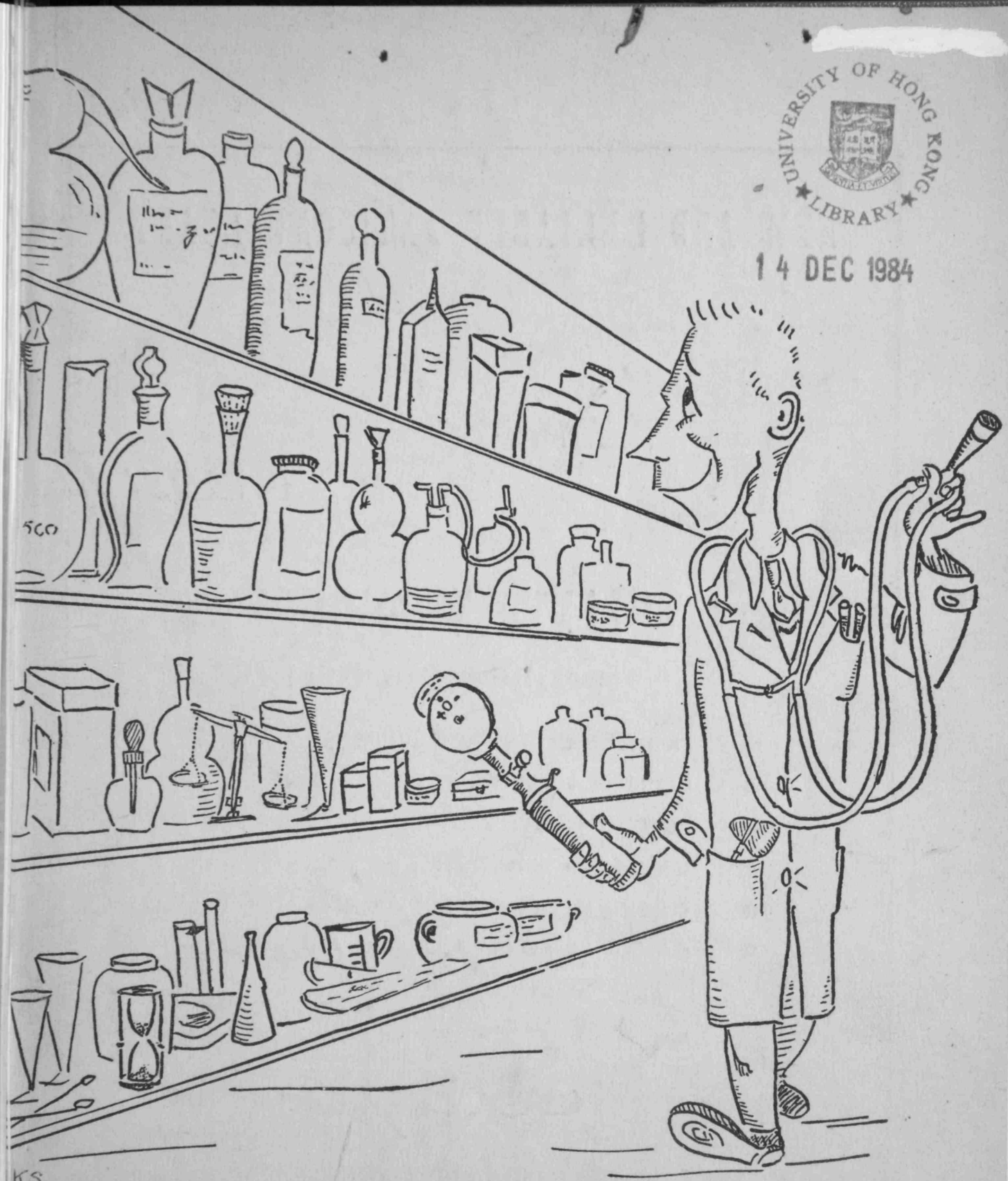

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Age Profession	Illness	Duration of Cure	Weight of Body		Amount Haemoglobine		N.o of red Corpuscles		Pressure of the Blood	
			on entering	on leaving	on entering	on leaving	on entering	on leaving	on entering	on leaving
B. M., 30 years, Sempstress	Anaemia Tumor adnex.	6 weeks	kg 58	kg 63½	60%	75%	4 210 000	5 735 000	95 mm	110 mm
P. I., 19 years, Sempstress	Chlorosis	7 weeks	42	46	20%	45%	4 060 000	5 040 000	110 „	120 „
P. I., 34 years, Smith	Anaemia Ulcus ventric.	4 weeks	61	64	30%	45%	2 400 000	3 240 000	90 „	90 „
H. E., 21 years, Servant girl	Anaemia Perlmetritis	5 weeks	53	62½	20%	40%	1 800 000	3 280 000	—	—
V. M., 24 years, Account. wife	Chlorosis	5 weeks	36	43	20%	60%	—	—	—	—
S. E., 23 years, Saleswoman	Chlorosis	4 weeks	49	51½	35%	60%	—	—	—	—
E. M., 16 years, Servant	Chlorosis	7 weeks	43	47	50%	80%	—	—	—	—

From the above figures, it will be seen that the patients show an increase in the quantity of Haemoglobine, in the number of red corpuscles, therefore that the changes which are generally produced by treatment with Iron are also produced by giving «Serravallo's Tonic».

I must however remark that this mixture was willingly taken by two patients, to whom other Iron mixtures had been given, but who could not stand them; that therefore this must be mentioned as an advantage which this mixture has over others: it never caused any disturbance to the stomach.

On the contrary, patients suffering from Chlorosis with want of appetite (in consequence of parenchimatose Gastritis) «Serravallo's Tonic» proved itself a very powerful appetiser. The same result was obtained in six other cases with anorexia during convalescence after different illnesses and always had a speedy effect.

The increase of appetite was ascribed by the patients themselves to this mixture, and was most willingly taken on account of its agreeable taste.

Therefore «Serravallo's Tonic» is most advisable in cases where the therapeutic use of Iron is intended to act as a tonic to the appetite, such as in primary and secondary Anaemia, in slow convalescence and especially for children.

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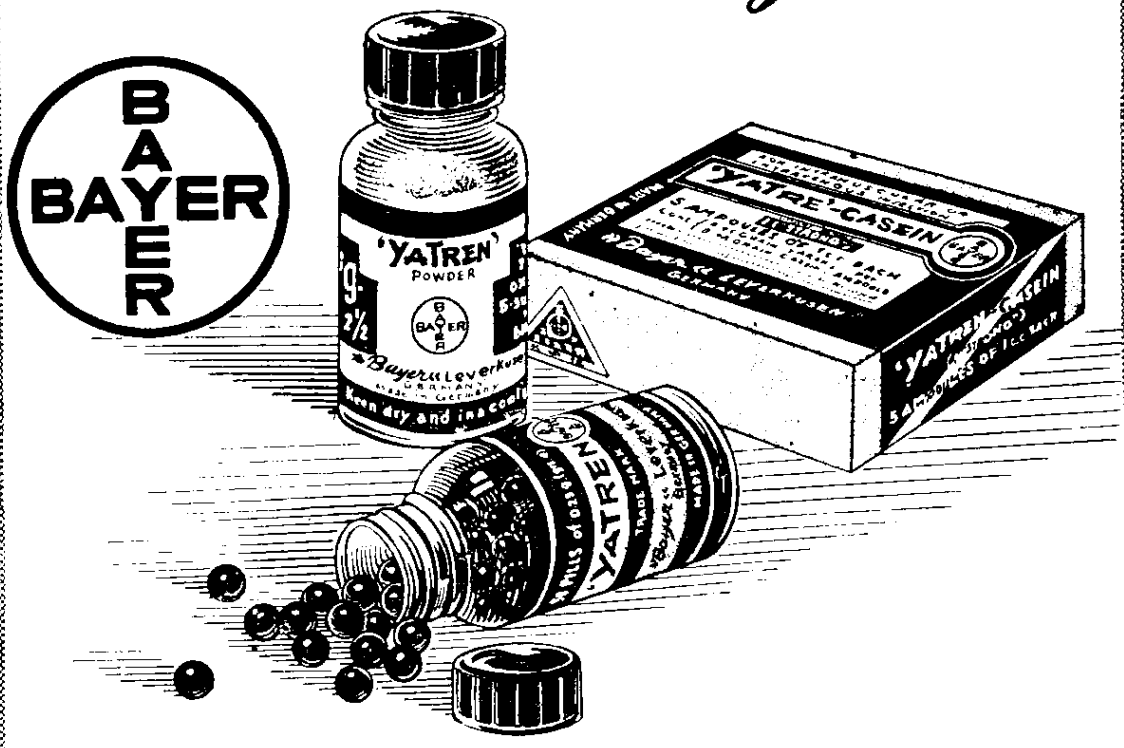

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The Elixir

Hong Kong University

Medical Society Magazine

1950

Printed by St. Louis Industrial School, West Point, Hong Kong.

FOREWORD

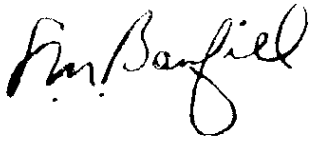
The Hong Kong University medical Society has had a magazine called the "**Caduceus**" since 1922. Before the war it published a great deal of original work and made its mark as a scientific journal. It has not yet resumed publication but when it does will contain serious technical contributions. This new magazine the "**Elixir**" is not to replace but to supplement the "**Caduceus**" by publishing items in quite a different vein, articles of general interest for, about and by medical students. The curriculum of the medical faculty is so crammed nowadays that the making of such a magazine as this is a labour which demands great initiative and energy on the part of editors and contributors alike. However there is no doubt about the value of such an effort.

The training of a doctor is such a demanding business that it tends to discourage the student from outside interests. This is deplorable if it prevents him from becoming a truly educated man with the breadth of interest and understanding which are necessary in a good physician. One of the greatest of medical teachers, Sir William Osler, wrote an essay called "A Way of Life" which should be familiar to all medical students. In it he advocated a system of self-education the basis of which was to devote a little time daily to reading classical literature.

Everybody can spare a few minutes a day, which amounts to a great deal in the course of a year. Try it and see how well it works! This habit can unlock in literature and history rich sources of that knowledge of mankind which gives a fuller life to the individual and makes the doctor better able to serve his fellow man.

There are other sources of this knowledge which are opened to the student in university life: plays, music, current history, in short, every thing which brings the student into social and intellectual contact with his fellows. The organizers of the excellent classical concert at Ricci Hall, the founders of the Questors Club, the producers of the Chinese play are only a few of those who have made a real contribution to student life.

The medical student, whose main purpose is to become a sound physician, must never lose sight of the fact that a broad human knowledge and understanding will help him to achieve that end, and he ought to take every opportunity the University affords of living a full life. The "**Elixir**" provides one of these opportunities. The editors have earned our gratitude for giving us such a vehicle for the exchange and dissemination of ideas. We wish them every success.



Dean, Medical Faculty,
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EDITORIAL

When we first undertook to prepare for publication the first issue of the H.K.U. Medical Society Magazine, we knew that we would be treading on new and unfamiliar grounds. We anticipated difficulties and hardships, yet we accepted the challenge because we felt certain that we would not be fighting the battle alone. The timely appearance of the magazine proves that we were right. The response to our appeal for articles has been most gratifying and encouraging.

The "Elixir" is not a by-product of the "Caduceus", the official journal of the Medical Faculty, to which are confined subjects of purely scientific and academic interest, but rather it purports to bring into the lime-light the lighter aspects of medical studies and to serve as a mouth-piece for medical students. More than a few pages of the magazine are reserved for contributions from our professors and lecturers who have been persuaded to produce less awe-inspiring articles. A still smaller portion is reserved for publishing any research work that may be undertaken by our own members.

It is beyond doubt that the teaching of Medicine in this University is of a very high standard and compares favourably with other medical schools throughout the world. However, as far as the question of teaching facilities is concerned we feel that certain criticisms might well be levelled.

The achievement of the Department of Anatomy since the war is nothing short of miraculous. Imagine the organising ability necessary to transform a building with only four bare walls into a department as formidable as it is to-day ! Nevertheless, an adequate anatomical museum is as essential to the student of Antomy as the cadaver, and we would be glad if someday this would become a reality.

With regard to clinical teaching in the Queen Mary Hospital, certainly there is no dearth of clinical material—rather is it overflowing with a remarkable variety of diseases which few other places in the world can rival. However, in view of the ever-growing number of clinical students, there is that crying need for expansion. At present there is hardly breathing space for the ninety-odd students who every morning crowd the oblong lecture theatre which was origin-

ally intended for less than half the number; those sitting at the sides have to be satisfied with just being able to hear the lecturer's voice with no hope whatsoever of seeing the blackboard.

In the wards the situation is more acute. To say that the number of clinical students equals that of patients is regrettably very near the truth. Sydenham's words: "Young man, go to the bedside; there alone can you learn disease." are just as true to-day as when he first said them, but what good does it do if there are not enough beds to go round. There are innumerable instances in which the patient—the sick person—gets so annoyed by being asked the same questions over and over again that he refuses to answer them. The student, on his part, always goes round the wards with a dread in his heart for fear of such embarrassment.

And what with lectures, clinical demonstrations, ward rounds, post mortems, laboratory work and O.P.D.'s—the poor student barely finds time to do a spot of work by himself. Moreover, when the hard day's work is done, he shudders at the thought of a game of tennis or badminton—for the soft bed is more appealing to his weary body which has had enough exercise running hundreds of steps from the hostel and back each day and almost going into a breakdown trying to catch buses which are always filled to capacity. He is justified in wishing that his hostel were just next to the Queen Mary Hospital. At least, facilities for lunch in the hospital would ease his aching limbs.

The much-talked-about "Tung Wah Eastern Hospital Extension Scheme" could do a great deal to alleviate these and other difficulties of the clinical student. Let us hope it will materialise soon.

The tribulations of a medical student also prevail in the library. More often than not, in the only time he manages to squeeze out of his heavy timetable to read some reference book or journal, the library is closed for the day. If only the University could provide night sessions in the library!

We conclude this editorial by recapitulating the tone of our opening theme. It is our great pleasure to acknowledge the full credit which should be given to all our contributors, professors and students alike, and to others for their invaluable advice and helpful criticism. Special mention must be made of our associate editor, Professor A.J.S. McFadzean, whose untiring efforts and much-needed inspiration made possible this publication. To the advertisers and printers we owe our sincere thanks for their kind co operation. To those contributors whose articles regrettably did not appear in print due to lack of space we extend our humblest apologies.

THE OSLER CENTENARY

(An address given to the Hong Kong University Medical Society on **November 21st.** *1949)*

By Prof. Gordon King.

This year the centenary of the birth of William Osler has been celebrated, and I have ventured to speak to you about him this afternoon as he was undoubtedly one of the greatest physicians of our time—and perhaps of all time—and it is fitting that we should do him honour on an occasion such as to-day's meeting.

He was born on July 12th, 1849, in a parsonage at Bond Head, near the edge of the wilderness of what was Upper Canada, between Lake Huron and Lake Ontario. His parents came from Cornwall, and he was the youngest of nine children.

His early years were spent in the hard and often exciting life of the sparsely populated backwoods.

In an address given in Glasgow fifty years later, Sir William drew upon his early memories of these days for the following comparison :

> "The most vivid recollections of my boyhood in Canada cluster about the happy spring days when we went off to the bush to make maple sugar – the bright sunny days, the delicious cold nights, the camp-fires, the log cabins, and the fascinating work tapping the trees, putting in the birch bark spouts, arranging the troughs, and then going from tree to tree, collecting in pails the clear sweet sap. One memory stands out above all others, the astonishment that so little sugar was left after boiling down so great a cauldron of liquid. And yet the sap was so abundant and sweet. The workers of my generation in the bush of science have collected a vaster quantity of sap than ever before known; much has already been boiled down, and it is for you of the younger generation while completing the job to tap your own trees."

Young Willie Osler was a boy of exuberant spirit, indulging in innumerable high-spirited pranks. He was expelled from Dundas Grammar School, and spent a day in Toronto jail and was fined one dollar for an escapade which

he organised at his next School at Weston. But Osler survived this incident and later became the head prefect of the school.

Osler owed his early love of books to his father's library, and to the influence of his teacher Mr. W. A. Johnson. His first purchase was a Globe Shakespeare, and the second book he bought was an 1862 edition of Sir Thomas Browne's Religio Medici which he purchased in 1867. This latter book was his constant companion and greatly influenced his writing and his style. Fifty-two years later this same copy had an honoured place on his coffin.

As a boy at school Osler was introduced by his master, Mr. Johnson to the microscope - and early came to discover the marvels of a drop of dirty pond water. Johnson was a naturalist of very wide interests and Osler took up these studies with enthusiasm along with his Greek and Latin.

As a boy of 18 young Osler went to Trinity College, Toronto with the determination to study Theology but after one year he decided that his real interest lay in Medicine and he entered the Toronto Medical School. Here he came under the influence of James Bovell, and later Palmer Howard who exercised an incredible effect on the young student. Years later he said, "To these two men, and to my first teacher, Rev. W A. Johnson, of Weston, I owe my success in life—if success means getting what you want and being satisfied with it."

In 1870 he transferred to McGill Medical School, and took up clinical work at the Montreal General Hospital, which he described as "a coccus-and rat-riddled building, but with 2 valuable assets for the student—much acute disease and a group of keen teachers."

He graduated after the usual 3 years course and then spent 2 years in post-graduate study abroad -in England, Berlin and Vienna, where he met and worked under some of the giants of those days—Virchow, Rokitansky, Billroth Helmholtz.

He spent some time in the Department of Physiology at University College London, under Professor Burdon Sanderson.

During this time, June to October 1873, he made his first and probably most important contribution to medical knowledge in the discovery of the blood platelets. The substance of this work was presented before the Royal Society by Burdon Sanderson in June 1874.

After this he returned to Montreal. He refused an offered appointment as Professor of Botany and took up practice for a time. Then he was appointed Lecturer for a year in Physiology and Histology. In those days students paid

their fees to the Lecturers and Professors, who in return taught their students, provided them with the necessary equipment and lived on the balance. After purchasing microscopes and other expensive equipment which he considered necessary there was little left in Osler's pocket and he was often reduced to borrowing to meet what he called "an attack of chronic impecuniosity." He was soon elected to the Professorship of Institutes of Medicine and during the forthcoming years devoted much of his time to Pathology. There still exist in Montreal 3 large quarto volumes of manuscript notes on 100 autopsies fully worked up and indexed by himself during this time.

In March 1882 Koch reported his discovery of the Bacillus Tuberculosis in Berlin. This was reported in Canada in June, and in the same month Osler demonstrated the organism in the lung to senior students in McGill Physiology Laboratory. Such was his keenness and initiative in those early days.

In October 1884, at the age of 35, he accepted an invitation to become Professor of Clinical Medicine at the University of Pennsylvania. At this stage he could easily have become a great scientist by remaining in Montreal, but he chose the path which led to the formation of the great clinician which he became.

He later wrote, concerning his departure for Montreal: "After ten years of hard work I left this city a rich man, not in this world's goods, for such I have the misfortune—or the good fortune—lightly to esteem; but rich in the goods which neither rust nor moth have been able to corrupt, in treasures of friendship and good-fellowship, and in those treasures of widened experience and a fuller knowledge of men and manners which contact with the bright minds in the profession ensures. My heart, or a good bit of it, at least, has stayed with those who bestowed on me these treasures. Many a day I have felt it turn towards this city to the dear friends I left there, my college companions, my teachers, my old chums, the men with whom I lived in closest intimacy, and in parting from whom I felt the chordae tendineae grow tense."

He remained for 5 years in Philadelphia, first renting two ground floor rooms in a private hotel where strict instructions were given that papers and books were to be left where they were on table, chair or floor!

To the students he appeared as a personality far different from their other staid and proper teachers. He offered them no polished oratory, or glowing word pictures of disease in general terms: instead he took them into the ward and the laboratory. No carriage brought him to the front entrance of the hospital, instead he jumped off a street car, carrying a black satchel filled with books and lunch, and popped in by the back door!

In 1885 he gave the Goulstonian Lectures to the Royal College of Physicians, of which he was elected a Fellow in 1883, on *Malignant Endocarditis*, the first comprehensive account in English of this disease.

In Philadelphia Osler developed still further his capacity of stimulating students to observe, record and publish. He had, as Clifford Allbutt said, that wonderful power only possessed by a few great teachers, of "inseminating other minds."

As an examiner he must have been beloved by students. His clinical assistant at the time, Dr. Crozier Griffith, recalls telling him one day that the boys were very much afraid of his approaching examination, and he replied: "I mean them to be; I am examining in the interest of the public, not of the students." But this, one fears, was an idle threat, for he could never bring himself to "pluck" students whom he had come to know and be fond of, however much he might talk in the open about high standards and rigid tests. Between the lines of his note to Ross' journal the confession of his own weakness stands exposed, for he says: "To reject a man in his final examination is no light matter. In every Faculty there are one or two members so kind-hearted that they cannot pluck a candidate. Sympathy for the man excludes all sense of justice." And yet in the next breath he adds: "A lively sense of responsibility to the public admits of no such sentiment, and if there is an occasion which demands strictness and firmness, it is when we are asked to decide whether or not a man is fit to take charge of the lives of his fellow-creatures."

Osler remained 5 years in Pennsylvania, and then he accepted a call to become Physician-in-Chief to the newly established Johns Hopkins Hospital.

His achievements in Philadelphia were summarised by one of his colleagues in the following words:—

> "What did he do for us? He made himself agreeable to the older men, and demonstrated to the younger men how medicine should be learned and taught. He broadened our conceptions in regard to the inductive method in medicine. Facts, facts, and always the facts. The facts of the ward, of the microscope, of the laboratory, of the post-mortem room. He made it clear to some of the younger men who are now reaping the reward of their work that it is not necessary for every man to be a practitioner in the ordinary sense, but that long years of hospital and laboratory work constitute a better equipment for the teacher and the consultant. He inspired his students with enthusiasm for letters and taught them the rare rewards that come of searching the medical scriptures. He showed that

in the democracy of our profession any man is free by a principle of self-election to attain the most coveted post of distinction and honour. He pointed out not only to us, but to all men, how fine and noble the profession of medicine is for those in it who are fine and noble."

Osler was the Chief of the Department of Medicine at the Johns Hopkins Hospital during the period 1889 to 1905.

Johns Hopkins, a Baltimore merchant, bachelor and Quaker, amassed a fortune of seven million dollars and on his death in 1873 the money was left for the establishment of a University and a Hospital to perpetuate his name. Hopkins felt that 2 things were sure to endure—a University, "for there will always be youth to train," a Hospital, "for there will always be suffering to relieve."

Osler's heart could have desired nothing more than the prospect which the appointment at Johns Hopkins opened up to him. To blaze a perfectly new road, untrammelled by tradition, unhampered by "deadwood", backed by a board of management which had a fundamental respect for scientific opinion, and commanding an ample budget—what more could he have desired?

The Chiefs of Service of the New Hospital were all young men. Osler (not yet 40) was the oldest: Welch, a year younger, headed the Department of Pathology: Halsted, the Surgeon, was 37: Hurd, the Superintendent of the Hospital, was only 36: and Kelly, the Chief Gynaecologist, at 31, was the baby of the group.

The Hospital was opened in May 1889, and soon established a tremendous reputation as a Hospital and Medical School.

Osler early started a "Journal Club", where current literature was reviewed each Thursday. Then came the Johns Hopkins Hospital Bulletin. Later, one Monday evening each month was devoted to the proceedings of a Historical Club.

Osler was one of the greatest medical teachers of all time. He regarded 3 things as essential. In one of his addresses he said:

"Given the sacred hunger and proper preliminary training, the student-practitioner requires at least three things with which to stimulate and maintain his education, a note-book, a library, and a quinquennial brain-dusting. I wish I had time to speak of the value of note-taking. You can do nothing as a student in practice without it. Carry a small note-book which will fit into your waistcoat pocket, and never ask a new patient a question without a note-book and pencil in hand. After the examination of a pneumonia case two

minutes will suffice to record the essentials in the daily progress. Routine and system, when once made a habit, facilitate work, and the busier you are the more time you will have to make observations. Begin early to make a three-fold category--clear cases, doubtful cases, mistakes. And learn to play the game fair, no self-deception, no shrinking from the truth; mercy and consideration for the other man, but none for yourself, upon whom you have to keep an incessant watch. You remember Lincoln's famous mot about the impossibility of fooling all of the people all of the time. It does not hold good for the individual, who can fool himself to his heart's content all of the time. If necessary, be cruel; use the knife and the cautery to cure the intumescence and moral necrosis which you will feel in the posterior parietal region, in Gall and Spurzheim's centre of self-esteem, where you will find a sore spot after you have made a mistake in diagnosis. It is only by getting your cases grouped in this way that you can make any real progress in your post-collegiate education; only in this way you can gain wisdom with experience. It is a common error to think that the more a doctor sees the greater his experience and the more he knows. No one ever drew a more skilful distinction than Cowper in his oft-quoted lines, which I am never tired of repeating to a medical audience:

Knowledge and wisdom, far from being one,
Have oft-times no connexion. Knowledge dwells
In heads replete with thoughts of other men;
Wisdom in minds attentive to their own.
Knowledge is proud that he has learned so much;
Wisdom is humble that he knows no more."

In 1892 Osler published his famous text book, "Principles & Practice of Medicine". There was great need for a new treatise. From the day of its publication on February 4, 1892, the book was an immediate success. On the day of its publication Osler went to visit Mrs. Gross (the widow of his former colleague in Philadelphia), tossed a copy of his book into her lap, and said "There, take the darn thing; now what are you going to do with the man?" They were married forthwith, and after a honeymoon in England Osler returned to his work with renewed enthusiasm. In 1895 his son Revere was born—the source of Osler's greatest happiness—and whose loss in the 1st World War was his greatest sorrow.

In 1904 he received an invitation to become Regius Professor of Medicine at Oxford-to fill the chair about to be vacated by his old teacher Burdon Sanderson. He was uncertain about the right course, so cabled to his wife who replied promptly, "Do not procrastinate accept at once."

The Oxford period of Osler's life extended from 1905 until his death in 1919. In spite of Osler's two fixed ideas, that a man is comparatively useless

after the age of 40, and that he is quite useless after the age of 60, he still managed to live a full and useful life during the 14 years that he held the Regius Professorship at Oxford. Instead of settling into a quiet academic life his life became filled with endless activities.

He promoted and extended the work of the Oxford Medical School. He was for a time the Curator of the Bodleian Library. He became the Master of the Ewelme Almshouse. He was Physician to the Radcliffe Infirmary. He became President of the Oxfordshire Association for the Prevention of Tuberculosis, and First President of the Historical Section of the Royal Society of Medicine. He gave innumerable lectures all over the country and to many learned societies He served on two Royal Commissions and during all these years he supervised the regular three yearly revisions of his Text Book. He was, at the same time, an ardent collector of old books, and first editions, and his private library assumed considerable proportions, and became famous as the "Bibliotheca Osleriana," the catalogue of which was finished in 1929, and the Library itself bequeatted to McGill University.

In June 1911 Osler's services were honoured by the receipt of a Baronetcy at the Coronation of King George V.

The war of 1914-18 added to his labours. He became an Honorary Colonel and Consulting Physician to the Navy, Military and Red Cross Hospitals in England, including Canadian and American ones. He was also a member of many special committees at the War Office and of the Committee concerned with the Medical History of the War.

His Son Revere, who had started his studies at Oxford, was commissioned a Lieutenant in the Canadian Unit and became an orderly officer in one of the Canadian Hospitals, later in the McGill Hospital Unit, in France. Then he transferred to the Royal Artillery and was killed on the Ypres salient in August 1917. This blow saddened Osler's last days. On the day he received the news, Osler wrote "We are heart broken, but thankful to have the precious memory of his loving life."

Osler's 70th birthday was celebrated on July 12th 1919, and the outburst of affection which it called forth would have been difficult to exceed. From far and near people vied with one another in paying him tribute. Special "Osler numbers" were issued by many medical journals in Great Britain, the Dominions and the United States.

In October 1919 he contracted a severe cold while returning from a visit to Scotland, and later broncho-pneumonia supervened. He retained his cheerfulness until the end, ond wrote letters and postcards and even a review of a

"Life of Horsley". But he knew that there could be only one ending. From his sick bed he gave last instructions about the most precious of his books, reiterating his desire that the old copy of the "Religio Medici" which he had prized for 52 years should be with him in death. He died on December 29th, 1919, and at an impressive service in Christ Church Cathedral on January 1st, 1920, men and women gathered from many parts to say farewell to one of the most greatly beloved physicians of all time. His ashes, together with those of Lady Osler, who died in 1928, repose in an urn in the Osler Library of McGill University, surrounded by the books so dear to him.

Finally, what of Osler's ideals and his philosophy of life? His early life and upbringing had a great influence on him and there is no doubt that he was a man of deep religious experience. And yet, at the same time, he was broad and tolerant in his views. In his valedictor address at the Waldorf-Astoria Hotel in New york in 1905 he said :

> "I have three personal ideals. One, to do the day's work well and not to bother about tomorrow. It has been urged that this is not a satisfactory ideal. It is; and there is not one which the student can carry with him into practice with greater effect. To it, more than to anything else, I owe whatever success I have had—to this power of settling down to the day's work and trying to do it well to the best of one's ability, and letting the future take care of itself.
>
> The second ideal has been to act the Golden Rule, as far as in me lay, towards my professional brethren and towards the patients committed to my care.
>
> And the third has been to cultivate such a measure of equanimity as would enable me to bear success with humility, the affection of my friend without pride, and to be ready when the day of sorrow and grief came to meet it with the courage befitiing a man,"

In closing, I think I cannot do better than to quote to you some of the words of Harvey Cushing's dedication of his splendid biography of William Osler:

> "To Medical Students, in the hope that something of Osler's spirit may be conveyed to those of a genertion that has not known him . . ."

I am indebted for much of the material used in this lecture to Harvey Cushing's Biography of William Osler. — The author.

THE GALLI-MAININI PREGNANCY TEST.

Pregnancy in its later stages is plain for all to see, but it is often convenient, and sometimes essential, to determine early whether or not a body is with child. Unfortunately amenorrhoea, the earliest sign of cyesis, may be due to a large variety of causes, and other early signs of pregnancy are vague and equivocal. In short, the early diagnosis of pregnancy on clinical grounds alone is difficult and uncertain. For this cause, many have attempted to invent a pregnancy test giving proof of the condition at a sooner stage than the patients' signs and symptoms do warrant sure diagnosis.

Twenty years ago Ascheim and Zondek succeeded in the matter, and their classical test remains a standard practice. It is a biological test. That is to say, it involves the use of an experimental animal. It depends upon the fact that the placenta secretes gonadotrophins; that these gonadotrophins are absorbed into the mother's blood stream; and that they are excreted by the kidneys into the mother's urine. The urine of a pregnant woman therefore, contains a concentration of gonadotrophins considerably greater than is found in urine from non-pregnant women.

Gonadotrophins are hormones normally produced py the anterior lobe of the pituitary gland and they stimulate the sex glands - the testes or ovaries, as the case may be. The injection into an animal of urine from a pregnant woman will thus stimulate the animal's sex glands. In Ascheim and Zondek's reaction, the injection of pregnancy urine into immature female mice causes the mice to ovulate: an event that would normally be delayed until puberty, when the ovaries come under the influence of gonadotrophins from the anterior pituitary gland.

Since this test was invented, over twenty pregnancy tests have been devised—some chemical, some biological. For accuracy and ease of practice, the biological tests remain unbeaten, and the latest of these is the Galli-Mainini male toad test.

In 1929 Houssay and Gonzales showed that implanting anterior pituitary glands into toads induces a series of changes in the toads' testes, culminating in the expulsion of spermatozoa into the cloaca; for frogs and toads void their spermatozoa, together with the urine, from the cloaca. Unless artificially stimulated in such fashion, frogs and toads only release spermatozoa when excited by the presence of their loved ones.

In 1947 Galli-Mainini showed that the chorionic gonadotrophins in pregnancy urine would cause release of spermatozoa into cloaca of *Bufo arenarum Hensel*, a toad indigenous to South America. In the months that followed, workers in various parts of the world obtained these toads at great expense from South America in order to try the test.

Later in 1948 intelligent souls began to wonder whether *Bufo arenarum Hensel* was being used because it was the only toad that would do, or because it was the sort of toad that happened to live near Galli-Mainini, and the more adventurous workers began to try out other more easily procurable toads and frogs.

Very soon it became obvious that a variety of frogs and toads from different parts of the world could be used, and in April of this year we experimented with the local edible frog, *Rana rugulosa Wiegmann*. It does very well.

TECHNIQUE OF THE TEST

A pipette is inserted into the frog's cloaca, and a drop of urine is withdrawn and examined under the microscope. This is in order to ensure that no spermatozoa are present before the test.

5 c. c. of urine from the patient are injected into the subcutaneous lymph space of the animal, either over the back or belly.

Half an hour later, a further specimen of urine may be drawn from the cloaca and examined. If this specimen contains spermatozoa (which are readily distinguishable and motile) the presumption is that the release of spermatozoa has been caused by the presence of chorionic gonadotrophins in the urine, and the patient is judged pregnant.

If the first specimen shows no spermatozoa, further samples are examined until three hours have elapsed, and if by the end of this time no spermatozoa have appeared, the resu't is taken as negative.

The end point is definite, for either spermatozoa appear and are obvious, or they do not. There is no such thing as a "doubtful" or "weak positive" reading.

The only possible sources of confusion are the various protozoa which inhabit the frog's cloaca, but spermatozoa once seen are never forgotten. Having been used for one test, a frog may safely be used again after a rest of one week.

If only 5 c. c. of urine are used, death of the frog during the test is a rarity. The urine need not necessarily be fresh, which is of some practical advantage to the busy doctor.

RESULTS.

Experience of other workers shows that false positive results do not occur. For various reasons, occasional false negative results may crop up.

In a series of 502 cases reported by Galli-Mainini in which Friedman and Toad tests were simultaneously carried out, 42 results were not in agreement. Of these 38 correct results were given by the toad, and 4 by the rabbit. In our own series of 150 tests, there have been no false positives.

Two negative readings were obtained from a case of chorion epithelioma. This patient had given a positive result before operation, a negative result on two occasions following operation, and then a further positive result when the presence of secondary deposits was already clinically well established.

We have had no false negative results with the urine of pregnant women. Our earliest positive result was obtained 7 days after the last missed period. Galli-Mainini records 23 positive results from patients with from 4-9 days amenorrhoea.

CONCLUSION.

The Galli-Mainini male toad or frog pregnancy test is easy, cheap, quick and reliable. It would appear to be the best pregnancy test yet devised, having the advantages of all the other tests, together with some of its own. Its unique virtue is the speed with which a result may be obtained. Our own record is 15 minutes. This may be an important factor in cases of ectopic pregnancy. Suitable frogs are easily obtained and are quiet about the house, so that every doctor can perform the test in his own consulting room.

We shall welcome at the school anybody who cares to come along in order to learn more of the technique.

Dr. Stephen Shuphon Jiang,
Low Soon Ghym,
School of Physiology
December 14th. 1949,
Hong Kong.

"Man can learn nothing unless he proceeds from the known to the unknown."—Claude Bernard.

A CASE OF INFECTIVE APPETITIS

I was written off as a case of Infective Appetitis and hospitalization was imperative. The nature of the malady being such, the period of incarceration would depend entirely on me—naturally.

The label of the disease speaks much for itself, but the onset, the course and the signs and symptoms associated with such a condition might throw some doubt in the mind of a layman. As a victim I shall unfold the mysteries of this common disease which I hear has only recently acquired the dignity of a name, though it is by no manner or means a new disease.

Of late, much re-search and yet more search has been conducted in the mysterious hinterland of the "Re-search and More Search Laboratories Incorporated," and the "Syndicate of Herbalists and Concoctionists" are hoping (and praying) to publish a detailed pamphlet on the "low-down" of this pestilence.

The onset is very gradual. So gradual is it that you scarcely notice it creeping on you through the ages. It usually starts from the time you started to crawl on all fours and learned to call a "spade" a "thpade". It commenced when I sprouted my first tooth—a sweet it was. No sooner did the first bit of dentine see broad daylight, it appeared I sneaked frige-wards for the jam jar and helped myself to liberal shovelsfull of the delicious concoction and was caught in the act and forcibly torn away from the object of my indulgence, but not until I had drained the last bit with great gusto. Thus, the first seeds of the disease were sown. This is the Incubation Period and advice is given to annihilate the disease at this juncture before it gets beyond control.

As the years went by and milk-teeth gave in to sharpeners and grinders, it was a craving for sweetmeats and the like. I had to match my wits against padlocked cupboards and refrigerators fitted with the latest combination locks. The disease was beginning to manifest itself. At first there was a feeling of frustration. As far as lessons were concerned it was always a case of amnesia. There were periods though, of extreme mental and physical activity when I literally "burnt the midnight oil" endeavouring to design a master key and work out the intricasies of the combination locks. My teacher had long given up hope that I was ever destined to eventuate as a savant, but little did he know the line in which my latent genius was directed to. At this stage, the

disease can be very infectious especially when one is in close contact with younger brothers and sisters. To prevent further spread of the disease one has to operate with the utmost secrecy. There are times, of course, when one fights a losing battle, and this stage of the disease is aptly termed the Stage of Frustration.

On entering adulthood, the disease becomes more deep-rooted and begins to take many a complicated course. There is a perpetual feeling of hunger, (for food and various other juicy objects), and an everlasting thirst. The latter is not for knowledge or even water, but for spirits, wines and the like. One's mental equilibrium, needless to say, is in a pitiful state, and you begin to really "see" things. You regard the opposite sex with much the same relish as you once did your first jar of jam, and use the term "Sugar" only too recklessly. Strangely, enough, the uncus at this stage becomes hyper-sensitive and you are not infrequently dubbed a "smeller" by your associates. There is frequent insomnia, lethargy, and mental symptoms sometimes bordering on the verge of lunacy. At this stage many rash decisions are taken which only aggravate the condition further.

One usually develops an "auricular flutter", (not to be confused with the cardiac symptom), which is due to an elongation of the auricles, ("ears" to the layman) and is the result of longstanding manhandling of the said organs by a second party. This may be unilateral or bilateral as the case may be, depending on the fancy of the causative "virus". There is commonly some "clubbing" (not of the fingers but of the skull and other unprotected parts of the anatomy) brought about by frequent impacts from hard objects like umbrellas, flying saucers and other unmentionable missiles. The above complications are a result of rushing in where angels fear to tread, thus proving that lunacy is setting in. By this time the disease is so well established that medical and psychiatric treatment is urgently needed. The latter mode of treatment is recommended only to those chronic cases. This is the Stage of Obsession, and the services of a specialist is strongly indicated.

Thus, it was at this critical stage that I came to be shanghaied into the XXX Hospital for treatment and if needs be for observation.

Without the vaguest suggestion of a complaint against the hospital in which I found myself incarcerated, all the staff from the lowest physician to the highest orderly was most kind, attentive and considerate—in his or her own little way.

I had smuggled a tiny bottle of Port just in case of bed-sores, and had it well concealed under my pillow, when an over-enthusiastic nurse pounced on

it and whisked it away for "safe-keeping". I later learnt that she had left the stopper open and the whole darned thing had, much to my regret, "evaporated". I was wondering if I should sue her for evaporation. But she gave me such a melting look in explanation, that I jettisoned the idea. Curse this disease!

I had not been in bed long when one of those white-robed zombies one usually sees wandering aimlessly around the wards with lean hungry looks, floated in with an air of importance and proceeded to ask me some very rude and personal questions. This last-mentioned creature was a medical student (in refined language). He started off with asking what my miserable name was; then what I did for an existence and if not why not; whether I was a parasite; how I managed to steal into hospital in the first place; my past history (my sore point); and ended up with some of the most personal of personal questions which left me blushing with shame.

I heaved a sigh of relief when the monster left but only to be plagued by a third. This was a nurse who was of Amazonian proportions and with a blood-thirsty look. I recoiled with horror when I noticed that she was armed with something that looked more like a spear than anything else. It could have been an optical illusion though, because everything was so confused around me then, and I meekly submitted to her whims and fancies.

"Blood!" she said. "Eh?" I replied, quaking. "I want your blood," she retorted, and without waiting for a hint of a reply from poor me, seized one of my paws with gloating eyes and gently proceeded to wipe it with cotton wool. Then raising the "spear" about three feet she drove the sharp end home so deeply that a trickle of blood issued and she smeared it on a couple of window-panes, and replacing my paw in its original socket departed triumphantly.

I had scarcely reached my pillow in a fit of nervous exhaustion, when I felt a cigarette tin being placed on my out-stretched hands. I reached up with a start and encountered a grinning orderly who smiled slyly and said, "Sugar". I mumbled a word of thanks and looked into the tin to find it empty! I was not exactly in a mood for practical jokes at this point and so gave him one of those withering glares in return. His smile gave way to an ear to ear grin and then pandemonium broke loose. I flung the empty tin on his face and howled for the Sister who came in and soothed me and said that I had to be tested for my sugar.

Now, sugar, as you have seen, is a sore point with me, for I remember I got a tight slap when I attempted to call a cutie "sugar" once. Besides, there was that other episode in the internment camp when some sugar was missing and the Jap guards turned the hut inside out and eventually recovered

two katies of unrefined sugar from my spare G-string! A "thoughtful" colleague of mine had lifted the sugar from the cook-house and "planted" it in my spare G-string for hard times – the brute.

"But Sister," I pleaded, "my sugar is not with me any more. The last but one that I did have decamped with a pal of mine and has been missing since. In any case I can assure you it would be too unheatlhy for you to know much about my present one". She fumed and said, "Oh! shut up. The lab. is the best judge of your sugar".

The next day I asked Sister how my sugar was and she gave me an evasive answer. The Quack was no help either. Surely I should be kept informed of how my stocks were so that I could regulate the supply. How many katies had they recovered I wondered. It was a top secret for I never found out, but strangely enough my morning cup of coffee and evening tea were sickeningly sweet for the next couple of days. They must have recovered some quantity. Or was it just coincidence?

Then there was that delightful period called "**Visiting Hours**'. The news had evidently got around town for I was soon surrounded by a motley crowd of pals and other shady characters. And the things they brought me. Oh! I was getting a relapse. One good soul brought a parcel of old Readers' Digests. I soon learnt how the Spanish Civil War was progressing. Another brought me a gilt-edged packet of cards. I could now play "Patience" for the rest of my life. One generous being, bless his soul, offered me a cigarette, but not until I had exhausted my supply in satisfying this chain-smoking crowd.

I was expecting my latest firebrand – I mean my flame. I had recently in a moment of extreme weakness, (partly aggravated by the disease I suffered) fallen heavily, the whole seven stones of me, for a huge piece of girl friend, and so I was counting the minutes for her arrival. Though she lacked that necessary fineness in handling men, I must confsss I had been well handled thus far, skipping a few scratches and scars here and there and we were really hitting it fine; (in fact, she was. Stage of Lunacy creeping in . . .)

Suddenly there was a distant rumbling and the Ward rocked in its foundations. My moll made a dramatic entry dressed in a delighful five-piece openwork trimmed with the latest Scotch tape! Her slip of dainty gunny sack cut in the most intriguing manner (that it gave one the false sense of looking at lace) was just showing, and revealed her well moulded billiard-table ankles to the vulgar stares of all present.

Soon we were alone . . .

She was going to a party with an old friend of hers she said. Trying to pull wool over my eyes, I mused, and just like her at a time like this too, when I was taken into custody and lying helpless. I began to have my doubts which I did not attempt to conceal. But she possessed a mental crowbar with which she prised things from underneath the inertia of my sub-concious (or my un-concious), and soon I got a lengthy discourse on how the happiness of many a couple had gone to the rocks all because of HIS unfounded jealousy and suspicion of her. I submitted and meekly ventured to ask her if it was a Fancy Dress Ball she was going to and who this long lost accomplice of hers was. Her reply sent me reeling. The impact of the contraption she called her hand-bag on my head cut short what I was going to blurt out next! Before I could gather my wits about she had rumbled her way out.

Of course, I was on a diet. I was assured of a "full diet", but had it not been for my moll (she always came back for more) who smuggled in an odd tin of sardine or so, I should have speedily died of hunger. Not to be caught again, I safely stored the grub under the floor-boards just in case that ambitious nurse found themand whisked them away for "safekeeping". What with my store and frequent curries and beef-steaks smuggled in thermos flasks, I managed to keep my skin clinging to my bones . . . . . .

At last the day arrived when I was asked to leave the hospital in favour of a sick patient. My moll had arrived promptly to take delivery of me and as we were leaving, the Sister called me aside and asked very politely who "she" was. "That LADY," I repied very SWEETLY, "is now my entire stock of sugar!"

D.

A famous surgeon was asked out to dinner. The hostess felt that because of his professional training he would be the logical person to carve the chicken, so she asked him to perform the little task.

All did not go well, however, and the bird slipped off the platter and landed squarely in the lap of the hostess. She was extremely embarrassed, but attempted to pass it off with a bit of pleasant banter.

"Gracious," she burbled, "I don't know whether I would trust you to operate on me or not!"

The surgeon pulled himself up to his full height.

"You, madam," he said, "are no chicken!"

EXPERIENCES IN MEDICAL EDUCATION IN THE U. S. A.

By Dr. Olaf K. Skinsnes.

Medical schools in the United States, as well as elsewhere, vary in their facilities and attitudes. Therefore, though the following statements are generally true for medical education in the United States, they are particularly based on experiences at the University of Minnesota, the University of Chicago and Cornell University.

The average medical student enters upon his medical studies after having completed two to four years of college preparation. His studies will have included biology, chemistry, physics, mathematics and such other related and general subjects as time and interest permit. As a rule he will have a "major" in either or both biology and chemistry. The preparation in biology usually includes general zoology, elementary physiology, comparative anatomy, embryology, and perhaps genetics and histology. Studies in chemistry go through inorganic, qualitative, quantitative, and organic chemistry and not infrequently include physical chemistry which is now also demanded as a prerequisite by several medical schools. The training in mathematics is usually limited to higher algebra and trigonometry but often the student also elects to study solid geometry and differential and integral calculus.

As he approaches the completion of these studies the candidate makes application to several medical schools, submitting his scholastic records, results of a medical aptitude test, letters of recommendation from science teachers and from one or two physician acquaintances, and then waits anxiously for the replies. If his record is mediocre, he may be accepted by only one, perhaps less renowned, school where he will receive a sound education but where the facilities may be more limited and the teachers in general less well-known. If his record is exceptional, he may have the opportunity of choosing from among several acceptances.

The first two years of actual medical study are a long hard grind of intensive work. Many of the detailed facts learned, are of course forgotten but through their learning a sense of understanding and judgement is fostered. The pre-clinical subjects of anatomy, neuroanatomy, histology, biochemistry, physiology, bacteriology, parasitology and pathology are covered fairly thoroughly. Emphasis is placed on allowing the student to have as much practical experience as possible in these fields. In bacteriology the student makes all the various cultures and studies himself, even though dangerous organisms may have to be handled. It is felt that it is better for him to learn to handle them at this point, under careful supervision, than to tell him what the precautions are and then have him wait for his experience till he has to handle them in

private practice. In physiology extensive animal surgery and experimentation is undertaken and in pathology opportunity is provided for interested students to participate in autopsies.

Despite all these activities, time is found for occasional exhuberant social gatherings and a fair number of students take time during the medical course to marry. Not infrequently they marry nurses with whom they come in contact in the hospital. A marital team is thus formed, which directs its efforts at getting the student through school. Often the wife works at her profession to help supply the necessary funds.

The clinical subjects are first encountered extensively in the third year of medical training. There have been previous courses in physical diagnosis, but contact with patients has been relatively limited. Beginning with the third year, however, the student is technically considered as a clinical clerk or extern. Actually, he is treated as a doctor. When he is called over the communications system he is referred to as "doctor" and when he is questioned about a case by the attending physicians he is addressed as "doctor." He is usually the first one to see the newly admitted patient, except in emergency cases. If he is assigned to a patient before 7:00 or 8:00 p.m., he is expected to have completed the work-up on the patient in time for clinical rounds at 8:00 or 9:00 a.m. the following day. This includes a completely written, detailed history and complete physical examination, routine blood, urine and stool examination. He draws blood samples for Wassermann or Kahn examinations and for the various chemical analyses that are indicated. In deciding which examinations are in order he may consult with the intern and resident on the case for advice and approval, and he is often prodded by them into thinking of things that he might otherwise forget. The externs are rotated from service to service in order to allow as varied an experience as possible, but as long as he is on the service he is responsible for keeping abreast of treatment and changes in the status of his patients. He has every opportunity to help the intern in giving blood transfusion, intravenous and other infusions and in performing various clinical and laboratory examinations. Sometimes these opportunities seem almost too extensive since interns are notorious for trying to pass off routine work on the externs. In surgery the student is expected to assist at all possible operations on his patients. His work is constantly checked by the interns and residents and finally by the attending physicians. He may be called upon to defend his recommendations or his opinion may be requested at any time by the physician in charge. This trust in the student's ability to think for himself often pays dividends and at times he is able to make suggestions that are of real value in treating the patient and in elucidating the disease.

Patients occasionally resent being re-examined by so many physicians, but in general they are co-operative and feel that they are getting more

attention and better care because of it. The extern developes confidence in his ability to think and act, and is quite free to differ with the attending physician on problems of diagnosis and treatment but if he does, he had best be prepared to defend his position. The professors, as a rule, are pleased at any signs of sound initiative on the part of the extern. I recall the genuinely pleased smile on the face of the chairman of the department of surgery one morning on rounds. He is a world-renowned specialist in his field. We had just spent some time in the room of a patient suffering from a puzzling abdominal condition, reviewing her history and asking her further questions. As we turned to leave the woman called out, "Now, if you are all through, I would like to see my doctor for a minute because I have something special to ask him." We thought at first that she meant the professor of surgery, but she meant the extern. When this dawned on us we walked out of the room and Dr. Phemister turned to us with a big grin and said, "That's fine! Dr. (extern) has conscientiously listened to and cared for his patient thus gaining her confidence. It pays to take a little extra time in order to get complete histories and to get complete physical examinations. You will practice better medicine, gain the patient's confidence, and justify the confidence that is placed in you. This is the spirit we are striving for in this school." And off he went, chuckling to himself.

In the fourth year the extern is assigned in rotation to various outpatient clinics. He works up patients, suggests the line of treatment to be pursued and assists the attending physicians in a variety of procedures. He is constantly under supervision and his work is thoroughly checked. The final responsibility, of course, lies with the attending staff but the student has every opportunity to discuss his patients, as well as the patients of his fellow students, with the staff.

There is a growing tendency in many places to reduce the number of hours of formal lecture work in the last two years in order to allow for greater opportunity to actually assist in clinical work. Nevertheless, formal lectures are usually held two to three hours daily. They are given by men working in the field being discussed in so far as possible. This usually means that the lecturer is actively engaged in research as well as the practice of medicine. The student thus has the right to expect that he will be given a summary of the basic and most recent advances in each field. This summary will then act as a guide to further reading. During the fourth year, while the extern is engaged in out-patient work, his evenings are free for reading and study except for a few clinical conferences. He then has more time for thinking and correlating all his past studies in preparation for his final examinations.

Various clinical conferences, including pathology, pediatrics, obstetrics, medicine, surgery, obstetrics and roentgenology are held each week and the externs, as well as the hospital staff, are encouraged to attend. The discus-

sions are usually limited to the partaking physicians and other staff members, but questions and comments by students are perfectly in order.

Examinations are held at the end of each term. Their results are not infallible by any means but they are valuable in giving an indication of the students' ability and effort. The close contact between student and attending physician in the clinics and in the wards enables the teachers to supplement the impressions given by the examinations. The great endeavour in this examination system is to find out as early as possible where the student is weak so that he may be better guided and to pick out the misfits before the final years. The final comprehensive examinations at the end of the fourth year carry considerable weight but the results are always reviewed in the light of past performance because it is well reallized that the misfortunes of a single examination may well condemn a student who actually is well-qualified.

In some schools the curriculum is so arranged that one term of the concluding year is an "elective." The student may chose from a variety of specialized seminars and lecture courses, or he may elect to spend the time in additional clinical work in that branch of medicine in which he is most interested. At the University of Chicago in particular, there is a strong emphasis student participation in research problems and many students on avail themselves of the resulting opportunities. By graduation time approximately fifty per cent of the class has assisted in or undertaken some research work under competent supervision. At several universities the Borden Dairy Products Company now offers each year a prize of five hundred dollars to the graduating student producing the most meritorious and original piece of research.

At graduation the degree of Doctor of Medicine is given. The graduate can not, however, immediately engage in medical practice. The universities all wholeheartedly encourage and the state licensing commissions demand, that the graduate serve a year of internship before being permitted to practice. On my graduation, I looked on this year of internship as an evil that had to be endured in order to obtain a license, especially so since I had already completed several years of graduate study in pathology before applying for internship. Instead it turned out to be an exceedingly rich experience. The intern is given much responsibility for the patient's wefare and takes the initiative in writing the medical orders. He is responsible for giving the pre- and post-operative orders and for seeing that they are carried out. He organizes ond carries out many therapeutic and diagnostic procedures in co-operation with the resident and his contact with the attending physician is more intimate and rewarding than can be that of the medical student. He plays an active part in emergency procedures. In obstetrics he performes many deliveries and assists at more difficult cases. In surgery he assists at a great number of operations and is permitted to perform others, ranging from biopsies and appendectomies to occasional cholecystectomies and hyster-

ectomies. The number and complexity of operations he is permitted depends to a good deal on the inclination of the attending physicians with whom he serves. Needless to say, he is assisted at any operative procedures either by an attending physician or by a competent resident. The intern also has considerable opportunity, in a teaching hospital, to instruct medical students in the more elementary procedures, and thus he learns more himself.

The sense of responsibility, of self-confidence and of service that comes from being able to alleviate the distress of some patient, even though the call comes at 3:00 a.m., are experiences that mature one's medical and spiritual life. And when some poor operative risk or some severe diabetic or cardiac patient finally is discharged happy, one quickly forgets the many night calls and the long hours of tedious routine work and observation that preceded the accomplishment. The internship, then, provides an excellent opportunity for the medical graduate to assume gradually increasing medical responsibility and to use his initiative while at the same time retaining sufficient supervision to tide him over the crucial decisions. The many little arts that he picks up from the residents and the attending men do much toward educating him in that phase of medicine which can truly be called an art.

Having completed his internship, the doctor is free to take the state board examinations in medicine, and, if successful, may then set up practice in general medicine and surgery and obstetrics.

If the doctor wishes to speciallize he applies for a residency in his field of interest. The residency system is a competative one, but if he is capable the residency may be renewed yearly for a period of five to seven years. During this time the resident assumes an increasingly important role in the care of patients and in the running of the service that he is on. Eventually he may be given a service of his own. He operates with his attending physician and gradually takes over the performance of increasingly difficult and technical operations and procedures, eventually performing the most difficult operations himself with the attending physician acting as assistant and lending his experienced suggestions. At the completion of varying lengths of residency, depending on one's specialty, the candidate may present himself before a specialty board set up by the American Medical Association. On successful completion of the practical and theoretical examinations he is certified as a specialist and is by then well qualified for his specialty. He then faces a a great variety of possible positions on university staffs, research institutes, private practice or charitable service. Whither he goes is his own responsibility and is dependant on his inclination, on opportunity, on economic desires and on moral sense. Whichever he chooses, he is usually capable of doing good work. Whatever his future, he can look back on a rich experience of close association with men who are good at the job, keen on advancing medical knowledge and earnest in the care of their patients. It is indeed, a rewarding experience.

THE MEDICAL GAUNTLET

The half-baked potato is neither available for seed nor good for consumption. Similarly, a half M.B.B.S. knows too little to write a thesis, yet knows something to confirm that wise old saying, "Empty vessels make the most noise." Be it as it may, the following is presented and should be taken with a grain of salt.

Those who aspire to be medicos must of necessity run through the gauntlet in whole or in part. The first trial that confronts the zealous student is that of ragging. No matter what the pros and cons of it are, one thing is certain, and that is, the fun and frolic available to the seniors on the one hand and the freshies on the other, are seldom if ever mutual. Although the greenhorn may think that he is very unceremoniously initiated into the student life of one of the hostels, he will no doubt, as the years pass by, thank his lucky stars, that he has undergone such an experience. It is a good way of training the greenhorns to respect their seniors. The involuntary antics, which are such an essential feature of ragging, are a severe test of humility for the once mighty newcomer, who, at that very moment, might still be thinking of the exalted position he held in school a formidable record of being a senior prefect, Editor of the school magazine, Troopleader, Captain of the school cricket and football eleven, Chairman of the Debating Society, etc. Indeed this training of humility goes hand in hand with the medical course here. You will be ragged when you enter a hostel; you will have to sharpen the scalpels for the seniors when you enter the Anatomy Laboratory: you will have to reach the hearts of senior students via their stomachs as soon as you set foot into Queen Mary; God only knows what you have to do besides swotting and sleepless nights to get your M.B.B.S. From what I can gather, you are still a greenhorn when you try to set up a practice after graduation.

The next stage of the gauntlet is when the student attends his first lecture. It happens to be Physics. This he hears for the first time in his life and is remote to what he expected. Then comes Chemistry and the student now really begins to wonder if he has entered the wrong Faculty. He fails to see the relationship which Physics and Chemistry bear to medicine.

Believe it or not Ripley has proved to us that the more we study, the less we know, but he has forgotten to warn us also that the more we know, the thinner we become. How often have we seen students coming back for lunch

after their first dissection turn vegetarians? How often have we stopped, pondered and reluctantly pushed away a plate of 魚生 for fear of clonorchis sinensis? How often were we tempted, on summer outings, to stop at one of the roadside stalls for a bite, but that the ugly heads of typhoid, cholera and dysentery must needs show themselves and dampen our appetites? And how often have we denied ourselves meat because of Taenia, milk because of tuberculosis and typhoid, water because it hasn't been boiled. To make matters worse, we worry to death trying to square a round meal, trying to replace salt and water loss, trying to calculate income and expenditure of calories, and last but not least, trying to achieve something with the highly reputed and much publicised vitamins. Ladies and gentlemen, I will be the last person to envy the doctor his appetite!

Dear reader, if you haven't been to the University Bus Stop at 8.25 a.m. anyday except Sundays, then you are to be pitied, for you have indeed missed a merry sight. If you haven't seen a sardine processing plant then I advise you to take a casual walk one of these fair mornings to the above place and witness a most humorous show gratis. You will then unhesitatingly laugh no doubt, and perhaps (if you have a soul) begin to wonder why people pay to suffer riding on a tuberculous, epileptic and rheumatic contraption and even heave a sigh of relief on being able to do so. What a life!

Every medical student must have suffered from "Examinariasis." This is one of those diseases which is assuming epidemiological importance, and like all epidemics, it occurs in waves, once before Christmas and once in May. The aetiology is still a much debated question but the theory that it is probably caused by the *Virus Procrastinatus* is much favoured by most learned and experienced people. With regard to the Bacteriology and the Pathology of the disease, we are not much concerned, although it would not be amiss to mention here that the virus takes a special liking to the Central Nervous System and Cardiovascular System. The signs and symptoms of a man stricken with "Examinariasis" are well known but for the benefit of those who haven't seen a case, the following is presented: –

Onset: Insidious

General Appearance: ill-looking, pale and very, very sleepy, with drooping eyelids aud a tendency to yawn. Temperature may or may not be raised. Anorexia, constipation and loss of weight.

C. V. S.: The pulse rate is increased, B.P. is invariably raised.

C. N. S.: Headache, nervousness, excitement, irritability, and all the signs of hyperadrenalinism, and if allowed to continue may lead to collapse and/or the lunatic asylum.

The treatment of such a patient is purely psychological. Just dangle the M. B., B S. in front of him or her. The prognosis depends mainly on the speed with which treatment is carried out and is generally believed to be good. The mortality rate however is nil. Immunity to the disease comes through experience. Natural immunity is unknown. The medical student is vulnerable to twelve epidemics during his or her run of the gaunlet (possibly more but never less!). But, being the adaptable animal that he is, it is hoped that he learns how to take each succeeding assault of an epidemic wave with a more highly resistant body, better equanimity of mind and tranquillity of soul.

If the gauntlet were run in the wards, the student spontaneously finds himself open to numerous attacks. There is the heavily pigmented student who has language difficulties with his patient. What with the different dialects and the four intonations current here, one can sympathise with the foreign student. Even to the native, this difficulty is not easily and wholly surmounted and may give rise to many humorous, but usually rather awkward and embarassing situations. A slip of the tongue is no fault of the mind.

Then, there is the case of Mistaken Identity. A student was walking leisurely down the Hospital steps, leather bag in hand, when a female attendant hailed him. On asking what she wanted, she replied, "They need a barber ....." Imagine the embarrassment !

Then there is the case of Indecision. The Surgeon extols surgical measures to the sky. The Clinician is equally firm on his ground. Between them both, the student is sandwiched in midair. "To be or not to be, is the question." Whether 'tis wiser (or more foolish?) to be a Surgeon or a Clinician.

Dear reader, the above is not by far a complete picture of what you expect to get if you are foolish enough to run the medical gauntlet voluntarily. I am however content to let it rest at that because I wouldn't like to spoil the fun and see an empty race due to lack of entries. So, ladies and gentlemen, the next time you receive a doctor's bill, you will not gasp if you remember the Medical Gauntlet.

B. S.

"The trouble with most doctors is not that they don't know enough, but that they don't see enough."—Dominic Corrigan.

THE KING'S EVIL

By Prof. A.J.S. McFadzean

"Scrofula", tuberculosis of certain structures especially of the glands of the neck, is a common ailment of mankind but it is possessed of two names which raise it from the common rut, "The King's Evil" and "The Royal Disease". It is even more interesting when one realises that the Kings of England and of France once possessed a remarkable reputation for curing it by the laying on of hands, the "King's Touch". It is commonly accepted that the two intriguing names owe their origin to the reported successes attending the therapeutic manipulations of these august but unregistered practitioners of medicine. It should be remembered that tuberculosis is very frequently a self limiting disease and the reported successes were uncontrolled. Furthermore, in the absence of the nice methods of diagnosis which we know today, the ancients included as the "King's Evil" a wide variety of swellings of the neck of other than tuberculous origin. Many of these were capable of dramatic resolution and, no doubt, such cases further enhanced the royal reputations.

According to English tradition the practice originated with Edward the Confessor. The account of the reputed beginning is that in a young woman "the humours collected abundantly about her neck and the glands swelled in a dreadful manner. Admonished in a dream to have the part washed by the king she entered the palace and the king himself fulfilled this labour of love by rubbing the neck with his fingers dipped in water. Joyous health followed his healing hand, the livid skin opened so that worms flowed out with the purulent matter and the tumour subsided. But as the orifice of the ulcer was large ond unsightly, he commanded her to be supported at royal expense until she should be perfectly cured. Before a week had expired a fair new skin reformed and hid the scars so completely that nothing of the original wound could be discovered". Before Edward's death in 1056 he had treated a great number of patients in this way. The practice continued and thrived among his successors. In the household accounts of Edward I we find that 288 persons were touched by the king on Easter 1277. After Richard II no mention is made of the practice until 1462 when Henry VI revived it and distributed gold coins (angels) as touch pieces. Wadd considered "that some were cured of the king's evil who never had any other evil than that of poverty, which brought more patients and more fame to those royal practitioners than they deserved". It is noteworthy that after Elizabeth the size of the coin was reduced—this of course coincided with the appearance of a Scottish King, James VI, on the English

throne! The "wisest fool" wished to discontinue the practice as a superstition and, quite possibly, as an economic measure. He was persuaded to retain the practice for political reasons but economy was insisted upon and the touch piece was reduced in value.

The practice reached its zenith with the later Stewarts and it would seem that the more dissolute the monarch the more effective his curative powers for Charles II in the year of his restoration 1660 touched 6,725 people and during his reign 92,107. He practised during his exile and it is stated that the crowds were so great that on one occasion 6 people were trampled to death, conditions somewhat worse than at the Sai Ying Pun. Pepys' view on witnessing Charles in action, was, "an ugly office and a simple". It should be noted that more people were reputed to die from "scrofula" in this period in England than ever before. William of Orange was very sceptical of his powers and when persuaded on one occasoin he said to the unfortunate sufferer, "God grant you better health and more sense". Queen Anne was the last of the royal healers and Samuel Johnson was numbered among her patients. He was no tribute to the efficacy of the treatment for he suffered from "scrofula" throughout his life.

The practice was not restricted to England. The French claimed that it was Clovis the Frank who first used this healing power after his coronation in A D. 496. The English maintaind that the kings of France inherited the power from their relatives the kings of England and, between the two kingdoms, a long and bitter dispute raged not only as to the first practitioner but also the relative merits of the two "schools". If we judge success of a practitioner by the number of patients attending him then the palm must go to Louis XIV who "touched" 1600 persons on one Easter Sunday. An outspoken commentator stated that no one was one whit the better. In France the practice continued well into the 19th Century.

If the specialist practice of "touching for scrofula" extended to countries other than England and France there is a singular absence of historical records. The general practice of "touching" is older and was more widespread. For example Hadrian cured dropsy by the Imperial touch. From the few cases recorded in other kingdoms it would seem that the royal general practices were far from thriving. In the accounts of the Lord High Treasurer of Scotland covering the reign of James IV there is but a single entry suggesting the practice and that a rather pathetic one. "Item: to one pure barne that tuke the King be the hand, three shillings".

Such, in brief, is the history of this extraordinary encroachment of the monarchy on the Practice of Medicine. It seems far from satisfactory. There is doubt as to the origin of the practice and the description of the beginning both in England and in France savours of the well nurtured legend. Again if

the kings did possess the healing "touch" why was their practice largely restricted to "scrofula". It is admitted that they did "touch" for other conditions for example, dropsy and epilepsy, but these were very minor and little known sidelines. Why, too, was the power related to their office? It cannot be related to their sanctity; witness the dissolute but popular practitioner Charles II. Finally, it is rare indeed even in folk lore to find disease named after its cure. That the Royal "touch" should cure the disease seems little justification for the nomenclature. Why should the disease be called "The King's Evil"? This is the question which I shall attempt to answer and for that answer we must turn to folk lore and to primitive man.

Among the most primitive people known we find magic conspicuously present and religion conspicuously absent. In such a community all are magicians. It is regarded reasonable to assume that the civilised races of the world passed through a similar phase. In savage society chiefs and kings owed their authority to their reputations as magicians. With the engrafting of religion the priestly, even divine kings appear and these carry us well within recorded history.

The belief that kings possessed supernatural powers by which they could confer benefits upon their subjects seems to have been world wide. There is evidence that it was shared by the ancestors of all Aryan races and maintained by their descendants. For example, it was believed that the ancient kings of Ireland and of the 4 provinces would bring prosperity to the people and to themselves provided they observed certain taboos.

Royalty were however a source of danger as well as of blessing for their persons were surrounded by numerous taboos and breach of these resulted in dire calamity to the offender. The eating of the monarch's left over food, the use of his utensils or clothing, entry into his house, his shadow, or even treading on his footsteps resulted in catastrophe. In Loango it was even believed that thinking adversely of the king was cause sufficient for punishment. It is surprising how frequently these transgressions were believed to result in swelling of the neck. For example, eating from the Mikado's dish or wearing his clothes produced swelling of the throat and neck. Again failure to observe the taboos surrounding the chief in Fiji resulted in swelling of the neck and abdomen. Numerous other examples might be quoted but only one more will be mentioned. The Tongan natives believe that "scrofula" (our "King's Evil") results from breach of the taboos surrounding their chief. Although totally unaware of any breach the native suffering from "scrofula" firmly believes that such must have been committed.

The protective or curative effects of the king's touch against breach of the taboos surrounding his person is also well recognised. For example, among the

Nubas of East Africa entry into the chief's dwelling is safe only if the king's hand rests on the bare shoulder. The natives of Angola believe that death results if they touch the king but this can be avoided by a ceremony involving slapping the king's hand. The Tongan natives consider that the only cure for "scrofula" is to touch the king's foot.

It would seem that the description "King's Evil" may well have had its origin in folk lore. If this be so then breach of taboos surrounding the king was originally regarded as the cause of the disease and the nomenclature is justified according to the modern practice of classifying disease according to aetiology.

I should like to think that the young woman who sought the help of Edward the Confessor was compelled thereto not by a dream but by the lore handed down to her through the ages.

On Circulation.

This is what Robert Boyle says: "And I remember that when I asked our famous Harvey, in the only Discourse I had with him, (which was but a while before he dyed) What were the things that induc'd him to think of a Circulation of the Blood? He answer'd me, that when he took notice that the Valves in the Veins of so many several Parts of the Body, were so Plac'd that they gave free passage to the Blood Towards the Heart, but oppos'd the passage of the Venal Blood the Contary way: He was invited to imagine, that so Provident a Cause as Nature had not Plac'd so many Valves without Design: and no Design seem'd more probable, than That, since the Blood could not well, because of the interposing Valves, be sent by the Veins to the Limbs; it should be Sent through the Arteries, and Return through the Veins, whose Valves did not oppose its course that way."— *Discuisition About the Final Causes of Things, 1688.*

"If a little knowledge is dangerous, where is the man who has so much as to be out of danger?" — Huxley.

RECENT RESEARCH ON PARASITOLOGY

The literature on parasitology has now become exceedingly extensive and more so with the inclusion of rare subspecies which attack man, cattle, dogs, cats, rats and hippopotomi.

In view of the large demand by the students for the study of rare forms of parasites, exhaustive research was carried out on protozoa, trematoda, cestoidea, and nematoda during the past year. To bring out salient features hitherto unrecognised by former authorities, new methods of staining and sectioning were revised, modified and discarded.

An attempt has been made by the authors to simplify the nomenclature of the use of descriptive terminology coupled with the International Code and commencing with the name of the genus in Greek or Latin.

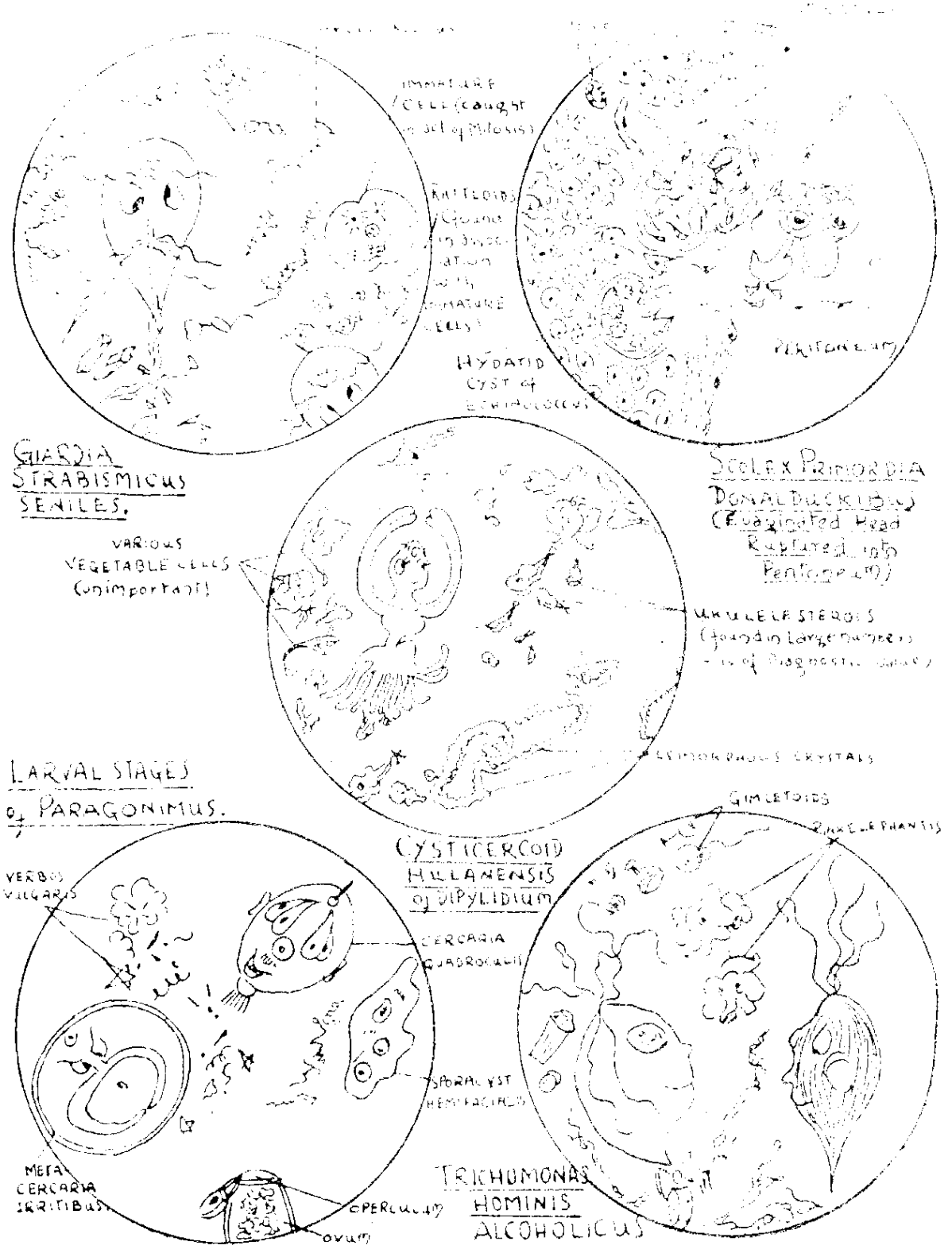
Acknowledgment is here made of the aid given by Sir Hubert Hues in the experimentation on the staining qualities of methylene red.

The use of certain portions of the microphotographs is by virtue of permission received from the Board of Trustees of the H.K.U. Parasitological Convention. The said Board of Trustees is not responsible for any inaccuracy of photographs and nomenclature.

It is reported with regret that Mr. Summerbath who made the final preparations for mounting the specimens and smears succumbed to infection after which postmortem showed five pathologies.

BERNARD ANDREW JONATHAN MILDEW

M.C. Ragging Society, S.P.C.A. (Oxo.), L.B.W., C.P.C., N.A.D., A.A.R.E. (Association for the Abolition of Retinal Examination).



Giardia Strabismicus Seniles, Scolex Primodia Donalduckibus, Cysticercoid Hulanensis of Dipylidium, Larval Stages of Paragonimus, and *Trichomonas Hominis Alcoholicus.* Photomicrographs of actual specimens observed under oil emulsion (Scott's) in methylene red stained, Summerbath fixed smears.

REMINISCENCE

As the first graduate of Hong Kong University, I have been asked to contribute a short article for the first issue of the Undergraduate Medical Magazine.

I find it difficult to select a suitable subject on which to write, but perhaps a brief account of undergraduate medical training in Hong Kong 40 years ago, as illustrated in my own case, might interest a few present medical students.

I entered the Hong Kong College of Medicine in March 1907 after having passed a nominal matriculation examination. This defunct College, as is well known, was founded in the 'eighties' by Sir Patrick Manson and others, and I believe its sole claim to fame rests on the fact that the Founder of the Chinese Republic was one of its first graduates.

The College had no building of its own, but used the old Alice Memorial Hospital on Hollywood Road as its headquarters. A few of the lectures were given there, but the majority were given at various places in the city and in Kowloon to suit the convenience of the part time lecturers.

The period of study was five years, and the curriculum conformed—at least on paper—to the then requirements of the General Medical Council, with the exception that there was no practical work of any kind in anatomy, physiology, and pathology. Anatomy was taught entirely from models, and bio chemistry was almost unknown.

The clinical training was better. The lecturers were all sound clinicians who gave of their best as well as much of their valuable time to teach in the wards of the hospitals connected with the College, viz., the Ho Miu Ling and Nethersole Hospitals and the Tung Wah Hospital; but they sadly lacked modern diagnostic facilities.

Surgery in those days was more of the antiseptic type than aseptic. Only the instruments were boiled, but the bowls, towels, swabs and dressings were not sterilized. Carbolic acid solution was used freely. The boiled instruments were immersed in the solution; the towels were wrung out of it and draped round the operation area Cotton wool was used as swabs which were soaked in carbolic solution and squeezed half dry before dabbing on the wound. Gloves were not worn except on special occasions and then by the surgeon only.

The poor students who assisted found their hands benumbed by the carbolic for the rest of the day. Caps and masks were not used; only aprons were worn, and if a gown were worn by the surgeon, it was not sterile, and he might have worn it right through several operations.

In the surgical wards carbolic acid solution was also freely used in the washing of wounds, suppurating and healthy alike. Iodoform gauze or iodoform-boric acid powder was the standard dressing for all wounds. Students who dressed the cases smelt strongly of iodoform wherever they went, and outside people suspected them of suffering from a chancre or bubo, for in those days V.D. and iodoform appeared to be inseparable in the mind of the public.

The teaching of clinical medicine was simple and straight forward; only the essentials were taught and emphasized, and the finer points in diagnosis were sacrificed in order not to confuse the students' minds.

Since almost all the lecturers in the College were graduates of Edinburgh University, the teaching and examinations followed those of the Edinburgh School. Students were permitted to sit the examination in each subject singly if they wished, but medicine and surgery had to be taken together. Materia medica and Medical Jurisprudence were separate subjects with separate examination papers.

I completed the five year course in January 1912, and was given the diploma of "Licentiate in Medicine and Surgery of Hong Kong" (L.M.S.H.), which was not a registrable qualification.

At about this period, the main buildings of the new Hong Kong University had been completed, and early in 1912, the University was declared open for the admission of students. The Hong Kong College of Medicine automatically ceased to exist.

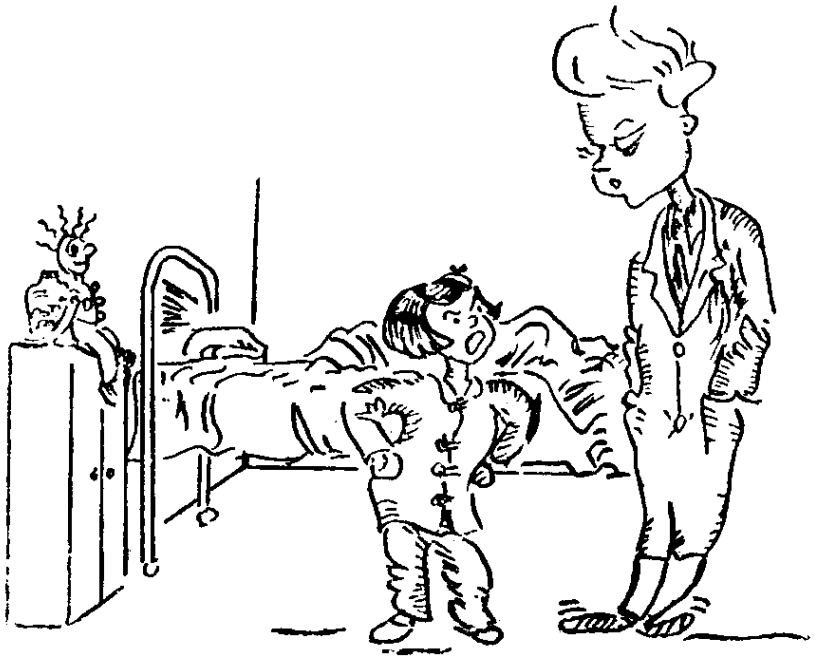
Of the three Faculties of Medicine, Arts, and Engineering, that of Medicine had the largest number of students, because all the students of the College of Medicine became undergraduates of the University with corresponding status, but a period of at least two years had to be spent at the University. I and two other Licentiates of the College of Medicine were admitted as Advanced Students eligible to sit for the degree of M.B.,B.S. after a period of two years of further study at the University. The course of study prescribed for advanced students was:- Practical Anatomy (dissections) for six months (held in a separate room at the Victoria Public Mortuary); attendance of lectures on Public Health, Midwifery, Medicine, and Surgery (including Operative Surgery). I regret to say that these two years were a mere formality. The University was only just

born, and there were no new facilities or new equipment. The lecturers were practically the same; only the set lectures had to be given at the University. We attended the same hospitals. It was only from 1914 onwards that the Medical School became better and better as the years rolled by.

At the end of the prescribed two years, seven candidates presented themselves for the Final Degree Examinations. Lavish preparations (including a banquet) had been made for the first degree conferring ceremony, in which the Chancellor (Sir Henry May) and the Vice-Chancellor (Sir Charles Eliot) would officiate; but, alas! it appeared that none of the seven aspirants had been found worthy of the degree. The University Authorities, faced with an awkward situation, apparently decided to produce one graduand for the ceremony according to plan. I believe they selected me on the mistaken assumption that I, who had already been holding the Government post of Resident Medical Officer to the Tung Wah Hospital since 1912, would probably be the one calculated to do the least harm to the community.

I firmly believe that this is the true story of how I, in May 1914, obtained the coveted but undeserved distinction of being the first graduate of Hong Kong University.

JONATHAN MILDEW



"I hate being stared at by strange men."

MENOPAUSE

They laugh so true and easily,
They crackle with some inner fire
Which constantly within them warms
The new found fullness of those forms
That so epitomise Desire;
They are too privileged who move
In prime of Beauty, Life and Love . . . .
I turn from my far window.

❖ ❖ ❖

That looking glass with which I view
The life-wild eyes now strangely tired,
The dimples that to gashes turned,
Th'advancing Age no art can hide,
I rudely shatter . . . .
An other mirror brings before
These self-same ravages but more.

❖ ❖ ❖

They say
Man too woos gentle Age,
When new serene refinement bears
A love less lecherous than sage.
Why is it that Man's love caresses
Unspeckled white or purest shade,
So rarely
Intermingled greying tresses?

UNIVERSITY  OF HONG KONG

The Faculty of Medicine

We consider that it would be of interest to all medical students to know something of the progress made by the various Departments of the Medical Faculty since the re-opening of the University three and a half years ago. Below are the fruits of our efforts for which we have to acknowledge with sincere thanks the kind co-operation of the Heads of the Departments concerned. Students would be delighted to know that our University is keeping pace with the rest of the scientific world by the creation of a new Research Department, directed by a committee of which Professor F. E. Stock is at present Chairman, and its amalgamation into our Faculty.

The Editors.

Department of Anatomy

By Prof. S.M. Banfill

In September 1947 our first post-war class consisting of 63 students was ready to start the study of Anatomy. A Reader was appointed and arrived in the Colony on September 1st to find that the Anatomy Building had been repaired to the extent of having a roof and walls but was bare of funiture or equipment. The essential tables and stools were obtained so that lectures and osteology classes were started on October first but it was not until the end of November that enough cadavers were obtained to start any dissection. With this late start steady work was required to complete the course by May and holidays were ignored by the staff and by a very reasonable and conscientious class.

At first lecturing, demonstrating and preparing specimens were done by a staff consisting of a Reader and two part-time Demonstrators but the appointment in March of Dr. E. Anderton as Demonstrator greatly helped the situation.

Volunteers from the Anatomy class worked throughout the summer vacation of 1948 to prepare specimens for teaching and to provide a nucleus for an anatomical museum.

By September 1948 there were definite signs of progress. For the first time there were two classes of students numbering in all 140. The staff was better able to cope with them for it now consisted of a Reader, 2 Demonstrators (Dr. Anderton and Dr. Lee), a part-time Lecturer (Dr. R.J. Wong), a part-time Demonstrator (Dr. S.Y. Cheng) and constantly changing but very conscientious volunteer teachers from the Services.

Since our first year we had learned a great deal about preparing and preserving anatomical specimens in this tricky climate and the standard of practical work improved.

Histology apparatus began arriving from England and a Histology preparation room was equipped and ready for use by January 1948. The refurnishing of the Physiology Laboratory had made it possible to hold classes in Practical Histology in September 1948 but teaching material was in very short supply. It was only through the kindness of Professor C.P. Leblond of McGill University, who gave us a supply of slides, that we were able to start teaching, and with the continued help of Professor P.C. Hou of the Department of Pathology we nursed the class through its first year. More equipment was received later in the year and as our technique improved we became more self sufficient.

In May 1949 our first class came up for examination. 68 students sat and 47 passed. A summer revision course was given in which the student was required to dissect the entire body in six weeks and at the supplementary examination held in September 23 sat and 14 passed.

The session starting in September 1949 saw an enrolment of 150 in two classes. The staff also had grown. It consisted of a Professor, 3 Demonstrators (Dr. Anderton, Dr. Lee and Dr. Pang), a part-time Lecturer (Dr. Raymond Lee) and our faithful part-time Demonstrator Dr. S. Y. Cheng and a new but still enthusiastic representation from the Services.

Teaching followed much the same pattern as before with one addition, the tutorials. Each class was given two lectures a week in Gross Anatomy and one in Histology or Embryology. The dissection was done as Regional Anatomy with three students to a part. Histology Laboratory classes were held once a week in the Physiology Laboratory and prepared sections issued to groups for home study.

The innovation of tutorials was prompted by our conviction that Anatomy is best taught in small groups. The class was divided into groups of twelve and each student attended one tutorial each week. The results of this method have yet to be seen but it seems open to the criticism that it is "spoon-feeding". Certainly it is difficult to prevent these classes from becoming a series of extempore lectures.

We have great hopes that the future acquisition of more space, more staff and better equipment will make teaching easier and allow time for research.

We look back on the last three years with satisfaction, at much good work accomplished, by both staff and students.

Department of Physiology.

By Dr. D.W. Gould

We are nearing the end of our 3rd post-war Session. So far we have passed on 60 young and knowledgeable physiologists to the clinical teachers, and we have taken in over two hundred from the pre-medical course.

With 70 students in each year, space and equipment are strained to the limit.

Practical classes were started for the first time in Sept. '48, and then only on a restricted scale, for the apparatus ordered from England so long ago took an unconscionable time a-coming.

The present 4th year therefore had short measure of laboratory work, but we doubt if they suffered much thereby.

3 sessions a week over two years provide far more time than can usefully be employed in experimental physiology by medical students. We aim to give our students a foundation of physiological knowledge upon which they can build their practice of medicine. We do not wish to make them physiologists.

Now, therefore, although we have an adequate supply of equipment, we are restricting practical work to one morning a week, in the hope that what is done will be well done, and that the important procedures will be all the better remembered and appreciated.

The Vice-Chancellor still delivers his well-famed early morning lectures' and with a further five teaching members to our staff we have found it possible to organise an experiment in our method of teaching.

So excellent are the lectures heard in the school that a large proportion of students feel that they have but to sit and listen (or sit and take copious notes) in order to become masters of the subject.

This is a false hope. Nothing but independent thought and reading can bring understanding.

In order to encourage this approach we have sent our 2nd year students away for a fortnight to read all about the kidney—an organ concerning which they have so far heard nothing.

When they come back, they will write an essay under a title given to them. Thereafter they will write essays twice a week, which, when written, will be read and discussed in tutorial classes. Finally, with the whole subject read, written upon and discussed, they will get their lectures once a day for a week or ten days, serving not to teach, but to correlate and put into order what is already known.

If this experiment is a success, it will be extended, and new students coming to us next September may find that their first task is to go away and do some simple, independent reading.

Professor Ride is establishing an Rh grouping service for the Colony. Our invaluable technician, Mr. Ling, has built us a very serviceable heart sound amplifier for class demonstration work. We are engaged on several research projects, and we hope that the first instalment of our slowly accumulating wisdom may soon be published.

Department of Pathology

By. Prof. P. C. Hou

The building and equipment of the Department of Pathology were badly damaged during the War. There was nothing left but the skeleton of a building. The most valuable pathological material, the records, and the teaching specimens, had either disappeared or been destroyed. Only a few pieces of furniture were discovered, accidentally in many cases, scattered about in other places.

The rehabilitation work of the Department of Pathology began in September 1948, and is still going on. It took nearly eight months to have the building ready for use. At present, the building is ready. The ground floor is being used as laboratories for bacteriology and parasitology, and there is also a museum. There is a preparation room for bacteriological work. To the ground floor was also added a cold room, capacity 4.5 cubic feet, essential for the preservation of fresh specimens, the keeping of stock cultures, and for some experimental work. The first floor is now used as laboratories for morbid anatomy, a class room and a laboratory for medical students. A photography dark room has also been re-established.

The staff of the Department consists at present of a Professor, one full-time junior lecturer, one part time lecturer, three demonstrators, one secretary, one superintendant technician, two senior technicians, and four attendants. The staff at first was much smaller, and has only gradually come up to its present strength, which is still below the optimum required.

The Department has received a number of its equipment, chemicals and glassware from England, but locally made equipment is also used to a considerable extent, since supplies from Britain are difficult to obtain. At present the museum is not yet ready, due to the inadequate supplies of museum jars and other necessary material. However, a few hundred gross specimens have been collected and are ready for mounting as museum specimens. A collection of histo-pathological microscopic preparations for teaching purpose is also being gradually built up.

Normal classes in pathology, bacteriology, and parasitology were resumed in the autumn of 1949. Clinico-pathological conferences started in 1948. Because of the inadequate space of the lecture room now used, the audience, which is usually large at these conferences, is rather cramped. It is hoped

that this also can be improved in the near future.

The Pathology Department does all the post mortems and surgical pathological examinations for the Queen Mary Hospital, and a part of the post-mortem examinations for the Victoria Mortuary. The number of autopsies performed varies from 1200 to 1500 a year. The number of surgical specimens examined also averages around 1,500 a year. The routine clinical laboratory examinations on urine, faeces, blood, etc., are now done in the laboratories of the respective clinical departments at the Queen Mary Hospital, and also in the Government Laboratory. This arrangement is convenient, and has saved a great deal of trouble in transport of material from the Hospital to the University laboratory. It has also made possible the immediate examination of fresh specimens, (e.g. amoebae in stools) when necessary. The photographic laboratory is doing a considerable amount of work for most of the departments, both of the University and the Government, at the Queen Mary Hospital.

The fairly rich supply of pathologico-anatomical material available in Hongkong gives opportunities to the members of the Department to study some of the diseases prevalent here. A few minor research problems are now being studied in the Department. The practice of weighing practically every organ of the body at the post mortems will, it is hoped, enable us, in the course of time, to accumulate enough cases for a correct estimate of the average weight of the internal organs among the Chiness. Photographs taken in black and white, and often in colour, of the diseased organs, are attached to the protocols. They demonstrate, at their best, the pathological aspects of the diseases. Strict experimental research so far has not been undertaken.

The aim of this Department is three fold: Teaching, not only of students, but also the training of teaching personnel for the University and also for service in China. Secondly, service to the hospitals. Thirdly, research work, which is an indispensable corollary to teaching in any university. It is our hope that as our scope extends we shall be able to carry out all these objectives: For their accomplishment, the basic needs are: adequate number of staff, adequate funds and equipment, a good museum, a good collection of pictures for visual education in pathology and microbiology, and an up to date reference literature to keep up with new developments and technique.

Osler's words: "As is your Pathology, so is your Medicine" was never so true as today. Pathology is the foundation of clinical medicine and surgery. Both benefit from a close association, which it is the aim of our clinico-pathological conferences to maintain at its highest level.

Department of Medicine

By Prof. A.J.S. McFadzean

"Young man, go to the bedside; there alone can you learn disease".

Thomas Sydenham.

The early training of the undergraduate is so designed that he brings to the bedside a knowledge of the normal in structure and function, Anatomy and Physiology. The recognition of disturbance of structure occasioned by disease, Pathology, coupled with the analysis of the disturbance of function associated therewith, Applied Physiology, constitute broadly the scientific approach to the study of disease. Osler claimed to judge the qualities of a man's medicine by his knowledge of Pathology. Without underestimating the immense value of Pathology to the clinician, pride of place must be yielded to Applied Physiology which now indeed merits its older title of "Institutes and Theory of Medicine". Viewed from this approach the study of disease is an applied science.

As in the days of Sydenham, even in this age of mechanical wonders, the patient, the sufferer from disease, remains the source of knowledge of disease. Teaching of the undergraduate, be it clinical or systematic, is largely an introduction to methods of tapping this source. Teaching can only be an introduction for understanding springs from independent thought alone. Ignorance is excusable, mental sloth merits the deepest torment of the damned.

Since the patient is the focal point of instruction in view of the large numbers of students entering the clinical years access to adequate numbers of patients must be afforded our undergraduates. A primary aim in reorganisation of the Department is to provide access to a greater number of patients, that is, expansion of the bed space of the Department.

As knowledge of disease and its management widens the demand for technical skill increases and specialisation is inevitable and desirable. Medical education follows this pattern and tends to become a procession through a series of specialist departments. Such a system is possessed of very real danger to the undergraduate who may have difficulty in seeing the wood because of the trees. Again the specialist in lumps and bumps interests himself in the lumps or bumps and barely spares the common civilities for the patient who chances to be attached to them. Within the Department of Medicine specialist instruction is given in Pediatrics, Infectious Disease, Psychiatry and Dermatology but the introduction to these specialist studies is provided by the parent Department.

"For where there is love of man, there is also love of the art".

Hippocrates.

"Not a typhoid fever but a typhoid Man".

Sir William Gull.

The Practice of Medicine is so much more than an applied science. The undergraduate must learn to study not disease alone but the patient and his disease. The two cannot be divorced. In handling the complexities of human nature and the many shades of human personality, in practising in the field of human experience Medicine can claim, and rightly claim, a place in the distinguished company of Art. It is to be regretted that the average undergraduate receives no training which fits him to approach Medicine from this, perhaps the major, aspect. Every effort in his training is concentrated on the scientific approach to disease yet so many of the problems which will confront him will lie far outwith the bounds of applied science. When the student can enter into an understanding relationship with his patient, when he can view disease with all its implications, so largely personal, through the eyes of the individual sufferer, when he knows the patient "even as a second self" then and then only is he equipped to practice the "art" of Hippocrates.

The writer holds the view that it is only in a happy combination of the philosophical and scientific approach that undergraduates can be trained to practise Medicine. That is the aim in undergraduate instruction of the Department of Medicine.

Department of Surgery

By Prof. F.E. Stock

Rehabilitation and reorganisation within the Department of Surgery have been made necessary not merely on account of the war but on account of the changes of thought with regard to the teaching of the subject. The days of the general surgeon are over and it is no longer possible, even if it were desirable for one man to cover the entire surgical field adequately. Furthermore, we now realize that the training of the surgeon is entirely a post graduate study and that surgical teaching in the under-graduate period must be focussed upon the pathological basis of symptoms, the differentiation of various symptom complexes and the physiological basis of treatment rather than upon the technical minutiae of surgical operations. The practice of surgery can only be learned by apprenticeship and not from any book however well illustrated, for while it is relatively easy to learn the surgical technique, to know when to operate and what to do

when presented with the unusual requires much more than academic learning.

This change in surgical practice has resulted in the appointment of part-time lecturers in diseases of the ear, nose and throat, the eye and in orthopaedics. Provision of part-time teachers however without adequate out-patient and in-patient facilities is not enough, and if the standard of instruction in these specialties is to be brought up to that of the average school in Britain, improved facilities must be provided. In particular, the lack of any adequate accident and orthopaedic service is a disgrace in a teaching hospital or in a civilized community and the provision of such a service for the Queen Mary Hospital is one of the most urgent of our requirements.

The change of outlook on surgical teaching has resulted in operative surgery being dropped entirely from both undergraduate curriculum and qualifying examination. In order to train the future surgeons of the colony, it will be necessary to provide additional post-graduate appointments both in and outside the University Unit through which the trainees can pass.

Finally it must be said that there is still far too much reliance placed upon actual teaching. Students must learn to find out facts for themselves from the text books, from journals in the library and from teachers by asking questions, but most of all by continued observation of patients in the wards. It is a serious criticism of any teaching school that a student can qualify to practise medicine by blindly accepting the views of his teachers. Medicine is not a dead subject but an actively growing one. Many questions remain to be asked and answered and the final reputation of a school or department will depend not upon one or two illustrious names but upon the records of the younger members of the school who have been taught to ask "Why" and seek the answer for themselves.

Department of Obstetrics & Gynaecology

By Prof. Gordon King

With the outbreak of war in the Far East on December 8th, 1941, the normal functioning of the Department was abruptly interrupted and many losses were suffered. The greatest loss which was sustained was the destruction of practically all the records of the Tsan Yuk Maternity Hospital and the Gynaecological records kept in the Queen Mary Hospital. Fortunately a copy of each of the annual reports of the Department for the years 1926 to 1940 has been salvaged,

gether with the monthly summary report books for the year 1941, so that it is ll possible to reconstruct in outline the record of the pre-war years.

At the time of the re-occupation in August 1945 it was found that the Queen Mary Hospital was no longer being used by the Japanese as a Hospital but rather as a godown for the storage of supplies and war booty. Within a few days of the re-occupation, however, this fine hospital commenced functioning again in its rightful capacity, under medical officers of the Civil Affairs Administration. Gynaecological work was, of course, done in the hospital from the time of its reopening, but it was not until the early part of 1948 that it was possible to reorganise the University Gynaecological Unit in the Queen Mary Hospital. From that time onwards the Department has steadily grown in staff and in the volume of work handled.

The Tsan Yuk Hospital, where students receive their training in Maternity work, had been entirely shut down by the Japanse in September, 1944, and it was at this time that the much valued records disappeared. Fortunately a great part of the equipment was saved by the devotion and ingenuity of the Matron, Miss S. C. Leung. The Hospital was soon put into working order again after the re-occupation and the first delivery under the restored era took place on September 12st 1945. From that date onwards the work of the hospital steadily grew until the record figure of 4,549 deliveries was reached during the year 1948, a figure which was almost equalled in the year 1949.

The Department is now able to offer a thorough training in Obstetrics and Gynaecology to senior students and to successive generations of Clinical Assistants and House Officers. It is encouraging to record that three of our pre-war students have gained the M.R.C.O.G., and others have been successful in obtaining the D. (Obst.) R.C.O.G. and that still others are aspiring to sit for these qualifications. In the obstetrical wards of the Tsan Yuk Hospital, with its 70 beds, students have an unrivalled opportunity of gaining experience in both normal and abnormal midwifery. There are few abnormalities of any importance which are not met with at least once during the months that a student spends in the Department. And a House Officer, in the course of a year, should gain experience of nearly everything that is of clinical importance in this subject.

In the Queen Mary Hospital 38 beds are set aside for Gynaecological cases. A large proportion of the beds in one ward are reserved for cancer cases, and we are fortunate in having temporarily at our disposal 250 mg. of radium for the treatment of these cases. In the other beds a large number of different cases is dealt with, and the student has an opportunity of seeing and

assisting in the treatment of a large variety of gynaecological cases.

The Department is now fully staffed. Professor King, after taking part in the medical rehabilitation of the Colony from September 1945 to November 1946, returned to Hong Kong in October 1947, when the Department was formally re-established. In January 1949 Lady H.E. Banting took up the duties of Junior Lecturer and two months later Dr. Daphne W.C. Chun returned to the Department as Lecturer. There are now two House Obstetricians, one House Gynaecologist and two Clinical Assistants.

Research problems are being undertaken in connection with Carcinoma of Cervix, in co-operation with the Department of Pathology. Further work on the the incidence of the Rh factor among the Chinese has also been planned with the help of the Department of Physiology.

Department of Medical Research

By Prof. F.E. Stock

This is the Cinderella of the University. The University in its post war reorganisation has fallen into line with current practice elsewhere by creating whole time chairs in clinical subjects. This change means that the consultating practice of the professors is reduced to that which is undertaken on humanitarian grounds alone. More time is thus available for the prosecution of research.

The division of medicine into three main departments is largely artificial and this is especially true in medical research. Few individuals will have sufficient ability or breadth of vision to prosecute research unaided, and the greatest measure of success is likely to attend that work on which there has been the greatest amount of consultation. It is intended therefore that the new department shall be a meeting place where research problems may be discussed around a common table. The new department is governed by a Medical Research Committee consisting of the heads of the departments of Anatomy, Physiology, Pathology, Medicine, Surgery and Obstetics. The Chairman of the Committee is responsible for the day to day administration within the department. It is not the intention of any member of the Committee to interfere with the research work of the other members, but it is hoped that within a reasonably short time the Committee will prove its value and that all members will want to bring their research projects before it for discussion.

A second function of the department is the provision of laboratory accommodation for the clinical departments for carrying out experimental research.

The departments of Anatomy, Physiology and Pathology have laboratories of their own already equipped and it is proposed to convert the former School of Surgery into laboratories for the clinical departments and the headquarters of the new department of Medical Research.

Another function of the department will be the administration and management of the new animal house which has been erected on the top of the School of Pathology. It is more ecoonmical to run the animal house as a single unit and it is intended that the newly built house will serve the needs of all the departments which require animals for teaching, investigation and research.

The new department will of course require funds and although there are sufficient funds at the moment for rehabilitation and equipment and for the payment of a skeleton staff, further development which will include the provision of Research Fellowships will depend upon the general University's financial position.

The First Vaccination.

In 1796 Jenner made his first vital and complete experiment on smallpox vaccination :

" Matter was taken from the hand of Sarah Nelmes who had been infected by her master's cows, and inserted by two superficial incisions into the arms of James Phipps, a healthy boy of abaut eight years old. He went through the disease apparently in a regular and satisfactory manner; but the most agitating part of the trial still remained to be performed. It was needful to ascertain whether he was secure from the contagion of smallpox. This point, so full of anxiety to Dr. Jenner, was fairly put to issue on the first of the following July. Variolous matter, immediately taken from a pustule, was carefully inserted by several incisions, but no disease followed." — *Baron: Life of Jenner, 1838.*

Doc's Eye View

» Members will elect the next Chairman and Secretary who can provide a free bus service between the Queen Mary Hospital and the University.

» A student found metastatic tumours from the prostate in a woman and acute salpingitis in a young man. He was doubly sure the examiners will not forget him.

» Sixth year students take the highest seats in the lecture theatre so that they can look down on those below. Wonder if those below ever look up to them.

» The first surgical operation ever performed involved aneasthesia and plastic surgery: "then the Lord cast a deep sleep upon Adam, and when he was fast asleep He took one of his ribs and filled up flesh for it." — *Genesis Ch. III, verse 22.*

» The bad temper of a certain professor was confirmed when one of the students overheard him saying to the sister in charge: "Before the bloody operation you must give 400 Dam units of Vitamin K."

» After eliminating all the etiological factors which caused the prolonged labour, the Professor finally traced the culprit to an intern inter who wc found singing to himself, "Baby, it's cold outside."

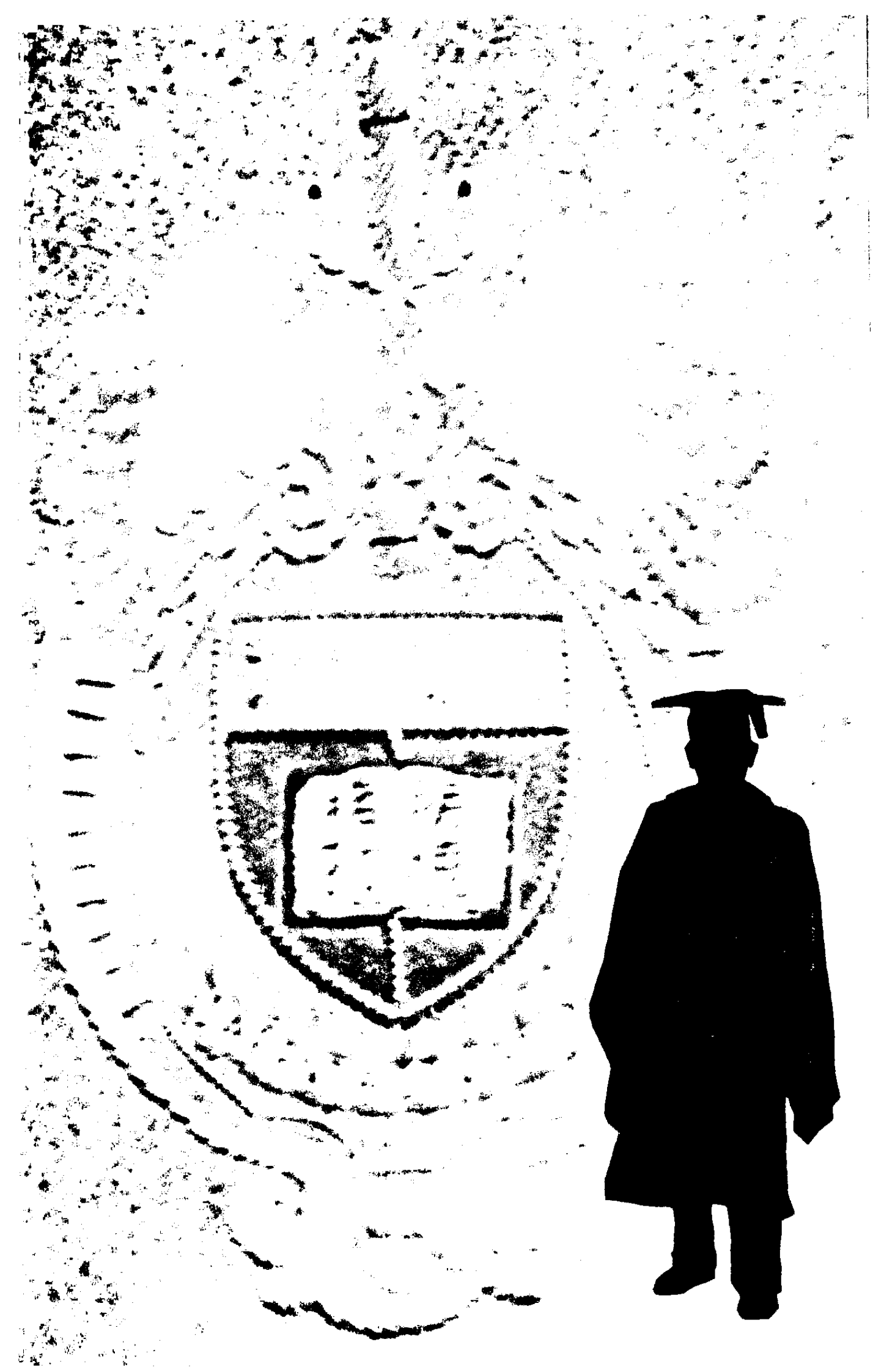
» The Babinski reflex is a pain in the neck.

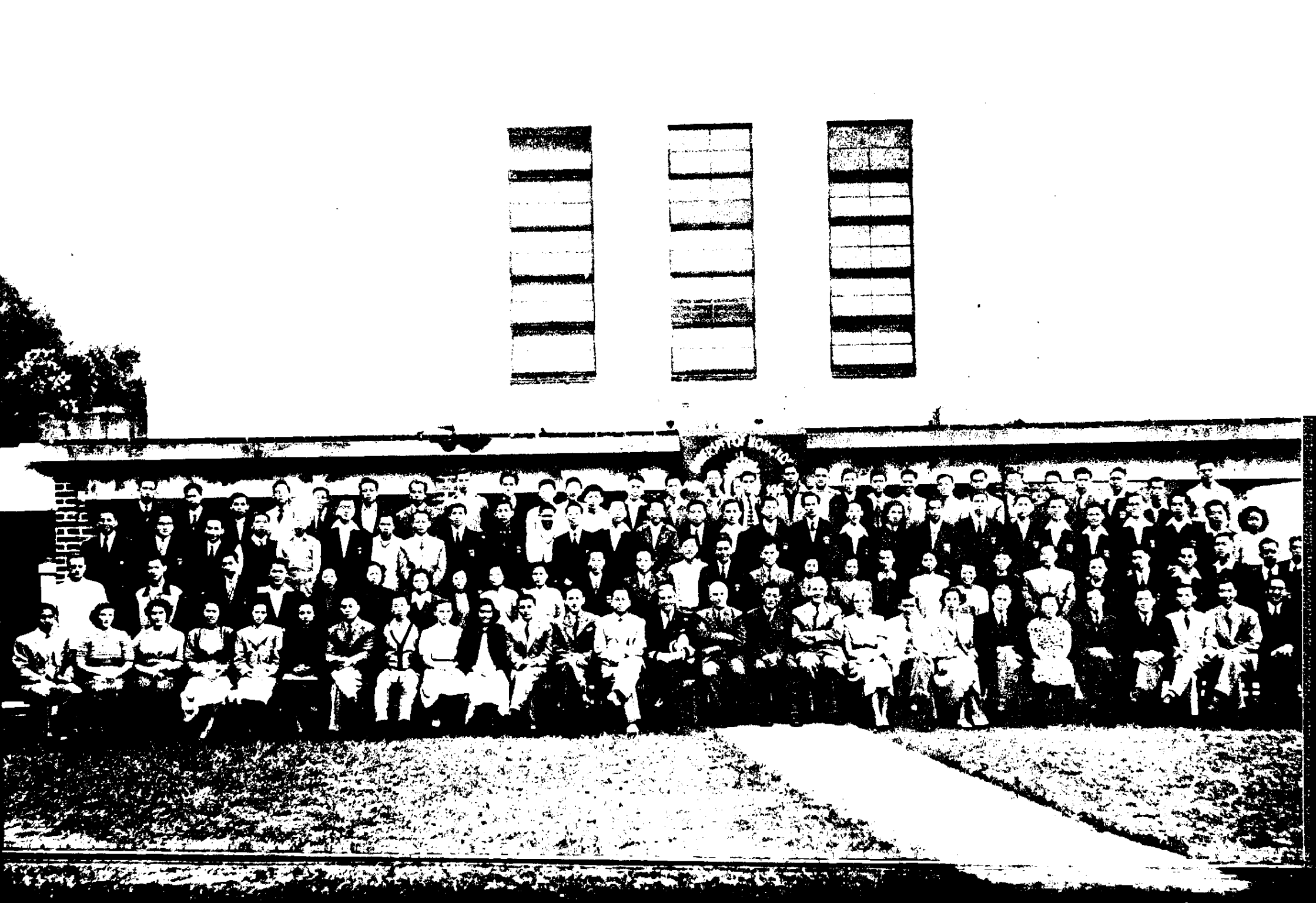
» Then there is a Professor McFadzean
Whose whiz you'd never imadzean;
By and large he would scream
At the lads who are green,
Damning their crude art of Medzean.

» Quotation from a lecture: "the intake and output of urine must always be estimated."

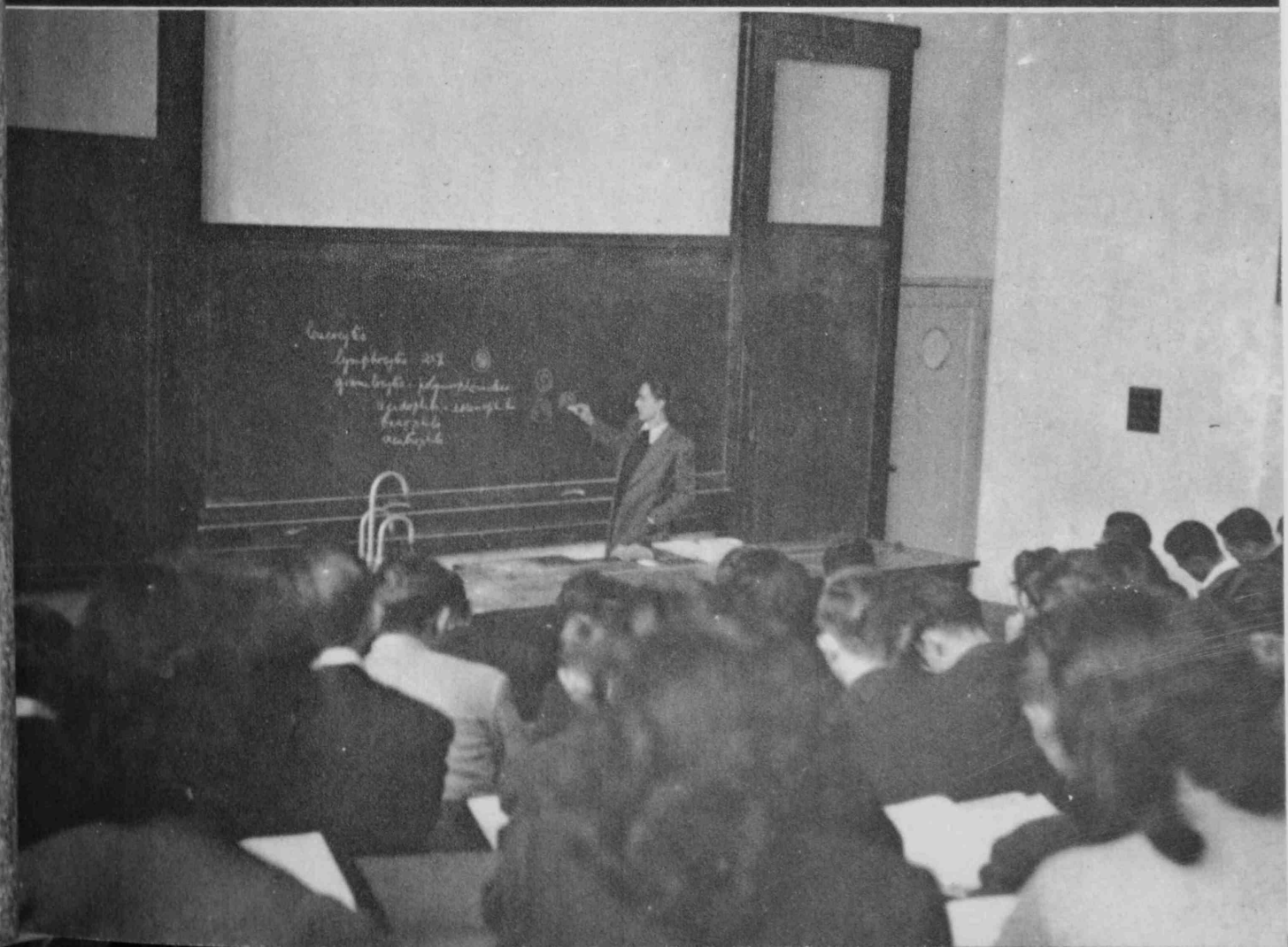
Life in this Medical Faculty

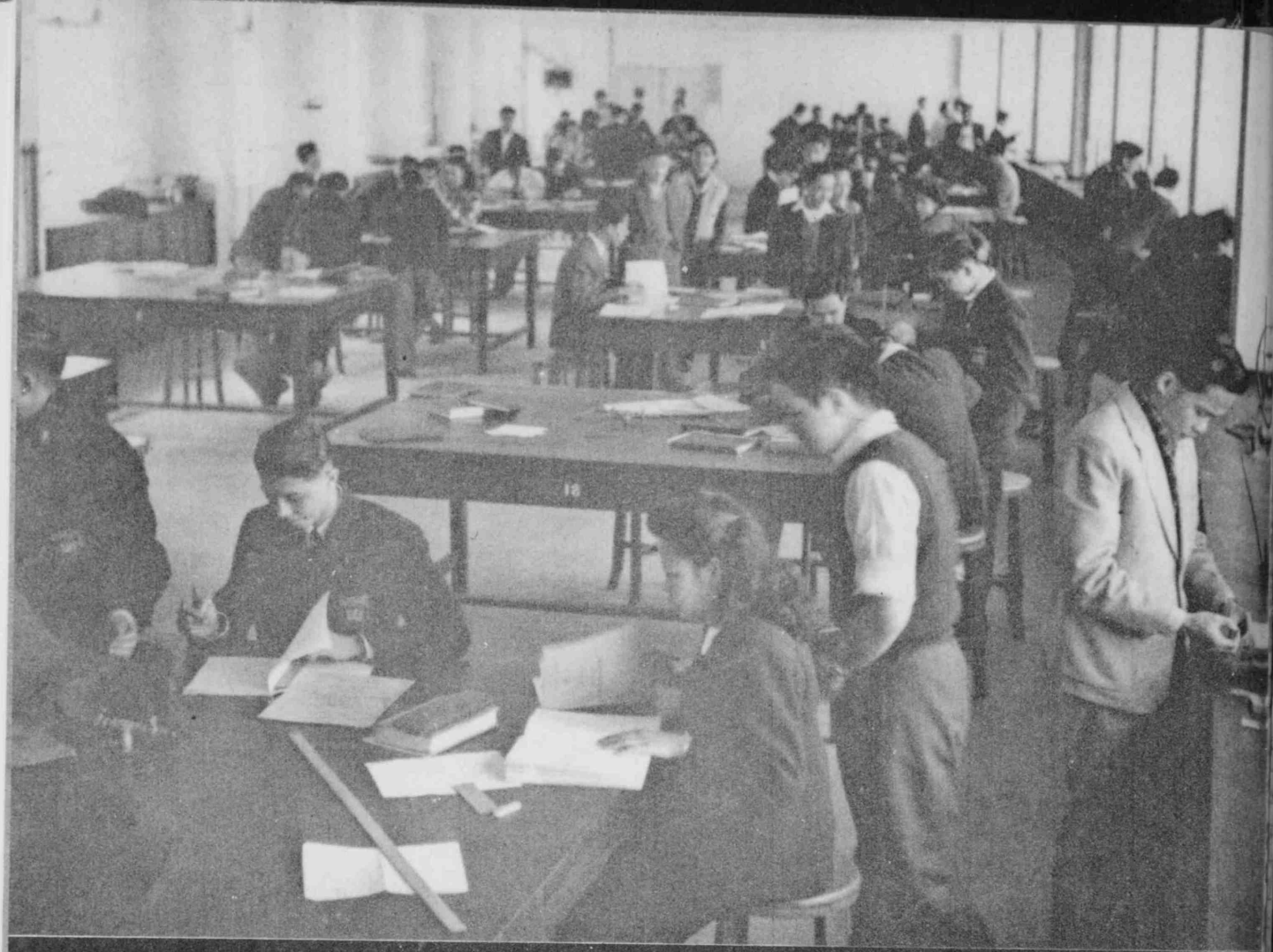
A Photography Essay





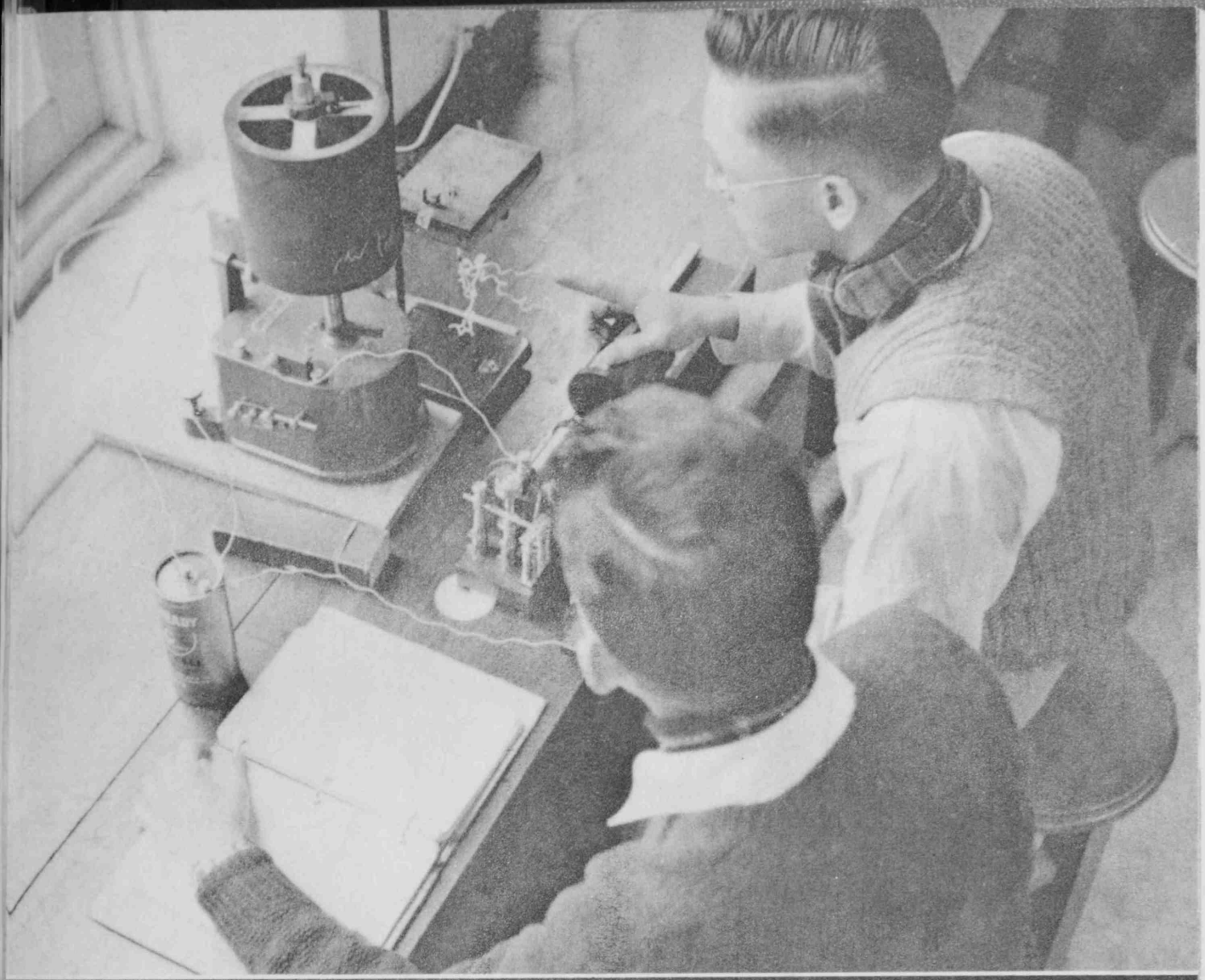
Pre-medical subjects, Physics, Chemistry and Biology, taught in the Northcote Science Building, equip the medical student with basic knowledge of the sciences.





The practical laboratories provide excellent facilities for experimental work and start the student on the path to careful observation, accurate method and detail recording.

Daily work does not terminate with the end of lecture hours, for the greater part of the evening t be spent amidst periodicals and textbooks in the Library or in the seclusion of their hostel room.

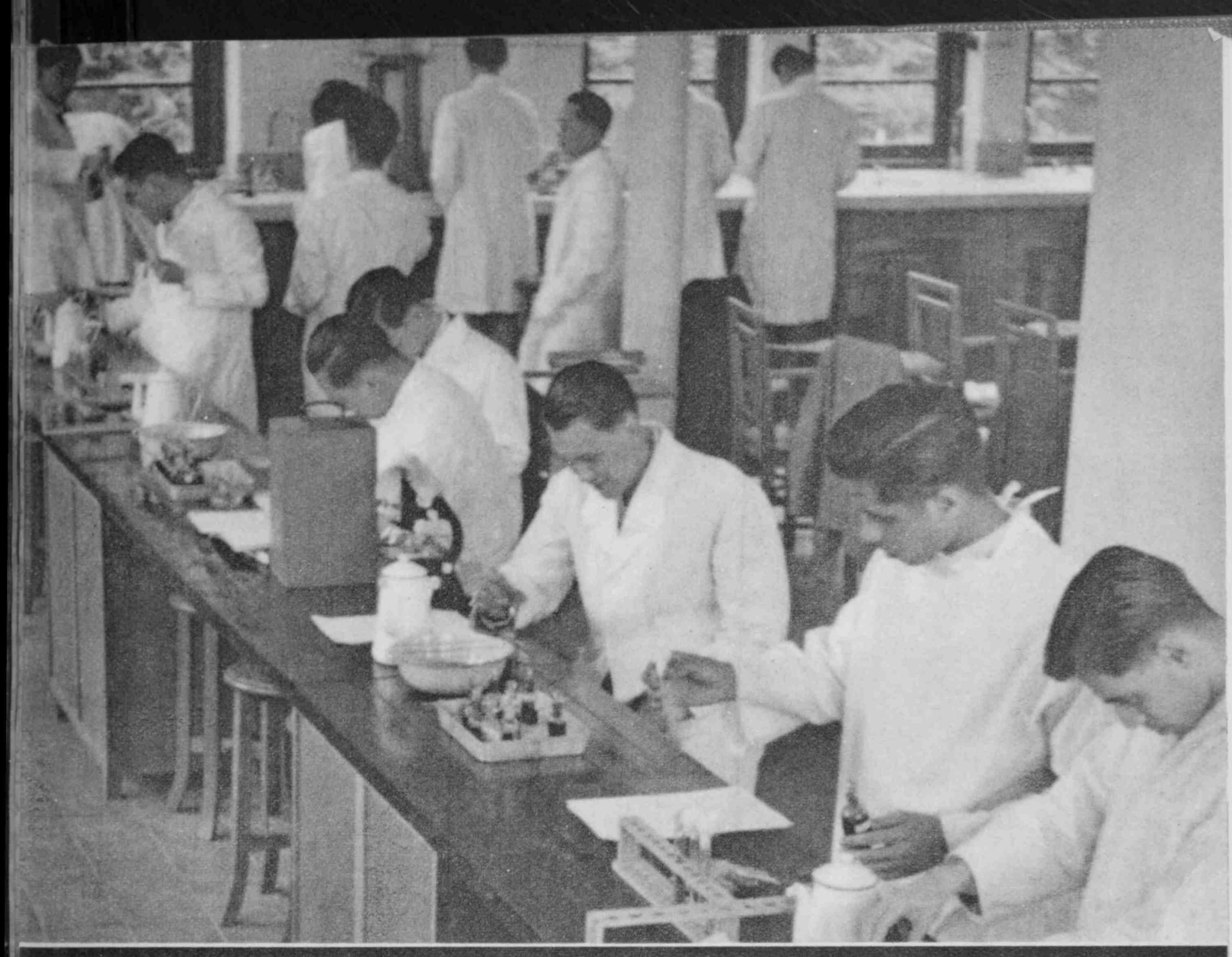


In his pre-clinical period, the student receives a course in Anatomy, Embryology, Histology, Physiology, Organic Chemistry and Biochemistry.

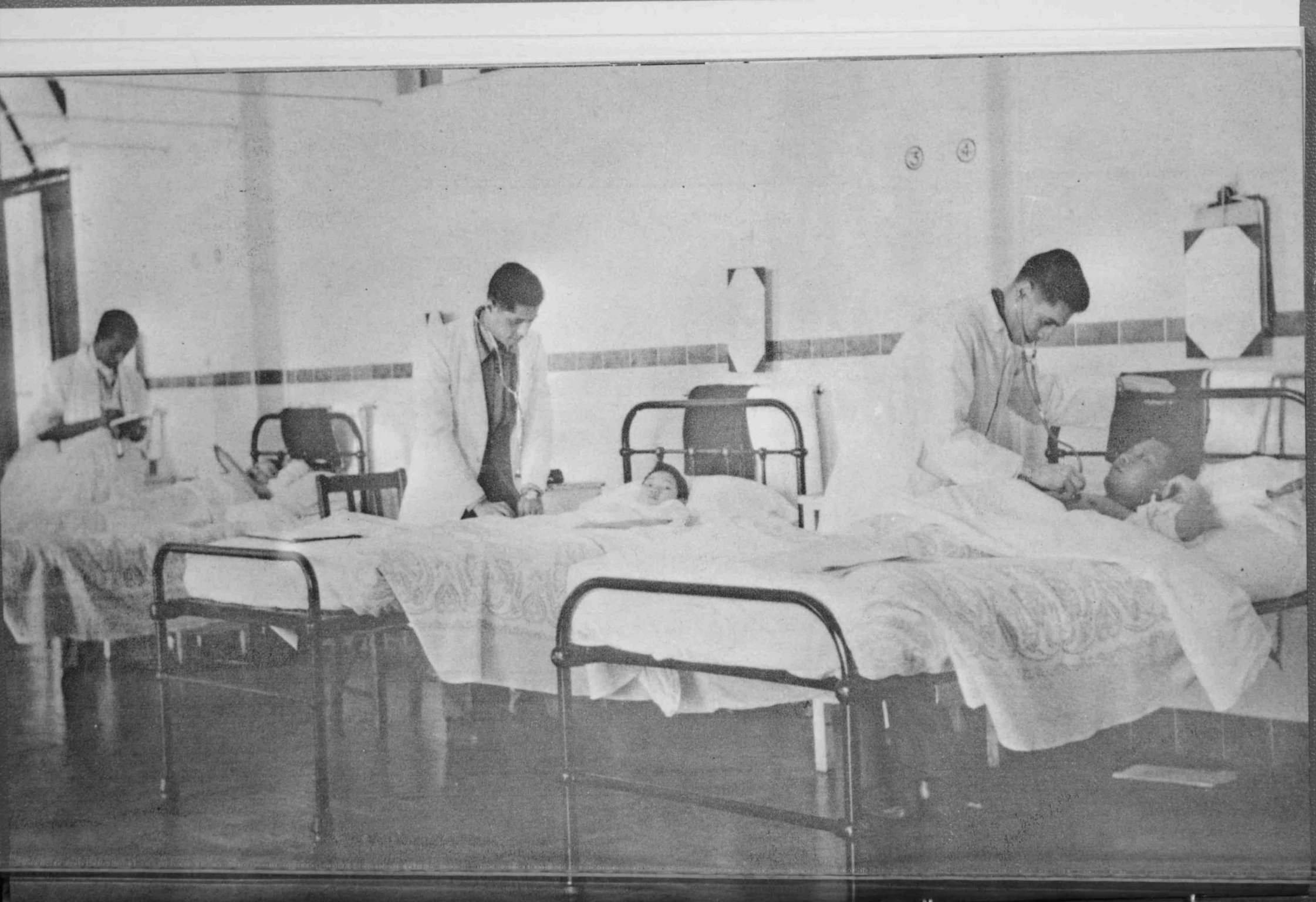
Dissection and experimental Physiology help unfold the mysteries of the human body.

The tutorial is an essential item in the course, giving individual attention to the student, whereby difficulties are cleared and interest redoubles itself.

After the study of the normal body, the clinical years introduce Pathology, Bacteriology, Parasitology and Pharmacology which are concerned with the essence of disease and its treatment.

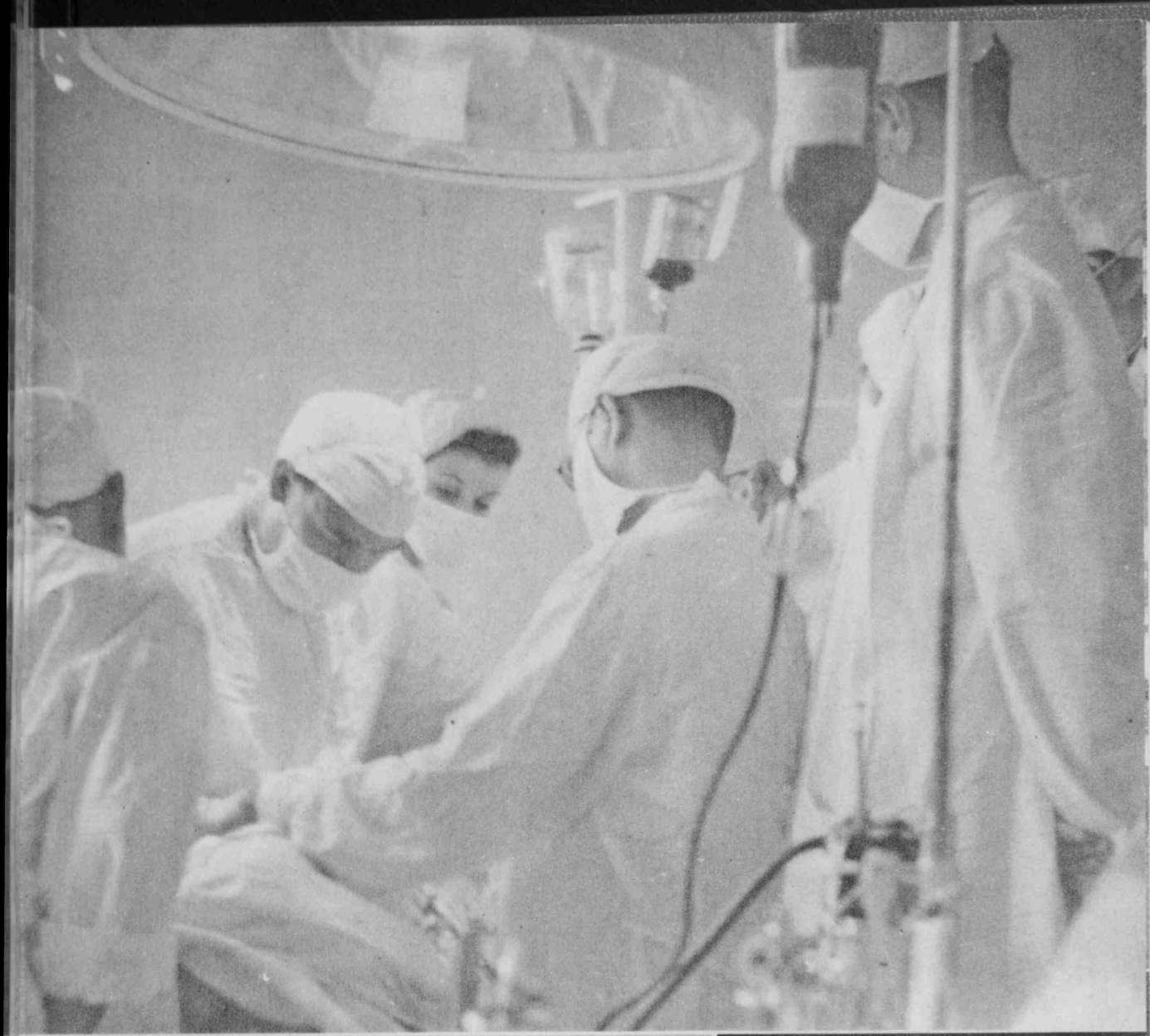


The Clinical Pathological Conferences, mostly presented by professors, correlates pathological with nical findings in actual cases, bringing up salient points on the difficulties of diagnosis and the ica ies of practical Medicine.



In the Wards, away from the rigid textbooks of Medicine and Surgery the student is led to seek the truth. Here every case is a case unique and every patient a throbbing personality.

The sifting and weeding out of the cases for hospitalisation is done in the O.P.D.'s at Sai Ying Pun Hospital. Here clinical students attend Clinics in Medicine, Surgery, Gynaecology, Pediatrics and E. E. N. T.

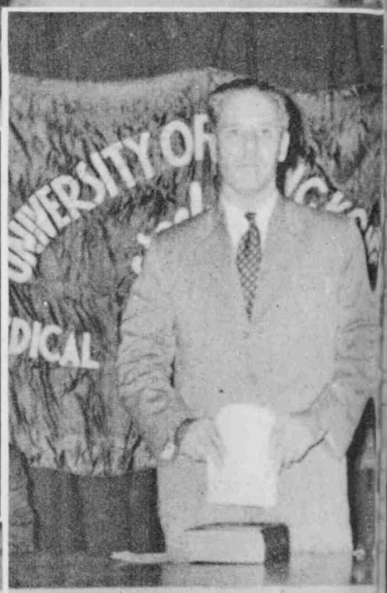


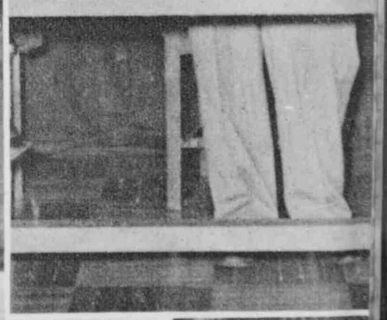
The Queen Mary Hospital forms the main stay in teaching, where lectures and ward work are carried out.

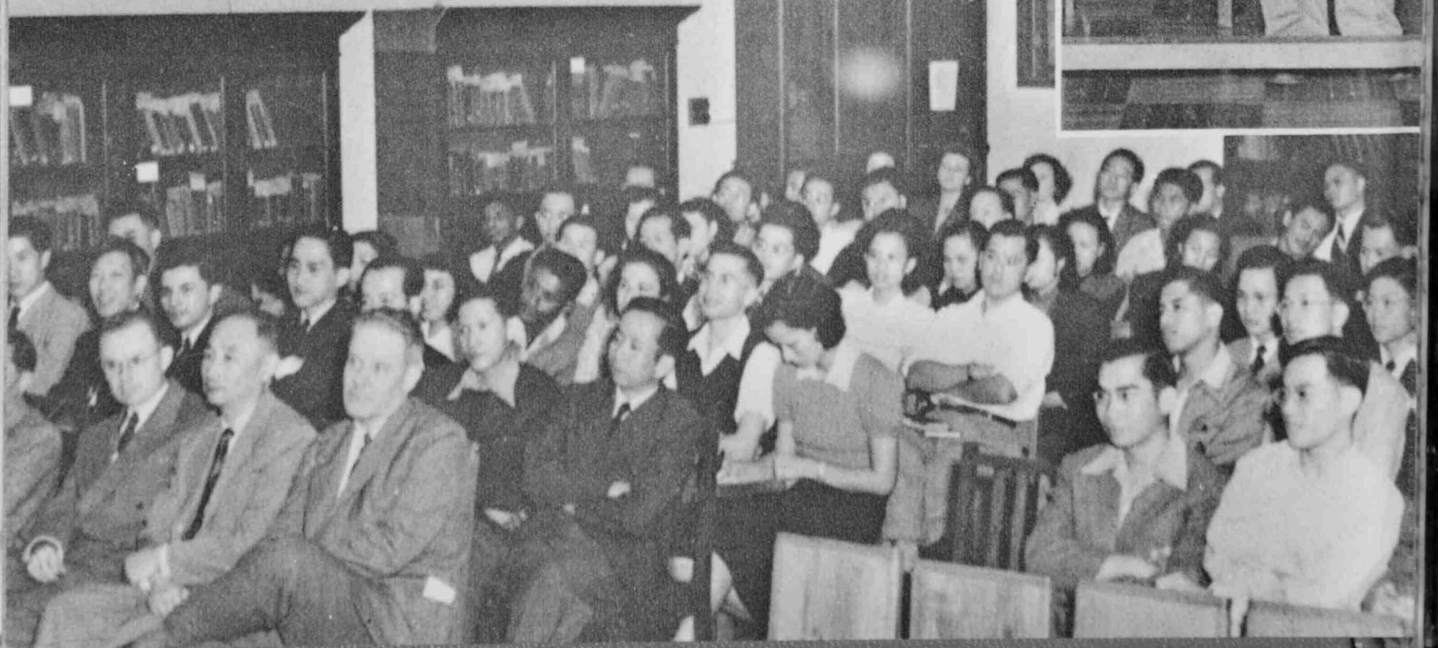
At the Tsan Yuk Maternity Hospital, undergraduates attend the ante-and post-natal clinics besides learning the technique and management of deliveries.

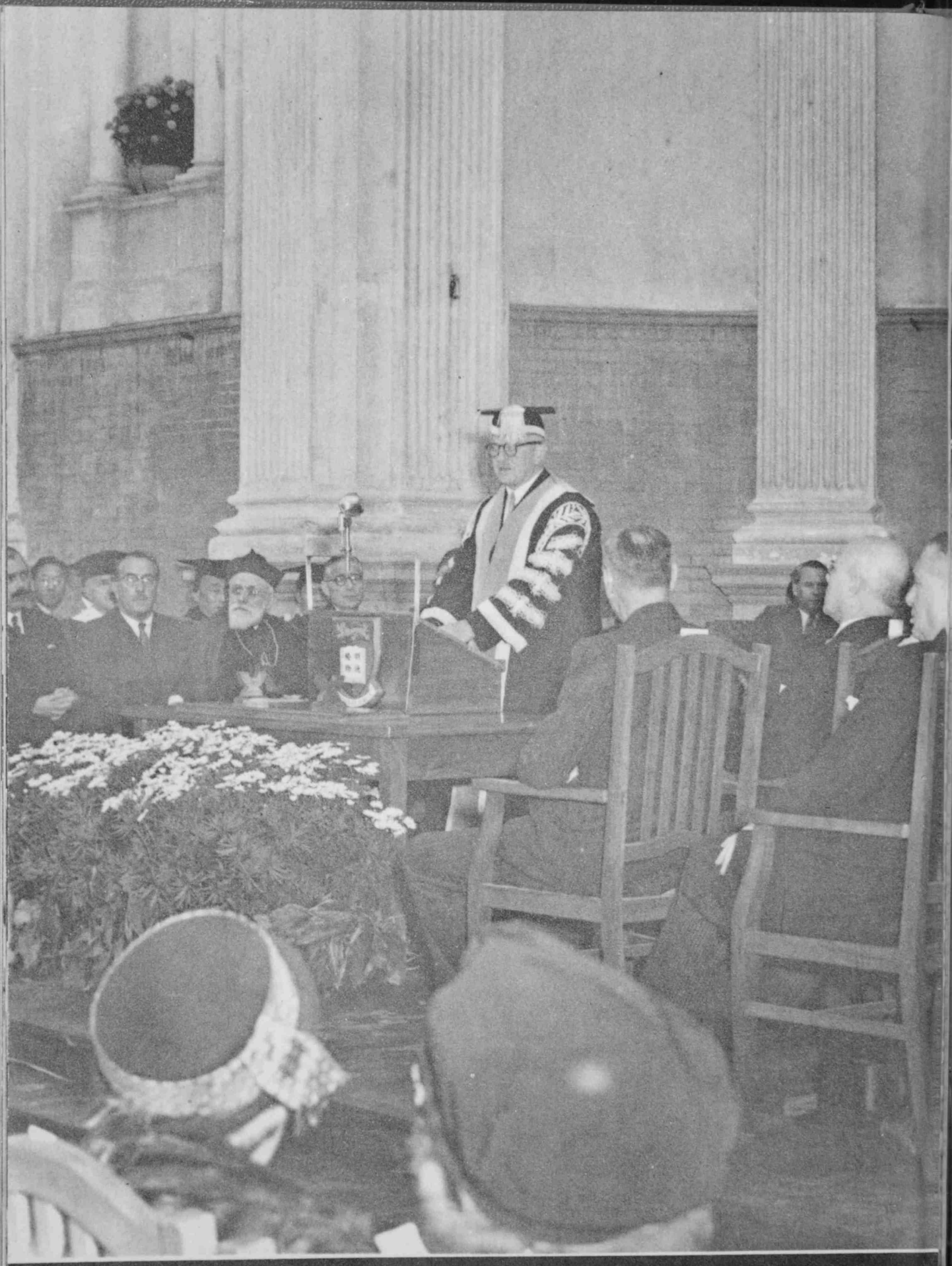
The Mental Hospital affords them an insight into Psychiatric Medicine, and the Harcourt Centre provides ample material for the study of Venereal Diseases. The Infectious Disease Hospital completes the list.

The medical Society provides the extracurriculum in the form of lectures, debates, film shows, excursions and the Annual Dance.









Graduation. . . .

This occasion, in all its dignity and pomp, will forever live in the mind of every graduate. It is a day of achievement, but more so one of promise. For now with cap, gown and diploma, the trained physician looks forward to a noble career in the service of mankind.

RADIOACTIVE ISOTOPES

By Prof. D. F. Davies

The first reason for this article is the personal one that a somewhat sinister request from your Editor elicited a promise from the writer in one of his weaker moments. The second reason is the more general one that in the years following the atomic bomb explosions over Japan the world's press has, from time to time, carried rather clipped references to the subject of the article. The third reason is more particularly applied to the readers of this Magazine in that the main fruitful applications of these Isotopes have been to the Medical and Biological Sciences.

As in legal preambles and to be reasonably clear as to what is being discussed, certain definitions must first be given. It is assumed that the fundamental brick in chemical structure is known to be the atom and that this is divided into a fairly massive and stable inner structure called the nucleus, surrounded by a much less compact outer stucture of electrons. Generally and certainly under normal conditions, the structure of the nucleus is fixed; but if it is subjected to tremendous forces, which fundamentally are electrical in nature, then this stable structure can be altered, leaving the atom with the same chemical properties that it had before the alteration but with a different mass. Such altered atoms are called Isotopes of the original atom. A simple example is Chlorine which, roughly speaking, has a common form of atomic weight 35 and another form (in abundance about one-third of the former) of atomic weight 37; both types being indistinguishable chemically from each other.

There should be no difficulty in defining Radioactivity for the Medical reader will recall that he uses this property in Radium for the therapeutic treatment of cancer. However this property can be briefly described as the natural breaking up of certain groups of nuclei (occurring continuously for thousands of years in the case of Radium) with the emission of alpha, beta and gamma radiations, this latter being the effective agent therapeutically.

Having dispered of their definitions, it must now be emphasised that their combination—Radioactive Isotopes—are artificially produced Isotopes which happen to have as a consequence of their manufacture, radioactive properties

which are, in certain cases, similar to those which are obtained from naturally produced radium. Though such Isotopes were first found in 1934 their main production had to await the techniques and apparatus developed with and from the so-called Manhattan Project and it is due to the terrific engineering problems that were solved in producing large quantities of previously unknown and non-existent elements that radioactive isotopes can now be produced in measurable and perhaps what is more important, in usable "doses". Even now, however, it can hardly be stated that these isotopes are available in weighable amounts since generally they are produced only in masses of the order (say) of micrograms and this implies that they must be detected and measured not by weighing but by means which use the effects of their radiations.

To describe how this is done the reader is reminded that the effect of Radium (and indeed also of X-rays) is due to the production of elementary charged particles in the tissues which affect the electrons in the atoms of the tissues and, in brief, produce what is called ionisation. This is essentially an electrical process and is thus measured and studied by electrical instruments. The main types of such instruments are the electrometer and the Geiger counter. Though the former is some hundreds of years old and the latter a mere stripling of some 55 years, both have their uses in measuring radioactivity and also they have much the same sensitivity but in general the Geiger counter is the more convenient and certainly more rapid to use. It consists essentially of a chamber containing a gas and an insulated conductor at a high potential. When the radiations from radioactive substances enter the chamber, charged particles are produced in the gas, causing a minute current to flow in the conductor. This current is then recorded and magnified by the amazing electronic valve circuits now available. Some idea of the sensitivity of the usual type of counter may be gathered from the fact that the Radium needles in the Queen Mary Hospital contain some 7½ milligrams equivalent of Radium and that the counter could certainly detect the radiation from one ten-thousandth of this Radium at a distance of 1 metre.

The production of radioactive isotopes has been effected by various means but all involve the bombardment of the stable (or ordinary) nucleus by certain particles (usually protons, alpha particles, neutrons or deuterons) resulting in a new kind of nuclear reaction (an internal nuclear reaction and not an outer electronic or chemical reaction) of which over 600 types are known and resulting in (up to 1940) over 300 different kinds of artificailly radioactive atoms. For the practical production of radioactive isotopes the bombardment is made to take place in the monstrous machines now used in nuclear physics

of which the better known examples are the cyclotron and the betatron. To what the urge (if not the need) for bombarding particles of greater and yet greater energy has been fulfilled may be gathered from the fact that the largest "atom smasher" now under construction (in America, of course !) will utilise electromagnets with pole faces some 15 feet across, weighing some hundreds of tons and producing as far as its nuclear bombardment is concerned an effect equivalent to about half a ton of Radium. To give this last statement its proper perspective it must be recalled that it is a very well-equipped hospital which has a 5 gram Radium "bomb" available for therapeutic use.

However as a direct result of atomic bomb technique, the atomic pile is now used, probably far more conveniently than other methods, for the production of radioactive isotopes. It is stated to contain Uranium (as the nuclear fuel) embedded in graphite, the whole forming what is essentially a nuclear furnace producing a large-scale selfsustaining nuclear reaction which results in a tremendous flux of neutrons which are suitable for nuclear bombardment. The main importance of the pile lies in its self-sufficiency (no external agency or energy being required once it is started) and in its tremendous neutron output. For example, one of the "national" piles now in use will produce, per square inch, as many neutrons as are expected to be produced by the 15 foot cyclotron previously referred to.

Thus, it is this atomic pile process which is used for the large scale production of radioactive isotopes. The principle is simple enough, merely the placing of the stable (normal) element in the pile, leaving it there for a definite time and then removing it when a minute fraction has been converted into the radioactive product. Within limits, the amount of radioactivity thus "induced" in the previously stable material is proportional to the time for which it has been irradiated by neutrons in the pile. Such production of radioactive isotopes is now practically a routine process with a regular scale of charges for "cooking" a given element (hardly to be compared perhaps with the fees charged for irradiating a patient with X-ray). But it must be remembered that since the bombarding particles in the pile are limited to neutrons only certain types of nuclear reactions can be produced in the pile.

Given then that the routine production of radioactive isotopes is virtually an accomplished fact there now remains a reference to their use. The best known use is perhaps as "tracer" elements in the study of the metabolism both of plants and of animals. To take a well known example, Iodine in the radioactive form of atomic mass 128 has been used to study the mechanism

of the absorption of iodine by the thyroid. Iodine 131 which is another isotope but radioactive for a longer time (with a longer "half-period value", in fact) has also been used, the development of the iodine in the thyroid being measured by an external Geiger counter. It is to be noted that as far as the thyroid is concerned there is no difference between ordinary Iodine 127 and the "tagged" or radioactive isotopes Iodine 128 and 131, the radiations emitted by the latter not affecting the tyroid but only the external counter. Similarly, radioactive Sodium 24, in sodium chloride, has been used to show that the sodium manifests itself in the hand within five minutes of feeding. Phosphorus 32 has been used for soil and plant studies since phosphorus is one of the several elements essential for plant growth. Besides being traced by a Geiger counter the radioactive phosphorus absorbed by the plant was made to photograph itself on a photographic plate by placing the plant on the plate, the resulting "radio-autograph" being produced by the same means as a radium needle photographs itself on a plate (this, in fact, being the routine method of testing the distribution and security of the radium in a needle).

To illustrate the extraordinary sensitiveity of the counter as used above, it is recalled that only a minute proportion, usually, of the bombarded element is transformed into the useful isotope. Again when this isotope is introduced into the subject and its effect tested at a particular location there is a tremendous dilution of the original active material. The actual value of this dilution must depend on the circumstances of the given experiment but it is stated that a dilution of one hundred million times can still be detected.

From the necessarily simplified sketch which has been drawn, one may be tempted to assume that tracer work is just a question of deciding what element is required for the particular investigation, cooking the element in the pile (usually for some weeks), injecting it into the subject and following the radioactive atoms with a counter. This is certainly the principle but the practice is complicated by several factors. The first factor is that it is usually a compound and often a particularly complex compound which has to be used and this, for technical reasons, maybe useless in the pile. The second difficulty is that the radiations emitted by the tracer may be so easily absorbed that they would not even pass through the tissue of the subject to affect the counter. Finally the time for which the induced radioactivity lasts may be too small for practical use; to mention as extreme example, radioactive Berylium 12 has a half-period value of 1/50 second only.

Finally, to close with an application of radioactive isotopes which is perhaps

of most local interest, consider the use of Cobalt 60, manufactured in the pile from fairly easily obtained "ordinary" Cobalt with a half-period value of slightly over 5 years and with a strong uniform gamma radiation. This appears to be the answer to the therapist's prayer for a cheap substitute for Radium. However, at the present day cost of irradiating Cobalt in the pile, it would appear that Radium costs initially some 150 times as much as Cobalt of the same therapeutic activity, but if the much longer half-period value (1590 years) of Radium is taken into account then as far as annual cost is concerned there is very little to choose between the two materials. In a nutshell then, for the budding therapist who does not wish his capital to be locked up for untold generations by the purchase of Radium, radioactive Cobalt would meet the case. With respect to convenience in preparation of needles or applicators of specialised or unusual form (and what therapist has not lusted after unconventional forms of applicators?) then Cobalt again is superior. This is so because the applicator can be designed and made up whilst the Cobalt is in its natural and quite harmless state and then placed in the pile for cooking to the required degree of activity. After such treatment, of course, the applicator must then be given the same cautious handling that is (or should be) given to Radium.

However, in spite of these advantages of Cobalt, British Medical Authorities have quite justifiably sounded their casual word of caution about the immediate use of this new therapeutic material. Radium has been used in cancer treatment possibly for some 40 years but it is only within the past decade that anything like comparable scientific measurements have been applied to its therapeutic use. In the intervening period much damage was undoubtedly caused chiefly due to the let's-slap-it-on-and-see-what happens technique Rather than allow history to repeat itself with radioactive cobalt it would appear to be wise to forbear with the therapeutic use of this element until such preliminary physical investigation and standardisation have been effected as will at least allow therapists to make mistakes in the same way! Only by agreed methods of standardisation will it be possible for the results to be compared and systems of radioactive Cobalt dosages evaluated.

Patient (at lunatic asylum)—"*We like you better than the last doctor.*"

New Doctor (flattered)—"*How is that?*"

Patient—"*You seem more like one of us.*"

THE PATELLA JERK

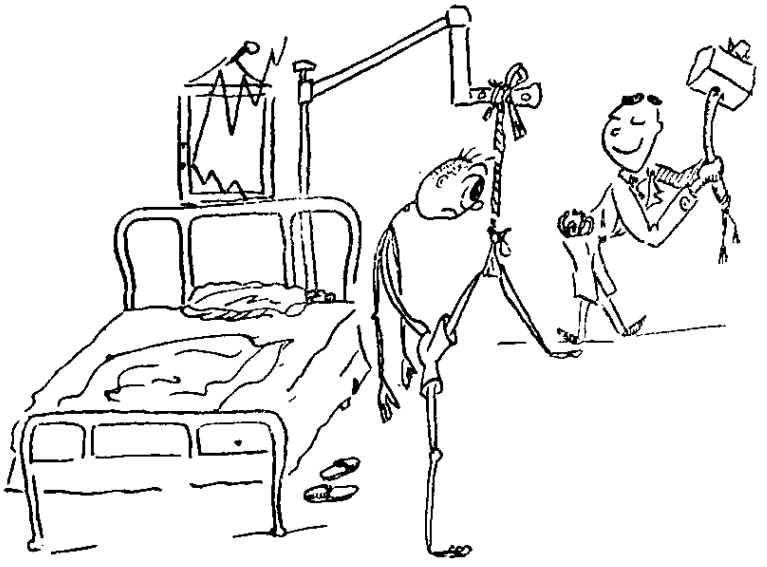
I performed a successful patella jerk. It was really nothing to boast of, but everybody in the ward congratulated me, even the patients. The news spread rapidly throughout the whole hospital, and soon there were long queues of my colleagues, past and present, who shook hands with me in turn, some wishing me future successful patella jerks, others advising me not to attempt it again until after the summer vacation. Two of my class-mates prophesied my ranking with Sir William Osler (heard of him in the Presidential address) and other illustrious figures in Medical History (whose names I forget). My pal Joe poured me a saturated solution of Epsom salts to calm my nerves.

I did not intend splashing this news and my name, Bernard Andrew Jonathan Mildew **M.C. Ragging Society, S.P.C.A. (Oxo.), L.B.W., C.P.C., N.A.D., A.A.R.E. (Association for the Abolition of Retinal Examination)**, all over the Medical Magazine, (I'm modest you know) but the proposal by the Subcommittee of the National College of Chiropractics to give me a gold medal brought things to a head and I feel obliged to further elucidate the finer art of the whole business.

Before I go on I must warn the non-medicals who have read my article this far not to read on because what follows needs some sort of technical knowledge, concentration and certainly no small amount of fortitude. The first thing the student should do is to search for the patella which is actually not difficult to find. It is a bone situated over the knee about the size and shape of a closed fist. (Mine moves up and down with respiration, but that's by the way.) The tendon hammer should strike paradoxical as it may seem, some distance below the patella. Now the choice of the "hammer" is of some importance. (The Professor tipped me on this.) The weight must not be too light, and the head of the hammer must at least be the size of a brick, - this ensures contact with the sub-patella region referred to above (from experience I have found this point of contact to be extremely variable.) Care however must be taken not to break the patient's shins because patients don't seem to like getting their bones broken and, what's more, broken limbs tend to swing to and fro in the most unearthly manner. It may be very embarrassing to the student, too, as this undoubtedly would entail a fracture and you won't learn about fractures until the final year.

Another point worth mentioning (you will not find this in textbooks) is the

relative position of the patient and examiner in space. This is difficult explain in words, so I shall do a drawing to illustrate. Thus :—



Observe that I am standing some distance from the bended knee. This is to obviate a kick between the teeth if the reflex is elicited. Notice the stance, a good swing with the weight thrown from the shoulders is necessary to cause a whole hearted healthy response. Sometimes the patient is unable to take up the position for more than 1 to 1½ hours as shown on the diagram, especially after having missed the patella a few times, and hitting the patient elsewhere instead. In that case, take about 2½ minutes time out, then come back swinging the hammer from below upwards, above downwards, midway to the left and right (not forgetting to stand far enough from the bended knee.) Four times out of ten you are bound to hit the spot. If you repeat the performance ten times your chances become ten times greater, that is, forty. It is a sheer contest of skill and agility. However if you are unsuccessful you will at least have the opportunity to follow him to the autopsy room. But don't be discouraged, there are many patients in the wards. Make another choice and practise on him. It is a matter of time, practice and more practice. Again I say, never be discouraged, if I can do it, well, may be you can do it too.

BERNARD ANDREW JONATHAN MILDEW

BUSH MEDICINE

By Prof. F. E. Stock

A canoe was drifting slowly up a backwater of the Niger. The water was yellowish brown and flowing fairly fast. The district medical officer was lying in the back of the canoe fully realizing that it was the thought of a lazy river trip and not any burst of medical enthusiasm which had persuaded him to visit this outlying dispensary which his predecessors at Lokoja had systematically ignored for two whole years. With him in the canoe in addition to the paddlers was an excitable blonde female, a new arrival in the colony, who had felt the need to visit the 'bush' while she was in Africa. Suddenly in the midst of this peaceful idyll, the boat was in an uproar! One of the famous Niger tiger fish had chosen this moment to give itself up The fish indeed presented a terrifying spectacle. Weighing about ten pounds with a mouth armed with vicious teeth which it was snapping continuously, it was jumping all over the bottom of the boat and getting nearer and nearer to the Windmill girl's feet. Fortunately just as the boat seemed certain to be upset the fish insinuated itself between the hull of the canoe and the floor mats and the canoe boys were able to deposit their passengers on the bank where an exceedingly ancient Ford truck was waiting. Over four miles of partially cleared bush path the doctor and his companions were carried to the town which was the divisional headquarters.

Most of the journey through thick forest was reasonably cool but the town itself seemed to be under a burning glass. The buildings and roads consisting of red laterite seemed red hot and the town was airless. A visit was paid to the dispensary where a Native Administration dispenser ministered to the needs of the local population. The medicine supplied was somewhat restricted in variety, being largely limited to castor oil or magnesium sulphate in 4 oz. doses, chrysarobin and sulphur ointments. The great occasion was the district medical officer's visit when injections of N. A. B. might be given (or sold) to those showing obvious signs of yaws. Yaws however, in its more florid form, was far from common and as it was difficult to disprove that all sufferers from rheumatism were not suffering from the late effects of yaws, a considerable amount of the drug was administered.

It is an interesting comment on humanity that the more painful the treatment the more effective it is thought to be by the patient. In general

practice, asafoetida has had a great vogue on account of its unpleasant taste; so in bush medicine, N. A. B. was considered to be much more effective when administered with the largest possible needle and given intramuscularly. The patients lined up against a wall, a large syringe was filled with sufficient N. A. B. to treat as many as possible, and the injections were administered as rapidly as possible *A posteriori*. The large needle, two or three millimetres in diameter and not more than 3 cm. long was of necessity "punched" into the chosen area, for the African hide was singularly elephantine.

The visit concluded with a rapid inspection of the dispensary daily attendance register which was badly kept and probably meant nothing; an inspection of the drug store, a visit to the prison and market place, the court houses and other places of interest and then back to the dilapidated Ford. The interest of the journey was not over however, for on the way back through the forest, five large baboons suddenly appeared in front of the truck and showed a considerable interest in both truck and occupants. The return journey however was completed safely, the party embarked into the canoe, transferred to the launch when the main stream was reached and went down stream between the ranges of flat topped hills to Lokoja.

Injections were over for the morning. The fees, collected in 'manillas' instead of official currency were lying in a pile on the floor of the court house where the fortnightly clinic had been held. The celebrated Ogoni dancers were coming to entertain the doctor and his party before proceeding to the next meeting place. The Ogoni dancers were a troupe specializing in stilt dancing, the stilts varying from six to twelve feet in length. The dancer's feet rested on a platform about one foot from the top and the calves were bandaged to the top of the stilt. The dancers were clothed fantastically with leonine masks, grotesque hats and with trousers reaching to ground level. The children in the party used the six foot stilts while the more skilful adult members pirouetted on the full length poles. The whole proceeding was unusual but scarcely graceful. It provided however, a pleasant half hour's rest before taking to the road once more.

Manillas were a curious currency. Their origin obscure, but possibly connected with the slave trade, they formed the staple currency in a small area in Calabar province. Made of cast iron each manilla was in the form of a small horse shoe about two inches across and weighing 4 oz. Their value fluctuated from time to time between ten and fifteen to a shilling. Despite the

fact that their formation was somewhat crude, counterfeit "coins" were recognised and if the interphalangeal joint of a man's thumb could be passed through the gap between the arms of a manilla, it was considered worthless. The currency was far from convenient, and carrying money to pay for expensive purchases required the assistance of one or more carriers. The standard payment for a wife consisted of a barrel of manillas (roughly 6000) and weighing more than a thousand pounds.

Medical administrative areas varied in size and the distances to be covered. In the south eastern provinces, the medical officer could visit all his dispensaries fortnightly and need travel little more than two hundred miles. In Bornu, to visit each dispensary once entailed a journey of one thousand six hundred miles over desert roads, most of which were passable only in the dry season. Only two of the dispensaries could be reached and visited on a single day's journey and these were in opposite directions. At the end of the very short rains, Lake Chad rose and overflowed its normal limits until it flooded an enormous tract of country and made all travel impossible. In the dry season, the lake receded, roads dried up, culverts were repaired and the medical officer, if he felt inclined, might visit some of the outlying dispensaries. Most medical officers did not feel so inclined however, and some dispensaries had not been visited for five or six years. In addition, as the roads dried out, the salt fish industry of Lake Chad came to life again and many hundreds of lorries bearing loads of dried salted fish started on the five hundred mile journey to the railhead at Jos. From thence the fish was distributed all over the colony, much of it passing on to the sea port of Lagos, a further seven hundred miles away.

⚜ ⚜ ⚜

Rail travel for the sick and injured was no small undertaking. Two so-called ambulance coaches were available. They were rarely used and in the long periods of idleness were left standing near a coaling depot. The inevitable result was that when required, the ambulance coach both inside and out looked singularly like a coal truck. After a very perfunctory clean - up, the coach would be dispatched by the first train to wherever it was needed. Even this took some time, for main line trains were infrequent, thrice weekly, and averaged only sixteen miles per hour. A severely injured patient would then be taken to the coach, placed on a narrow and very uncomfortable bed and taken by rail to one of the two or three centres where X ray facilities were available, a journey which might easily take two days. Nevertheless, the very existence of the coaches served a useful purpose, for they could be shown in the annual report and it would appear to the uninitiated that everything that could be done

was being done to facilitate the medical treatment of those who could afford two shillings per mile for the coach.

Five miles of winding bush path covered with thick sand in the boiling sun on a borrowed bicycle took us to our destination, a village consisting of small mud huts in one of which was a woman with retained placenta twenty-four hours after delivery. Not having previously carried out a manual removal the thought of the procedure did not weigh very heavily on the medical officer's mind, who was armed only with his hands and twelve sulphanilamide tablets. It was an interesting experience. The spectacle of a man holding each leg, the missionary sitting on the chest to keep the patient still and the medical officer struggling to push his hand through a contracted cervix to extract a placenta which was very reluctant to come out, was reminiscent of pictures to be seen in Haggard's "Devil's Drugs and Doctors". Nevertheless it was a convincing demonstration of the efficiency of sulphanilamide in the control of sepsis, for the woman survived an operation which in the presulphonamide days had been attended by a very high mortality rate.

Lokoja, despite its singularly unpleasant reputation, was not altogether objectionable. The climate was hot all the year and damp for a considerable part. The town was a small one, the population being about 20 Europeans and two or three thousand native inhabitants. Situated at the confluence of the Niger and the Benue it was an important trading centre and was one of the earliest inland settlements on the West Coast. The great majority of the early settlers died on the station and in the cemeteries are still to be seen the tombstones erected to their memory. Lokoja had three main cemeteries, one for Mohammedans, one for Christians and one for Europeans !

The water supply to the town came from a series of springs all at the top of the flat-topped hills which overlooked the town. The water flowed to a reservoir and the overflow from the reservoir in the summer months filled a small swimming pool. This was one of the great attractions of the station, for there were very few pools in Nigeria and bathing in the rivers was far from safe.

The medical officer's day started with a routine visit to the prison at 8 a.m. to see sick prisoners, inspect kitchens and cleanliness, certify prisoners as fit for hard labour or other punishment. The prison was also the criminal lunatic asylum for the northern provinces, and the more violent of these unfortunates were daily taken to a large covered concrete slab and chained to

rings in the floor at sufficient distance apart to be unable to injure themselves or one another. The population of the prison was about a hundred and fifty of whom one third were prisoners, one third lunatics and the remainder criminal lunatics. The non-criminal lunatics were employed in gardening and weaving, while the prisoners were for the most part made to carry out the general domestic duties in the prison. A few of the more hardened prisoners committed to hard labour could usually be found chained to large iron weights in front of the prison gates breaking stones.

From this hive of industry the medical officer went on to the hospital which in Lord Lugard's day had been the officers' mess. A large one-storey building on concrete piles with termites in the timbers and bats in the roof, it provided accommodation for about fifty patients and was usually full. Out patients were conducted in the mornings with the aid of an interpreter who spoke eleven of the local languages and a dozen or so new patients were seen. This was followed by ward rounds, operations or attention to the volumes of correspondence which emanated from every government department. The outlying dispensaries had to be visited about once a month, and this meant two or three days away from the provincial centre.

Life was pleasant and not too hectic while the evenings were given over to tennis, golf, swimming and Bacchanalia.

How It Came To Be.

"In 1816 I was consulted by a young woman presenting general symptoms of disease of the heart. Owing to her stoutness little information could be gathered by application of the hand and percussion. The patient's age and sex did not permit me to resort to the kind of examination I have just described (i. e., direct application of the ear to the chest). I recalled a well-known acoustic phenomenon: namely, if you place your ear against one end of a wooden beam the scratch of a pin at the other extremity is most distinctly audible. It occurred to me that this physical property might serve a useful purpose in the case with which I was then dealing. Taking a sheaf of paper I rolled it into a very tight roll, one end of which I placed over the precordial region, whilst I put my ear to the other. I was both surprised and gratified at being able to hear the beating of the heart with much greater clearness and distinctness than I had even done before by direct application of my ear."
Laennec: Translation of several passages, Sir William Hale-White, London, 1923.

A Prophylaxis against Housemaid's Knee applied to Tennis Elbow

by B. Mellor, g. p.

(The following is an extract from a paper read to the Cardeck Bridge Club)

It was not until the middle of the nineteenth century that any notable progress was made towards discovery of a method of preventing Housemaid's Knee. Previously the only tenable theory that had been advanced was that of an enlightened chiropractitioner∢ who sought to cure the disease by shaking a leg in a Baird and Tatlock Centrifuge (Indent and Circumvent type)≒ followed by joyriding it off a Cambridge Rocker. The leg still has its place amongst the more valuable pathological specimens pickled at St Balsam's Hospital□. My father, the late Z. Mellor, g.p., who in the 1850s and in spite of his youth gained immediate fame by early plastic surgery on the gums of the then reigning sovereign in order to enhance the royal smile×, began investigations on the diagnosis of Housemaid's Knee by Phonoarteriography (listening to the arteries harden) — see fig.xv.

I took over my father's unsuccessful investigations where he had ceased at senility, and was proceeding satisfactorily on a substantial grant from the Stonyman Foundation when I first met the famous physiologist, Dr. Gould, at a learned conference on New Year's Eve 1939, at which he propounded his theory of better results obtaining from experimentation on a real piece of human than on a piece of Phantom⊥. This set me on a long and unsuccessful search for real Housemaid's Knees, of which there was an acute shortage during the whole of World War II through shortage of Housemaids. Even in the Nunneries, where the disease is normally endemic△, found I nun⊙. It was at Dr. Gould's suggestion that I turned steps to China, where, at Neeling in the North, there was news of a vast outbreak, or eruption.

∢ *Dr. Hobble: Med. Soc. Pub. cvii, 183..*

≒ *The author of this paper has tried the method on one of the knees he has collected (see below) with Hobble's own Centrifuge, and finds it just as ineffective as the modern Centrifuges.*

□ *Just next to Jeremy Bertham as you go in.*

× **vice** *Lytton Strachey: Queen Victoria,* **passim.**

⊥ *His arguments, supported by profuse illustration, rose from different fields of survey: notably the effect of Alcohol on Nicotine consumption and on what he called Tendencies to Warble; and I definitely decided to cast my lot against the Phantoms.*

△ *See my paper: "Get thee to a nunnery", Journ. Lit. Hum. iv (1938) where I had proved conclusively that Ophelia suffered from Housemaid's Knee, and not Leprosy, as Lord Tuhasty contended.*

⊙ *Misprint—not a nightmarish pun.*

The disease, unfortunately, turned out to be totally dissimilar from Housemaid's Knee, and was in fact Amah's Knee. The symptom of the one is difficulty in descending to a kneeling position, and of the other in ascending from a squatting position[▽]. Finally, however, it was decided that this distinction was so subtle as did not affect the investigation, and could be allowed for as and when results might be obtained. During the course of eighteen months in Neeling, I managed to obtain (by amputation) sufficient Chinese knees to enable investigations to proceed smoothly, thus removing the source of the infection (to the never dying gratitude of the sufferers) and at the same time gathering a collection of members now noted throughout the world.

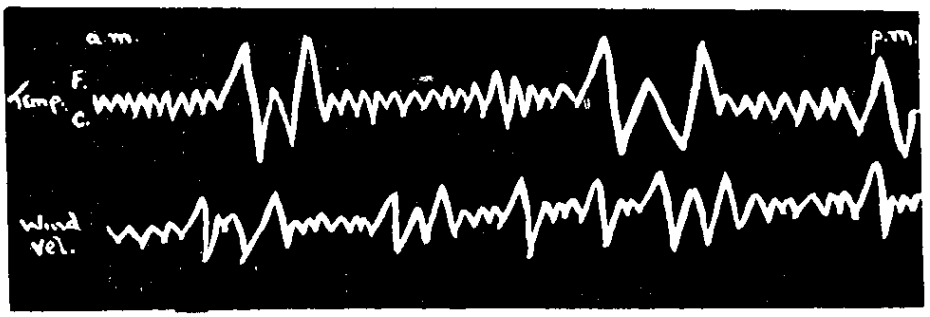


Fig. xv. **The living Buddha, after two drinks.**

It was at this point that my long association with the eminent Dr. Gould began to bear fruit. I had, so to speak, the real knees in my pocket, and was searching for a point from which to begin when he called upon me and suggested the use of Sphygmomanometry combined with a Stethoscope. Knowing what a Stethoscope was, I turned to that excellent reference book of Medicine, the Oxford English Dictionary, and managed to acquire a crate of old sphygmomanometers. Selecting two (the others were put to various uses: as inner tubes, and for by-passing the gasmeter) I placed one as a tourniquet below my right knee, effectively stopping the blood-flow, and the other lightly around the above knee for purposes of pumping up the blood pressure. Applying the Stethoscope I was amazed to hear above the fluffing sounds of arteriosclerosis a sound of creaking as I genuflected, the sound growing louder as I bent further, and softer as I arose. Suspicious, I divested myself of stays; but even stayless auscultated the same sequence of sounds. I have tried this several times since, but have never again heard those creaking sounds. All that happens is that subsequently I suffer from a mild attack of Amkneesia[◯]. It is possible that the arteries are now approaching solidity, or that I do not suffer from Amah's Knee.

▽ *This is symptomatic of other causes in Hong Kong. See my occasional papers in Caulies Magazine: "Squatting as a Career"*

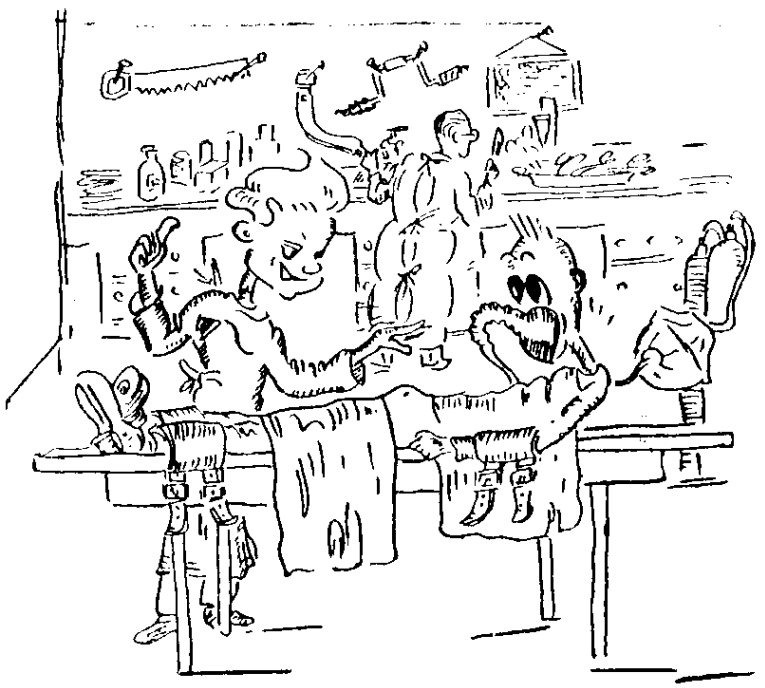
◯ *This usually results from excessive alcoholism and is not to be confused with Amahskneesia, a term with which I have recently graced Medical Terminology—see my paper in Med. Term. vol.ii (1948), in reply to which the President of the Med. Term. Soc. likened me to Aeschylus and James Joyce (Med. Term. vol. iii 1949).*

However, this has been tried with great success on a long series of amputated knees; and I am now giving notice to the professors of medical research that I claim this particular field of research for my very own (no swops), always provided the Stonyman Grant continues to be as generous as it is.

The research must continue with all due speed as there is a possibility of Amah's Knee disappearing as effectively as Housemaid's Knee. If so, I shall safely be able to conclude that the disease is occupational and, unlike that of baby-sitting, dependent upon the economic stability of the community.

It may well be, also, that with the slowly popular advent of professional Tennis, Tennis Elbow will be found to be an occupational sickness, like Bottle Nose, Mah Jjongg Purse, and Hong Kong Football. For it has been found that in ten cases of Tennis Knee out of a hundred of Housemaid's Elbow, prevention or (for the purpose of further research) amputation may be the only alternative cures. In this event (if the grant lasts) I shall be compelled to turn to Miller's Thumb as a subject for investigation, and herewith stake a claim in the rush of research.

JONATHAN MILDEW



"Don't worry, Mr Weatherstorm, statistics show only 22% of cases die from faulty surgical treatment of appendicitis and Dr. Morg has just used up his quota."

MUSIC AND MEDICINE

At first glance the above title would seem more than a little incongruous. It is best therefore to present straight away something palpable for having linked two such seemingly diverse entities under one heading. As it is, an amazingly large percentage of the Colony's musicians come from members of the Medical profession. Listed below are but a few of the many who have distinguished themselves in music as well as in medicine.

Dr. S. M. Bard is the conductor of what probably is the best orchestra Hongkong ever produced. Professor L. T. Ride is another conductor of no mean calibre. Only lately he gave an impressive rendition of Brahm's "Requiem". Professor Gordon King is one of the Colony's leading pianists. One has only to see him at work either on a surgical case or a Chopin composition to realise that here is a master craftsman of two very different and difficult vocations. Dr. Stephen Chang, another member of the University medical staff, is a first class organist. In the vocal field too, there is a representative in Dr. Talbot, a well known baritone.

The list of name above connecting eminent men of Medicine with those of music is impressive. In fact, it is significant. Why, for instance, are the members of other professions not represented in the field of music in anything even approaching a similar proportion to that by medical men? Could it be that doctors and surgeons are more aesthetically inclined than others; that they are more learned and therefore possess keener sensibilities and deeper appreciation of the higher arts? Surely such a view is erroneous as well as presumptuous. Evidently the true answer to the question must be more elemental and bear some semblance of logic.

The average doctor, after all, is only an average man. His appreciation of the purely aesthetic quality in music—its tonal, colourful and rythmical appeal—cannot therefore be more than there is in the average human being. His extraordinary attraction towards music then, must be due to the fact that he, more than most other men, has discovered something else that is inherent in it.

The dictionary defines art as "human skill as opposed to Nature". Music, like other forms of art, is an expression of a human being. And is here that the clue to the whole enigma probably lies. It is this particular quality in music, this peculiar form of expression of the human soul, which so many doctors and potential doctors are so aware of.

To learn to know human nature is not an easy task. For human beings do not reveal their own selves and feelings even to their own kith and kin. Exhibitionism in all forms save one is frowned upon. And so it is that Bach, Beethoven, Chopin, Mozart, Schubert, Tchaikowsky, Wagner and others—men who knew the extremes of grief and happiness—turned to music as an expression and outlet. It is from their music that we can appreciate the fearful depths of human emotions potential and existent in our fellow-beings.

It is the contention of this article's main theme, therefore, that the doctor can find (and indeed many have found) in music a precious vehicle towards a better understanding of, and sympathy with, mankind in general and his patients in particular. In considering this proposition it is necessary that we delve breifly into the lives and music of a few representative composers.

Four distinct and different types of human-beings in the persons of Beethoven, Tchaikovsky, wagner and Schubert may be taken as fairly representative of a great number of our present day fellowmen. All these four composers have known hardship, family troubles, poverty, sickness, failure and frustrations. Their ordeals and the ways they faced these and other obstacles are in their music.

Beethoven's music was perhaps the most beloved of all. For there is something in it even more striking than its unparalleled splendour and majesty. Beethoven was, above all things, a fighter, and in his works we find a record of his titanic and all but hopeless struggle with Fate and Misfortune.

Ludwig van Beethoven's life was not a happy one. He was born physically ugly and clumsy, and even in his early childhood could not adjust himself to the world around him. His parents were poor. The father was a weak-minded man who took to drinks, and his beloved mother died while Beethoven was at the impressionable age of sixteen. Even in his early youth, Beethoven had to fight hard and bitterly in order to support his family and also to make himself a name as a musician. He experienced in his lifetime several love affairs which were all unhappy and unsccessful. Eventually he concentrated all his love on a nephew who later turned out to be a dissappointment.

The worst calamity that could happen to a musician befell on Beethoven when at the age of twenty-seven he discovered that he was getting deaf. After three years his distress was such that he wrote a poignant letter to one Dr. Wageler, laying bare his misery, and begging for sympathy and advice. "My hearing has grown steadily worse. My ears whistle and buzz continually day and night. Heaven knows what will become of me."

The essence of what was in this letter is to be found in the well known *Sonata in C Sharp Minor* which he composed during this period. This piece,

absurdly called *Moonlight Sonata* (not by Beethoven himself), is not a romantic composition. It is an expression of deep and unrelieved despair. There is, however, nothing pitiful about it. For even in its utter hopelessness, there is unsurpassed dignity.

Ludwig van Beethoven won in the end by simply refusing to acknowledge defeat. His music is testimony to that. There exists no more thriumphant piece of music than Beethoven's Ninth and last symphony, the *Choral.* It proclaims the fighter and champion who, despite being knocked down round after round, yet emerges victor. At the first performance of this symphony, Beethoven was already stone deaf. Three years latter, he died.

There are and will be people who find themselves leading a life analogous to the tragic one of Beethoven's. Not all of them, however, will face it in the same manner. In Beethoven's music we discover how a particular type of man reacts to and is moulded by a particular form of life.

If there are amongst us people who are like Beethoven, there are also to be found many kindred in spirit to Tchaikovsky. Perhaps most of us as individuals lie somewhere between the extremes that find in their personification these two men—Beethoven and Tchaikovsky. For the latter was the very antithesis of the former.

Peter Ilyitch Tchaikovsky was a defeatists of the very first rank. It is true that his music contains numerous beautiful, lyrical and sometimes even happy melodies; but equally obvious and prevading throughout almost all his major works are expressions of self-pity so extreme as to be almost exquisite. Tchaikovsky wanted more than an thing else to love and to be loved. But his mental make-up was such that both these satisfactions were denied him. His final work, his sixth and last smyphony, the *Pathetique,* is that of a man hopeless and licked in life from the very start. It was truly the composer's swan song. Shortly after this symphony was completed, he died of cholera through drinking (some said deliberately) unboiled water that was known to be polluted.

In Wagner we find another type of personality quite distinct from the other two. Here was a character that is becoming more and more common in our present day world. Richard Wagner was what is now commonly called and vulgarly known as a "hard-boiled tough guy". He was a bitter and sardonic man who considered that the world had treated him badly. People did not appreciate him and so he was going to pay them back in kind and incidentally show them a thing or two. He created music that was defiant and arrogant where Beethoven's was majestic and Tchaikovsky's pathetic.

In Schubert and his music we uncover another variation of human nature.

In his own way he had to make what he could of a hard life Of all his works, it is perhaps his last-but-one symphony, the *Unfinished*, which is most revealing. Here we find a soul constantly in search of peace and happiness; finding them for a short time only, alas, to be overtaken by something which forever dogged him. What was it that haunted Schubert throughout his life? His consience? His past? Some shame he had commited?.... Whatever the reason may be, it affected him tremendously and made him a pessimist and fatalist The *Unfinished* testifies to that. It ends with a tragic yet peaceful resignation—acceptance of the very worst Fate may have in store for him. And therein perhaps lies the reason why the *Unfinished Symphony* was never completed. It has said all that it had to say.

One can go on indefinitely with the other composers. Bach, and his mysticism. Mozart, and his extraordinary, yet paradoxical simplicity. Brahms, who despite his eccentricities and failures, yet one must conclude after hearing his music, was of a sweet and noble nature.

Sibelius, who perhaps more than any other composer, knew how small and insignificant mankind is to the rest of the Universe. From his music we must perforce learn something of humility.

Schumann, in whose music something always seem to be deliberately left out—the tragic Schumann who came of a family a few members of which were mentally unbalanced. Robert Schumann himself after an abortive attempt at suicide was confined in an insane asylum where he died three years later.

There are still a great number of musical geniuses whose names will have to be omitted in so short an article; but what has been discussed so far should prove that in music we have a veritable treasure-house for those who wish to derive something more than aesthetic pleasure. It is to be regretted that altogether too many of our medical students seem to have but one aim in their University life—that of getting a diploma. They have no deep interest other than their text-books, which to most of them serve perhaps only as a means to attain their final goal—the M. B., B. S.

To endeavour to be a doctor in the finest sense of the word, a medical student has to be well-equipped. A deep understanding and a true appreciation of his fellow-beings is as essential to him as his text-book or his stethoscope. There are several ways to achieve this, but music is perhaps the most rewarding.

A.

I AM A SKELETON

I abide in a glass case in the Laboratory of the Anatomy Building. For years I have been here and for just as many years shall I remain here. Cooped up in such a cage year in and year out, you might think I should have wept with boredom. But no, these "eyes" are no longer eyes; they are sunken sockets and cannot weep. Furthermore, there is no cause for me to feel dull for my surroundings are pleasant, my associates are human. I am grateful to be here, rather than moulder away six feet underground. You wonder why? Let me tell you.

Every day of the week I am entertained by troupes of actors—actors on the Stage of Life. I come to know nearly one hundred and fifty of them—all those that come to the Laboratory to satisfy or feign to satisfy their thirst for Knowledge of Anatomy. Some are brilliant actors, fooling everyone, including themselves; some are poor actors because they naturally averse to such.

The dozen actors immediately by my glass case are rather disinclined to be active. In sun and in rain, in wet and in cold, theiy turn up without fail They work a lot, read just as much, talk a little and laugh even less, in other words, a sombre lot. Yet credit must be given them for their diligence, their steadiness, their punctuality, their earnestness. This troupe of actors are usually "homosexual." That is, they are unenlightened by the company of the fair, weaker sex.

Further across the room there would be a bunch of "adolescents." I say "adolescents" because some of them are over twenty-one, and are really not adolescents. These act spontaneously, with no artifice, for they are natural sons and daughters of Hongkong. They are rare, for nearly all Medicos (with the exception of the first-years who have not taken their first degree examination and are therefore not real Medicos) are sombre. "Adolescents," therefore, are the light and the salt of the world of the Medical Faculty. I see them using coloured chalk to ruin each other's gowns, or playing "catch" amidst the stools, tables and specimens of humanity. I hear them praise with respect the leniency of this lecturer, or condemn with vehemence the

"soppy appearance" of that screen actor. They are constantly laughing, joking, playing pranks and tattling. Maybe I should not have said "constantly," for these dear ones have keen brains which they well know would rust if they are not sharpened occasionally on the Whetstone Anatomus.

Lastly, I would like to mention one or two that I am not so well acquainted with. Maybe if I had my brain, I would still be uuable to figure them out, for they are indeed eccentric. They will loll into the Laboratory in the middle of the morning or afternoon, as the case may be, sleepy-eyed. After sauntering lazy-like around the room once or twice they will wander up to the sink to sharpen their scalpels. After what seems too long a time, they replace the scalpels in their pockets and settle down onto their stools. I realize they turn their eyes in the direction of the clock more often than others. Anyhow, they must be busy people, for they invariably leave in a hurry.

Yes, I have come across many actors, but my conclusion to that, be they adept, be they like fish out of water, they all amuse me in an objective way, for I am no more one of them: their sorrows do not depress me; their contentions do not disturb me; neither do their joys delight me nor their goodness touch me.

Fudge

JONATHAN MILDEW

"All I said to the Professor was give her 500 c.c. of plasma rediffusion."

FOR SERVICES RENDERED

Although it happened eight years ago, the memory of this amusing incident still remains vivid in my mind. The new year of 1942 found the Medical Staff of our well known teaching hospital carrying on, despite the confusion resulting from the fall of the Colony a few weeks before.

I was serving as anaesthetist to the hospital, and on the day in question a call came through from the operating theatre: "Would you come up quickly, please?" Philosophically, I donned my only white gown, now the worse for wear and tear, and proceeded up six floors — on foot, the lifts were not working, you see!

Quite frankly I was not prepared for the sight that met me on arrival! Two malevolent-looking 'sons of Heaven' were on guard with fixed bayonets, one outside the theatre doors, and one just inside the theatre corridor, in addition to a sprinkling of curious Nips hanging around, presumable having been refused admittance by the Sister in charge for having dirty boots on.

The consultant surgeon came to me and with a calm voice explained the situation: "We have a bad case of multiple injuries the result of a grenade explosion under the patient's seat. The unfortunate victim is an N. C. O. of the Kempetai, a V. I. P. The Japenese have requested me to operate, because their surgeon is incapable of attending. He has been celebrating the New Year and their glorious victory. The condition of the patient is far from good. However, I leave it to you!"

With these encouraging words I entered the theatre where six Japenese officers complete with top-boots and sword were gazing around and one in particular was fiddling with my anaesthetic machine. With an indifferent air I approached my patient and one glance was enough to tell me that he wasn't too well. Looking around, I could see in the eyes of those gallant warriors the expression of "You fix, or else!"

Being then twenty-six, in good health, and desirous of enjoying further good health, I quickly had a drip going and whispered a few encouraging word to the afflicted man who seemed to understand my fluent Cantonese. Having obtained his confidence, I commenced to put him to sleep. As soon as he was under, the work of cleaning his wounds and treating the fractures was well

under way. Our eminent surgeon was noted for his metuculous slowness, but on this occasion he surpassed all expectations with his speed.

At this stage, I may mention that considerable interest was being taken in our performance, especially in the excursions of the rebreathing bag. This rather fascinated the spectators with the top-boots and swords. Apparently most surgery in Japan was performed under local, spinal or intravenous anesthesia, apart from the odd case where no anaesthetic is required for the full blooded 'samurai' who is insensitive to pain. After three warnings that the patient was sinking fast, the operation was finished. By this time he was rather cold and clammy. So was the anaesthetist !

I then accompanied the patient to his bed, which was in one of our best maternity private rooms, hoping that his spirit of 'bushido' will help him to recover.

After a rather restless night I was getting ready for the day's work when a knock sounded on my door. In response to my invitation to enter, the door opened and I noticed two pairs of shiny top-boots underneath the black-out curtains draping the entrance.

Of course, at that time the services term of "You've had it, chum" was not too clear to me in its meaning. However, my visitors entered, exhibiting smiling faces and buck teeth. They were both officers and obviously gentlemen. Both saluted, and one of them, clicked his heels, bowed politely and after a loud hiss, said : "Doctor—san, the patient operated upon, who is a most honourable and important member of the Emperor's Illustrious Army, is now recovered judging from the fact that he is hungry and asking for his rice and turnips. We are extremely grateful for your effort which we had occasion to observe. On behalf of his Commander and ourselves, allow me to make you a little presentation."

With these words he produced out of his voluminous pockets two tins of bully-beef, a tin of Maxam cheese, one Sunkist orange, and a cigar ! They saluted and departed.

I was staggered by this gesture ; but then could I accept this present without asking permission from my superiors first ? However, I thought of the abnormal circumstances then existing, and resolved to explain the matter after the war. Believe me, those tins were very welcome, after a week of rice and beans only.

In the midst of my reflections I suddenly realised I had forgotten something—I'd forgotten to enter the case in the operations book !

O.

Determination Of The Basal Metabolic Rate By Use Of The Haldane Gas Analysis Apparatus.

Nothing in the realms of natural science holds so much fascination for the physiologist as the determination of the Basal Metabolic Rate by gas analysis methods.

The theory behind the procedure is a delight in pure logic. The practical steps involved constitute an exercise in disciplined precision such as no other undertaking can give

I propose, briefly, to describe the operation in the hope that some of you may be inspired to adopt and enjoy this unique recreation - for so it is.

Apparatus required.

Douglas Bag
Rubber tube
Glass connection
Glass valve and mouthpiece
2 airtight caps to fit mouthpiece
Wet gas meter
3 pencils
2 reams of foolscap paper
Watchmakers lense
6 screw clips
500 cc. Absolut Alcohole
Clean Beaker
Nose clip
Gas Sampling tube
Mercury Reservoir
Haldane gas analysis apparatus
Thermometer
Stop-watch
Barometer
Du Bois tables
Nomogram for correcting to N.T.P.
B.M.R tables
Logarithm tables
3 retort stands
Pulley mounted on shaft
Bag of weights
Spare mercury
Ball of string
Reel of wire

Procedure.

Connect glass valve to rubber tube. Hand valve and tube to patient and instruct patient to try it out, so as "to get feel of it".

When all is going well connect other end of rubber tube to bag and start collection of sample.

Notice that no air is entering bag and that patient appears to have difficulty with inspiration.

Reverse valve to correct position.

Resume collection of sample.

Remember that you should have started stopwatch.

Empty bag, begin again, this time starting stopwatch simultaneously with start of collection of sample.

Remember that you should have applied nose clip.

Empty bag. Start again.

Notice that stop-watch has stopped.

Wind stopwatch — Re-set — Empty bag — Start again.

At end of five minutes remove valve from patient's mouth, shake hands with patient, and carry your bagful of air home.

Half-way home remember nose clip. Return to patient's bedside. Remove nose-clip. Shake hands again and carry on.

Reaching your laboratory, notice that bag seems just about half the size it was when you left the patient

Try to persuade youself that this is due to the cooling of the expired air in the bag. When this persuasion fails, notice that valve is leaking merrily.

Adjust valve to a functional state. Tactfully arrange to repeat collection of sample next morning.

Having collected a fresh sample, clamp rubber tube leading from bag firmly and force rubber caps over valve openings as an extra precaution against leakage. **Do this before leaving the patient's bedside.** Get ward sister to apply Elastoplast to your bleeding fingers and to sweep up the broken valve from the floor.

Carry the bag back to your laboratory.

Connect to gas meter.

Begin measuring sample.

Connect thick-walled rubber side-tube from Douglas Bag to tap of gas sampling tube. The junction between the tap and the bulb of the sampling tube is the weak spot. Remember this as you once more apply Elastoplast to your bleeding fingers, and be more careful in connecting up the second gas sampling tube.

Transfer sample from sampling tube to gas analysis apparatus.

Notice that the levels of the potash and pyrogallol have altered consider-

ably during the process.

Obtain a fresh gas analysis apparatus with a tap that does not leak.

Repeat transfer.

Carry on with analysis.

Drop mercury reservoir of gas analysis apparatus.

Take a large draught of water in an attempt to minimise the effects of mercury that you have somehow managed to swallow.

Apply water liberally to the parts of your trousers which have became splashed with the pyrogallol-saturated KOH solution.

Obtain a fresh apparatus and start again.

By the time the analysis is complete, it will be quite late. Remember that allowance must be made for the evening fall in temperature that will have occurred.

Take your figures, your pencil, your tables and your two reams of foolscap into a quiet corner.

Three hours later ask yourself seriously whether a Respiratory Quotient of 0.2 and a B. M. R. of plus 360% is reasonable.

Take the 500 cc. of absolute alcohol and pour it into the clean beaker.

God be with you

D. W. Gould

The physician, after a patient died, went the executor of the estate and presented his bill.

"Do you wish to have this sworn to?" he asked.

"No," said the executor. "The death of the deceased is sufficient evidence that you attended him professionally."

Patient — "Doctor, what I need is something to stir me up—something to put me in fighting trim. Did you put anything like that in this prescription."

Doctor — "No. You will find that in the bill."

ON MEDICAL FILMS.

We are not in a position to give our readers a detailed account of the technical side of film-making. This is definitely beyond our scope. What we endeavour to discuss here, however, are the difficulties that have to be overcome in the making of medical films and its advantages in medical training and to the average practitioner.

Medicine is a specialised subject in which many are interested but few understand: to that extend production by non-medical technicians is limited in value and efficiency—a criticism commonly made by teachers of all subjects who have seen films on their own speciality. Medical films made for training medical personnel can rarely employ professional actors, for slight lapses of behaviour are immediately detected by a critical medical audience; yet relatively few medically qualified people are prepared to devote the time and trouble necessary for film-making.

Where the recording of operations or animal experiments are concerned, an added difficulty arises: the camera-man cannot make any mistakes, for "re-takes" are impossible, and composite records compiled for several cases are unsatisfactory: the individual variation in disposition of structures is too great to allow any sense of continuity.

This leads us to disclose yet another task in this field—that of script writing. More often than not, the script has to be re-written many times before the final one is agreed upon and produced. Even then we may be so frustrated by the poor quality and unsuitable nature of the resulting product that the whole project for that particular subject has to be abondoned.

Also, we can never know before hand what subject we are going to film. We have to decide there and then whether any case is worthy of production. This means to say that if it is an emergency surgical case we wish to record, we must have a full film-unit on hand any time of the day. Furthermore, major surgical operations are often performed in several stages, between which there is a definite lapse of time.

This directs us to the greatest obstacle of them all—the high cost of production, which can rarely, if ever, be met by sale of copies of prints or tickets of admission. One library in England, holding over two hundred titles,

which are hired at out a few shillings each, was only just able to recoup each year the cost of clerical work involved in sending out bills; the hire fee was made more as a matter of principle than for profit.

For reasons given above, by far the greatest number of films made up to the present time are made *ad hoc*, with no thought even of making the film in such a manner that it can fit into an existing or proposed curriculum; an individual or group becomes enthusiatic over an item of knowledge which is customarily accorded a few minutes consideration during a student's curriculum, and they make on this topic a film of half and hour's duration. What hope is there that it can be used? By this criterion nearly all existing medical films will be found unsatisfactory!

But, the potential audience of these films is limitless. May we be scientists, poets or engineers; economists or politicians; Indians, Chinese or English, we have this in common: we desire to maintain good health and do not want illness. The medical film then has the whole world for its audience, for diseases recognise no boundaries, and ignorance for the normal is even greater than ignorance of disease.

This, to the layman, is that important. How many times more, then, does it apply to us?—we, who have chosen as our profession the medical course whose sole aim is to maintain them in good health and to cure their diseases.

Medicine in itself is a science, and like other scientific subjects there are always certain aspects which students find it difficult to understand—to no fault of either the lecturer or the textbook. Here is where medical films can be of great help. What better illustrations students can hope for than that which are drawn out with sub-titles on the screen in a life like cartoon fashion and which are followed up by explanations by a narrator from a well-prepared script. Those who went to the film on "Menstruation" and "Circulation of Blood" will certainly appreciate its value.

Let us now turn our attention to the practice of Medicine. The application of the Science of Medicine to the treatment of sick persons is an art which can only be acquired through long practice. Practitioners who depend sorely on textbooks for their knowledge of Medicine are traitors to their profession. As one of our professors once said: "Every individual case is a case by itself; the disease may be constant enough but the patient is damned inconstant". "Textbook" cases are exceptions. With the aid of Medical films we are given the chance to view at leisure a far greater variety of diseases that can be offered to us by a single community. Furthermore, we are constantly informed of the latest developments of various branches of Medicine through this medium.

This is more important in the case of Surgical films in which we can

actually see specialists at work—opportunities which, if not for these films, are seldom open to the majority of students. To illustrate this point, the British Council will be showing to us a series of films on Plastic Surgery, a subject which has made such tremendous strides in the recent years in the United States and other parts of the world but which, so far, we can only learn through medical journals or the latest textbooks.

In short, no matter what the shortcomings of these films may be, the fact still remains that it forms an invaluable part of our medical education.

L.

Our readers may like to know how we manage to get these films that are shown regularly on Wednesday afternoons at the Anatomy School. These are obtained through the courtesy of the British Council which, soon after its establishment in Hongkong in the latter part of 1948, arranged with the Dean of our Faculty for regular demonstrations of documentary and instructional films on Medicine and Surgery primarily.

The British Council is an agency which functions under the Royal Charter and financed by the Government in London for the interchange of cultural relations abroad. Films, Combined Sciences, and Medicine are three of the technical departments concerned with this side of its activities at the headquarters in London from which material and information are despatched to many countries according to the local needs and available supply. These films are in most cases produced by commercial firms such as Gaumont-British and Realist Film Unit under the supervision of the medical profession, frequently portraying actual cases and happenings in the course of their work and regular routine. Some of the films are lent or presented to the British Council from their library for showing to medical students by trading firms such as Burroughs Wellcome & Co. and Imperial Chemical Industries.

All films shown are selected by the Medical Faculty from the catalogue of the Representative of the British Council in Hongkong who then make the necessary arrangements.

Due acknowledgment must be made to Mr. Bruce and Mr. Dubee of the British Council for supplying the author with necessary materials for the writing of this article.

THE O. P. D.

The Science of Medicine is divided into the study of its principles and its practice. The latter consists of experience gained from the wards and from the out-patients department, where a different kind of knowledge is infused into the students. They come into direct contact with all sorts of patients suffering from different diseases.

The University's O. P. D.s are conducted at the old Government Civil Hospital at Sai Ying Pun. These clinics are separated into various groups embracing the more important branches of Medicine. Thus they are divided into sections concerning inernal medicine, general surgery, ophthalmology, oto-laryngo-rhinology, obstetrics and gynaecology, paediatrics, veneral diseases and dermatotogy. The student attends each by rotation.

Under the guidance of professors and lecturers the students learn how to approach the patients, find out their complaints, look for indicative signs, come to the correct diagnosis, and mete out the necessary treatment. The students are the first to see the allotted case, and then present the whole picture to the Professor or lecturer who will discuss the subject matter with the whole class, stressing on the more important factors and directing the students towards the understanding of the cardinal symptoms and signs with their co-relationship as a group so that the final correct diagnosis can be reached with ease It is different from ward work in that a composite picture of the case, with emphasis on diagnosis, has to be obtained with minimal laboratory aid It is here that the students are especially trained to be on the toes all the time, as one little bit of negligence may result in overlooking the true nature of the disease.

As the main purpose for this department is to teach the students, the cases presented are selected ones, often referred here by general private practitioners or from the medical officers of other Governmert Institutes It therefore offers the students great opportunity to examine and study the common, sometimes rare and interesting cases. Frequently these patients are admitted into Queen Mary's Hospital for further investigations and treatment. The O. P. D. offers the students the chance to apply their knowledge gained

from lectures and books to often split-second diagnosis of cases; vital experience gained at the O P. D would by indispensable for future use when they conduct the clinics themselves after graduation.

However, there are many difficulties met with in the O. P. D. It is not an easy task to get a comprehensive history of the ailment as most of the patients are illiterate. The new ward clerk, already jittery at the thought of having to prepare his case for presentation to the Professor (a terrible thing even to the more experienced Senior Ward clerks) becomes more and more agitated at the stupid answers he often gets. He is apt to lose his head at times and flies into a rage, or he may get a jumbled-up picture of the case, especially if the patient speaks a dialect other than his own. So he presents his case to the Professor. What happens? Ask the poor victims, of whom some have even been asked to change their vocation. The moral is, therefore, as Confucius might have said, "Be patient with patients."

It is best to be a linguist, at least to be able to ask the patient directly for first-hand informations. Interpreters are often very misleading. There are some students who, with a gift of many tongues and/or with special aptitude, thus managing to get all they want from the patients, often finish their cases with ample time for a cigarette before the Professor's arrival. Those medical students who are still at sea with their colloquial Cantonese should devote their vacations to master the dialect. It is a great advantage if a student chooses to pick up some Mandarin, and Amoynese in his leisure They all come in useful in the O. P. D.

The O. P. D. is also a good training ground for the students to develop their personalities and bed side manners. They learn to be sympathetic with the sufferings of these poor souls—some are so far advanced in their diseases, that no medical aid could prevent their doom. Words of comfort should be freely given. The O. P. D. is indeed a melting pot for knowledge, both for the study of Medicine and that of Human Psychology. Let's have more of it!

Mandible.

"Sellers of drugs have two eyes;
Givers of drugs have one eye;
Takers of drugs have no eyes."

— Chinese Proverb.

PROFESSORPHOBIA

This, as the term suggests, is mainly a psychological disturbance. It is too real, however, to be lightly dismissed as a neurosis.

It affects both sexes with the same frequency. There is a difinite relationship between the occurrence of the disease and the occupation of the individual. It is found almost exclusively among Medical Students, by and large among those beginning their clinical training. But it is not necessarily limited to this group of people as Nurses, Dressers and other members of the hospital staff have been known to succumb to the disease. By and large, the majority of the sufferers are between the ages of 20 and 30 years.

The disease is known both in the acute as well as the chronic form. In the acute form there is a number of attacks, which may at times be severe, the patient being asymtomatic between attacks. The chronic condition is more serious.

The acute attacks may come on at any time and place, but the commonest time of occurrence is during a ward round.

Symptoms: The classical attack may be described thus :—

With a ward round at hand, the student (usually a Junior Ward Clerk) experiences some anxiety. He then follows the rest of his group into the ward. The anxiety is slowly reduced when suddenly the student realises that he is being addressed. All at once the attack comes on. There is :—

1. *Mental Confusion.* The patient tries hard to think with one or two results, both drastic. Everything may come to his mind at once There is a jumble of Anatomy, Physiology, a little Clinical Medicine, etc., etc. It is a hopeless confusion that he just cannot straighten out. Alternatively, all is a complete blank.

2. *Impaired Sensation.* Hearing is the sense most affected. Try as he would, the patient cannot quite seem to hear what is being asked.

3. *Slowed Reflexes.* This applies to the reflexes involving higher centres and

more complex responses, e. g. the patient tends to hesitate in answering even when asked his or her name. As for simpler reflexes the response is exaggerated. A little knudge from the neighbouring student causes the patient to jump. The same result is obtained by a slight increase of volume in the Professor's tone.

4. *Impaired Speech.* This is the result of slowed reflexes and impaired function of higher centres. Stuttering is common. The patient has also a distinct liking for adjectives, especially those as "quite", "somewhat", "a little" etc., and would substitute one for the other with the greatest of ease. Spoonerisms are not uncommon. In very severe cases, there may be aphonia or dysarthria.

5. *Cardio-Vascular Symptoms.* There is palpitation. The pulse is rapid. Blood pressure rises. In very severe cases there may be dyspnoea.

6. *Facies.* There may be flushing of the face or pallor. The patient usually has an anxious expression but this may be replaced by a stupid blank stare.

The symptoms may subside after a few minutes. Sometimes, the patient does not recover completely from the attacks but the disease quietens down a little and becomes chronic. This is much more serious for there is a state of continuous mental confusion and anxiety. In time, there may be loss of appetite and weight and more serious trouble may develop.

Aetiology: The aetiology is not well understood. The following are some of the predisposing causes:—

1. Second rate knowledge of Physiology, Anatomy, Clinical Medicine and Surgery and insufficient number of hours spent in company with "Clinical Methods", "Textbook of Medicine" etc. This is by far the commonest cause.

2. Absence from lectures—inattention thereat or failure to read over notes.

3. Infrequent visits to the Wards.

4. A party on the previous night.

5. "Boogie-Man" stories told by the Seniors.

6. A previous reproach. Each reproach predisposes a further attack which is severer than the first.

7. Inferiority complex.

Treatment: This depends on the removal of the cause. Some therapeutic measures are:—

1. The patient should be instructed to spend 2-3 hours every night familiarising himself with his notes and textbooks. It will be found that it is not an easy task to get the patient to conform regularly to this routine.

2. The patient must make it a point to attend all lectures and to arrive on time. Once at the lecture, his full attention will be required and it is advisable for him to take notes.

3. The patient must be encouraged to visit the Wards more often and to get acquainted with the cases there.

4. Discourage late nights during the week.

5. Boogie-Man stories. This is not easy to treat. These tales have profound effects which cannot be eradicated unless the patient sees for himself the contrary.

6. Increase patient's self-confidence. Convince him that everyone has a right to express his own opinion. After all, all that can happen is that he gets bawled out.

Prognosis: This depends very much on the patient. With the proper treatment, cures should be close to 100%. If the disease is allowed to settle into the chronic form, prognosis is not so good and the psychiatrist or the Professor himself may be required to treat the complications.

Quack

"I just found out your uncle's an undertaker. I thought you told me he was a doctor."

"Nope, I just said he followed the medical profession."

Prof: *"Why are you late?"*

Stude: *"Class started before I got here."*

Review

INTER-FACULTY GAMES 1949 — 50.

CRICKET

Sunday, February 19th, 1950 saw the Medical Cricket XI take the field against "the Rest". Present at the Pavilion on this occasion were distinguished guests as the Vice Chancellor Prof. L. T. Ride, the Dean Prof. S. M. Banfill, Professor and Mrs. King, Prof. P. C. Hou, Dr. Banting, the Chairman of the Medical Society Mr. Tan Ewe Aik and others. Their presence was most gratifying and encouraging.

The Medical Team was not at its best. At full strength it would have included 9 of the 11 regular players in the University's 1st. XI. The Medicals were without the services of their spin bowler J.C. Koh who was away playing for the Civilians against the Combined Services. Also absent were T. Lo and C. L. Huang, two useful batsmen. But in spite of this they proved their superiority in the game, defeating the Rest by 54 runs.

The Medicals went in to bat first. Stopping for lunch, they continued their innings in the afternoon and finally declared at 144 for 7 wickets. Top scorer for the day was S. A. Vanar with 35 runs. The only "Rest" bowler who could in any way hold the batsmen was H.G. Amann (Engineering).

H.G. Amann and D.G. Honson (Arts) put up a fine second wicket stand for the Rest and for a while it looked as if the game might have come to a close finish. The partnership was broken with 47 runs on the score board. B.C. Roy and S. Hollands scored 10 and 13 runs respectively. The remaining batsmen failed miserably, the final score being 90 runs. B. K. Poh (Medicals) took 5 wickets for 13 runs in 3 overs one of which was a maiden.

Full results are:—

Medicals.

B. K. Poh	caught Honson	bowled Amann	0
D. Chelliah	caught Amann	bowled Elliott	20
N. Peters	L. B. W.	Elliott	14
S. M. Teh	run out		11
S. A. Vanar	bowled Amann		35
T. C. Lean	not out		26
T. H. Lean	bowled Elliott		23
James Peter	bowled Amann		3
			144 for 7 wkts.

C. H. Chan, J. P. Ooi, S. N. Pooniah did not bat.

Bowling Analysis

	O	M	R	W
H. G. Amann	15	6	45	3
S. Hollands	7	-	33	-
G. Elliott	8	-	43	3
D. G. Honson	1	-	12	-

The Rest

H. G. Amann	caught Chelliah	bowled Teh	20
G. Elliott	caught Chelliah	bowled Lean	5
D. G. Honson	caught Teh	bowled Lean	29
B. C. Roy	caught Poh	bowled Lean	10
W.D.L. Ride	caught and	bowled Poh	1
S. Hollands	caught Pooniah	bowled Poh	13
G. Wagner		bowled Poh	0
M. Dietrich	caught and	bowled Lean	0
A. Yeow	stumped Peter	bowled Poh	0
A. Kramstov	Not out		0
G. C. Foo	caught and	bowled Poh	0
			90 for 10 wkts

Bowling Analysis

	O	M	R	W
S. M. Teh	9	-	29	1
T. H. Lean	12	2	36	4
B. K. Poh	3	1	13	5

HOCKEY

Another Inter-faculty game played off was a Mixed Hockey match on October 28th, 1949. Again, it was a "Medicals" vs. "the Rest" affair, but this time "the Rest" got the upper hand, winning by 4 goals to 1.

Each team was made up of 6 girls and 5 boys. The rule that "no boy, except the goalkeeper, is allowed in the dee" was added. This made it imperative for the boys to pass the ball to the girls who were, by this rule, the only persons who could score. In this respect, "the Rest" had the advantage for their forward line consisted of the regular forwards of the University's Ladies team whereas the Medicals had the defence part of the same team.

This became obvious when, despite brilliant efforts and good passes on the part of the Medical boys their lady team-mates could not score.

The chivalry of the Medical goalkeeper who refrained from hitting hard was further opportunity for "the Rest" to score.

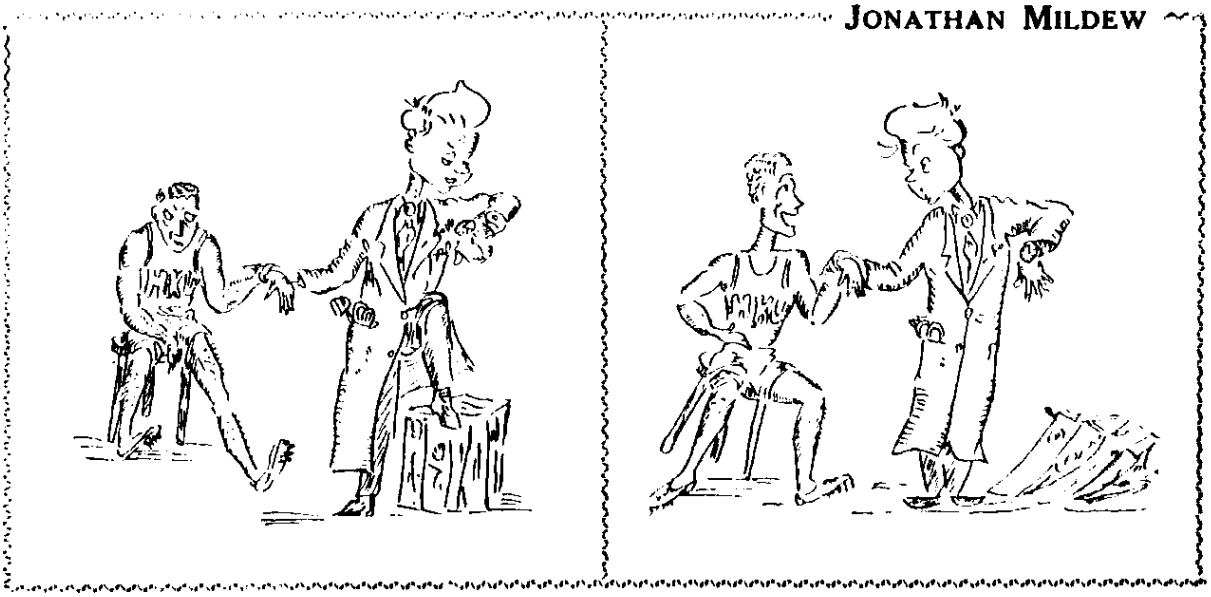
The teams were:—

Medicals	The Rest.
Miss Irene Osmund (Capt.)	Miss Marian Ahwee (capt.)
Miss Margaret King	Miss Betty Choa
Miss Adeline Heah	Miss Hanifa Abdullah
Miss Eleanor Smart	Miss Valerie Beeching
Miss Teoh Han Eng	Miss Winifred Huie
Miss S. H. Kwok	Miss Daisy Ho
Mr. B. K. Poh	Mr. J. P. Too
Mr. S. M. Teh	Mr. P. S. Liew
Mr. D. Chelliah	Mr. B. C. Roy
Mr. L. P. Lung	Mr. C. H. Chew
Mr. J. S. Ng	Mr. C. H. Wong

TENNIS

The Inter-Faculty tennis has just been played off. The Medicals had fairly strong opposition including the younger Lo brothers. We were unable to field our regular team owing to the fast approaching examinations and were beaten by the Arts Faculty 6—3.

JONATHAN MILDEW



"Your pulse is 101."

"What's the record?"

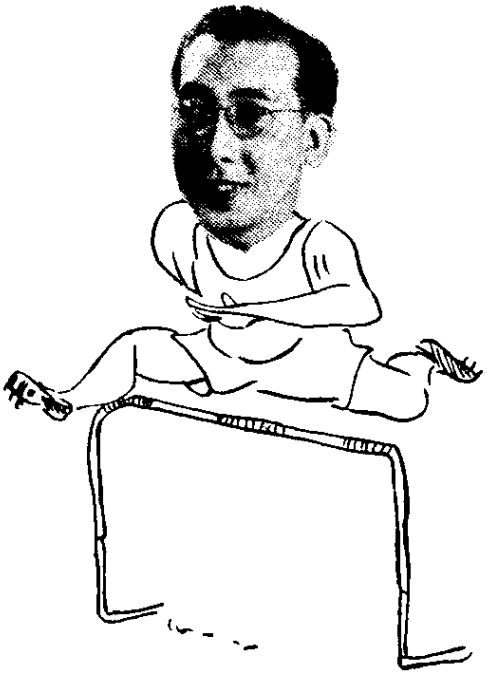
POST-WAR MEDICAL STUDENTS AND SPORTS.

Medical students have earned for themselves a creditable reputation in sports. From the early years of this University, the Medicals have won most of the Inter-faculty games. In Basketball, between the years 1931 41 they won the Annual Inter faculty games seven times. The Cricket title has been almost completely monopolised by the Medical Faculty since 1928, the only exceptions being in 1933 when it was won by the Engineering Faculty and in 1929 and 1930 when the games ended in draws.

The post war Medical students have kept up this reputation. Most of the games now are Medicals vs. the Rest but still the Medicals have been able to do more than hold their own, having won all the Cricket games and all but one of the Tennis matches organised in the post-war years.

Among the present Medical students are numerous outstanding sportsmen and holders of Greens as :—

T. T. Chin.



Known to all as "T.T.", our former Union President, is a very popular member of the student body of this University. He holds the Athletic Green which he won in 1940 when he set the University record of 27.6 secs. for the 220 yds Low Hurdles. His record still stands unbroken. During the war years, he set another record at the All Chungking Intervarsity Meet when he completed the 110 meters High Hurdles in 17.2 secs. "T. T." has given up competing in athletics and has turned Coach.

"T.T." plays a good game of Badminton and is a member of the University's "A" Team. In partnership with K.S. Low he won the University Open Doubles Championship last year. He was awarded Badminton Colours in 1941. "T.T." is an all-rounder and represented the University in Hockey and Cricket in 1941. He was awarded Hockey Colours in 1941 and represented the University in this game on several occasions last year.

"T.T." is now in his Final year and before long will be listed with our graduate sportsmen of whom, as is well known, there are many.

Lim Thiam Tet.

T.T. Lim is known as a tennis pla,er, but little is known of his great successes in Table Tennis. In 1936 he was ranked as Malaya's fourth player in this game. He won both the Singles and Doubles Titles in the Open Perak Table Tennis Championships. It was only then that he took up Tennis, but he picked it up so quickly that the same year he won the Perak Junior Championship and this title he retained until he left Mala;a. In 1937 he was chosen to represent the Fede ated Malay States against the Malayan Crowned Colonies. In 1938, he won the Men's Open Perak Tennis Championships, acquiring both the Singles and Doubles Titles.

Here in Hongkong, in 1939, he reached the Semi-finals in the Open Colony Doubles and the Quarter-finals in the Open Singles Tennis Championships ,n 1940 he was awarded the Tennis Green being the only undergraduate who had got so far in the Colony Tennis Championships

Last year, T. T. Lim was both Singles and Doubles (partnering T. Lo.) Champion of the University. T. T. Lim is in his fourth year, having rejoined the University in Sept., 1948.

Charles L. Huang.

Charlie has the rare distinction of holding four University Men's Swimming records, namely, 100 yds. Free Style (58 4 secs), 220 yds. Free Style (2 mins 36.2 secs.), 440 yds. Free Style (5 mins. 47.8 secs.) and 880 yds. Free Style (12 mins. 14.8 secs.) all of which he set in 1941. That same year he won the Individual Championship. He was awarded the Swimming Green in 1940.

Charlie is also a Cricketer. He is a good fielder and a much improved batsman who has at times put up some fine scores. His best this season was 72 runs. At the Athletic Meet this year, Charlie won the Shot-Put event and

was second in the Javelin. Charlie also plays a good game of Tennis and Foot ball.

S. A. Vanar.

A keen sportsman, Vanar, a Fourth year student, has been known to participate in various sports. The height of his acheivement was in Badminton when with K. S. Low he became Doubles Champion of Hongkong in 1948. For this he was awarded the Badminton Green in the same year.

Vanar played Cricket, Hockey and Badminton for the University in 1941 and on his return after the war was elected Captain of the Cricket XI in 1947 which position he held for two more seasons. He was awarded the Phoenix in 1947. His acknowledged interest in sporting activities was well rewarded when he was elected the first postwar President of the Hongkong University Athletic Association.

He won the University Men's Doubles Badminton Title this year in partnership with K. S. Low.

D. Chelliah.

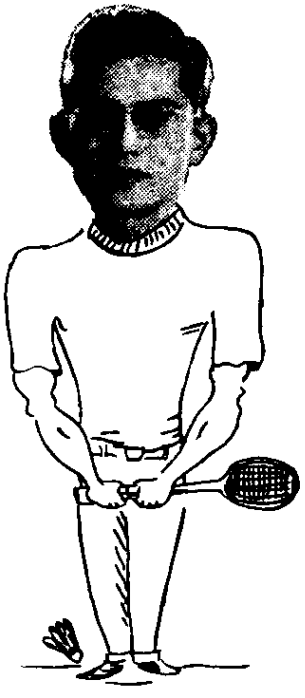
Chelliah was awarded the Hockey Green last year and was chosen for Interport Hockey trials. He is now in the third year He plays Cricket and is a useful batsman with a sharp eye and a keen fielder. When in form he has been known to put up a good score. He topped the University batting averages and ended the season last year with a brilliant 87 runs. He was awarded the Phoenix in 1949.

Chelliah was awarded the Hockey Colours in 1941 and was elected Captain of the University Hockey XI. In the same year he reached the semi-finals in

the Colony Junior Singles Badminton Championship.

He rejoined the University in 1948 and was elected to captain the University Hockey XI for two seasons. In the same year he won the University Open Mixed Doubles Badminton Title in partnership with Miss A. Heah As coach of the Ladies Hockey XI Chelliah has done much for this team. He was invited to go to Singapare this year to represent the H.K.D F. in the Far Eastern Inter-unit Hockey Tournament, but was unable to accept owing to approaching examinations.

Low Keat Soo, Raymond



A Fourth year Medical student, Low Keat Soo, is the University Badminton's star. Ipoh-born Low was his school's Singles and Doubles Champion, Perak Doubles Champion and Malayan Doubles Champion all in 1939. He was a Perak State player between 1937 and 1941, he was considered as one of the top notches in Malayan Badminton circles. On his return to Malaya in 1946, in combination with his former partner he defeated the then reigning Malayan Doubles Champions, Ooi Teik Hock (now World Doubles Cnampion) and Tan Kin Hong.

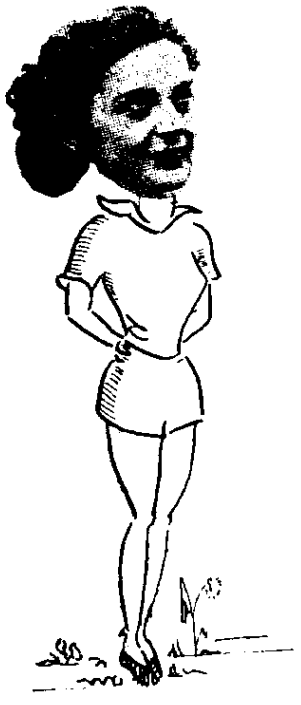
Here in Hongkong he is a well known figure in the local Badminton world. In partnership with S.A. Vanar he won tne Colony Doubles Title in 1948 for which he was awarded the Badminton Green. Partnering H. T. Heah this year, he was favoured to walk off with the Colony Doubles Title, but, as luck will have it, his partner has had a spinal injury and will be unable to play.

Whenever he has competed in Intravarsity Badminton Tournaments, Low has always emerged with the Triple Crown (Singles, Doubles and Mixed Doubles).

Thomas Lo.

Keeping up the family tradition, Tommy has excelled in Tennis. With his brother, Kenneth Lo, (formerly of this University) he reached the semi-finals of the Colony Open Doubles Tennis Championship in 1948. For this he was awarded a Green. He won the University Doubles Title in partnership with T. T. Lim and was runner-up in the Open Singles Tournament last year.

Tommy also takes an active part in Cricket and is the regular opening bat for the University First XI. He was awarded the Phoenix in 1948.



Inge Renner.

This fourth year Medical student has just set a new University record of 14 ft. 4 ins. in the Ladies Long Jump. She also holds the 100 yds. Sprint record at 13.2 secs. Although she was second in both the 50 yds. and 100 yds. events this year, she secured wins in the High Jump and Long Jump and won the Ladies Individual Championship for the second time.

Inge was born in Bavaria and later her family moved to Shanghai. Her athletic career began during her school days when she replaced her elder sister, after the latter's graduation, as the school Champion. This Title she retained until she left school.

Inge was awarded the Athletic Green last year.

J. M. Gosano.

An Interport Cricketer, our Cricket First XI suffered a great lost when "Zinho" left last year to continue his studies in New Zealand after a short stay here as a pre-medical student. He was, without doubt, the Colony's best Wicket keeper and his departure has left a vacancy in the University First XI that cannot be adequately filled. He ranked among the Colony's best batsman, and was always good for a score of fifty or more. His top score last season was 122 not out. He was awarded the Green in 1948.

We wish him every success in New Zealand.

J. C Koh.

Jesse has featured in various sports. During the last two years, however, he has concentrated his efforts on Cricket. He is a left arm spin bowler and ranks among the Colony's best. Selected to represent the Civilians against the Combined Services in a two day match, he proved his worth by taking 3 good wickets. Jesse got his Phoenix in 1948.

Jesse plays Badminton and was awarded the Badminton Colours in 1947. He plays a good game of Tennis and also participates in Football and Hockey.

T. H. Lean.

A well built fourth year student, Harry Lean shared the honour of Victor Ludorum in the Athletic Meet this year and the runner-up position last year.

At the Intervasity Meet against Lingnan last year he won the Individual Championship. He is an all-rounder, acquiring a win and 5 places at the Annual Athletic Meet this year.

Besides Athletics, Lean is a keen Cricketer. A medium to fast bowler, his best performance last season was 9 wickets for 29 runs. He captains the University's First XI this year and is one of the side's opening bowlers. He was selected to play for the Rest of the Colony against the Scorpions of the Hongkong Cricket Club, the League Cricket Champion this season.

Lean was awarded the Phoenix in 1948 and Athletic Colours last year.

S. N. Ponniah.

Ponniah, now in his third year, should get his Hockey Green soon. He was selected for Interport Hockey trials last year. This year he has earned a place in the Interport team.

Quiet and of slight build, his appearance indicates nothing of his ability on the Hockey field. Ponniah is a dependable goal keeper being able to use his feet, stick and hands with the greatest efficiency. He has done much in the formation of the University Men and Ladies Hockey XI. He was awarded Hockey Colours in 1949.

Heah Hock Thye.

Youthful Heah is one of the Colony's best Badminton players. His combination of skilled courtcraft and inexhaustible stimina is hard to beat. As captain of the University team, he has done very well in the League matches, partnering Dr. T. B. Teoh. Heah is also a good Mixed Doubles player and the Heah Heah combination (with his sister Adeline) is formidable.

H. T. Heah, a potential Green, was rather unfortunate to sustain an injury which robbed him of the Colony Open Doubles Title in partnership with K. S. Low.

Besides being a Badminton player, he is also a Cricketer and a Hockey player. Heah joined this University in September 1948 and is now in his second year. He will be with us yet for another four years and this will be a credit to University Badminton. He was awarded the Badminton Colours last year.

It is traditional that the Medical Faculty should excel in sports and this tradition it is our hope we will maintain. Yet win or lose, the Medicals shall ever be known to show true sporting spirit.

REPORT FOR THE ACADEMIC YEAR - 1949/50

The Medical Society opened its third year of post war existence with more energy and vigour than ever, and, at this point, it is appropriate to record here our deep gratitude and sincere thanks to those by whose strenuous efforts and untiring devotion the Medical Society has become so popular in this University. All have witnessed the slow but steady growth of the Society after its resuscitation from a mere strapling to vigorous youth and then to maturity. By next year the Medical Faulty will be in full strength with all six classes and the membership roll will be greater even than that of pre-war days.

Annual Supper Dance.

This year, the Annual Supper Dance was held on Saturday, 12th November 1949 at the Peninsula Hotel. We are happy to record that we were graced by the presence of the Vice Chancellor, the Deans of the various faculties and the Professors and teaching staff of the Medical Faculty. The Master of Ceremonies and the Committee deserve full credit for making this dance the most enjoyable and successful one of the season. Congratulations are due to the M. C. Mr. Robert Barnes, for his very able management of the programme that included many novelty dances of which the Candlelight Dance deserves special mention. Dr. Gould kindly honoured us with his hilarous skit "Russian Songs" which was a brilliant display of wit and talent.

Presidential Address.

Professor Gordon King delivered his Presidential address on Monday 21st, November, 1949. The subject was "The Centenary of Sir William Osler." The talk was both instructive and enlightening to the ordinary Medical student who, in his hurly burly of facts gathering fails to learn much about this great physician and teacher, rightly called the "father of Modern Medicine". Professor King gave an insight into the real man and revealed him as a model for the moulding of our own lives.

Monthly Talks.

This was one of the items planned for this year's activities. The first of the series of talks was given by Professor A.J.S. McFadzean who delivered a lecture on "Paracelsus" on Monday 30th January, 1950. It was a very inter-

esting talk in which we learnt not only about the man but also something about the History of Medicine and its evolution from folklore, traditions and superstitions to present day Medicine.

In the near future we will have the honour to listen to a talk by Professor F.E. Stock, following that, Professor S.M. Banfill and Professor P.C. Hou will each give us a talk.

Debate with the Arts Association.

On Monday, 20th February, 1950, we were invited by the Arts Association to take part in a debate in the Jordan Memorial Library. The motion was "That the Arts have done more for the good of mankind than Medicine". The proposer, Mrs. Evelyn Lu, supported by Mr. John Swaine, both of the Arts Association, spoke eloquently for the cause striving to move the house with promises of a better world of finer arts and culture. Miss Irene Osmund ably aided by Mr. Robert Barnes hotly contested the government by viewing the common man as a pitiable creature to whose aid and benefit the blessings of Medicine have tremendously contributed. The debate was then thrown open to the house. On voting, it was found that the motion was defeated by 23 votes to 19.

Picnic to Lions Rock.

The Committee organised a hike up Lion's Rock on Sunday 26th February, 1950. The weather was fine and the party spent an enjoyable day scaling the heights of Lion's Rock and going down to Shatin on the other side. Thanks to Mr. Haroon Abdullah who led the way and provided the "clowning", the picnic was a cheerful affair. After a stiff climb over Lion's Rock a luxurious Chinese lunch made impossible a return on foot. Hence the glorious "homecoming" by train amidst song and cheer.

Informal Social.

This was held on the 18th March, 1950 at the Castle Peak Hotel. For the occasion was chartered two buses which had to make several trips to transport all the members and their guests. After tea, games were played under the leadership of M.C. Mr. Li Kwok Chu. Dinner was substantial and was followed by dancing The highlight of the evening's entertainment was provided by our one and only "genius" Mr. Haroon Abdullah. Credit for the success of the social goes to Mr. Li Kwok Chu, Mr. Haroon Abdullah and members of the organising committee.

Hon. Secretary,
Medical Society.

ERRATA CORRIGE

Page:	Line:	Mistake:	Correction:
14	16	bequeatted	bequeathed
14	38	ond	and
15	28	befitiing	befitting
15	32	genertion	generation
22	28	confsss	confess
23	17	themand	them and
27	18-19	students on	emphasis on student
27	33	weiare	welfare
33	20	maintaind	maintained
33	35	one	ane
47	21	Chiness	Chinese
51	19	12st	21st
53	7	ecoonmical	economical
71	29	dispered	dispersed
74	17	sensitiveity	sensitivity
87	30	unscccessful	unsuccessful
90	16	theiy	they
91	6	uuable	unable
93	1	metuculous	meticulous
94	20	Absolut Alcohole	Absolute Alcohol
96	20	went	went to
98	31	sorely	solely
100	9	inernal	internal

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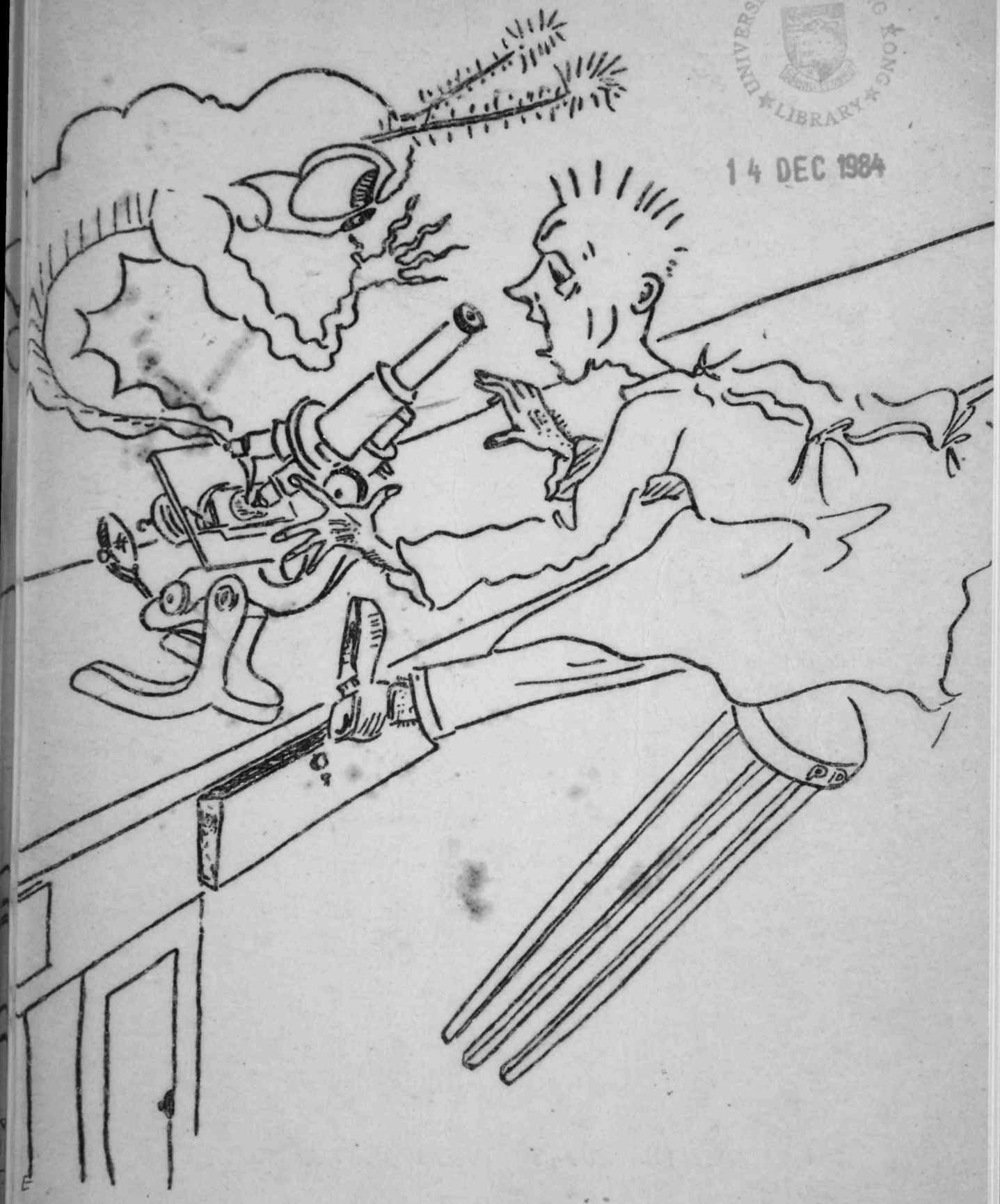

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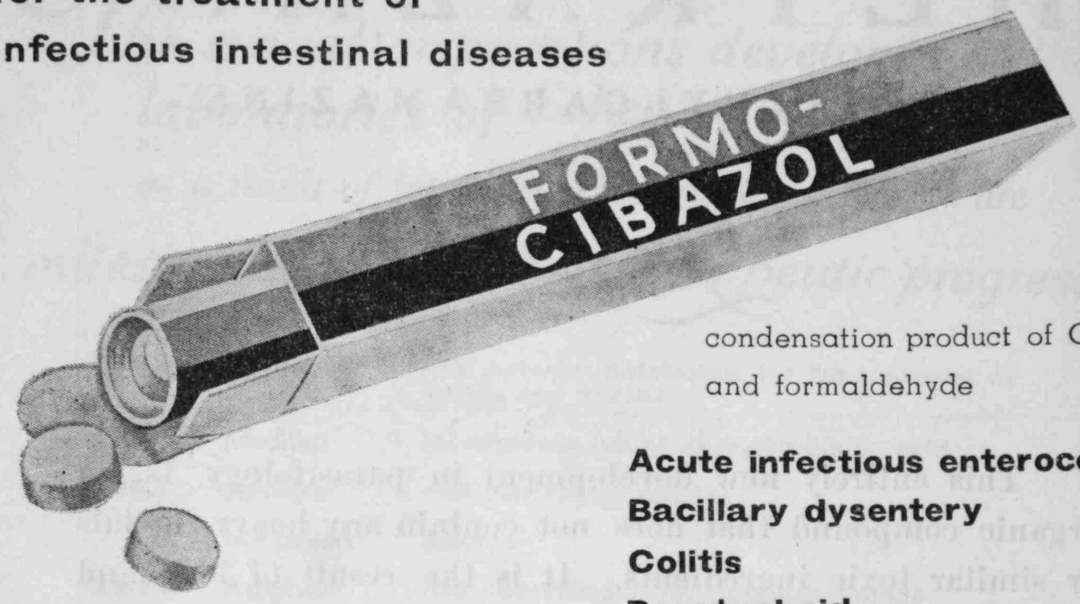

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