想，有個能眞切地洗滌掉那些把人類思想蒙上一層厚霧汚濁的思想先驅，中華民族還是不能堂堂正正地屹立在天地之間！

（三）

順道提一提現時那些新興的非洲國家的情況，而讓一讓我們這個歷史改革的步驟來作一個引例。現時的非洲大陸的新興國家有些雖然資源豐富，先天條件充裕，然而却因爲本身沒有一套完美的文化及理想，但又因爲在此之前的殖民地統治者的別有用心地限制了他們的思想發展和學術追求，於是，名義上的獨立却造成了他們國內的連續不安，戰禍連接而來，政權却由外國野心家所把持控制，民生可以說是比獨立前更加凋零疲憊。任何沒有文化上有所成就的社會，是沒法達成社會、政治及軍事上的成功！

（四）

由此可見，想建成一個富强安康的國度，首先要從每一個國民的思想改革下手，建立成一套完整的文化，纔能夠有社會的改革，而從而保證了政治改革的成功（注意：政治改革並非等於政權的變易，而是一個完整開明政治制度的確立）。一個强大的政府和健康的社會所提供的就是一個富强的國度，那裏的一切，當然包括軍事和科學的發展，是健全的。

故此，我們可以知道近世的中國自强運動從開始就是走錯了門路，把先後的次序顚倒。像一個金字塔一樣，除非建造時是從下造起，確立了一個堅固的基層，否則，是永遠沒法建成的，而縱有所成，也就是一個爛攤子而已，絕對是無法經得起風雨的考驗。

新的思想應該是怎樣的呢？依我看不外乎是提倡一套大公無私的精神，把自己變成社會上一條負担起自己責任的棟樑，把自己與整個人類結合，培養出「心懷祖國、放眼世界」的正確人生觀。

國父曾說過：「吾國欲收革命之成功，必有賴思想之變化。」兵法以攻心爲上，所以，樹立起目前所急需的文化及思想地基，是當前的要務，也是每一個國民所負的責任！

HER DAY WITH THE MEDICS

by S. S.

The day was fine but not unbearably hot. Now and then a drifting nimbus shaded off the blazing sun, while the salty freshness of sea-breezes stimulated her spirit.

They had just served tea, these medics on her deck. They were quite different from what she had expected. They were fresh and gay, carefree and enthusiastic, so very different from what she was told: "All book-worms, that's what they are. They walk about with their burden of heavy books and bones, their shoulders rounded, their backs bent."

Thus cautioned she had expected little mirth from this launch picnic. But these medics turned out to be merry, and even musical. They sang songs, . . . songs that were, perhaps, not too well sung, but nevertheless, she liked such choral singing, such combination of tenor and base, which, mixed with chatting and laughter was, in her opinion, a justification to wild bliss, if not to prime music. After all, life would be better spent in soaring spirit than under the yoke of vain culture.

Amidst the tumoult of music and laughter sprang a game of Bingo. Nearly all joined in the game, roaring off with excitement as it proceeded. A few who did not participated scattered themselves, in the stern, at the bow, or down the railed starboard, chatting lightly by, or enjoying the soft kiss of sea-breezes, or just day-dreaming, drifting off to the metaphysical world. . . .

Even as she lay serenely there, in the tranquility of "Picnic Bay" she could sense the pulsating excitement of her fellow-passengers: as they dived into the rippling brine, or rowed off in their boats, or fished with silver thread that dipped like willows and vanished into the deep. She became engrossed with the little fishing party, with their intensity and their laxity, their smiles and frowns, as they waited patiently, waited impatiently. She cried out when the first fish was caught and brought in after a wretched struggle. She laughed as one of the girls yelled for help every time she found a fish on her hook. She almost wept as she saw how they cherished this precious instant of pastime. She knew such passion was but brief. She realized only too well how little they would value this treasurable moment were it prolonged . . . . such as the same passion these students bore for their academic year; such was the passion man bore for his daily life. With this wistful outlook, she wondered at human nature, at passion, at life.

Resignedly, she turned from these brown studies to the living present: luxuriant forests: barren spurs rising in grotesque transfiguration then sloping down to an undulating plain that stretched to the wavy margins of gilted sand, like the plinth of some gigantic statue; three or four super-de-lux sailing boats anchored near by. . . .

But humble be her little launch, her fellow-passengers' gaity won the day: game after game was introduced: a wild "duck" chase was invented, concluded by presentation of the prized duck to the swimming champ by the class-rep.

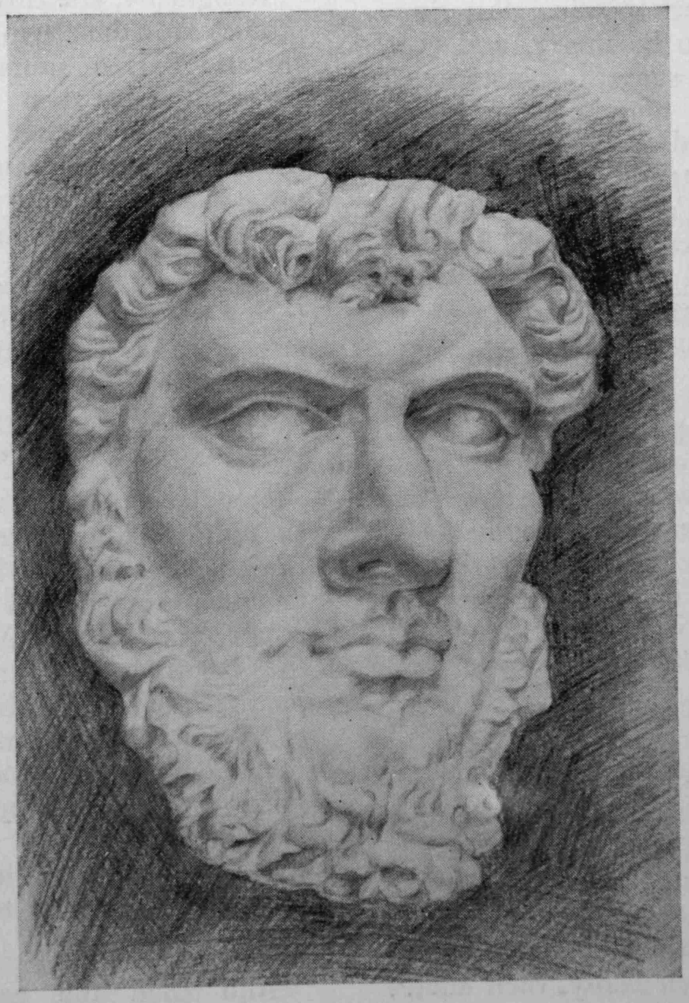
Iregular shadows were stretching from the fading contour of towering mountains . . . time to depart! Slowly, but with no reluctance she tore herself from the embrace of outstretched cliffs. Much as she relished the beauty of sloping green fields and picturesque tea - gardens, and the romance of glazed hillsides and dark-loomed caves, she knew that she could not dwell among them for long. Soon they would merge into darkness. Too see them fade away would be even more heart-breaking than to leave them now and take their beauty with her.

And then the enchanted lights and shadows and the euphony of dashing waves were no more.

But what was still with her, sharing with her the stark reality: her medical friends. Here was only laughter, and no room for wistful thoughts. Life was still too young to look back into the past. Perhaps, amidst that throng of noises, there might be a heavy heart or two. . . . but who cared. . . . only blissfulness could be detected from the atmosphere, an atmosphere pregnant with joy and life.

Beyond the stretch of brine, over the rolling mountains, beneath the crimson cirus, the blushing sun was rapidly sinking. She could see her own dilated shadow bisecting the glitering water in front, the golden rays and glamorous gems tossed at the bow, the exotic charm of twilight veiling down silently, invincibly. . . .

Gone was this memorable day. In a moment, she would have to part with the medics who had shared with her a voyage that seemed so long, but passed so soon. She wished she could relive it. And yet, between smiling today and unpredictable tomorrow, she'd rather choose tomorrow. . . . for after all, the treasure of today's memory was made for tomorrow, and tomorrow's for another day.



Sketch by a 4th yearer.

三　十　人　行

·四年級·

九月尾一清早，各式老爺車齊集九龍城碼頭，載了三十初級黃綠小馬，出發西貢青年營，幾經脫卡，拋錨，總算安全抵達。

早餐桌上，擺滿碗和筷。大家滿以爲必非粥即麵。不料竟是奶茶麵包。無可奈何，我們祇得用飯碗喝奶茶，筷子搽牛油，吃了一次最 "MOD" 的早餐。

巧婦難爲無米炊，買少了油，氣得火頭大將軍七竅生烟。「買辦，你可謂食『油』深矣，慢走，人膏充生油，勿怪我屠刀無禮。」此公可說大有 Ong 叔之風，乃大 Surgeon 之器也。

晚飯後，大家閒着無聊，實行「夜照田鷄」各同學踴躍參加意見，口沫橫飛：「這個有」桃花運，齊人相，那個要臨老入花叢，—— 眞個 Professional 也自嘆不如。

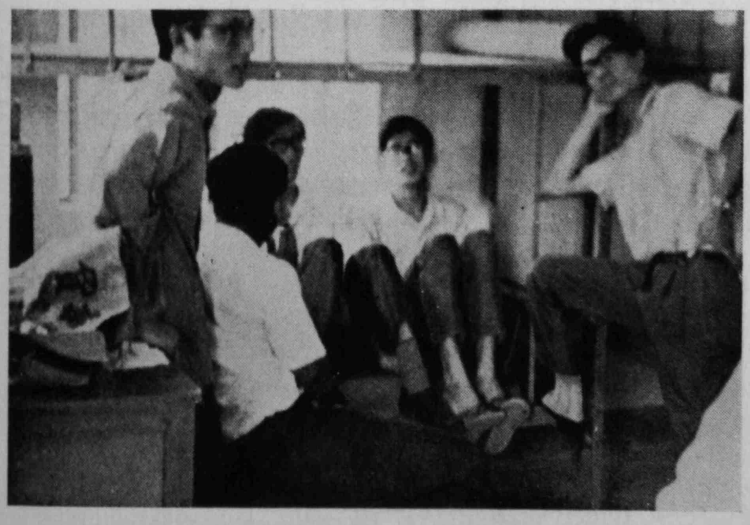
黃河之水不知何向來，竟流入西貢一個灣頭，難怪獨木舟也翻了。(按：黃河乃一行友之名)

唉吔，Alaine Deloin 嚟了

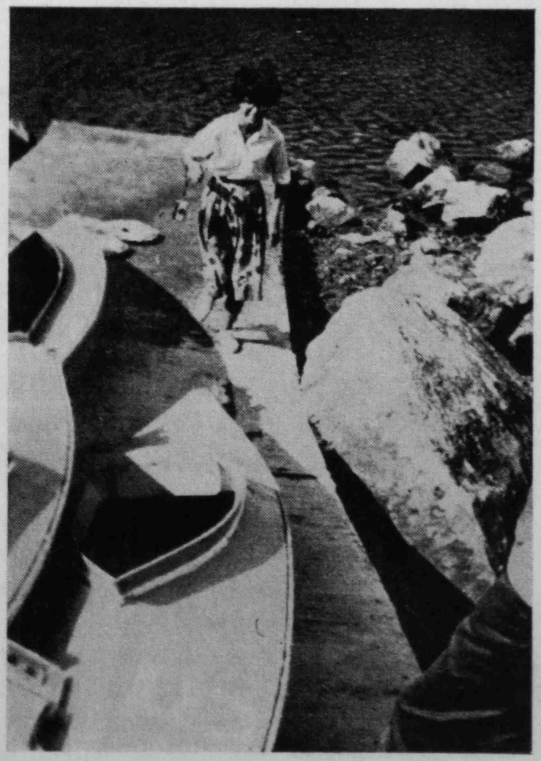
灘頭大批海星，隨手拾來幾十隻。有人說定是尋到海星祖居，有人說它們在開海星 "Social Gat。" 一面謬論連天，一面拾滿幾 Canoe。

半夜傳來陣陣怪聲，悽厲入骨，各人畢竟是未來大國手，毫不動容，蒙頭詐睡。

翌日議論紛紛，查出怪聲乃某睡星鼻鼾聲也。



相量怎樣潛入女生營 Plotting a Panty raid?



乜哥，等等

Immunity to measles from a single injection of a safe vaccine

"The analysis was completed of the results of the recent field trials of measles vaccine sponsored by WHO in several countries in order to compare the severity of the reactions and the antibody level produced by various available measles virus vaccine strains.[1] It was found that the Schwarz vaccine caused less reaction than the others tested and gave a satisfactory antibody response. Further studies to measure the duration of immunity provided by different vaccines have been planned. Present evidence indicates that the live measles vaccine will give good protection for years. Despite the pyrexias which they induce, no serious untoward sequelae have been reported from their use on a large scale, and there is good reason for using them for the routine immunisation of children where mortality from measles is high.[2]"

Mevilin-L

Mevilin-L is the new single-dose live attenuated measles vaccine. It is manufactured by Glaxo Laboratories Ltd from the Schwarz strain developed by the Pitman-Moore Division of the Dow Chemical Co.

1. See Off. Rec. Wld. Hlth Org. 139,16
2. Official Records of WHO No.147

Presentation
Single-dose vials, in boxes containing one vial of Mevilin-L, one ampoule of Water for Injection, one sterile disposable syringe.

Mevilin-L is a trade mark

GLAXO

Glaxo Laboratories, Ltd., Greenford, Middlesex, England.
Agents: Dodwell & Co., Ltd., Hong Kong. Tel. H 237011.

TO BE A DOCTOR

Felix Marti-Ibanez M.D.

EDITOR-IN-CHIEF OF MD, THE MEDICAL NEWSMAGAZINE;

FORMER PROFESSOR AND CHAIRMAN OF THE DEPARTMENT OF THE HISTORY OF MEDICINE,

NEW YORK MEDICAL COLLEGE, FLOWER AND FIFTH AVENUE HOSPITALS

NEW YORK, N. Y.

MY COURSE on the history of medicine had ended. Facing me were a hundred and twenty-eight young men and women. There were pale faces and swarthy faces, students with dark, blond, or red hair, but throughout the entire group the same restless light shone in their young eyes, as if they had captured a spark from the sun. These freshmen of mine asked me to tell them what it means "to be a doctor," and I ended my course with this explanation:

Ever since the day you first said those magic words, "I want to be a doctor," you have been wrapped in the colorful fabric of the history of medicine, a fabric woven from the ideals, wisdom, endeavors, and achievements of our glorious predecessors in medicine.

You have just embarked on a fascinating voyage leading to the harbor of one of the most dynamic professions. Year after year new windows will keep opening before your eyes, revealing the multifaceted landscape of medical art and science.

But medicine today is so complex that no human mind can possibly absorb it all, as was possible a few centuries ago. Only by using the history of medicine as a gigantic frame to contain what you learn is it possible to integrate the numerous fragments of medical theory and practice that will be taught you in your student years. Only through the history of medicine can one appreciate that to be a doctor, in the true sense of the word, is to be not only a wise man but, above all, a good man. To be a doctor is, in other words, to be a whole man, who fulfills his task as a scientist with professional quality and integrity; as a human being, with a kind heart and high ideals; and as a member of society, with honesty and efficiency.

Contemporary medicine is founded on a series of events that resulted from the thoughts and deeds of a few men in the course of history. History is made by men, and the greatest among the makers of history is the physician because of the effects of his ministry on all other human beings.

Man is the only creature able to make tools with which to make other tools, and of all the tools made by him words are the most important. The fabric of medicine is woven with words that express the ideas from which they sprang. The original meaning of the three words—physician, medic, doctor—that describe our profession is highly illuminating. The word "physician" derives from the Greek *physis* or nature, denoting that the physician has his roots in an understanding of the nature of things; the word 'medic" comes from *mederi*, to heal, and the root *med* means to meditate or think, so that medic is equivalent to thinker and healer; the word 'doctor" originally meant master, instructor. Thus, semantically, our profession involves learning, knowing, healing, and teaching.

In its turn, the word "medicine" not only means what medical men do (many of the great figures in medical history, such as Pasteur and Leeuwenhoek, were not physicians), but also denotes a *social* science that uses the methods of the natural sciences to attain four objectives: to promote health, to restore health, to prevent disease, and to rehabilitate the patient.

Every day, more and more, medicine becomes, above all, the prevention of disease and the promotion of health. For only by knowing the healthy man can we cure him when he falls ill. Knowledge of the healthy man is obtained by studying our fellow beings, both the healthy and the diseased, not only in the mirror of classical and modern medical literature but also in current newspapers. You will then learn that poverty is still the main social cause of disease, just as it was in archaic times.

The history of medicine epitomizes the history of civilization. The history of man has passed through three great stages: man learned to master nature by yielding to her laws; he learned to live in society by establishing the first communities; he acquired consciousness of his human dignity and of his ability to forge his own destiny, which in turn enabled him to acquire greatness.

The physician in his threefold capacity, as a professional, as a member of society, and as a human being, has throughout history helped man in his physical, mental, and social ascent. As a professional man in particular, the physician has always acted as a healer, using magic, faith, empiricism, or rational resources; as a knower, for he knows the secrets of nature and of the human being; as a preventer, for he can arrest disease by forestalling its vanguards before they develop; and as an organizer, for he can guide society in fighting the historicosocial process called disease. To heal, to know, to prevent, to organize—these will be your four future spheres of professional activity, embraced in the expression "to be a doctor."

To be a doctor, then, means much more than to dispense pills or to patch up or repair torn flesh and shattered minds. To be a doctor is to be an intermediary between man and God.

You have chosen the most fascinating and dynamic profession there is, a profession with the highest potential for greatness, since the physician's daily work is wrapped up in the subtle web of history. Your labors are linked with those of your colleagues who preceded you in history and those who are now working all over the world. It is this spiritual unity with our colleagues of all periods and of all countries that has made medicine so universal and eternal. For this reason we must study and try to imitate the lives of the great doctors of history. Their lives, blazing with greatness, teach us that our profession is the only one that still speaks of its duties in this world of today, in which almost everyone else speaks only of his rights.

An ideal of service permeates all our activities: service especially to the patient, as a fellow creature isolated on the island of his suffering, whom only you can restore to the mainland of health. For that purpose you must know thoroughly not only the diseased but also the healthy.

Your own contributions to medicine can begin even in the golden years of student life. There is no need to wait for your medical degree to start making medical history. Many physicians while still students made historic contributions to medicial science: Vesalius, Stensen, Laennëc, Remak, Freud, Best, men who believed in themselves and were dedicated to the profession you have chosen for your own.

From now on your professional conduct must adhere to the moral code of medicine that began with the Hippocratic oath. Despite its negative aspect in prohibiting a number of activities, the Hippocratic oath was not a law but a precept self-imposed by physicians who accepted an ideal of devotion and service conjoined by their moral conscience. Five types of ethical duties must guide your life: duties to your teachers, to society, to your patients, to your colleagues, and to yourselves.

You have duties to your teachers, because they, the parents of your mind, are the most important people in your life next to your own parents. I do not mean only your university professors, but any physician from whom you learn anything—his science, art, ethics, self-denial, or example—that may become a source of inspiration in your professional life. You must honor your masters with devotion and friendship, for friendship is man's noblest sentiment, greater even than love.

Your duty to society is to be idealists, not hedonists: as physicians, to accept your profession as a service to mankind, not as a source of profit; as investigators, to seek the knowledge that will benefit your fellow beings; as clinicians, to alleviate pain and heal the sick; as teachers, to share and spread your knowledge and always because you are imbued with an ideal of service and not the ambition for gain. Thus will you maintain the dignity of our profession as a social science applied to the welfare of mankind.

Your duty to your patients will be to act toward them as you would wish them to act toward you: with kindness, with courtesy, with honesty. You must learn when and how to withhold the truth from your patients if by not telling them all the facts of the case you can relieve or console them, for you can cure them sometimes, and you can give them relief often, but hope you can give them *always*. Remember that a laboratory report is not an irrevocable sentence. A hematological determination, a roentgenogram, an electroencephalogram may supply vital information on the organic working of the body, but it is even more vital never to forget that, behind all such reports and data, there is a human being in pain and anguish, to whom you must offer something more than an antibiotic, an injection, or a surgical aid; you must, with your attitude, your words, and your actions, inspire confidence and faith and give understanding and consolation.

To your colleagues you have the obligations of civilized men sharing a great and noble task and fighting for a common cause in a great crusade. Medicine lives and is nourished by the great social prestige it enjoys. Hence, never speak ill of a colleague, since to do so would be the same as speaking evil of medicine and therefore of your own selves. If you have something good to say about a fellow physician, say it everywhere; if you have not, then keep silent. You belong to a team of gallant professionals of all races and eras, bound together across the ages and continents by a glorious ideal.

Finally, you will have obligations to your selves. Every man in his youth forms an ideal profile of himself or of what he wants to be. He envisions, while young, an ideal program of things to do in life. The rest of his life is spent trying to fill in that profile with achievements. Some fail to reach fulfillment, and later it is tragic to see that ideal profile, of which they dreamed during their youth, in ruins, with the stumps of things begun but never completed. But in the majority of cases, that ideal silhouette created in youthful days really represents our true selves. You must live to be worthy of that silhouette. Your life, your work, and your personality as a physician must be such that your ideal profile of yourself will be filled in with brilliant achievements.

Learn to live perceptively, using that key to wisdom that comes from seeing everything with a total perspective and in view of eternity. Learn through science to correlate things in space, through history, to correlate events in time, and combine all this knowledge esthetically through the beauty of art.

You are embarking on a noble career in which there is no room for amateurs or dilettanti, a career in which we must all aspire to be masters of whatever we undertake, for the mistakes of medical carpenters and prescribers' apprentices can have tragic results.

Remember that the important thing in life is to be great, not big, a *great* man, not a big man. Let your actions be great, but preserve your personal modesty and humility. What counts in a man and in a physician is his greatness. By greatness I mean grandeur in the things we do and simplicity in the way we do them, doing things that influence the lives of many people, but preserving always the greatest personal simplicity. For greatness *is* simplicity. Know how to feel yourself an important part of the deeds of history. Try to find out as soon as you can what your ideal self is. Try to be what you truly are; otherwise you will be nothing. Such was Pindar's theme: "Be what thou art." Man's dignity rests in his ability to choose his destiny. You have chosen the best destiny of all, a life of dedicated service and dynamic activity. If you work with faith and without dismay, all your dreams will come true.

In your future work you will be in good company. The great physicians of history, the glorious figures of the past, will always be near you. When you perform a dissection, a red-bearded young man with flashing eyes, Andreas Vesalius, will be peering over your shoulder; when you make a physiological experiment, the melancholy, pensive eyes of William Harvey will be watching you; when you teach medicine, the venerable figure of William Osler with his Apollonian head will come and sit like a medical Goethe beside you; and when you approach the sickbed, the shades of Hippocrates, Sydenham, and Fleming will gather round to counsel you.

The Greeks created the legend that Delphi, site of the famous oracle, was the center of the world, because if two eagles were to fly from any two points of the globe, sooner or later they would meet in Delphi. We now know that the two eagles of science and medicine do not fly only in space but also in time, and their wings hover over the illustrious shadows of the investigators, clinicians, educators, pioneers, rebels, and martyrs of the history of medicine. The meeting place of those two eagles lies not in space but in time, in the future, and in the mind and the heart of every one of you who answered destiny's call to greatness when you decided "to be a doctor."

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MINI SCHERZO

A lady doctor, whose engagement dated back to the archaeological days of her preclinical course, finally took the plunge after eight years. Her bosom friend cabled her, "Congratulations. What's new?"

A young woman walked into a gynaecological clinic complaining of a discharge. During a P.V., the doctor told her everything seems normal. She replied, "But doctor, the discharge is from my ear."

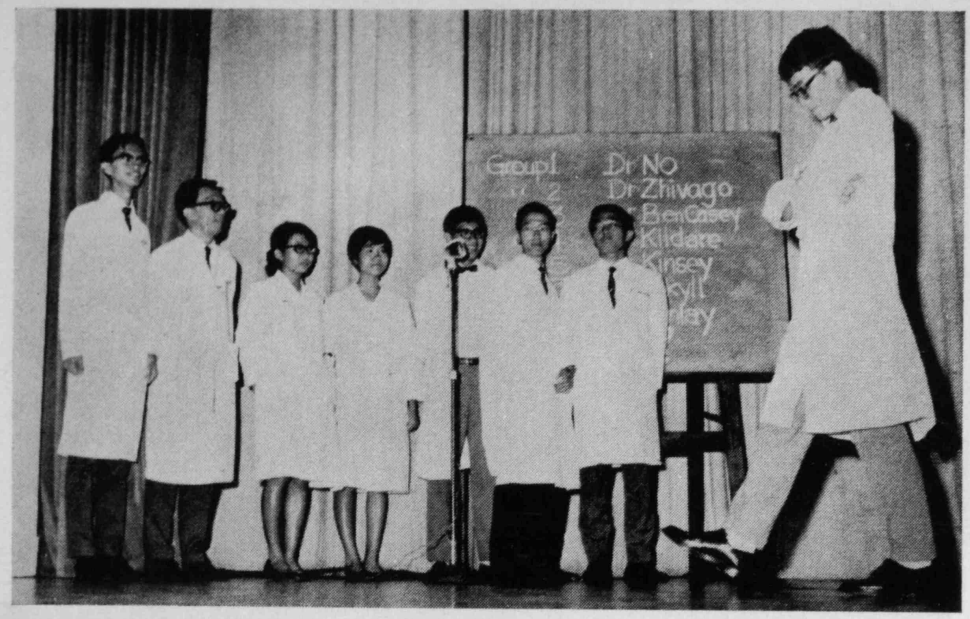
Doctor to nurse, "Nurse, please look this up in Mrs. Summerhaye's case history, Volume V, book three."

One lady psychiatrist to another, "Put up with me Emily, I feel a bit schizophrenic this morning."

"Good," said her colleague, "That makes four of us."

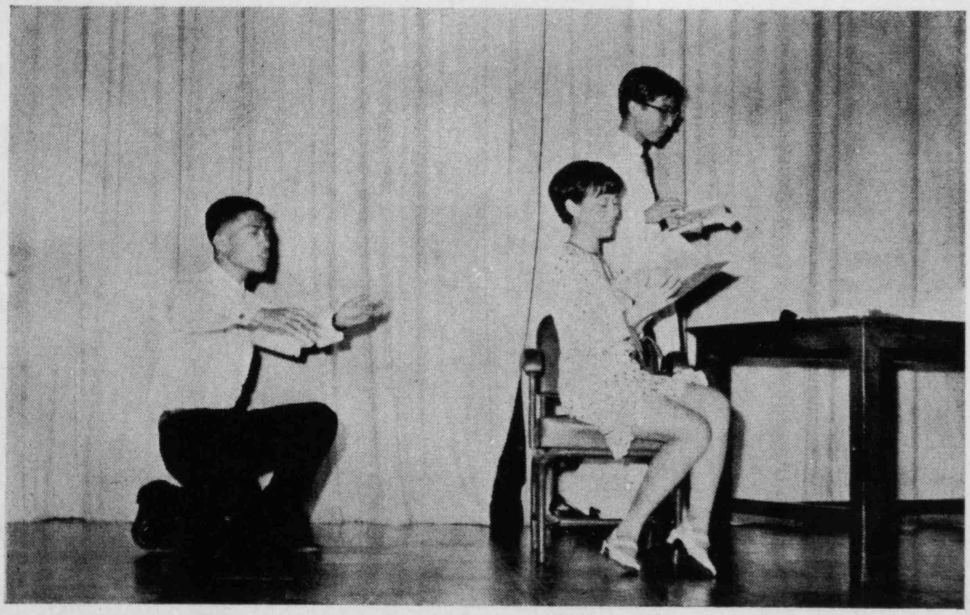
Mrs. Gold's past complaint, "Can't find anyone good enough to marry her daughter."

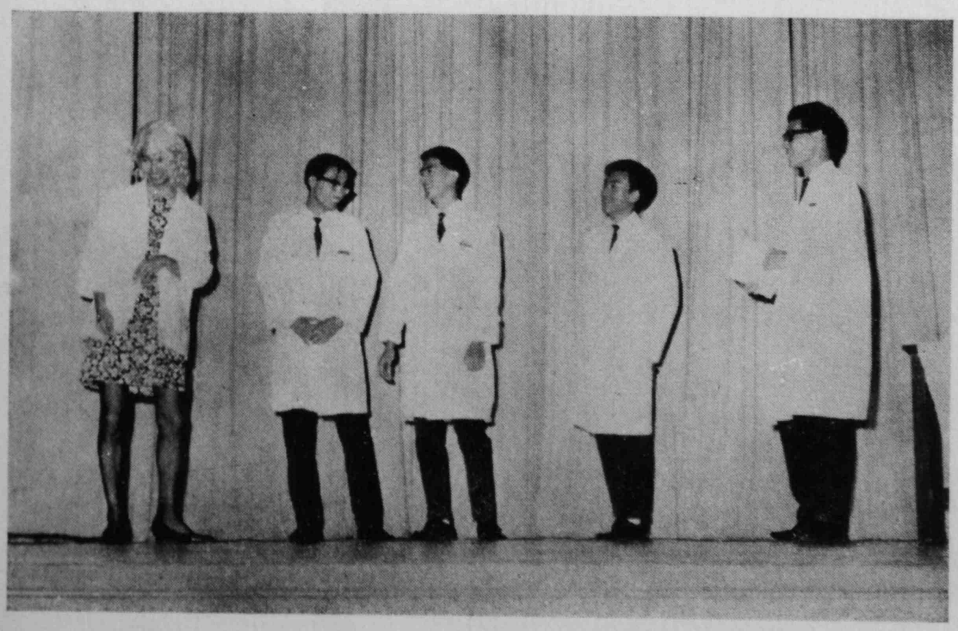
Glimpses from Med Nite



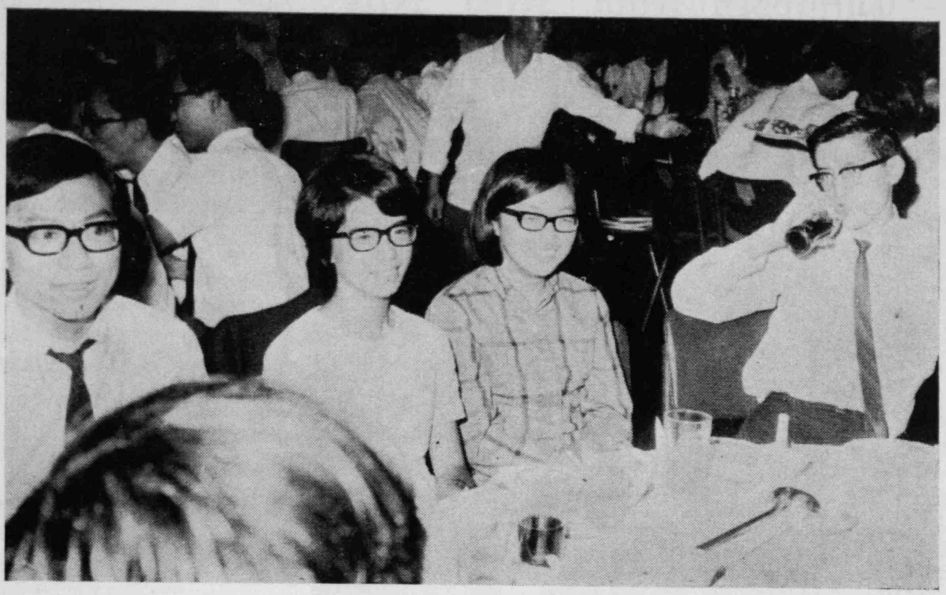
Doctors Hit Parade

Petruchio to Kate:
Will you, Nill you,
I will Marry you.





Loveliest legs
around campus



Things go bctter with coca cola

No no, I want to become a houseman, not a housewife, not yet . . . .

Pleasure . . . Can I give you a lift in my Alfa Rome o

Opea a little wider and say' Ah . . . h . . . h!

Charle Brown: Misery is the back that itches in public.

PROFILES or Long stories.

Bob Newhart on a comedy sketch of the expectant father: "My wife and I were married last December, and we had our baby five weeks ago. To save you from counting on your fingers, I can assure you that everything was all right.

We were on our way to the maternity hospital, and my wife said, 'Did you call the doctor?'

'Yes,' I said calmly, 'Dr. Ellis is on his way.' My wife said, 'Dr. Ellis is my dentist.'

On reaching the hospital, I was given a form to sign. I said to the nurse, 'While I am doing this, can you please take my wife to the labour room?' Nurse said, 'No sir, After you're through with the form, she'll have to sign at the bottom.' I said, 'If she wait fifteen minutes longer, all three of us will be able to sign the form.' On hearing this, the nurse got frightened and complied.

In the waiting woom, I found out that the lowest creature in a hospital is the expectant father.

You also see lots of people running around looking important and worried. They aren't really hospital personnel. The hospital hired them to look worried so that the expectant father wouldn't feel so bad.

When everything was over, you begin to wonder why the world ever gets over-populated, for each time you say to yourself, 'I'll never go through all that again.' "

"The development of Public Health in Hong Kong: the Past, Present and Future."

By Andrew S. P. Hua

Introduction

The story of the development of Public Health in Hong Kong, like the story of Hong Kong herself, is an epic of a people who have continually stood up against incalculable odds, faced challenge after challenge, and have emerged as a mature and healthy community. In the following account I will endeavour to relate the development in history, the present situation and possible future developments in the Public Health of the colony. I shall not deal with the Medical aspect in this present account. Mention will be made however of the work of the Urban Services Department as it has direct bearing upon the health of the community.

General development

Even from her earliest infancy, Hong Kong, with a land area of less than 400 square miles, had to cope with giant problems. Natural calamities and political unrest in the mainland brought huge waves of immigrants into the colony. Such human influxes overleaded the capacity of the colony's resources in more ways than one. As early as 1841, the now common-day words like "overcrowding" and "squatter problem" were already upon the lips of concerned people of the day. These early experiences with sudden increases of population served to prepare the Colony to adapt herself to cope with the gargantuan influxes of refugees she was to foster in years to come.

Public health work in these early days were directed mainly towards the control of plague, cholera and other epidemic diseases and the betterment of environmental hygeine. In 1932, responsibilities for the then Medical and Sanitary Services were defined. The colony was divided into health districts, each supervised by a District Health Officer. All aspects of health work found today were a ready carefully delineated in these early plans of development. In 1936, further divison of labour say the administrative separation of the Urban Services Department from the Medical and Health Department.

The First World War saw a new influx of refugees, an outbreak of cholera and the occurence of a severe typhoon. Anti-Cholera measures were undertaken. 1938 saw a prevalence of infectious diseases while the next year witnessed another influx of refugees which swelled the population. Refugee Camps and Emergency health measures had to be taken. Malnutrition, unplanned housing and limited water supply were the other enemies against which Hong Kong had to battle. Deficiency diseases such as Pellagra and Beri beri claimed many lives around the time of the Second World War.

After the War, residents rapidly returned to the colony and in the new climate of peace, every aspect of the colony including the health services prospered. This was well timed, for in 1949-1950 the Chinese Civil War brought an unprecedented flood of immigrants into the colony, doubling the population. All essential services were taxed to the limit, especially so in the field of public health. Unlike previous influxes, there was no subsequent emigration, thus it soon became evident that permanent and long-term measures had to be taken to accomodate and care for the health of these newcomers. Meanwhile, illegal immigrants continue to pour in, adding yet another burden to the immense load. Severe shortage of housing, severe overcrowding led to the creation of huge areas of makeshift "squatter" huts. These factors plus the poor general health and poverty of the immigrants provided ideal conditions for the spread of diseases. Tuberculosis was rife, infant and maternal mortality was unbelievably high, while general hospital services were grossly overloaded.

In the face of these problems and the limited resources available, priority was given to institute immediate measures to combat the major threats to health. These included the development of a quarantine service, an epidemiological service to limit the entry and spread of epidemic diseases; maternal and child health services to reduce the high mortality rates; and the control of tuberculosis. Results in the ensuing years have shown that this timely decision had been a wise one. Tuberculosis mortality and maternal and child mortalities have since dropped precipitiously down to levels which may be compared favourably with those of any nation. Extensive immunization was one of the major factors contributing to this achievement. Small—pox, Diphtheria, Cholera, typhoid and poliomyelitis vaccines were given widely to children and vulnerable groups; and the percentage of babies vaccinated with B.C.G. vaccine is undoubtedly the highest in the world.

These and other efforts, as outlined later in the paragraphs that follow, have resulted in the production of a high standard of health in the colony. Statistics relating to the development of public health are provided in tables at the end of the essay.

Control of Communicable Diseases

A study of the trends in the incidence of the various communicable diseases serves both to guide the efforts of the Health authorities as well as to assess their success. As notification of diseases was comparatively a late institution, the number of deaths per year resulting from the diseases over the years is a convenient guide and index of the prevalence of the diseases concerned. For statistics from 1901 until 1966, please refer to Table 1. In the following paragraphs, some of the prominent landmarks have been pointed out.

Plague

Plague reached epidemic proportions early in the 1910s especially in 1912 and 1914 when the death incidence headed the death list by a fair margin. As a result of strict anti-plague measures and quarantine control, the disease gradually came under control in the 1920s with the exception of 1922 when another outbreak occured. The last reported case of Plague was in 1924.

Tuberculosis

Tuberculosis had always been a great killer. especially among infants and young children, After the war, tuberculosis rivalled with pneumonia as the Number One killer. However as a result of intensive work by the Tuberculosis Service and the widespread vaccination with B.C.G. vaccine the incidence has greatly decrease. Further details are provided under the heading of the Government Tuberculosis Service.

Pneumonia

Pneumonia, especially Bronchopneumonia or the "Old man's friend" visited many an infant and old man throughout the years. It headed the death list from earliest times. With the onset of better treatment, the death incidence has shown a considerable decline especially in the last decade. In the 1957 epidemic of Asian influenza however, pneumonia complicating the viral infection caused many deaths.

Malaria

Hong Kong was and is a potentially dangerous malarious area and yearly malaria claimed several hundred lives and crippled many more previously. The death incidence reached its zenith in 1950 when about 1,500 persons died of the disease. As a result of strict control measures (please refer to the section on Malaria Control) the incidence has been drastically reduced.

Smallpox

This quarantinable disease claimed lives annually until 1949 with severe outbreaks in 1923, 1938 and 1946. Strict vaccination and quarantine measures have caused the eradication of the disease since June 1952 when the last case, an imported one, was recorded.

Cholera

This severe acute gastrointestinal disease often reached the colony from other countries. Outbreaks in the colony often follow epidemics in China. After severe epidemics in 1932, 1938 and 1946, the colony was free from cholera from 1947 until 1961 when cholera reappeared and continued to reappear every year for a few years. This persistence is probably due to a high carrier rate.

Enteric fever

Typhoid and Paratyphoid are diseases of bad hygeine and they have their annual share in the toll of lives. Hong Kong has a very high carrier rate and the disease is endemic. Due to the difficulty of elimination of carriers, eradication of the disease is difficult. The decrease in the incidence has been due to improved hygeine and better medical treatment and follow-up of cases.

Diphtheria

This disease, usually of children reaches epidemic proportions every year with the highest death toll in 1936. Since the advent of the anti-diphtheria campaigns the disease has seen considerable decrease in incidence.

Measles

In Hong Kong as in other countries, the disease occus every two years as a wave of infection spreading through the population under 2 years. Although mortality has remained low, the effects of post-measle complications were high. The erroneous traditional belief that herbal treatment was superior to scientific care has substantially handicapped the control of the disease.

Poliomyelitits

Little was reported of the incidence of Poliomyelitis before the war. However the incidence rose to alarming proportions in 1949. A survey indicated that the majority of the children of Hong Kong possessed immunity. The Salk vaccine and later Sabin oral vaccine given in massive campaigns in 1963 have caused a great decrease in the incidence.

Influenza

After the outbreak of 1957, small outbreaks have occured. Virological investigations continue.

Other Diseases

Deficiency diseases such as Beri-beri and Pellagra was rampant among poor refugees and as the war further aggravated the situation beri-beri claimed 7229 vicitms in 1940 while Pellagra made a sudden appearance shortly before the Pacific War. However after the war the diseases gradually faded from the scene as the standard of living rose and the dietary knowledge of the public increased.

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Meningitis was rampant from 1938-1940 but but also calimed annual victims.

Ameobiasis and baccilary dysentery also occured sporadically every year.

Rabies had not been reported on Hong Kong island for many years while the last death from Rabies occured in 1956.

As the situation continues to improve, the next aim of the control of communicable diseases is the eradication of diseases. This may be achieved through strict quarantine and port health control, mass vaccinations, follow-up of contacts and carriers and widespread health education.

Maternal and Child Health and District Midwifery

To understand the importance of Maternal and Child Health and Midwifery work, we must cast our minds back to the early 1900s. In 1908, of the total deaths recorded, 31.6% were infants under the age of one year. Although the infant mortality rate cannot be calculated accurately then due to incomplete notification of births, the mortality must have been very high as witnessed by the common practice of dumping of dead infants onto streets. To combat this appalling situation, emphasis was placed upon proper midwifery and maternal and child health since the 1920s. By 1928, a Maternity Hospital was operating and Maternal and Child Welfare established as a part of the Medical and Sanitary Services. Infant Welfare centres were set up by government and charity organizations. The first government infant welfare centre was set up in 1932 on Hong Kong island, while a Kowloon centre was opened in 1934. Even in these early days, the nutritional status of the mother was taken into consideration and soup and synthetic milk were given as food supplements. Cholera vaccinations at the centres were started in 1937. In the same year, Family planning advice was already started and the Eugenics League was recognized by government in the next year.

By 1949, as a result of these efforts, 97.8% of all briths were attended by doctors or midwives. The infant mortality rate was also brought down from 662.9 (per thousand live births) in 1929 to 99.4 in 1949. This remarkable achievement paved the way to further developments in the years that followed.

In the meantime, midwifery has also developed considerably. In 1910 the Midwives' Ordinance was passed requiring the registration of midwives. Since 1920, chinese midwives have been trained in special training schools but the real step forward was in the mid-1950s when the new Tsan Yuk Hospital was opened.

The need for care of children in the postnatal and preschool years was realised in 1951 and plans were made to fill the gap. The prospects of B.C.G. vaccination was also explored and a mass campaign finally launched in 1952. Midwives were also encouraged to urge pregnant mothers to attend ante-natal sessions. Health education in the form of puppet shows, demonstrations, films, flannelgraph and competitions were utilized to the greatest extent.

However, the development of the services was not without its share of burdens. In the year 1953, temporary maternity hospital and Maternal and Child health centres had to be set up to serve victims of a great squatter fire. Acute shortages of maternity beds were experienced in 1952. These heavy demands led to greater efforts so that by 1953 there were 17 centres, 26 midwives, and 138 registered private maternity homes. In the same year, post-natal care was organized. During this period, midwives had to work under great pressures; in 1955, the annual case-load per midwife was 323. In 1954, a team from the World Health Organization came to help, completing their mission by the next year. Investigations into the nutrition-disease relationship and the problem of birth registrations were undertaken in 1954. By 1956, of the total of 265 babies born per day, 249 survived (as compared with previously when over 100 of them died before their first birthday). The success of the service may be summed up in the remark made in the Annual Departmental Report of 1956, "this dramatic success of the Maternal and Child Health Scheme is most gratifying." For detailed data please refer to Tables 2 & 3.

At present, the Maternal and Child Health service operates 15 full time and 16 subsidiary centres, with a record low infant mortality rate of 23.7 in 1965. 61% of children born have attended a Clinic. The emphasis at present is still on the prevention of disease and on health education. Ante-natal, postnatal and Toddler sessions are held daily. Vaccinations are given free and as a routine. VDRL tests are performed free for all expectant mothers. Home visitation, food supplementation also play a part in the work. Other functions include the training of personnel and lectures to the public.

Future development includes improvement in the post-natal attendance, investigations into the neo-natal mortality rate and the setting up of more centres in developing areas. Health education will continued to be used extensively especially for the teaching of nutrition and the prevention of disease.

Development in the District Midwifery Service will be mainly the gradual transfer from domiciliary deliveries to institutional deliveries. This will ential the increase of maternity beds, the training of more midwives and the wide us of Health education. More centres will have to be opened so that an expectant mother will find one located at short distances from her home.

Port Health

As early as 1928, it was recorded that "Hong Kong is one of the 5 greatest ports in the world." such, it is inevitable that diseases from other as countries will be imported into the colony and vice versa if proper control is not exercised. Indeed as early as the turn of the century, daily

inspections of shipping and emigrants and immigrants have been carried out. Quarantine requirements for ships were also in force. The "Q" flag was raised on half a dozen occasions annually mostly for ships infected with smallpox, cholera, or the plague. These careful measures reaped early rewards for in 1916 when neighbouring areas experienced severe outbreaks of cholera, only 10 deaths occured in Hong Kong. In 1923, Vaccination Ordinances were constituted with application to smallpox. Hong Kong had no quarantine station then and infected ships had to lie in the quarantine Anchorage. The Port health force then consisted of 2 health officers, and two medcial officers. In 1932, a pandemic of Cholera occurred in China and to cope with the vast shoreline, one medical officer, one sanitary inspector, and several government vaccinators were added to the force. In 1934, the service took over the task of fumigation and disinfecting of ships after dissolution of contract schemes. Aerial Traffic regulations were set up in 1937. The volume of work done steadily increased and as seen in Table 4, the volume of air traffic has rocketed in recent years. When a serious outbreak of infectious diseases occured in Canton, ships from Canton were quarantined for the first time in 1938. After the war, in 1948, International Certificates for vaccination and inoculation were adopted. In 1949, the first quarantine station was opened at Junk Bay.

By 1951, Hong Kong was free from quarantinable diseases until the outbreak of Cholera in recent years. In the same year, an Anti-epidemic team was formed under the Senior Port Health Officer dealing especially with vaccinations and prevention of smallpox, cholera diphtheria and typhoid. A close link was maintained with the W.H.O. Epidemiological Intelligence Station at Singapore. In 1959, 4 radio launches were added to the service. At Kai Tak Airport night landing required an extension of the service. In the same year, modifications were made at the frontier post at Lo Wu to facilitate traffic flow. In 1962 the service maintained four centres where inoculations for certification were available. In 1963 and outpatients clinic was opened at the Airport for employees of the Airport and includes a vaccination post and a first aid post.

At present, the service continues to prevent the introduction of quarantinable diseases, the sanitary control of ports of entry, the provision of International Sanitary Regulations and a regular exchange of epidemiological information with the W.H.O. as well as with other ports and airports. A 24 hr. service is now being operated.

Future development will probably see the separation of a vaccinations branch from the main service to deal with the increasing volume of vaccinations. Facilities may be extended to guard the coastline more closely to prevent the illegal entry of small crafts.

Tuberculosis Control

Due to the great prevalence of tuberculosis caused by factors mentioned earlier, the emphasis on tuberculosis control began in the 1920s. In 1939, pastuerization of all milk was required by law. In 1940 the Anti-Tuberculosis Association was established and the Ruttonjee Sanitorium was opened after the war. As statistics have shown, the relative importance of tuberculosis as a killer became more evident. In 1947, the Government Tuberculosis Service was instituted. A tuberculosis clinic with daily sessions with free treatment was started at Harcourt health clininc and was joined in 1951 by a second clinic in Kowloon. The social aspect of patients were cared for by the almoner and by 1951, the service was well established. A X-ray survey of government servants was performed in 1951.

In 1952 as a result of tuberculin tests, 95% of those tests were found to be tuberculin positive. Consequently a wide-scale B.C.G. Vaccination campaign was launched with the assistance of the World Health Organization. School children, general public, organizations and later toddlers and neonates were vaccinated. This intensive campaign had far reaching effects in the control of the disease. In the meantime treatment was revolutionized with the introduction of INAH and combined therapy with Streptomycin and PAS. Surgery and rehabilitation have been important aspects of the work but due to the lack of hospital space, the great volume of the work was done on an outpatients basis. Tuberculosis visitors, numbering more than twenty, helped also in the work of health education of patients. Contacts were examined and treated. In 1953, the service moved into its new headquarters at Wanchai. The X-ray service was extended to include prisoners and school teachers. By 1960 the death rate has been reduced by half, and it was said that "tuberculosis is now an almost insignificant factor in mortality amongst children under the age of one year." However no efforts were spared to further reduce the mortality. Professor Heaf and Dr. Wallace Fox made a survey in 1961 and reported on the ten years' progress since the B.C.G. Campaign.

At present, the mortality rates have steadily continued to decline while the percentage of babies vaccinated with B.C.G. vaccine is the highest recorded in the world. In addition to the ambulatory chemotherapy for the majority and hospital admissions for those requiring special treatment, the service also provides medical social work, contact tracing and supervisory services and the undertaking of surveys of selected groups. For the very poor, regular subsidizing with funds are maintained.

Future development will be more towards the public health aspects of tuberculosis including home visits, vaccinations, health education and anti-spitting campaigns. Attention will also be drawn to the elderly male patients who now from the group of greatest vulnerability as the infant mortality decreases even further.

Malaria Control

The need for Malaria control may be seen from the fact that in 1844, serious considerations of abandoning the island were made when a

terrible outbreak of malaria occurred during the breaking of the soil for the construction of Queen's Road. The first anti-malrial measures were taken in 1899. By 1909 there was already a 20% reduction in malaria. Despite the clearing of breeding grounds and the teaching of hygeine, malaria was still rife as new cases were imported from the mainland. A mosquito survey was performed by the Bacteriological Institute in 1914. By 1928, malaria constituted less that 2% of deaths. Provisions were made then for the creation of a Malaria Research Office later known as the Malaria Bureau. The first Malariologist arrived in 1930 and in its first year the Bureau undertook a number of surveys. Policemen were issued with mosquito netting, prophylactic quinine and insecticide sprays. The construction of the Shing Mun Dan in 1933 brought on further investigations and control and by 1936 we find the statement," the colony now possesses all the knowledge necessary to successfully combat malaria." By 1938, malaria was limited mainly to the outskirts of towns and country districts, After the war, in 1945, notification of malaria became compulsory. In 1951, the introduction of water-miscible Gammexane revolutionized the control of mosquitoes. In the next three years much work was done to extend the control areas and researches on the habits of mosquitoes were also undertaken.

In 1954, it was stated that "Malaria is not a serious problem in Hong Kong. . . . but it must not be overlooked that this had only been achieved by constant and careful larvicidal control. Hong Kong was and still is potentially a dangerous malarious area." In 1956, the Bureau saw an increase in staff when they moved into their new office. Blood examinations for parasites were done on all infants attending health clinics. In 1958 a pilot scheme of giving prophylactic Paludrine was launched in Sai Kung, with great reductions in the incidence of malaria the next year. However this practice was terminated when the interest of villagers flagged.

At present the Bureau continues routine control measures in control areas and also regular malariometric, mosquito and parastie surveys are pursued in unprotected areas. The function of the Bureau was transferred to the Urban Services Department in 1966. Daily mosquito catches and larval collections are done to monitor the prevalence of the parasites among mosquitoes. For the decline in the incidence of malaria please refer to Table 5.

Future development of the service will involve the extension of control areas in rural districts. The scheme of prophylactic Paludrine for border areas may be restored with the help of publicity and health education.

School Health

From the census of 1961, it can be seen that Hong Kong has a very young population, and the importance of healthy youth to the colony needs no elaboration. The first medical inspection of school children was performed in 1921, while the first full-time school medical officer was appointed in 1925 with the specific duties of inspecting eyes, teeth and throat and reporting deformities and to give some health education. In 1928, the School inspection branch of the Medical Department was started with one medical officer and one nurse. They inspected all government and government aided schools and their 3732 students. By 1929, the numbers of children inspected had risen to 8834. In 1932, the first school clinic was established at Ellis Kadoorie School. A second clinic was started at Yaumati School. The need of a school dentist was also recognized. 442 homes were visited by nurses. Hygeine was made a compulsory subject for English school teachers. A Health Exhibition was organized and a Health Museum started. Free spectables were provided for the first time for those needing them. In 1939, Regulations on School Premises were passed. Physical Education was also emphasized. In 1952, doctors in maternal, infant and school health programs commenced preparations for joint educational sessions including the care of preschoolers. A nutritional survey of school children was made in the same year. For partcipation in the Health scheme, students of government and government subsidized schools paid $5 per year while students and teachers from other schools had to pay $15.

In 1953 school children were tuberculin tested and vaccinated with B.C.G. vaccine. Other vaccinations were also given free. A Public Health School Nurse Instructor and an Education officer assigned to work with Health Education were added to the service. Health education was given to many school children in the form of filmshows, talks, competitions etc.

Since 1955 no new entrants were accepted due to the lack of staff and clinics. A Working Party to study the problem of providing a comprehensive School Health Service was formed. A survey in the heights and weights of school children showed improvements of standards over those of 1940. In 1960 a new scheme of School Medical Service incorporating the service of general practitioners was proposed, a working party was constituted and the service began in 1964.

At present the Medical and Health department provides an advisory service to the Education Department on matters of environmental health and hygeine in schools. Routine inspections of schools are carried out to ensure proper lighting, ventilation and sanitation. Immunizations are also carried out. Home visitation and Health Education are also part of the program.

Much remaines to be desired. Greater attention may be paid to the services in future. A comprehensive health service for every child may be provided for. Home visitation and Health Education directed towards students and parents will help booster attendance. In the tense atmosphere existing among the student population, advice on physical education and good study habits and studying environment will be of great benefit. Sex education may also become a responsibility of the department in the future.

Dental Service

The first Out-patients clinic was opened in 1917 wuth 2 dental surgeosn working on three days a week. This service was unfortunately terminated in 1919 due to a lack of staff. After the Pacific War, three government clinics at Sai Ying Pun, Harcourt Health Clinic and Kowloon Hospital came into operation on a part-time basis. In 1951, the Dental Subdepartment was responsible for both the school health dental service and the General Dental service which included the care of government servants and pensioners and their dependents, poor individuals in the public, and referred in-patients of government hospitals. Eight full-time dental clinics were operated then. In 1954, in their new headquarters at Wanchai, the service saw further expansion of their work. A school dental clinic was opened, two dental inspectors for the control of the colony's dental practice were employed and a Dental Scholarship Scheme was established for the training of dentists in other countries. In 1959, a prefluorination dental survey on 10,000 school children was made. In 1961, fluorination of the water supply was commenced. Health education played an important part in the work of the service. Future development will consist of expansion of present services and extension into rural areas of the colony. Health education on the care of teeth will continue to play an important role in the prevention of dental caries.

Social Hygeine Service

The first Venereal Diseases clinic was opened in 1928 at the Government Civil Hospital. A second clinic was opened in Kowloon in 1933. Two other clinics were opened in 1935 at Kowloon Hospital and Violet Peel Health clinic. A report in 1939 recommended the expansion of clinical facilities for the treatment of prostitutes. 1940 saw an expansion of staff, opening of new centres and domiciliary visits. Films on venereal disease were shown to the public in 1951. Routine blood specimen were taken at ante-natal, infant welfare and maternity clinics. In 1952, free tests were made available to midwives for pregnant women. Health visitors formed an essential part of the force and traced contacts and defaulters reported by the armed forces, medical officers and general practitioners. Wide publicity and health education boostered attendance in 1953, the Kahn Test was replaced by the VDRL test. 1955-1958 saw the decline of venereal diseases but this was followed by a rise in 1959, a phenomenon reported in many other countries. However the teen-age group showed no concomitant increase in incidence. By 1964, the diseases again began to show a decline.

The Service also is responsible for the control of leprosy. Leprosy has been associated with promiscuity by tradition and the popular belief of "selling" one's won leprosy by sexual contact with another person probably accounted for a considerable proportion of cases. In 1935, Tung Wah hospital opened a refuge for lepers. Treating it as a dangerous disease, new legislature for the control of lepers came into force in 1938 whereupon lepers were locked up and guarded by policemen. Provisions were made for a leper colony in Hay Ling Chau in 1951. However by 1953 it became evident that lepers should be treated on an out-patients basis as in-patients often refused to be discharged because of the prejudices that the public harboured against them. Thus in 1954, it became a general policy to treat lepers as out-patients while child contacts were treated with B.C.G. Vaccine. By 1959, ten weekly sessions in eight outpatients clinics, with four other monthly sessions at social hygeine clinics were held. In 1963, Weekly Ulcer clinics were started for treatment and fitting with plaster, footwear or splints. Public prejudice began to wane as a result of social welfare work, rehabilitation became easier. In 1964, the Leprosy (Repeal) Ordinance was enacted—adding leprosy to the list of notifiable diseases instead.

The Dermatological Service witnessed rapid expansion in 1959 with the advent of Griseofulvin which revolutionized the treatment of fungal infections. A complete survey into the incidence and cultural characteristics of mycological conditions was done by the mycological diagnostic service in 1963. In recent years increased incidence in systemic lupus erythematosis was noted and investigations are made into the possible reasons.

Future development consists mainly of expansion of present services to include most areas of the colony. Health education and close cooperation with the Social Welfare Department will further eliminate public prejudices and increase notification of the diseases.

Health Education

Health education may be found as an intergral part of every subdepartment. Mention of the specialized forms of Health Education has been made under the various sections concerned. Special mention may be made however of the general development of Health Education. As early as 1926, health education was recognized as a necessity and was placed under the School health service. Anti-spitting campaigns were held every year in the early 1900s. In 1954 UNICEF helped in the organization of an effective health education program. In the same year a health education course was made compulsory for trainees at the Northcote Teachers' Training College and undergraduates in the Department of Education in the University of Hong Kong. A survey into the effectiveness of various means of publicity showed that loud hailers on mobile inoculation vans brought in the greatest numbers while direct conversation and discussions were found to be the most effective technique. Films, filmstrips, posters, pamphlets, exhibitions, competitions, talks and radio-plays were among the methods used. Radio talks by a Radio doctor was started in 1957 and was met with great success. In 1958 long-term programs were planned by a special Select Committee of the Urban Council. As the

importance of lung cancer became more and more alarming in recent years, anti-smoking measures were planned in 1964. Future developments may involve more expansion in the field of television but other more conventional means will be further utilized. Probable subjects of the future will probably on the problem of home accidents, prevention of cancer and cerebrovascular diseases.

Pathological Institute and Chemical Laboratories

Playing an indispensible role in the development of public health and yet seldom in the lime-lights are the unsung heroes in the Pathological Institute and the Government Chemical Laboratories. As far back as the 1900s when public health was still in its earliest infancy, the Bacteriological Institute was already efficiently engaged in the routine work of examining pathological specimen, water examination and the preparation of lymph vaccines. When Bacteriology was itself a new science, the work done in these early days was quite remarkable. Rats and rabies were among the important items of research while studies into outhreaks of meningitis (1918) and Cholera (1919) were made. Other special surveys included a Milk analysis in 1923 and a rat flea survey in 1928.

Through the years, the volume and variety of the work increased but members of the institute have dutifully faced up to the challenge. At about the same time, rehoused in a new labouratory the government laboratiories shouldered their load of the work, analysing foods, drugs, chemicals, narcotics and chemicolegal material. Reasearch into the harbour water pollution was also undertaken.

At the years progressed, new responsibilities were added, including the supervision of mortuaries and blood banks. New developments include the replacement of the Kahn Test by the VDRL test in 1953, setting up of a poliovirus laboratory in 1960 and the employment of Fluorescent microscopy in the diagnosis of tuberculosis.

Meanwhile the volume of work continue to expand. In 1946, 72799 specimen were examined. By 1950 the number had doubled. By 1955 the number had quadrupled, and by 1964 more than 1,000,000 specimens were examined yearly. To cope with this task, the institute moved into its new home in the Sai Ying Pun Polyclinic in 1960. New laboratories were also provided in Queen Elizabeth Hospital in 1963 and in Kowloon Hospital in 1966.

At present, the work of the Government Institute of Pathology includes routine clinical bacteriological work, monitoring of nightsoil and cases of gastroenteritis for cholera vibrios, testing of drug sensistivity; clinical pathological work with recent advances into the fields of chemicopathology and cytology, serological studies, supervision of bood banks, virology and parasitological studies. The Government Chemical Laboratory concerns itself with the examination of narcots, dutiable commodities and foods. Analysis for private concerns are also undertaken. The duty of water monitoring has been transferred to the Public Works Department laboratory.

As the volume of work shows no sign of abating, future development will mainly be concerned with expansion of facilities and staff. New methods which will facilitate a faster turnover rate and automation will be employed.

Forensic Pathology

Ever since the beginning of the century the department has been undertaking the work of examining medicolegal cases and the control of public mortuaries. Its functions were delineated in 1936 and as the years progresses the amount of work done also increased. In 1954, two medical officers with experience in forensic pathology were seconded to the Police Department. Their responsibilities included Forensic work: the examination of victimes, inspections of scenes of crime, giving evidence at court, doing medicolegal autopsies and raiding of illegal set ups; Laboratory work; and teaching responsibilities. In 1955, blood grouping of police recruits was performed.

At present the Forensic Pathology service continues to work in close co-operation with the Police Department in all branches of medicalegal work and in the operation of the two mortuaries.

As the present number of staff is inadequate, future development will be in the expansion of the staff of the service so that an adequate coverage of the whole area of the colony may be achieved.

Industrial Health

The first mention of labour conditions with no provisions of medical services was in 1928 when the Secretary of Chinese Affairs enforced factory regulations. When the Shing Mun reservoir was constructed in 1932 plans for the supervision of worker's health were drawn up. In 1936, the Public Health (Sanitation) Ordinances also mentioned the maintenance of health of workers. In the late 1930s when huge influxes of refugees entered the colony, unemployment was widespread, while those who were employed were subject to very poor working conditions. The same year saw the passing of legislature requiring employers of labour in the New Territories to provide suitable housing for workers. In 1951, an X-ray survey of factory workers was undertaken be UNICEF. By 1954 a Factory Health Service was beginning to take form as one medical officer specially trained in industrial health was seconded to the Labour Department. In the same year, a Workmen's Compensation Ordinance was passed.

By 1957, an Industrial Health section existed under the Commissioner of Labour with one industrial health office, two health officers, one

health visitor and a technical assistant. Their duty was to prevent occupational diseases and to improve medical facilities in factories. From 1957 to 1962, surveys were undertaken of diseases such as silicosis, lead poisoning, dermatitis, radiation, brass-founder's ague and insecticide poisoning. Conditions in quarries, stone grinding works and bitumen works were studied. In 1962, following the Russian nuclear explosions, aircrafts contaminated by radioactive dust was monitored. 1964 saw the introduction of new laws requiring the notification of certain industrial diseases and affording compensation for confirmed cases. An Industrial Hygeine Laboratory was opened in 1965. A hearing conservation program was also started recently.

At present, work in the industrial health service includes the inspection of industrial works, the monitoring of conditions of workers in places using known pathogenic substances as well as health visitation and teaching responsibilities. Special investigations are also undertaken as the need arises.

As home industry continues to mushroom, it will be increasingly difficult for the service to monitor all the factories and factory workers. Hence an increase in staff is an imminent requirment. Close cooperation with employers and general practitioner will ensure good notification of disease. A close watch for chronic diseases such as Byssinosis will have to be kept as industry comes of age.

Rural Health

Since the takeover of the New Territories in 1898, public health measures have gradually extended into the rural areas. n 1900 a dispensary was opened at Taipo. Leper huts were erected at Au Tan in 1901 but were discontinued in 1911. Registration of Births and Deaths was instituted In 1911. The first government midwives were sent to Un long and other areas in 1914. In 1920 a non-Government hospital was opened at Un Long. In 1930 a Committee on Enquiries was set up and in 1932 recommendations on district health were made. First aid stations were set up at Kam Tin and Fanling and periodic visits by medical practitioners were carried out. Extension of legislature to the New Territories was done in 1938 and a cleaning-up campaign was started.

By 1951, clinical work under the Medical Officer of Health New Territories included the operation of two hospitals with general and maternity wards, two clinics with maternity beds with doctors, six without doctors but with midwives, and two travelling dispensaries. Infant welfare antenatal and V.D. clinics were present in Taipo and Un Long. Leprosy sessions were held from time to time. Dental, tuberculosis and eye clinics were held by visiting medical officers. Vaccination posts were set up at Taipo and Un Long. Much of the time was spent on the curative side with little time left for preventive medicine, 1956 saw the transfer of Scavening service from the Medical Department to the District Administration. A Health launch, the "Chee Hong" was added to the force in 1957. Control of food premises and the gradual replacement of dry latrines with aqua privies and also a pilot cooperative village cleansing scheme to improve rural sanitation was carried out since 1959.

As development of rural areas continue stricter control measures like those operating in urban Hong Kong will come into operation. All divisions of the Health work will have to be further extended to cover the whole area of the colony.

Urban Services Department

Environmental health is perhaps the most important and also the most difficult aspect of Public Health. Before the creation of a separate department, the work formed a large part of the responsibilities of the Medical and Sanitary Department. In the early years when plague was widespread, Anti-plague measures were carried out including rat proofing of houses and ships, provision of rat bin, destruction of rats, quarterly painting of houses with kerosene, daily refuse cleaning and disinfecting of plague-infected areas. Resettlement of refugees was one of the things considered at the time. The practice of Street Watering was practiced as early as 1911 using bullock carts. Regular housing cleaning with soap and water, and later limewashing, was performed regularly and free of charge. Great emphasis was placed on the scavenging services as part of the Anti-plague program. After the previous contract scheme expired in 1913, government took over the responsibility of scavenging. The colony had no water carriage sewer system until late in 1928. Regulation of eating houses, markets and and the destruction of stray dogs were also enforced in 1914. A close watch on the water supply and the harbour was kept throughout the years. From 1928, the new Sanitary Department took over the duties of town cleaning, scavenging and conservancy and other duties. Reorganization of the department was made in the years that followed and by 1936 the department was placed under the control of the Urban Council. Its responsibilities were defined as; "prevention or mitigation of epidemic, endemic, contagious or infectious diseases in humans and animals; prevention of diseases caused by mosquitoes; measures for ensuring purity and wholesomeness of foods during preparation, storage and sale; control of abbatories, markets, dairies and barkies; control of eating houses; town cleansing, scavenging and collection of nightsoil; disposal of the dead." Space does not allow detailed accounts of the work done throughout the years but it suffices to be said that without such basic control on environmental health all other efforts would have been in vain.

At present some 6,000 employees of the Urban Services Department are engaged in street cleansing and the removal of refuse and night-soil. In 1966 the daily load of refuse has reached 1,800 tons. Refuse are transported by

road or barge to Gin Drinker's Bay, a coastal dump. Two incinerators dispose of 1,000 tons of refuse a day. Licencing and control of eating houses, Markets, abbatoirs and the inspection and sampling of foods continue to be an important task. Pest control is also in force. Cooperative efforts with the Local Kai Fong Associations have promoted cleanliness. A new abbatoir is being constructed.

Conclusion

From the above account, it may be said that the maintenance and development of Public health has been, is and will be a constant crusade against ill-health and disease. It is only through the untiring efforts and far-reaching insight of the people concerned that the present situation of good health has been attained.

Future development of the various aspects of Public health has been dealt with in the respective sections. But beside the general treads in disease prevention and extension into rural areas much has to be done in the combatting of traditional erroneous belief in the superiority of herbal preparations over scientific drugs and treatments especially in the treatment of infectious diseases. Such efforts must be gradual and persistent. Another important fields will be in the combatting of the non-infective diseases such as cancer, cerebrovascular diseases and accidents for these will dominate the scene as infectious diseases are stamped out.

From what has gone before, one can be more than confident that the community will continue to enjoy better health in the years to come.

Acknowledgements

I wish to extend my thanks to the Librarian of the Medical and Health Department, the University of Hong Kong library staff and the City Hall Library staff, without whose assistance this essay could not have been possible.

(appended graphs had been omitted)

Appear With Permission from
The Council of the Society of Medical Officers of Health

PROFILES

Lord Moran, the attending physician of Sir Winston Churchill, ascribed Sir Winston's longevity to "50% me, 50% Sir Winston, and 50% nature." "I know," continued the doctor, "That adds up to 150% but then, Sir Winston is not just one person."

Cassius Clay to friend, when doctor examined him after a fight, "It is an examination to see how beautiful I am."

"When I asked the doctors for the X-ray of my brain," said Bob Hope, "They said it is not developed yet."

Lord Adolf's forensic epigram, "the law is such that a doctor can make a patient out of his mistress, but cannot make a mistress out of his patient."

Twiggy to her psychiatrist, "I dreamt last night that I was in my Maidenform bra."

Isak Dinesen, "The cure for anything is salt water: sweat, tears, or the sea."

RAZOR'S EDGE

Surgeon, at operating table, scalpel in hand, to patient, "And now sir, there is just this little matter of your last operation's unsettled bill. . . . . "

Who is the hero in heroic surgery? The patient.

Dodd's VOWEL aphorism about conservative treatment in cases of paralytic ileus not due to mechanical obstruction:

"Aperients, Enemas, Injections; and Operations lead to the Undertaker."

Sung to the tune of "Oh where oh where has my little dog gone":

"Oh where oh where has my scalpel gone,
Oh where oh where can it be?
Oh may be it is inside my bag,
Or may be in Mrs. Cabtree. . . . . "

ASTRONOUGHTS

The only thing that medical students take up in college is space.

Lecturer to junior clerk, "Why must you always answer a question with a question?"
Replied the student, "Why not?"

"How do you investigate a duodenal ulcer?" asked the doctor.
Replied the student, "Barium enema."
"That," said the doctor, "will take hell of a lot of barium."

LONG STORIES

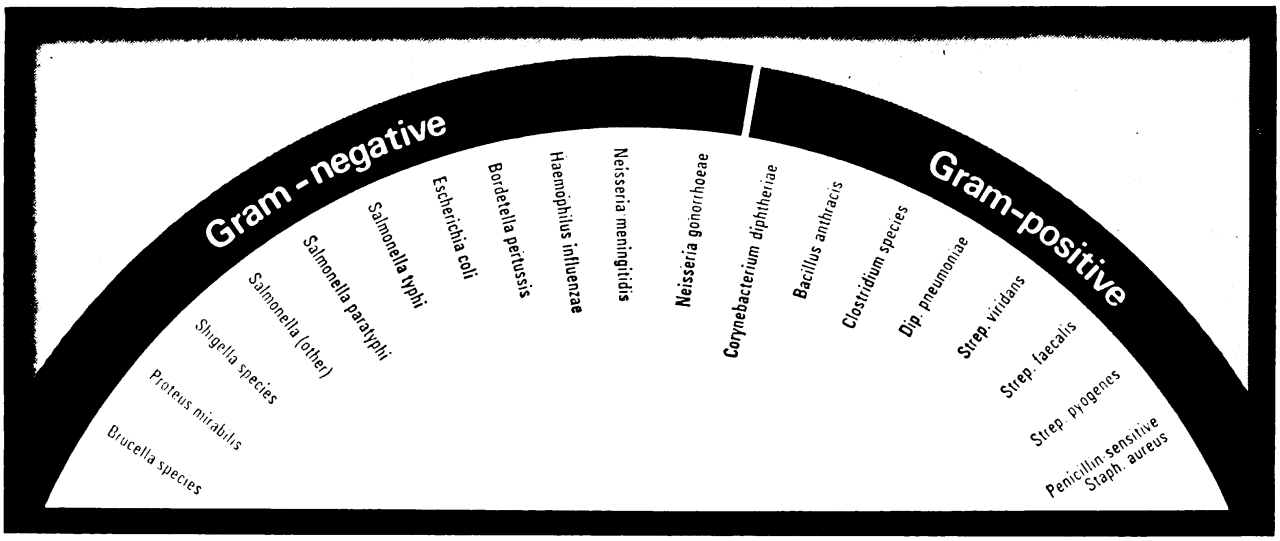
A doctor requested a patient to bring in a 24-hour urine specimen. The patient appeared without the specimen and explained, "I couldn't hold it that long."

Doctor to a patient hospitalized for quite some time, "And how are we this morning?"
Said patient, "Judging by the way I feel and the way you look, I'd say that we are both in trouble."

A female patient came in complaining of abdmonial pain. The doctor learned that she was pregnant and asked her husband, "How long has this been going on?"
Said husband, "Well it all started one cold night last March, when I couldn't sleep. . . . . "

PENBRITIN

the powerful broad spectrum antibiotic



with all the advantages of penicillin

Penbritin (ampicillin) is a product of research by Beecham Research Laboratories—the originators of the 'new semi-synthetic penicillins'.

Penbritin is broad-spectrum
Its range of activity covers all the organisms listed on the chart—and this makes it an extremely effective antibiotic in the treatment of:

Respiratory Tract Infections

Gastro-Intestinal Infections

Urinary Tract Infections

Skin and Soft Tissue Infections

Typhoid Fever

Gonorrhoea

Miscellaneous Infections: Meningitis, Endocarditis, Secondary Bacterial Infections, Scarlet Fever.

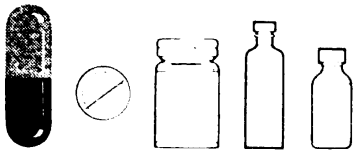
Bactericidal Action
Unlike the bacteriostatic drugs which merely inhibit the growth of bacteria, Penbritin *kills* the infecting organisms, thereby reducing the risk of relapse or re-infection.

High blood, tissue, urine and bile levels
Peak serum concentrations are obtained within 2 hours when given orally and half-an-hour following intramuscular injection. Doubling the dose virtually doubles the blood levels.

Safety in patients of all ages
Penbritin, because it is a penicillin, shows selective activity towards bacteria yet remains virtually non-toxic to body tissues. Penbritin is rapidly excreted, so even after prolonged dosage, there is no harmful accumulation in body tissues or fluids.

Flexible Dosage
The wide range of Penbritin presentations available makes it easy to alter the dosage and route of administration.

Availability:
Capsules, 250 and 500mg. Injectable, 100, 250 and 500 mg. Paediatric Tablets, Syrup and Suspension.



Penbritin is a product of research at
Beecham Research Laboratories, Brentford, England
The originators of the New Penicillins.

A Message from the ARMSA President.

With the close of the second General Assembly, ARMSA (Asian Regional Medical Students' Association) steps into her second year of existence. Although still a very young association ARMSA represents medical students of this part of the world who have taken the initiative to promote a better understanding among themselves and to strive after the aims set out by the Constitution. In the past year active correspondence has been maintained between member countries; and the second General Assembly, for which thanks must be given to the Organising Committee headed by the Chairman Miss Christina Wang of Hong Kong, was an unqualified success. Each delegation took away with it a deeper understanding of the attitudes and aspirations of fellow medical students of the other member countries. It remains the duty of the members of each delegation to bring back to their respective countries the fruits of the Assembly and to sow new seeds for the future.

Between now and the next General Assembly, scheduled to be held in Kuala Lumpur, ARMSA will endeavour to continue the good work done in the past session. Furthermore, every effort will be made to recruit more members so as to achieve a greater representation of medical students of this part of the world. In this respect, work is already underway; although results are not yet definite, the outlook is most promising and we hope to see some new members in the next General Assembly.

A full scale drug appeal, administered by each national Medical Students' Association and under the co-ordination of Mr. Kevin Loh of Hong Kong, the Director of SCOMEH (Standing Committee of Medical Education and Health) is already in progress.

As for the professional exchange for students, many obstacles have still to be overcome in order to attain any active and meaningful exchange between member countries. However, with the co-operation of the university authorities of member countries, it is hoped that this goal will be attained.

Woo Chi Pang,
President, ARMSA.

The Ever-Growing
A.R.M.S.A.

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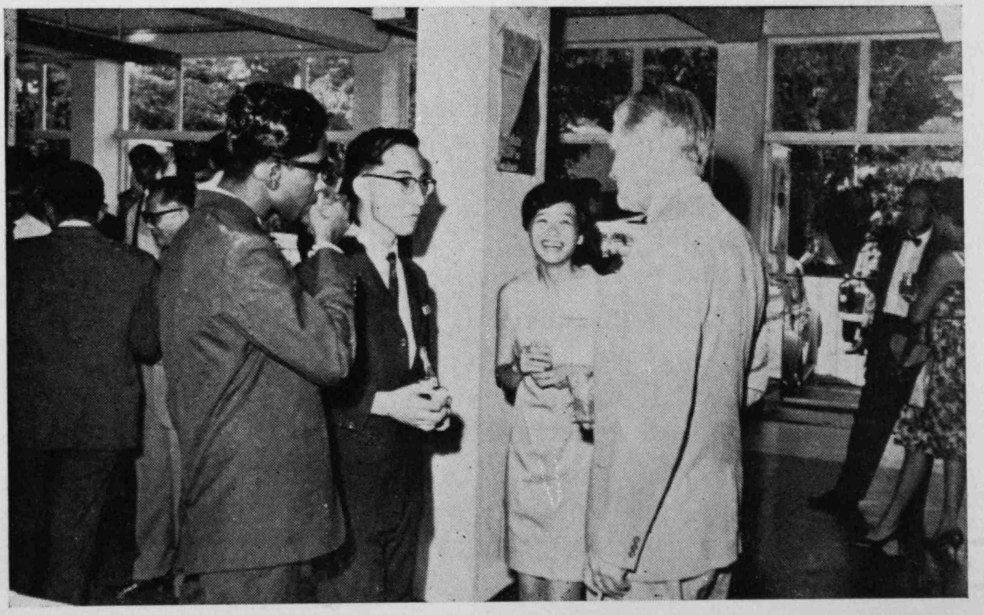
Woo Chi Pang,
President, ARMSA.

Swinging Time in the Armsa

Second General Assembly.

(August, Hong Kong)

The ARMSA President, "Chris, you've just got yourself a date!"

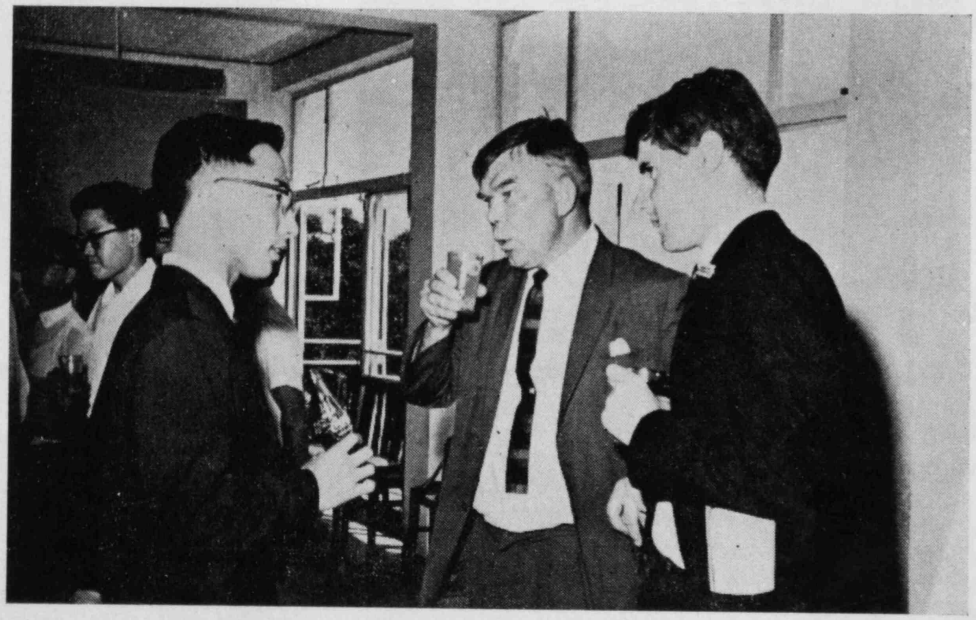


The Scotsman, "Look here lad, she'll be going out with someone else and stop making a big fuss over it!"

Our Chairman, "It's the same old story, boy meets girl, and one plus one gives you three."

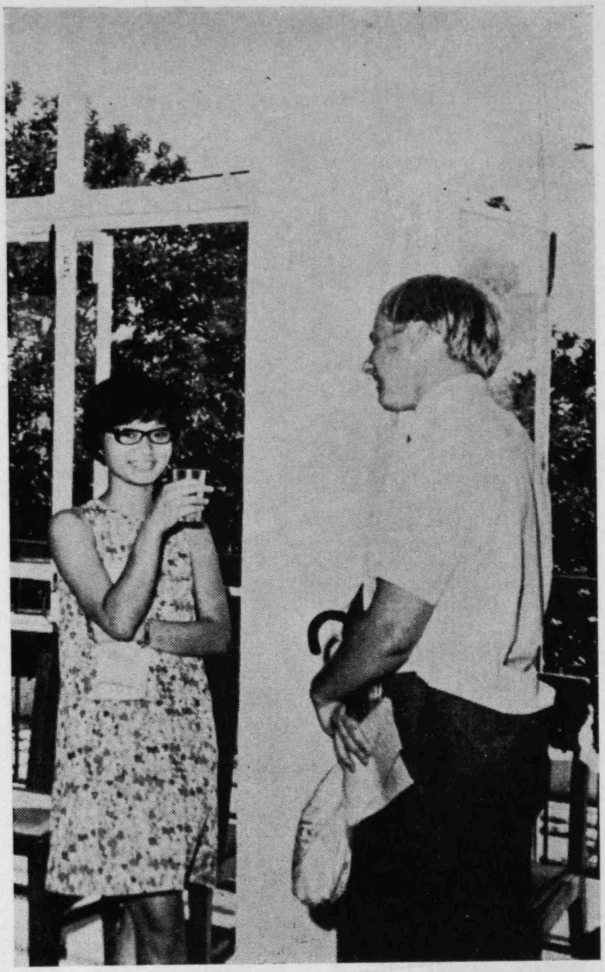
The Singapore National Exchange Officer, "Gee, they sure have a different taste here in Hong Kong. Shall I try western or local . . . . . ?"

Prof, "Gee, what's this stuff from Australia? It certainly is HOT!"



Prof, "Don't look so scared, our nursing staff won't bite you, they only . . ."

The ARMSA secretary general "Oh, the SOUL is easy, just let me show you."



"How dare you! . . . . . now, don't you come nearer Illya, or I . . . . . "

MINI SCHERZO

Present complaint, "Can't find anyone old enough to marry her daughter." Diagnosis: "Compulsive man-hunting."

"Dear doctor, I went to a teenage party wearing patched dungarees, a torn sweatshirt and old sneakers. When I walked in, I heard the kids laughing at me. Do you think it was because of the way I looked, or am I too sensitive and neurotic?"

"Dear Susan, yes, they were probably laughing at the way you looked. You know, no one dresses formal to a teenage party."

"Dear doctor, I am a 57 year-old spinster living alone. Every day I see men eyeing women and read about attackers on the prowl. Should I get a double lock for my door, or would that be too neurotic?"

"Dear Miss Brown, by all means fix your door, and when you come home at night, lock and bolt your door from the inside so that if there is an assailant in your apartment, it makes it tougher for him to get out."

SCOMEH'S REPORT

ON MEDICAL EDUCATION IN ASIA & AUSTRALASIA

INTRODUCTION

One of the resolutions of the 1st General Assembly of the Asian Regional Medical Student Association was to make a general survey on medical education in Asia & Australasia. This is a stone to hit 2 birds: firstly, to collect relevant information for purposes of professional exchange programmes; secondly, to look into the possibilities of enlarging the membership of ARMSA.

A total of 183 circular letters with attached questionnaires were sent to 174 Asian Medical schools, 7 Australian, 1 Fiji and 1 New Zealand. 57 came back, a return of approximately 31.1 per cent. In addition a few university bulletins and a few photographs are received. At the same time, Australasian Medical Student Association has kindly inserted a questionnaire in its circular bulletin, which elicited some additional information.

This report is written on a general basis, especially when there are more than 1 medical school in one country.

AUSTRALIA

All the 7 Australian Medical schools have kindly replied to our circular letter.

Candidates for entrance to an Australian university must take either a matriculation examination conducted by the university itself or an examination conducted by the state education department. These examinations are taken after 5 years of secondary school education preceded by 6 years of primary school, and include English, Chemistry and Physics or Mathematics.

Medical education in Australia lasts for 6 years, divided into 3 parts, namely pre-medical, pre-clinical and clinical. The pre-medical period, i.e. the first year, is devoted to Chemistry, Physics, Botany and Zoology, or Biology. Both lectures and practical work are conducted with a view to their application in medicine.

The 2nd and 3rd years are the pre-clinical period, covering the following subjects: Anatomy, histology, embryology, physiology, pharmacology, biochemistry, psychology and pathology.

The clinical period occupies the last 3 years of the course. During its early stages, basic sciences including pathology, bacteriology and pharmacology are completed. Clinical studies in medicine, surgery, obstetrics, gynaecology, paediatrics and psychiatry occupy the rest of the course.

The curriculum leads to the degree of Bachelar of Medicine and Bachelar of Surgery (M.B.; B.S.)

The medium of instruction is English.

Of the 7 universities, 5 provide elective posting, mostly in the 5th year. University of Western Australia is considering the addition of an elective posting in its curriculum.

All the medical schools have student organisations, and the national union of medical students, namely, the Australasian Medical Student Association (A.M.S.A.) has been active for years. It is one of the founder members of A.R.M.S.A.

The Fiji School of Medicine, founded in 1928, is the only medical school in Fiji, which serves a population of 4 million.

The entrance requirement is a secondary education up to Senior Cambridge Certificate standard (4 years course). An entrance examination is necessary only when the candidate has a lower standard of secondary education. The candidates who fail in this examination shall be placed in a preparatory class for 1 to 2 years.

The 5-year curriculum consists of 1-year pre-medical period, a 1-year pre-clinical period and a 3-year clinical period.

The pre-medical period is devoted to chemistry, physics and biology, with special emphasis on these aspects related to the future medical training. The pre-clinical period covers anatomy, histology, physiology and biochemistry.

The clinical years are devoted to pathology, bacteriology, materis-medica, medicine, surgery, obstetrics, paediatrics, ophthalmology, dietetics, anaesthetics, public health, and forensic medicine. The course leads to the Diploma of Assistant Medical Officer. The language of instruction is English.

Exchange are taking place with U.K. (Nuffield Overseas Scholarship), occasionally with New Zealand.

There is no medical student society in Fiji.

HONG KONG

The Faculty of Medicine of University of Hong Kong is the only medical school in Hong Kong, serving 4 million people.

Candidates for entrance must pass the Matriculation Examination at Advanced Level in Physics, Chemistry and Biology. Prior to this examination, there are 7 years of secondary school education (5 years school certificate plus 2 years matriculation), and 6 years primary education.

The course lasts for 5 years, consisting of a 2-year pre-clinical period and a 3-year clinical. There is no pre-medical course in the University, which is compensated for by the 2 years matriculation class before entrance.

The first 2 years are devoted to Anatomy, histology, embryology, physiology, biochemistry. The 3-year clinical period deals first with pathology, bacteriology, parasitology, pharmacology, social medicine, and forenasic medicine. At the same time, medicine and surgery are commenced. The 4th and 5th years are devoted to various special ties, such as Gynaecology and Obstetrics, Paediatrics, orthopaedics, medicine surgery, psychiatry and radiology.

The course leads to the degree of M.B.; B.S. The medium of instruction is English.

There is no elective posting in the curriculum, but there are long vacations in the first 3 years, when exchange programmes may be contemplated. In the past 2 years, Hong Kong has entertained exchange students from Australia and England. Last year, 2 Hong Kong students were sent to U.K. on exchange.

The Medical Student Society is one of the founder members of A.R.M.S.A.

INDIA

There are 60 medical schools in India to-day, 13 of which have kindly replied and returned the questionaries.

The admission requirements are similar to those of other countries, namely, a pre-university examination with passes in biology, chemistry and physics. Some universities require good results in this examination.

The curriculum of medical education in general lasts 3-6 years, average 4 years. Only 2 out of the 13 colleges provide pre-medical courses. The clinical training is much more emphasized, lasting 2-3 years. English is the medium of instruction.

The 2-year pre-medical course in Jawaharlal Institute consists of English, physics, chemistry biology in the 1st year, organic chemistry and biophysics in the 2nd year. The 1-year pre-medical in Calcutta University consists of Chemistry, anatomy and physiology. The last 2 subjects are in fact pre-clinical.

Internship is required only in some universities, e.g. Kasturba Medical College and Sawai Man Singh Medical College. Over 3,000 doctors graduate in India each year.

In late 19th Century and early 20th Century, the Licentiate system was introduced in order to meet the people's needs in a shorter time. Today only 1 medical school of the Licentiate type still continue to exist. The graduates of such schools receive the L.M.P. Diploma. Provision is made in certain universities for a "condensed M.B.; B.S. course" lasting 2 years for the benefit of Licentiates now in practice so as to enable them to take a university degree in medicine.

There is no elective posting in the curriculum of any medical school. Therefore, professional exchanges with India will not be possible at least in the near future.

3 of our 13 medical schools have no student societies. 7 are rather active in student activities. The students of Kasturba Medical College and Calcutta Medical College showed interest in joining A.R.M.S.A. and requested further information.

There is at present no national organisation in India to represent all medical sutdents.

IRAN

The Faculty of Medicine of Tabriz is the only 1 out of 7 medical schools in Iran that replied.

The entrance requirement to any medical school in Iran is a secondary school certificate (obtainable after 6 years at a secondary school, preceded by 6 years of primary education) and passing a competitive entrance examination which is held when there are more applications than vacancies. All 1st year students are vaccinated against smallpox, typhoid and tuberculosis.

The course is said to last for 7 years, the 7th year is actually compulsory internship in hospitals for 12 months. The other 6 years include 1 year premedical, 2 years preclinical and 3 years clinical. The course leads to the degree of Doctor of Medicine.

There is no elective period, no medical student society, no national medical student society is known to exist.

JAPAN

There are 46 institutions for medical training in Japan. 10 have replied.

To gain admission to the pre-medical training course, a student must either have completed his school education (6 years primary school, 6 years high school), or passed the national examination. Each university conducts its own entrance examination. The language of instruction is mainly Japanese, although English and German are used sometimes.

The course lasts 6 years, leading to the degree of Bachelar of Medicine. These 6 years cover a 2-year pre-medical period and a 4-year medical period. Not all institutions provide pre-medical courses, some start straight ahead with the medical course, provided the students have received pre-medical education elsewhere.

The pre-medical subjects include algebra, geometry, physics, chemistry, biology, foreign languages, physical training. Art and music are included in some schools. The medical course is divided into 2 parts, the pre-clinical (2 years) and clinical (2 years), dealing with the usual subjects.

None of the 10 medical schools that replied provide elective postings in their courses, nor did they show any intentions of professional exchange.

Local medical student association is present in almost all the universities. 7 claimed the existence of a national medical student association, in connection with this association, 6 different names were given, namely:—

Zenkoku—igakusei—renmei
Japan Medical Student Association
All Japan Medical Students' Union
The Federation of Medical Students of Japan
Japan Medical Student Union
Association of Japan Medical Students.

If the last 5 names are just different English translations of the first name, investigations into detail of this Japan national medical student association will be worthwhile, and liaison with it is certainly desirable.

KOREA

5 of the 8 Korean medical schools have returned the questionnaires.

Applicants for admission to the medical course must hold the secondary school certificate (obtained after 5 years of secondary education, preceded by 6 years of primary school). Previous academic achievement has generally been the most important factor in deciding on the admission of a student to medical school. The language of instruction is Korean; English, German and Latin are used sometimes in addition.

The course also lasts 6 years, 2 years pre-medical, 2 years preclinical, 2 years clinical.

There is no elective posting. 3 out of 5 have student societies. National Medical Student Association does not exist.

LEBANON

The 2 medical schools in Lebanon shall be discussed separately, because one follows the American system of medical education the other French.

American University of Peirut

In order to be eligible for admission to the medical course a sutdent must be at least 18 years of age; he must have completed the 3rd year in the Faculty of Arts and Sciences of the American University, including courses in chemistry, physics, biology, mathematics, English and 2 of the following subjects: philosophy, psychology, sociology. He must have passed an examination of proficiency in the use of the English language. Bachelor of Arts degree is given to the students on passing their examination at the end of their 1st year medical course. The language of instruction is English, but students must acquire a speaking knowledge of Arabic before 3rd year.

Medical education proper takes 4 years. The 5th year consists of a rotating internship. The degree given at the end is M.D.

There is no elective posting available for exchanges.

The student society in this university has been very active. It has hosted the student conferences on tropical health for the last 2 years. Invitation were extended to ARMSA at both conferences. Unfortunately, we could not attend owing to financial difficulties.

National union does not exist.

University of St. Joseph

A candidate for admission to the French Faculty of Medicine and Pharmacy must be a national of one of the countries of the Middle East, or be domiciled in that region. He must hold the French of Lebaness baccalauriat, or its officially recognised equivalent. He must pass a competitive written and oral entrance examination in the French language, chemistry, physics, natural sciences, and mathematics. The language of instruction is French. The course lasts 6 years. The 7th year is internship. Degree attaind is the French diploma d'Etat of Docteur en Medicine. Elective posting does not exist. There is a student association.

Both universities are interested in joining ARMSA.

NEW ZEALAND

The University of Otago Medical School is the only medical school in New Zealand, serving a population of 2½ million.

The first year of the Medical Course (known as the Intermediate year) may be taken at any of the five main universities in New Zealand (Auckland, Massey, Victoria, Canterbury and Otago) and is done in the Faculty of Science. After completion of this Intermediate Year, the student enters the medical course proper which lasts for 5 years, 2 years pre-clinical and 3 years clinical.

The language of instruction is English, and the Degree attained is Bachelor of Medicine and Bachelor of Surgery (M.B.; Ch.B.).

The Medical Student Association of this University has already contacted Mr. A. Rajadurai for joining ARMSA.

PAKISTAN

3 out of 15 medical colleges have kindly returned the questionnaires.

The admission requirement to a university in Pakistan is to have passed the matriculation examination or its recognised equivalent. The matriculation examination is taken on completion of the secondary school studies, and is conducted by each individual university.

After passing the matriculation examination, a future medical student must study chemistry; physics, biology and English at a Faculty of Science for a period of 2 years, and then sit for an intermediate examination in science. If he passes the examination, he is eligible for admission to a medical college.

The language of instruction is English, but conversation with patients is almost entirely in the language of the district.

The course at medical colleges lasts for 5 years, not including the 2 years of premedical studies, and leads to the degree of M.B.; B.S. The course at medical schools lasts for 4 years and leads to the diploma of Licentiate of Medical Faculty (L.M.F.)

The 5-year course is divided into pre-clinical (2 years) and clinical (3 years). Elective posting is non-existent. 2 out of 3 have student societies. There is no national union.

PHILIPPINES

All 7 medical schools in Philippines returned the questionnaire with prospectus attached.

As a rule, the minimum requirement for admission to the medical course is completion of 2 years of general university studies, including physics, chemistry, biology and mathematics. Preference is given to those condidates who have completed three or even 4 years of such studies.

The language of instruction is English, although contacts with patients is generally in one of the local languages.

Medical education in Philippines lasts for 5 years, including 1 year's service in a rotatory internship, and leads to the degree of Doctor of Medicine.

The first 2 years are devoted to pre-clinical subjects, while the 3rd and 4th years to the clinical subjects.

Three universities, namely, Far East University, Manila Central University and U.P. College of Medicine have elective postings in their curriculum.

Local student societies exist in all 7 institutions. The name of the national medical student organisation is "Student Philippines Medical Association". Some local unions showed interest in joining ARMSA.

SINGAPORE

The University of Singapore provided the only medical school to serve a population of 1.9 million.

Admission requirement of this medical school is either a high school Certificate (obtainable after a 2-year pre-university course plus 4 years of secondary school education) or its equivalent. The medium of instruction is English.

The course lasts 6 years, leading to a M.B.; B.S. degree.

1st year Physics, chemistry, botany, zoology.

2nd year Anatomy, biochemistry, physiology.

3rd year Anatomy, biochemistry, physiology, pathology, social medicine and public health, medicine, surgery.

4th year Pathology, forensic medicine, social medicine and public health, surgery, obstetrics, gynaecology.

5th year Pathology, forensic medicine, social medicine and public health, medicine, obstetrics, gynaecology, Anaesthesia, dermatology, infectious diseases, ophthalmology, E.N.T., psychiatry and radiology.

6th year medicine, surgery, obstetrics, gynaecology.

The elective posting is a 3-week period in August.

The University of Singapore Medical Society is a Founder Member of ARMSA, and hosted its Inaugural Conference.

TAIWAN

There are 4 medical schools in Taiwan, half of which returned the questionnaire.

The admission requirement is a previous primary and secondary education, each lasting 6 years. It is also necessary to pass the entrance examination. Both Chinese and English are used in instruction.

The course lasts for 6 years, except in the National Taiwan University College of Medicine which carries a 7-year programme including a 2-year pre-medical course. The degree of M.B. or Bachelor of Sicience in Medicine is awarded.

The pre-medical course, lasting 1 or 2 years, includes physics, chemistry, mathematics, biology, general psychology, humanities and languages. This is followed by a 2-year course in the basic medical subjects; biochemistry, histology, embryology, anatomy, physiology, pathology, bacteriology, parasitology, pharmacology and medical psychology.

The subsequent clinical period (2 years) is devoted to the study of clinical medicine. The final year is a rotating internship.

The student activities in Taiwan is rather dormant. There is no local student societies not to speak of a national student society. Elective postings do not exist.

THAILAND

Two out of three medical schools in Thailand returned the questionnaire.

Requirement for admission to medical studies include completion of a five-year secondary school course (preceded by 7 years of primary education, as well as two years of pre-medical education at university level.) The language of instruction is Thai, but English language textbooks are used.

The course lasts for 4 years, 1 preclinical, 2½ clinical, covering pre-clinical and clinical subjects respectively. The degree awarded is Bachelor of Medicine.

No elective posting is included in the curriculum. Both universities have student societies. A national medical student association is not yet formed. The Chiengmei University of Medicine has shown interest in taking the lead in establishing a national union. The same university was the host for a WUS Medical Health Conference in 1966.

VIETNAM

There are 2 medical schools in Vietnam, serving a pupolation of 14 million.

For admission, a candidate must hold the baccalaureat (obtained after 7 years of secondary schooling, plus 5 years primary), and a certificate to who that he has completed a course in physics, chemistry and biology taken at the Faculty of Science after he has obtained his baccalaureat.

The languages of instruction are Vietnamese and French. The course lasts for 5 years, 2 years preclinical, 3 years clinical, leading to the degree of M. D. The 6th year is spent on "stagiaire interne" (internship) at an approved hospital.

The University de Hue has provisions for an elective posting. Student Society also exists in the same university. There is no national student union.

CONCLUSION

One special feature in medical education systems in Asia and Australasia is the remarkable uniformity throughout the region.

The general pattern is as follows: a pre-medical course, average 2-3 years, taken either inside a university or in a special pre-university course. This is followed by a pre-clinical course which usually lasts for 2 years, then a clinical course of 2-3 years. Then comes a one-year internship in a hospital.

The degree obtained at the end matters very little, be it M.B., B.S., or M.D. These constitute the basic degrees in the medical profession. What is important is the uniformity of the system in way of duration and subjects, which strongly suggests a laudable uniformity in the standard of medical education in the region.

This fact by itself should be encouragement enough to stimulate mutual recognition and professional exchange programmes. The lack of an elective posting in most universities should not hamper exchange programmes, for these can always be arranged with full co-operation from the authorities. Of course the provision of elective posting would greatly smoothen the arrangement for exchanges. The countries which provide for elective postings are Australia, Philippines, Singapore and Vietnam. Most other universities have long vacations during which time exchanges are feasible.

The countries which have national medical student organisations are:—Australia, Hong Kong, Japan, Malaysia, New Zealand, Philippines and Singapore. 4 are already members of ARMSA. It will be interesting to see if the other 3 will also join. It is highly recommended that liaison be established with them through the Secretariat.

This report is apt to be incomplete, especially in the aspect of detailed information, which, we think, requires separate reports for each country. All we hope to achieve by this roport is to trigger off a series of studies in the relatively unexplored field of medical education in Asia and Australasia.

By Peter Chang, Director-SCOMEH
Wu Ho Mun, Ass. Director-SCOMEH

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NEWS FROM THE GAZETTE

15th June, 1967

PERSONALIA

Professor Daphne Chun accepted an invitation by the Royal College of Obstetricians and Gynaecologists to serve as overseas examiner for the January 1967 Membership Examination of the College.

Professor A. R. Hodgson attended the 40th Japanese Orthopaedic Association Congress and the 17th Japanese Medical Congress in Nagoya during March 29—April 3, 1967.

Professor G. B. Ong has been elected to the Fellowship of the Royal Australasian College of Surgeons.

Dr. Y. C. Tsao, Lecturer in Paediatrics, attended a World Health Organization Seminar on Paediatric Education held in Manila during February 12-19, 1967.

Dr. Carol A. Braga has been elected to the Fellowship of the Royal College of Obstetricians and Gynaecologists, and awarded the degree of Master of Arts (Endocrinology) by the University of California.

Dr. Chan Pang Ling, Lecturer in Obstetrics and Gynaecology, has been awarded a travel grant under the Commonwealth Interchange Scheme to enable him to undertake research projects at the Universities of London and Glasgow during 1967-68.

COUNCIL

Gift

Li Shu Fan Foundation: a portrait of the late Dr. Li Shu Fan.

SENATE

Sir James Fraser, F.R.C.S.E., Senior Lecturer at the University of Edinburgh and Consultant to Royal Infirmary, Edinburgh, for the degree examinations in surgery in May 1968.

Professor Douglas Hubble, C.B.E., M.D., F.R.C.P., Professor of Paediatrics in the University of Birmingham, for the final M.B., B.S. examination in paediatrics in January 1968.

Mr. J. I. P. James, M.S., F.R.C.S., Professor of Orthopaedic Surgery, University of Edinburgh, for the degree examinations in orthopaedic surgery in May 1970.

Dr. K. B. Noad, M.D., F.R.C.P., F.R.A.C.P., President of the Australian Postgraduate Federation in Medicine, for the final M.B., B.S. examination in medicine in May 1967.

Mr. R. Smith, M.S., F.R.C.S., Surgeon of St. George's Hospital Medical School, University of London, for the degree examinations in surgery in May 1968.

Scholarships and Prizes

The University has accepted the following:

A donation of $20,000 from several persons to provide a gold medal to perpetuate the memory of the late Professor K. H. Digby;

An offer from the Society of Medical Officers of Health to inaugurate a prize essay competition in any branch of Preventive and Social Medicine (value $250 annually).

FACULTY OF MEDICINE

Appointments

Doris Edna Gray, B.A., M.Sc., Ph.D. (Western Ontario); F.R.I.C., Senior Lecturer, appointed Reader in Biochemistry from October 1, 1966.

Arnold Chia-Loh Hsieh, B.Sc., M.D. (St. John's), D.Sc. (Hong Kong), Senior Lecturer, appointed Reader in Physiology from October 1, 1966.

Li Fook Chiu, M.B., B.S. (Hong Kong), Temporary Assistant Lecturer, appointed Lecturer in Obstetrics and Gynaecology from January 1, 1967.

Huang Ying-Yu, B.Sc., M.D. (St. John's), Assistant Lecturer, appointed Lecturer in Biochemistry from April 1, 1967.

John Chi Yan Leong, M.B., B.S. (Hong Kong), Temporary Assistant Lecturer, appointed Lecturer in Orthopaedic Surgery from July, 1, 1967.

Peter Kai Fai Lo, M.B., B.S. (Hong Kong), appointed Li Shu Fan Lecturer in Paediatrics for one year from the date of his arrival in Hong Kong.

Visiting Fulbright Lecturer

Leonard Marmor, M.D. (New York), Associate Professor of Orthopaedic Surgery at the University of California at Los Angeles, appointed Visiting Fulbright Lecturer in Orthopaedic Surgery for the academic year 1967-68.

Resignation

Dr. Tsao Yen Shui, Lecturer in Orthopaedic Surgery, from July 12, 1967.

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

Dr. Doris Edna Gray, Senior Lecturer in Biochemistry has been promoted to a Readership from October 1, 1966.

Dr. Gray was educated at the University of Western Ontario, London, Canada. As holder of the Leonard Scholarship she graduated with a B.A. degree in 1949, subsequently working in the Laboratory of Professor R. J. Rossiter, F.R.S.C., as Research Assistant. In 1951 she was awarded the degree of M.Sc. and in the same year appointed Baxter Research Fellow.

In 1953 after the awarding of the degree of Ph.D. for her research on 'the Influence of Vitamin E on the Carbohydrate Metabolism of Rat Diaphragm', Dr. Gray became part-time Lecturer in Chemistry at St. Joseph's Hospital, London, Ontario. She first joined the staff of the University of Hong Kong as Lecturer in Biochemistry and was promoted to a Senior Lectureship in 1955.

Dr. Gray was elected Fellow of the Royal Institute of Chemistry (F.R.I.C.) in 1963. Her research has been principally in the fields of nutrition and intermediary metabolism.

ARNOLD CHIA-LOH HSIEH, B.Sc., M.D. (St. John's), D.Sc. (Hong Kong)

Dr. A. C. L. Hsieh, Senior Lecturer in Physiology has been promoted Reader from October 1, 1966.

Dr. Hsieh was educated at St. John's University, China, where he obtained his B.Sc. degree in 1943, and the degree of M.D. in 1946. He first joined the University in 1953, and in 1960 was appointed Senior Lecturer.

In 1956, Dr. Hsieh was granted a Fellowship by the China Medical Board of New York to spend one year in the Department of Physiology and Biophysics at the University of Washington Medical School, Seattle. He revisited United States in 1963 as Visiting Professor at the University of Kentucky Medical School, and worked in close collaboration with Professor Loren D. Carlson.

In 1956 he became the first recipient of the degree of Doctor of Science ever awarded by the University for original contribution to scientific knowledge in the field of the effect of low temperature on animals and man, with special reference to the role of the thyroid gland and the sympathetic nervous system in the phenomenon of cold adaptation. Since in 1965 he has sat on the Senate of the University as one of the two co-opted teachers.

LEUNG LICK SANG (1930-1967)

Mr. Leung Lick-Sang died on March 17, 1967. He joined the University in 1956 as a technician in the Department of Anatomy, and served in that capacity until the date of his death. Mr. Leung was a capable technician, devoted and loyal in his job and was always willing to be of help.

He is survived by his wife and two children.

F.K.S.C.

PUBLICATIONS

DEPARTMENT OF ANATOMY

M. M. C. Lee: 'Pseudoepiphyses or notches in the non-epiphyseal end of metacarpals during growth in children', *Anatomical Record* Vol. 154, No. 2, pp. 375-376 (February 1966).

M. M. C. Lee (with S. M. Garn, C. G. Rohmann and P. Wiggins): 'Skeletal maturity and total number of ossification centers present in hand and wrist radiograms of Chinese children', *American Journal of Physical Anthropology* Vol. 25, No. 2, pp. 202 (September 1966).

DEPARTMENT OF MEDICINE

A. J. S. McFadzean and Rosie Young: 'Periodic paralysis complicating thyrotoxicosis in Chinese', *British Medical Journal* Vol. 1, p. 451, (1967).

A. J. S. McFadzean and D. Todd: 'The blood volume in post-necrotic cirrhosis of the liver with splenomegaly', *Clinical Science* Vol. 32, p. 339, (1967).

DEPARTMENT OF OBSTETRICS AND GYNAECOLOGY

Therese Lu and K. H. Lee: 'Two cases of congenital sacral teratoma obstructing labour', *Journal of Obstetrics and Gynaecology of the British Commonwealth* Vol. 73, pp. 853-854, (October, 1966).

DEPARTMENT OF EDUCATION AND DEPARTMENT OF PAEDIATRICS

Anita M. C. Li and Alice S. Chau: 'Jaundice in Chinese infants', *For East Medical Journal* Vol. 3, No. 2, p. 45, (February 1967).

DEPARTMENT OF PHYSIOLOGY

B. P. N. Mo (with E. Leong Way): 'An assessment of inhalation as a mode of administration of heroin by addicts', *Journal of Pharmacology and Experimental Therapeutics* Vol. 154, No. 1, pp. 142-151 (October 1966).

DEPARTMENT OF SURGERY

F. C. Y. Cheng: 'Acute retention of urine', *Bulletin of the Hong Kong Chinese Medical. Association* Vol. 17, pp. 61 (July 1965).

P. C. Kue: 'Intussusception', *Pacific Medicine and Surgery* Vol. 74, pp. 186-191 (July—August 1966).

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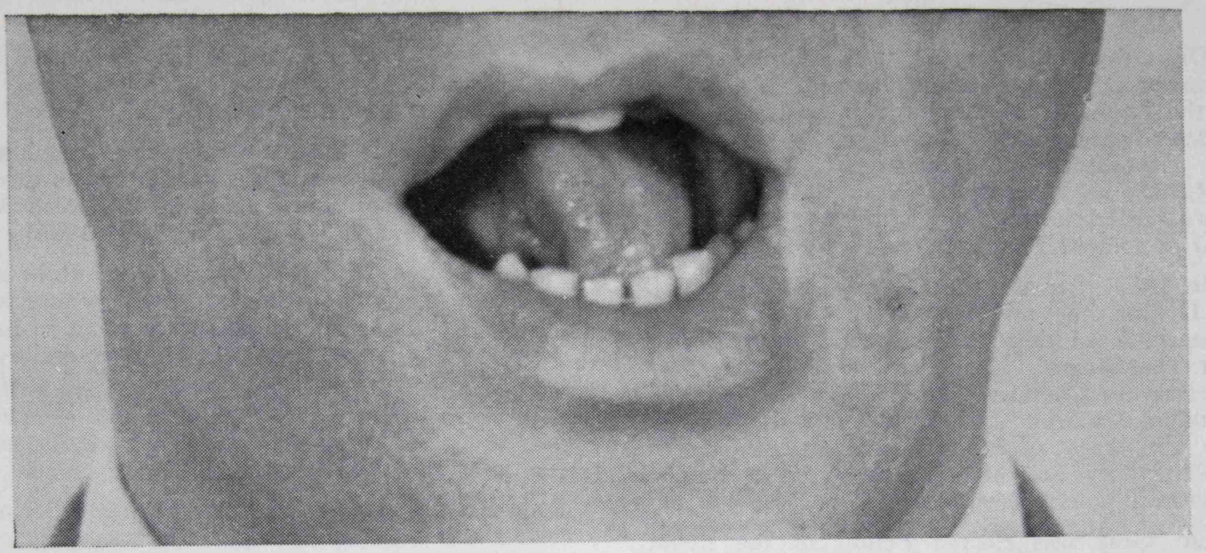

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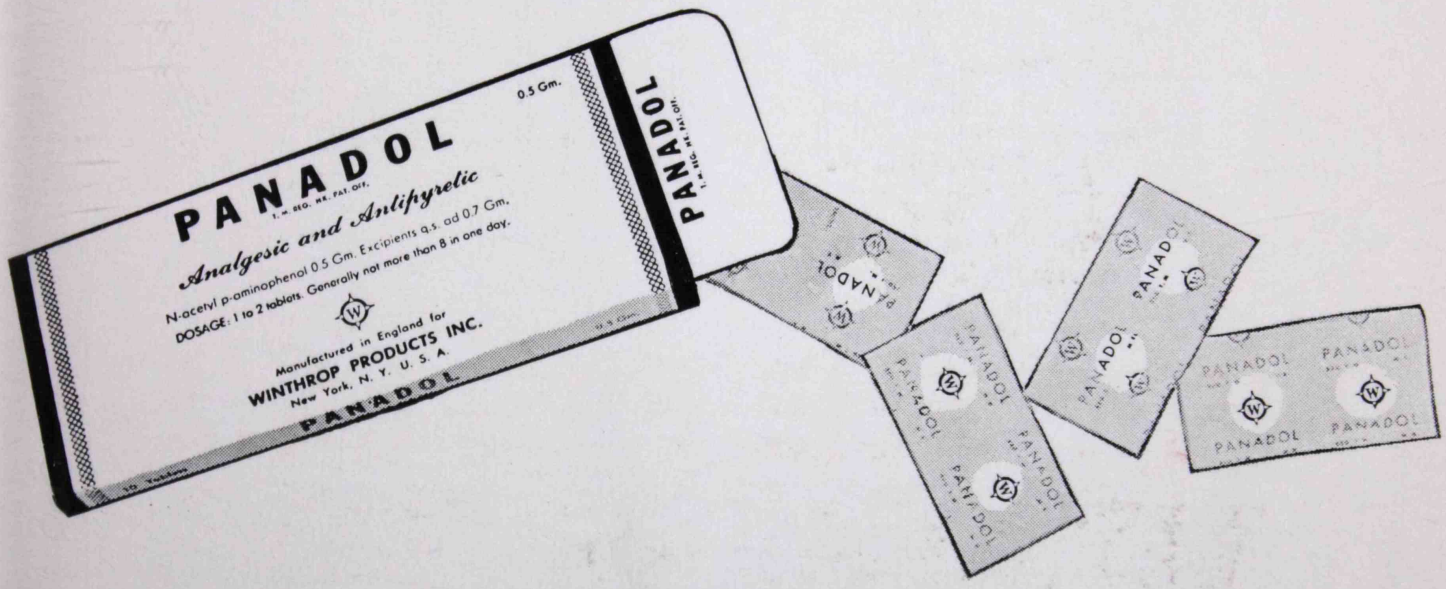

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