Caduceus

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Should the Patient be ALLOWED TO DIE???

In the cycle of human life, one is aware that sooner or later, one has to die but the problem of death has now reached a new dimension due to the great advances in medical science. Must doctors always extend life when they are technically able to do so, heedless of the quality of existance they are preserving?

Better medical care and education have effected a low morbidity and mortality among the people. The number of old people is on the rise, and as a result, there is an increasing number of people with malignancies and chronic disease associated particularly with old age and cancer. These are the patients who would most likely request that the doctor should allow them to die before the disease takes its natural course. Should doctors comply with such a request?

"Allowing the patient to die" seems at first sight to imply just the "permitting" of death by omission. Where such decision is come to at the doctor's sole discretion without the patients' consent, on the grounds of the hopelessness of the patients' case or the degeneration of mental state, we are involved in involuntary euthanasia. However, "allowing the patient to die" may be taken to mean that the doctor, at the patients' request to be allowed to die in comfort and dignity, acts positively to terminate life, for example, by injecting a drug which kills both the patient and the pain. This is voluntary euthanasia. Therefore, in the following discussion, we shall consider the issues involved in both voluntary and involuntary euthanasia administered to patients who have no chance in recovering.

It would be useful to investigate the problem with regard to its medical, legal, religious, ethical, social and economic aspects because these are the considerations which will guide doctors in their decisions between life and death.

THE MEDICAL ASPECT

The prime function of medicine is to promote human health, hence, doctors are concerned intimately with the postponement of human death. Doctors are reluctant to violate the Hippocratic Oath which obliges them to do all they can to preserve life. However, it is not clear what a doctor should do when the first part of the oath "to help the sick according to his ability and judgment" conflicts with the second part, "not to give anyone a lethal dose even if asked to do so . . ." The helping of the sick involves the ending of pain and suffering and there may be cases when pain cannot be ended without ending life itself. Furthermore, the reduction of pain often requires sedation, sometimes to the point that the patient leads an almost vegetative, albeit comfortable, existence, when the usefulness of the body is completely gone. It is debateable whether by keeping the oath in such a case, doctors are actually preserving life or prolonging the act of dying.

The International Code of Medical Ethics states that a doctor must always bear in mind the importance of preserving life "until death". This shows the importance of the definition of death. At what point in time is the patient considered dead, so that the doctor should abandon all methods of saving his life? The conventional criteria is the irreversible cessation of heartbeat and respiration. However, other authorities propose that the cessation of brainwave activity measurable on an electroencephalograph (EEG) is a more reliable index of death. Yet brainwave activity can resume after some period of time. Just recently, in Russia, a patient "woke up" after 21 years of unconsciousness. It is important that in such a case, at least, doctors should not allow patients to die.

Some doctors object to the idea of euthanasia because they say it will undermine the relationship of confidence between doctors and patients. The knowledge that the doctor will fight for his life is of great importance to the patient in helping him to play his part in following the doctor's instructions and strengthening his will to recover. Although euthanasia would only be administered to patient who had no chance to recover, it is feared that the idea of euthanasia will affect all classes of patients. When a doctor enters the room, the patient will not be sure whether he has come to kill or to cure. Clearly an effort must be made, were euthanasia to be implemented, to disassociate in the patient's mind the doctor and the destroyer. This can never be complete, however, granted that the doctor must advise whether the patient is a suitable candidate for this extreme cure.

THE LEGAL ASPECT

Another reason why doctors are reluctant to allow their patients to die is that they can be prosecuted under the present law. Since the Suicide Act 1961, it is not illegal to attempt or commit suicide but doctors who assist persons to take their lives are held responsible as aiders and abetters to the act of self-murder.

In analysing a doctor's legal duty to his patients, one must first consider whether the question involves an act or an omission. A doctor who performs a deliberate act resulting in death is guilty of murder. If he causes the patient's death by negligent conduct but without the intention to kill, he is liable for manslaughter. However, if he merely "omits" to do something to keep his patient alive, he may only be liable for negligence if he is under a duty to act. Sometimes, a physical "act" such as switching off the respirator, can be an "omission" in law if it merely yuts into effect a decision to take no further steps.

Let us now consider the second element of murder, namely, intention and malice aforethought. The aim of the doctor is not to kill, but to relieve pain, yet if he knows for certain that death is to follow as a result of his administering a pain-killing drug, that knowledge is enough to establish intention in law.

Applying the natural meaning of the word "malice", one cannot say that a doctor who kills a patient to save him from pain does so with malice aforethought. It is actually compassion that urges him to kill but malice in the legal sense does not involve ill will or base motive, it is implied from the course of conduct. Therefore, it is true to say that unless the law is changed, doctors are exposed to the danger of being prosecuted.

Different ways of amending the present law have been put forward. The Parliament Bill 1936 requires the patient to sign a formal application for euthanasia. However, the elaborate safeguards that accompanied that application were criticised as bringing too many formalities into the sick room. It is also asserted that when a patient is so distressed by his terminal illness as to want death, he is in no mental condition to have his request for euthanasia taken seriously and conversely, when a patient is so well-adjusted to life that his request to die would be respected, he is unlikely to ask for death.

It is also argued that the patient can never give a truly informed voluntary consent to die. Either he is not yet suffering pain, in which case his consent is merely an uninformed and anticipatory one, or he is crazed by pain in which case he is not of sound mind. Furthermore, the consent may be negated by undue influence both from the relatives and the doctors.

Since the patient nearing death may not have the mental condition to consent to die, the Parliamentary Bill 1969 suggested that he may make a declaration in advance stating that he wishes in certain circumstances to be put painlessly to death. The problem in this case is the maintenance of that wish up to the very last moment.

THE RELIGIOUS ASPECT

The Roman Catholic Church, in Pope Pius XII's Encyclical, Mystic Corporis, has made clear its rejection of any form of euthanasia. The Archbishop of Canterbury, speaking in the House of Lords debate 1936 echoed the same view.

There are three reasons why Christians condemn euthanasia. First, they regard Life as belonging to God. Man only holds it in trust. He has the use of it but he may not destroy it at will.

Secondly, Christians think that no man has the right to take an innocent life. "The innocent and the just, thou shalt not kill" says Exodus (23:7)

Thirdly, suffering for the Christian is not an absolute evil. It may be an occasion for spiritual growth and an opportunity to make amends for sin. Christians should offer up their suffering in union with the Passion of Christ.

Although Christians officially condemn euthanasia, one can actually justify euthanasia on Christian principles. The root of all Christian morality is "Love God and Thy neighbour". Love would urge us to permit our suffering neighbour to choose an easy death and to obtain medical aid in implementing that choice.

The Scripture tells us "Blessed are the merciful." If we show mercy to our dogs and cats by putting them to "sleep" (when we cannot reduce their sufferings), why should we be less merciful to men especially when men can express their wish to die and expect the doctor to help?

Some may say that it is God's will that we should use the reason, conscience and freedom of choice which He has given us to fight against the evil of a painful death and seek a remedy from a doctor. Alternatively, other Christians may present the complete reverse with the same argument.

THE ETHICAL ASPECT

The first ethical argument in favour of euthanasia is that it is cruel to allow human beings to linger for months in the last stages of their lives in agony, weakness and decay and to refuse them their demands for death. It is also cruel to force the relatives to see their loved ones in the desperate plight in the long-drawn-out process of dying.

The second argument is that of Liberty. The liberty involved is that of the patient as well as the doctor. A patient should have the right to choose a death of dignity and repose. On the doctor's part, if he honestly believed that the best service he can perform for his suffering patient is to accede to his request for euthanasia, he should not be forbidden to do so.

The third argument is that the value of life is its quality and not its quantity. Severe pain demoralizes personality and destroys personal integrity, and thus negates the quality of life. Quality is also measured by the value of an individual's life to the community.

However, the concept of the "quality of life" is vague. By what possible standard can anybody assess the level of quality below which life is worthless? It is impossible for death to improve the quality of life. The only possible way in which the death of an individual can be said to enhance the quality of life, is statistically: the elimination of the lower quality lives would leave the survivors showing a higher average quality of life. But this principle is inhuman and shows no respect for the individual.

Let us now consider the ethical arguments against euthanasia. First, there is the risk of an incorrect diagnosis. We cannot expect to give the average doctor the responsibility for ending a patient's life. This decision is fallible and the consequence of the mistake is irreparable. Doctors can be careless and unstable at times; they might be misguided by a pity that overwhelms judgment.

It is true that the possibility of a mistake does not deter society from pursuing a particular line of conduct — if the line of conduct is compelled by need which overrides the risk of the mistake. The need for euthanasia to relieve pain must be very great before one can tolerate the possibility of a fatal mistake.

Moreover, there is the risk of administering euthanasia to a patient who could later have been cured by developments in Medical Knowledge. While there is life there is hope. The argument against this is that new discoveries require a long time before they can be applied generally

(Continued on Page 2)

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RAMBLINGS

Man is such a self-centred creature. When he is happy, he is too elated to give others a thought. When he is sad, he is so engrossed in his own misery that the rest of the world does not exist for him. It is only when he is idle, so idle, that he suddenly remembers that there may be another fellow-man who needs a willing ear, a helping hand.

If there be light,
give me light;
If there be power,
extend it to me;
If there be forgiveness,
forgive;
If there be tomorrow,
grant me a hope in it;
If there be these things,
but not for me,
give me the patience to endure the not **having.**

At first glance this philosophy sounded so passive and resigned. But gradually I came to appreciate the faith and strength behind it. Very often, we pray and wish ever so fervently for this and that. Is it not high time that we ask, not only for what we want most, but more for the courage to overcome frustration in case of disappointment, and the faith that the morrow will bring yet another bright day for us to try again?

* * * * *

We are living in a world full of people, people with eyes, ears, mouths, 6th sense and what not senses, though not always used to the best ends. Our standard of judgement, our moral code, our sense of values, our mode of behaviour, are influenced, more than we would like to admit, as everyone wants to think that he is an "individual individual", by the opinion of those around us. Whether we like it or not, we are constantly under the control of negative and positive feedback mechanisms. In the former, we may give up many things due to social pressure; while in the latter, we gradually come to the point where we feel obliged to live up to the expectations of others, irrespective of our own beliefs. In this humdrum living with its complex human interactions one does need some of the simple-mindedness of a child and nonchalance of a lunatic to maintain an integrated personality.

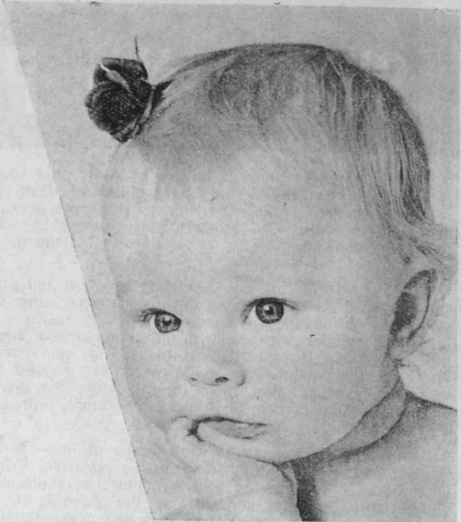
* * * * *

Someone told me that he has decided to be more selfish because it doesn's pay to be "good". I had nothing to say at that moment, because I felt it so hypocritical if I were to give him a whole lecture on why we should never lose heart in the struggle against egoism, etc, for after all, how "selfless" am I, despite my advocations? However, I do remember having read somewhere (dare not claim credit for it for fear of possible liability) that whatever service we render other is the rent we pay for our lodge on earth — and remember, what with inflation and deflation, the rent is bound to be on the ascendency daily (the tragedy of the modern man?!)

* * * * *

That day, as I walked out of the library after a day's "digging", the sunset seemed more beautiful than ever, and the "flame of the forest" looked a dazzling blaze. Impetuously, I made myself promise myself that throughout the years of labouring through books and gruesome sights of sickness and sufferings, I will still be able to appreciate beauty, so boldly exhibited in nature, so skilfully presented in the arts, and may be not as explicit (in fact, often too well concealed), in man.

by D.



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and there can be cases where the doctors know for certain that nothing short of a miracle could restore the patient within a brief period.

It is also feared, that once voluntary euthanasia is legalised, it would inevitably extend its scope to all those who could be shown to be a "burden" to society This is the wedge argument. All moral questions involve the drawing of a line, but the "wedge principle" holds that it is impossible to draw a line because the line would have to be pushed further and further back until all action became vetoed.

THE SOCIAL ASPECT

Very often, it is the social aspect which gives rise to the patient's wish to die. Whatever the patient's belief about his fate after death, the loss of life is an event greatly feared by human beings. Patients only wish to die because they feel lonely, helpless and afraid that their remaining days will bring about more suffering for themselves, more burden to their families and more trouble to society. A doctor should remove these wishes for death instead of submitting to them. In addition to giving treatment that relieves pain, he should consider the patient's psychological problems and discuss them frankly with him. He should re-assure his patient that he is not giving him up because of his diagnosis, that it is a battle they are going to fight together — patient, family and doctor. Such a patient will continue to have confidence in the doctor.

Since the doctors would never have time to deal with both the medical and the social aspects in the care of terminal patients, social workers should be introduced. Experience has shown that in the sympathetic and sometimes surprisingly cheerful atmosphere created by social workers helping in terminal hospitals, very few patients would ask for death even if euthanasia were permissible. This is actually admitted by the Euthanasia Society in London in 1936. It is true that there are very few of these terminal hospitals, and efforts should be made to build more of these hospitals.

In making decisions between life and death, how much weight should a doctor give to the wishes and resources of the patients family? Helen Silving regarded that the wishes of the family should not be relevant at all, and that euthanasia should not be administered for the benefit of a person other than the suffering patient. This belief is based on the tenet of the equal value of all human beings which bars the sacrifice of one individual, however, useless and burdensome, for the benefit of another, however, useful. However, one must not ignore the fact that if the family cannot support the patient, the burden would fall on society. If society needs its resources for other more worthwhile projects than keeping dying patients alive, the former will have to take priority.

Instead of granting relief, euthanasia may cause domestic complication, guilty feelings and dissensions among the members of the family. It may also impair the relationship between the patient and his family.

However, if a patient genuinely wishes to die because he wants to relieve his loved ones of the burden of looking after him, it may be considered unfortunate that he has to implement this noble and unselfish wish in a lonely, miserable and sometimes messy act of suicide. He needs help and advice over such grave matters as his death and if he knows that the doctor would be sympathetic he would discuss it with him, but at the moment disclosing the wish to commit suicide means imposing on the doctor the duty to prevent him from doing so.

THE ECONOMIC ASPECT

Let us face the fact, resources are limited. Manpower, finance, time and special equipments as the respirators, used for one patient will deprive another patient of the chance of benefitting from them. If patients who have no chance to recover are allowed to die, resources can be freed for the benefit of patients who have a better chance to recover. With the success of organ transplantation, the organs of the former can also be used to replace those of the latter.

To an economist, death has an important part to play in the human economy. It eliminates the worn out and those whose part has already been played and maintain the adaptability of the human race to an ever changing environment.

However, if euthanasia is used as one of the ways to eliminate the worn out, the problem of selection would arise as to who should be allowed to die and who should not be. There is also the question of assessing at what stage of an incurable illness would it be reasonable to end life.

CONCLUSION

From the above discussion, it is clear that there is no easy way out of the euthanasia dilemma. Doctors oppose the idea for the fear of being branded as licensed killers and to avoid admitting defeat in the face of illness. Diagnosis can be wrong, diseases claimed to be fatal previously might become curable within the life-span of the patient and a truly informed voluntary consent is an ideal impossible to achieve. Then, there is the problem of selection, the difficulty of defining death and the fear that the recognition of the individual's right to die would merely be the first step towards the state control of the right to live.

While individuals will continue to be influenced by one or more of the above aspects, society is under an increasing pressure to come to a solution weighing these aspects against each other. Whether euthanasia would violate Christian teachings, or undermine the doctor-patient relationship or create a sense of insecurity within the patient, or cause domestic complications or grant relief to the members of the patient's family, are, in fact, matters of opinion. Nor can the solution be found by following the high-sounding moral principles, such as Liberty, Cruelty, Right to Die, Quality of Life and Equality of Men, which are vague and debateable.

A doctor must treat each patient as an individual person whose life has philosophical and theological implications. He must make his decision answerable to his profession, his religious belief, his conscience, and the society. All the aspects set out above have to be carefully considered and balanced against each other.

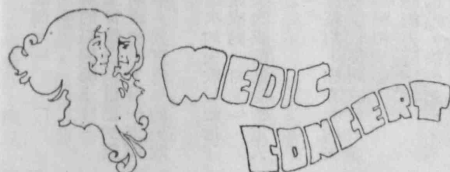
By Life

Medic Concert

Amidst the pressure of coming examinations and apprehension of failure, medical students bravely face the challenges in September, an unusual month of the year — criticisms as well as appreciation from the public in exchange for months of painstaking preparation for the health exhibition on General Health & Common Diseases, to express our hearty welcome towards the 150 future colleagues, and yet not to alarm them with the impending hardships, in the freshmen orientation programme, and a night of enjoyment at Loke Yew Hall as a conclusion to the series of extra-curricular activities.

Members of the Medical Society have always been confronted with the problem of fitting into reality the hope of promoting friendly relationship among fellow students and between students and staff. In retrospect, there are but only few occasions when these aims can actually be fulfilled. The Medic Nite, branded "grand" by the few who appreciate the "subtlety" of the language, is rejected by the majority. Participants in sports activity join the inter-year sports competition with good intention but sometimes find themselves rewarded with an unhappy ending. Therefore, one can see that what we are still lacking is a common interest among students and between us and the staff (apart from academic interest). It is with this in mind that the Medical Society organizes the Medic Concert. It will be a night of joint effort by medical students, members of the teaching staff, fellow students from other faculties, students from secondary schools as well as a few eminent professionals in the Colony. Meanwhile, the Medic Choir, still in its embryonic form, awaits the nurture of those who spare ther precious time attending choir practices.

We are greatly honoured by group performances by members of the Union Choir and students from secondary schools. Besides being a friendly gesture towards each other, this provides us with an opportunity to let those who envy us know that, no matter how much our future profession is being idolized, life ahead of many of us seem to be as yet unknown and so very often, we feel like being blind-folded, striving only for the apparently nearest goal of passing the M.B. Examinations. Geographically isolated, medical students are barred from participation in the extra-curricular activity in the main campus. Therefore, whatever misunderstanding and estrangement between medical students and other fellow students that have arisen thereof, or whatever divergent viewpoints on our social responsibility, let us grasp this chance for clarification and as a step towards greater unification, both within and without the faculty.



HOT LINE

I. Message from Fraternity Committee

1. Fraternity Nite
   Date: 25th Sept. (Wed.)
   Time: 7.30 p.m. to 10.00 p.m.
   Place: Loke Yew Hall
   Programme: Drama
   —by seniors and freshmen
   Musical items
   Debate
   —between seniors and freshmen

2. Friendly matches
   —between freshmen and seniors

Football
Date: 4th Oct. (Fri.)
Time: 5.30 p.m.
Place: Sports Center

Basketball
Date: 9th Oct. (Wed.)
Time: 5.30 p.m.
Place: Sports Center

II Message from the classes

3rd year
—photographic course on developing is to be held in Sept.
—a camp was held in Chek Lap Kok Island (赤立角) on 2nd Sept. to 4th Sept.

2nd year
—a trip to Macau was made on 6th Sept. during which a visit was paid to the Kiang Vu Hospital.

III. 學聯中國週

近代史圖片展覽

內容：介紹近百年來（1840—1974）西方列强對中國的侵畧及中國人民奮起反抗，追求獨立，富强，民主的歷史。

日期：十月五日至十日

地點：陸佑堂

A questionnaire on student opinion on the various facilities of the Medical Library has been set recently and the resulting data is now listed below.

(1) 69.3% of students think that the opening hours on MON, TUE, THU, FRI during the summer vacation are adequate. 30.7% of the students think that the opening hours during the above stated period are inadequate and should be changed from the present 9.00 a.m. — 10.00 p.m. to 9.00 a.m. — 11.00 p.m. schedule.

(2) 40.5% of the students think that the opening hours on WED. during the summer vacation are adequate. 59.5% of the students think that the opening hours during the above stated period are inadequate. The majority of them suggest that the Library should be opened from 9.00 a.m. — 10.00 p.m. as opposed to the present hours of 9.00 a.m. — 7.00 p.m.

(3) 62.1% of the students think that the opening hours on SAT. during the summer time are adequate. 37.9% of the students think that opening hours are inadequate and should be extended from 9.00 a.m. to 11.00 p.m. as opposed to the present 9.00 a.m. to 5.00 p.m.

(4) 24.6% of the students think that it is all right for the Library to be closed on Sunday during the summer vacation. 75.4% of the students think that the Library should be opened from 9.00 a.m. to 11.00 p.m. in the above stated period.

(5) 40.8% of the students think that the establishment of a 24 hours opening study room is necessary. 59.2% of the students think that it is unnecessary.

(6) 60.1% of the students think that the 'checking system' of the library on the person leaving it is efficient. 39.9% of the students think that it is inefficient and should be reinforced.

(7) 138 students think that the newspapers are insufficient in the library. 131 students think that the magazines and the periodicals are insufficient in the library. 127 students think that the reserve books are insufficient in the library. 74 students think that the reference books are insufficient in the library. 20 students think that journals are insufficient in the library.

(8) If the newspapers are to be put in a single place 52.2% of the students think that it should be placed in the library. 24.4% think that it should be placed in the common room and 23.4% think that it should be placed in the canteen.

(9) Some students think that the ventilation in the library is poor, the air condition being too noisy and too chilly.

(10) Some students think that the paper-cutting machines should be renewed because the present machines are too old and too blunt.

(11) Some students think that the borrowing period of books on half day loan should be prolonged. Some hope that the journals can be borrowed on a 2 days loan basis.

(12) Some students think that in general the library is in lack of books on Chinese medicine, prose of any language, jokes (eg. Mad, Charlie Brown) and Chinese fiction.

Thanks to our fellow students who have voiced their constructive opinion and thus made the collection of the above data possible.

By the student representatives of the Medical Library

浪

戴國平（新生）

在我的意識中，無論是街上的行人，或是車上的乘客，都以羡慕的目光向我望來，看我這個準大學生，未來的醫生，社會的棟樑。心中的幻想成了一雙無形的巨手把我的頭越抬越高，漸漸我的眼睛也似乎只能看見天了。

「哼，天雖然很高；但我還不是攀到了嗎？」心想。

「不錯你是攀得很高，但你能夠肯定你落脚的地方就是天堂嗎？」遠方傳起一陣虛幻飄渺的聲音。

「難道你沒有看見我現在已經和天很接近嗎？」我大聲辯護。「我想只要我再跨多一步就已到達天堂了。」

「可是你看清楚前面沒有？」

「周圍滿佈浮雲，眼前境物都是朦朦朧朧的，就算眼力再好也要費好些神才能看得清楚呢！我沒有多餘的時間去浪費在這些無聊的事上，我只知道向上攀爬，不停的攀爬就能到達天堂。」

「不過如果你不辨清眼前事物就盲目的攀爬，你隨時都可能墮入無底的地獄呢！」這是告誡？

「不，絕不……。」我歇斯底里的亂叫。

………………

「花開遍野，綠草如茵，陽光燦爛，這不就是我未來的寫照嗎？光明，燦爛！」

「你可知道你爲甚麼要做醫生？」

「當然是爲人服務，濟世活人。」我驕傲的說。

「謊話！」

「你侮辱了我。」我十分激憤。

「一個卑怯的人是沒有自尊的。」

「你……。」

「待我告訴你吧，你做醫生的目的是爲了有一份理想而受人尊敬的職業，輕易的取得金錢和地位，至於生死肉骨只不過是你的烟幕。」

「廢話！我是有理想的，我的目的並不單繫於金錢和名譽，我還要救人，我要做一個令人尊敬的好醫生。」

「不用爭辯，如果你眞不重視金錢，你爲甚麼對每月的零用毫不滿足？你眞不重名譽，爲甚麼又要和我爭辯呢？你要救人，但却連在巴士上讓座也不能做到？虛僞的人，你的夢該醒了……。」

中學會考放榜後的日子我的確過得十分快活。不但生活寫意，地位也因會考成績而受重視。校內的活動開始有我的份兒，我甚至成爲校中的學長之一。似乎周圍的人都因我的成績而開始重視我個人的工作能力了，回想起來我那時只不過是一個打著會考證書爲招牌的光棍，眞是可悲。

「你說可悲，那時你不是以此爲喜嗎？你不是曾經利用種種式式的方法去宣揚你的成績嗎？你不是一度以爲那些絕無誠意的讚嘆十分悅耳嗎？………。」

「我求你，求你不要再說了，讓我安靜下來好嗎？你這魔鬼！」

兩年的預科純粹是在虛榮的心境下，胡胡混混，半清醒半迷惘中渡過。一直都自己欺騙自己時間還多的是，直至臨近考試前的兩個多月才開始著急，在慌忙中每科只讀得些少皮毛，但却仍心存僥倖，以爲已操勝券。

「我很高與你仍然沒有離開。」

「我一直都在你的身邊。」

「你可以告訴我今次失敗的原因嗎？」

「你失敗是因爲你根本未會想過以自己的眞正實力去應付這次的考試而期諸僥倖，另一方面又完全籠罩在自我的虛榮心中。其實這次的失敗根本不值得一顧。」

「爲甚麼？你可知道我這次的失敗已斷送了我的前途，使我的志願永無達成的一日。」

「你眞死心眼，難道一次的成敗就能斷定人的一生？」

「可是我的家庭？……」

「你的家庭對你是寄望極高的，你今次的失敗無疑會令他們失望，但你可以日後的成就來滿足他們，而他們亦會因你而感驕傲。」

「可是我有這反敗爲勝的能力嗎？」

「你的能力還未眞正發掘呢，快些起來，不要再呆在這裏，美好的世界正在向你招手呢！」

「你說的不錯，可是你可以告訴我你是誰嗎？」

「我就是你思潮中的波浪，我的責任就是把你衝擊成一個勇敢的人。我是浪，我要不斷的衝擊」。

"If a drug could be produced that had the anti-asthmatic properties of steroids without their side effects, the trials and tribulations of asthmatic patients would be at an end."

Lancet (1966) **2**, 1354.

steroid control without steroid side effects

Extensive clinical trials of Becotide Inhaler have shown that it gives effective control of asthmatic symptoms in patients who are no longer obtaining adequate relief from bronchodilators or sodium cromoglycate.

In addition it has been shown that Becotide Inhaler therapy can be used successfully to replace systemic steroids even in asthmatic patients who have become steroid dependent.

In a double-blind controlled trial involving asthmatic patients, Becotide Inhaler provided control which was at least as effective as that obtained from oral prednisolone; the only significant difference was that plasma cortisol levels were not depressed with Becotide Inhaler therapy.

(Brit. med. J., 1972, 3, 314)

IMPORTANT

Clinical trials have highlighted the need to pay particular attention to the selection and clinical management of patients.

It is also important that the patient uses Becotide Inhaler correctly and regularly and that it is not confused with bronchodilator aerosols.

Becotide Inhaler ensures for your asthmatic patients:

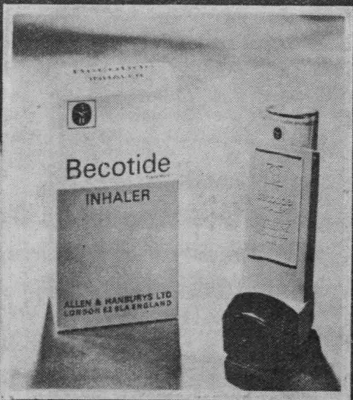
☐ Highly effective treatment controlling the three main pathological processes involved in asthma – bronchospasm, oedema of bronchial mucosa, and hypersecretion of mucus.

☐ Freedom from steroid side effects including adrenal suppression.

☐ A fuller and less restricted life as the advantages of steroid therapy can be introduced at an earlier stage of the disease.

PRESENTATION

Becotide Inhaler is a metered aerosol which delivers 50 mcg. beclomethasone dipropionate BP per inhalation. Each container of Becotide Inhaler provides 200 inhalations.



Becotide INHALER

puts steroid therapy in its place

Full information is available on request

Glaxo

Glaxo Hong Kong Ltd.
[illegible] Floor, Block B, Watson's Estate, North Point, Hong Kong
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THE HONG KONG MEDICAL ASSOCIATION

All registered doctors in Hong Kong are eligible for Regular Membership of the Hong Kong Medical Association and all medical students can join as Student Members.

One particular privilege of regular members is that they can obtain medical protection by joining the Medical Protection Society through the Hong Kong Medical Association. Every doctor should acquire medical protection, including house officers. Even those working in Government service should join the Medical Protection Society because if trouble arises they cannot expect assistance from Government. The Medical Protection Society will advise you, defend you and indeminfy you against damages and costs.

Join the Hong Kong Medical Association. Obtain application forms from the Association Premises, Wyndham Mansion, 6th floor, Wyndham Street, Hong Kong, or telephone H-231898. Medical students can also obtain application forms from the office of the Hong Kong University Medical Society.

The EB wishes to thank the special support of Glaxo Hong Kong Limited.

高等教育

（上接第一版）

（國內）：我們曾參觀南京的復旦大學，學生多是工農子弟，在入學前都已在農村或工廠勞動過一段時間。

國內大學一般的取錄標準與其他國家很不同，每一個學生都要經過自行申請，羣衆推舉和領導批准等幾個步驟，至於入學後的一切學習費用全由國家負担。

大學有學生會的組織，可直接參與校政，共同改進教法和課程，與校方的關係爲甚爲融洽。

校方並不主張在求學時期談戀愛，所以拍拖的風氣在校內絕不盛行。

（臺灣）：大學生都很惇樸，時常舉辦文藝活動，體育活動亦頗受重視，三民主義被列爲每一大學生必修的課程，在大學生裏，男生比女生的數目多，在社會上重男輕女的情形仍然存在。一般大學的學習費用頗多，窮苦人家不容易負担，而政府助學貸欵又不多，所以富家子弟上大學比較容易。

（星加坡）：學生都幾「書蟲」，暑假期間在圖書館也見到很多人勵書。

有學生會的組織，其選舉制度是先選若干名Councillors，然後再由Councillors自己選出學生會幹事，通常在普選Councillors時得票最多的便任會長，而該職位又多由法科學生出任。我們在星時適逢星大選舉，但所聽到的競選口號不外是要增加會方行政效率，內容頗爲空泛，又不重視參與校政或社會行政。

學生們都很以自己的國家爲榮，華僑亦不大認同自己爲中國人，這種情形在普通市民中亦可察覺得到。

我們曾和一些學生談到政治，他們表示不敢到中國大陸參觀，可能因爲在星加坡要有公民權才可進入大學，而公民權可以隨時被褫奪，通常這種情形都和政治有關。

（馬來西亞）：學生的衣著很隨便，男女學生的頭髮都很長，男生很輕佻，以撩女同學爲樂事，醫學生則比較斯文。我們曾和一些學生談話，發覺他們不大關心學運，而社會意識亦不高。

可能爲了配合將來的發展，理科人材頗爲吃香，而一般大學生畢業後都能找到合適職業。

（泰國）：大學生中有很多是富家子弟，這可由他們所擁有的汽車看出來，因爲在泰國汽車是奢侈品，窮人很難買得起。

學生讀書頗「夫碌」，絕不是examination orientated之流，曾見他們下午有測驗，上午還陪我們到處玩。

以前從報章上知道學生竟可以將舊政府弄垮，便以爲該地學運很蓬勃，但我們在各大學很少見到標語，而以攪學運出名的法政大學也不見有甚麼特出的地方，據當地人說上次的政變根本是基於羣衆要求，當然大學生亦會扮演一重要角色，而無可否認大學生在社會上頗有勢力。

（菲律賓）：大學的數目很多，但有一部分只是濫竽充數，佔一幢樓宇的二、三層便算大學，與香港的私立中學相若，當然頗具規模的大學亦有，如University of Philippines便很不錯，學生亦很勤力，在第一年，全部學生都要讀文科。

很多學生讀商科，因爲他們喜歡做文員，然而很多時學非所用，有不少學生都希望能到美國去發發展。

學運並不突出，學生對於找生活比攪政治更關心。

工農業

（國內）：以發展農業爲主，而以工業配合之，很强調自力更生，絕不倚賴外國，所以並無外資介入。

就工業技術來說，比西方先進國家還差一段距離，尤以小鎮的工廠爲最甚，有些仍沿用土法生產，但工人的工作精神很好，時常都能超額完成。

（臺灣）：一般工人的工資少，所以成本低，對貿易競爭有利，我們見到有不少工廠，但很多爲外資控制，其中以日、美爲主，幾乎成爲兩國的經濟殖民地。

（馬來西亞）：頗注重農業，以我們沿途經過的地方來看，很多地方已開發，橡膠樹矚目皆是，以前政府甚至貸欵資助私人開拓橡膠園，但現今趨勢是不再鼓勵橡膠園的設立，可能是與國際橡膠園的價錢不穩有關。

（菲律賓）：似乎還未地盡其用，而國家發展好像沒有甚麼計劃，手工業十分吃香，主要手工藝品，以外銷爲主，收入每每比一個普通文員爲多。

生活程度

（國內）：沒有貧和富的分別，就以工資爲例，一個工人平均月入四、五十元左右，而醫生、工程師等技術人員月入亦只是六、七十元，又因爲一般必需品如米、油、糖等是依配給方可購買，所以人民生活比較劃一平均。

（臺灣）：很多婦女有職業，除工商業外，一部分女性是在消費場所服務，由於有義務軍役的制度，職業女性可以解決一部分的勞動力。

貧富的差別存在着，但因生活水平不高，所以情況比香港好。

（菲律賓）：非人生活一般比較優閒，所以日常生活並不如香港般緊張，有一句流行語：「窮人坐五小時巴士，富人坐半小時飛機」，可見雖然貧富在享受方面有分別，但機會則均等。

非的社會福利工作「似乎」做得不錯，因爲每每在報章的第一頁都可以見到總統夫人的活動情況（她是掌管著全國的社會福利行政）。

（泰國）：貧富懸殊得很，例如一個工人平均月入約七十元，而一間普通酒店的房間每日亦要七十元，一般消費品價錢也不便宜，所以享受幾乎是富人的專利，此亦可以由色情事業的蓬勃反映出來。

娛樂

（國內）：一般人都喜歡逛公園、下棋、玩樸克和看電影、戲劇等，事實上國內亦有很多名勝古蹟，這些也是市民流連的地方，在逗留的日子中，我們沒有看見或聽到有人搓麻雀，這和香港的情形，簡直有天壤之別。

電影很普及，票價亦廉宜，然而因以教育爲目的，所以內容多含政治性或科教性，更有所謂革命樣板戲，絕少愛情文藝悲喜劇之類。

在各城鎮有所謂「工人文化宮」，相約於外國的俱樂部，在上海的一間，我們見到的活動有戲劇、音樂、美術、舞蹈、象棋，各類學習班，還有圖書室，閱覽室等。

色情事業可說絕無僅有。

（臺灣）：日常消遣以看電影、逛公園爲最普遍，搓麻雀並不如香港人「熱心」，反之甚多人喜歡閱讀。

（菲律賓）：夜總會設備不及香港港好，不過這些地方並不是一般人所能負担得來，至於紅燈區的情況則不大清楚，但男同學在酒店時頻頻被人問要不要「姑娘」陪。

（星加坡）：滿以爲星加坡治安好，民風樸素，誰料也有色情事業公然存在，我們到過一條「人妖」街，首次有機會看到不男不女的shim（即不是she，又不是him），在大庭廣衆面前騷首弄姿，他（或她）們一部份是爲了錢，另一部份則因嚮往女性生活才做這種工作。

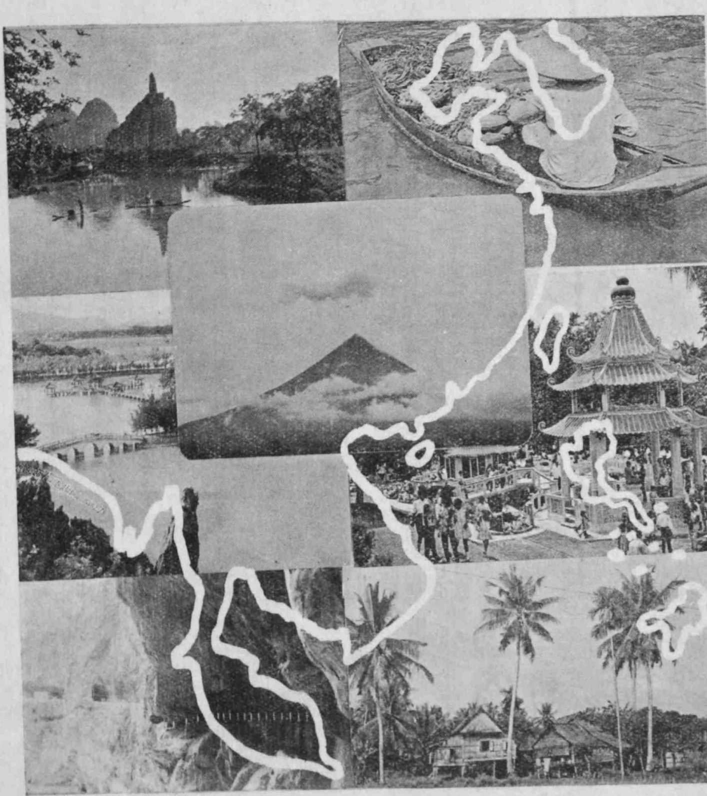
（馬來西亞）：電影很普及，有不少香港製作的舊粵語片上映，內容都是描述五、六十年代香港封建社會現象，所以當地一些未到過香港的人看後還以爲香港仍是一個古舊保守的城市。

（泰國）：電影院很有氣派，影片亦很新，有些甚至在香港還未上映，不過票價絕不便宜，所以看電影屬奢侈享受。

色情事業極之蓬勃，有次坐的士，司機竟然將印滿「架步」的咭片遞上，據曾到過紅燈區參觀的同伴說，各色各樣色情玩意都有，比香港過之而無不及。

（菲律賓）：音樂很普遍，尤以流行音樂爲甚，幾乎每輛公共汽車內都有音響設備，大有「仙樂飄飄處處聞」之感。

電影院似美國一樣，座位並無劃分，而電影除本國製作外，大多爲美國片子，所以可能因爲電影院太多，所以每間電影院的觀衆並不多。



治安

（國內）：沒有所謂正規警察，維持治安則由民兵、解放軍負責，治安甚佳，我們在居留期間甚少聽聞有搶劫的案件。

審訊程序和香港頗有不同，犯人是交由民衆公審，疑犯要提出證據表示清白，而不是由檢控官找出罪證，刑罰注重思想教育。

（臺灣）：治安甚佳，我們在晚上逛街也不提心吊胆，這可能與法例執行嚴謹有關，在臺灣，有時偷竊罪亦可判處死刑。

（泰國）：治安頗壞，兇殺案甚多，泰人的舉止給與人一種野蠻感，同時槍械在泰亦很普遍，單身女子不宜在街上停留，因爲擄掠女子的案件無日無之。

（菲律賓）：所接觸的菲人都很友善，報章很少提及罪案，治案「似乎」不錯，不過在旅店有人勸告我們小心財物。

刊物

（國內）：在每一地區有一、兩份地方性報紙，而全國性的報紙則有人民日報，其內容多屬理論性文章，時事新聞比較少，我們逗留期間適逢尼克遜下台，而見到一般反應都很平淡。

有一份叫「參考消息」的刊物，是節錄外地的報章消息，其中包括香港、台灣等，但不公開發售，通常能夠看到的是知識份子或幹部人員。

書刊有哲學，政治、科教、文藝和音樂等多方面，一般人都喜歡閱讀小說，而大部份的書籍都有宣傳共產主義的意味，至於古典文學作品則不大見。

還有所謂街頭大字報，很多時是作爲政治鬥爭的工具，然而就所見，並不是全部都含政治性，有些是具宣傳性的，如預防傳染病便是。

（菲律賓）：報章的國際新聞有檢查過的痕跡，外電消息頗多，而報紙內容以娛樂版爲最受歡迎，文字主要用英文，風格模仿美國。

我們曾到一大書局，書籍種類繁多，大部份爲美國書，有很多美國的暢銷書籍都可以買到，正如在台灣一樣，翻印書籍是合法的。

交通

（國內）：單車極普遍，幾乎人手一車，公共交通有人民汽車（即巴士）、無軌電車、火車、公共汽車（約等香港的計程車，但沒有咪錶，車費面議）、內河渡輪、內陸飛機、三輪車等，不過陸上公共交通工具數量不應需求，往往很擠，其情況絕不比香港的遜色。

可能因爲車輛數目不多，而一般主要道路也很寬闊，所以塞車的情形甚罕見。

（台灣）：單車和電單車很普遍，私家車的數目不多，公共交通有巴士、計程車、內陸飛機等，巴士和火車均甚擠。

主要道路都很寬闊，甚至可八綫行車，更且車輛數目不多，塞車幾乎絕無僅有，車輛在市區內也可以開三、四十咪。

行人路都很闊，甚而比香港的還要闊，但過馬路時則要格外留神，因爲在斑馬綫前車亦未必會停下讓你過。

（泰國）：交通很壞，駕車不必領執照，只要有錢買車便可在路上恣意奔馳，而一般司機猶胆色過人，在路上東奔西竄，好像表演亡命飛車一樣。

（菲律賓）：公共汽車除巴士和計程車外，還有一種吉普車改裝的客車，該等車輛大多是二次大戰後美軍的剩餘物資，只作短途之用，和香港的小巴相若。

後語

在今次的座談會，談話的形式是先提出一個中心題目：如教育，醫療等，而由各同學就他們到過的地方作一介紹，原先希望在交流見聞之外，更能將幾個地方作一比較，然而筆者在將紀錄整理後，發現是次假日旅遊的感受基本上可以分爲兩種，到國內旅行的同學原則上是抱著認識新中國精神面貌的心情而去，至於其他的同學則或多或少是懷著遊玩的目的，因而大家所著眼的目標便截然不同，在國內有很多節目是安排參觀工廠和農村的建設，其他國家大多數是參觀名勝古蹟。在接待方面而言，亦有所不同，在國內是以同胞視之，中國在這些年來的發展和成就，很注重宣揚，是以對待遊客的態度而給與服務（在台灣可能稍有不同），所以純粹是商業上的交往。

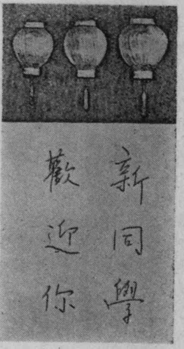
基於上述原因，要將各個地方作一比較是不可能的，猶幸大多數同學都能利用他們敏銳的觀察力，所謂見微知著，因而仍可粗略看出在不同社會制度下的不同表現，然而究竟是否只是瞎子摸象，管中窺豹呢？不過無論如何，通過今次的座談，大家總算能交流一點旅遊的感想。

啓思

香港大學學生會醫學會月刊

六卷九期

本期發行四千份
一九七四年九月



編委會

在一片鬧醫生荒之聲底下，百多位新同學邁進了醫學院，加入我們的行列，倍感意義深刻！爲這我們對此生力軍表示熱烈的歡迎！

或許新同學對新的環境感到陌生，都需要一段時間來適應；但可以肯定的是，這一階段將會是多姿多釆的！醫學知識既廣且深，在逐步掌握知識過程中，定有無限的快慰，卽使遇到疑難，只要提出，老師都樂意指導，高班同學（尤其導師）更義不容辭，同班同學亦可通過互相帮助，一同解決。學生會的活動也是多樣化的。新同學自入學以來，已有不少迎新活動——學院學生會的，大學學生會的、屬會的、宿舍學生會的，隨之而來還有展覽會、音樂會、學聯的中國周、大學的開放日等等，其內容豐富，適量的參與不僅能促進友誼，更有所廣益，盡使大學生活能在德、智、體、羣全面發展。

醫科同學，無論是那一班的，都有共同的目標，同是任重道遠，讓我們在共同探討的前提下，在未來的歲月中，栽出團結、友愛之花！

醫學院向你們招手

東風

港大學生是否一班自以爲是的特權階級，一羣這個社會制度下之寵兒，既得利益者？醫學院大部份學生是否滿腦子金錢、地位、甘心爲專利壟斷制度而自肥嗎？這些都將要暴露在一羣剛踏越大學門檻的新同學面前。在世界潮流的推動下，港大同學的面貌可曾轉變了？同學們是否安心於把自己關鎖在狹隘的象牙塔中？可以肯定的是：沈迷於個人名利的逐鹿從而渾渾噩噩的讓生命無聲無臭地溜走的思想已爲時代所摒棄，而我們也相信新同學們也不是爲社會給與大學生在就業前途和生活待遇的特殊地位而進入港大，尤其是醫學院。

不錯，很多新同學可能還未能了解自己讀大學，唸醫科的目的；有些可能認爲考試的成績決定了他所要走的道路。這當然不能全部把它歸咎於中學教育的失敗，枯桎青年思想的塡鴨奴化教育已令多少有崇高理想的同學們被拒於大學門外；社會對大學生的態度也促使學生讀書的目的模糊起來，政府是在培養一些怎麼樣的大學生？

大學裏的環境較中學的開放。生活的圈子擴大了；以前小圈子的三數知己已被學生會及其各屬會多姿多采的活動所吸收及組織起來。個人的接觸面擴大了，同學間的思想交流促使了和啓發了對人生目的，生存意義和現存眞理的懷疑和探討。和中學時期的不一樣，思想受到多方面的影响而得到鍛鍊、成長；不再滿足於學制內的框框；轉而着重個人人生觀的培養。社會的發展已令我們再不能安於鴕鳥式的生活。隨着眼界的開放，胸襟的舒展，確立奮鬥目標的要求益趨殷切。那麼正確靈活的利用課餘，處理課內外的學習、活動不是比中學的書本生涯，考試奴隸生活更有意義嗎？

知識份子可愛的地方在於熱衷於尋求眞理，接受眞理，對現存制度的不平最易醒覺。他的使命感促使他對不平作出反响、提出改造。但要做事論事不脫離實際，符合客觀要求，就必須努力衝破自己周圍的局限，身體力行，走到各階層中體會他們的疾苦，了解他們的喜樂；培養一個不脫離人羣、不脫離社會、國家甚至世界的人生觀，從而確立將來的服務對象。

我們醫學生已漸漸從過去的課室、圖書館、宿舍的刻板生活抽脫出來，慢慢地學會利用課餘，從無意義的分數包袱解放出來。但是功課担子還是重的，是掌握服務人羣的本領的重要環節。但是，我們將來的職業，分工上的崗位，更需要我們認識社會的本質，更需要我們了解社會上那一角落正向我們招手，正向我們露出一絲絕望中的希望。

啓思錄
音樂與醫學

每文

自古人類便察覺到音樂與醫療的關係，希臘的「阿婆羅」是音樂、詩歌與舞蹈之神，亦是健康之神。派得格拉斯(Pythagoras)認爲食物及音樂乃清淨靈魂肉身，使其和諧的因素。柏拉圖亦以音樂爲導致兒童身心健全的一個方法。

由於這些覺察，無論在理論和實際上，音樂和醫學一直都維持相當的互相影响，在文藝復興時期，有人提議把希波格拉底斯（Hippo-crates）的醫學理論應用到音樂去。有名的軍醫安布魯士・巴爾（Ambroise Par'e）把音樂看作是醫治蜘蛛毒、坐骨神經痛及風痛的良藥。直至現代，音樂在醫學上很多方面已佔有無可置疑的地位。如在物理治療、心理治療、職業治療、麻醉學等，它都有其特別用途。

因此，我們不難看到醫生與音樂家合併的例子。有名的外科專家比洛夫（Billroth）也是有名的音樂評論家、鋼琴家、小提琴家和中提琴家。伯拉姆斯可算是他最知心的朋友。波羅汀醫務繁忙，但他「業餘之作」（？）：「中亞細亞草原」、「伊高皇子」使他永垂不朽。近世來說，我們首先當可想到「史懷惻」，沒有人敢否認他在這兩方面的崇高地位。而本世紀最偉大的鋼琴家巴德瑞夫斯基（Paderew-sky）和小提琴家克萊斯勒（Kreisler），也是習醫出身的。

那麼，我們醫學院當然也不會缺少有音樂天份的人。沒錯過九月廿一日醫科音樂會的人都會知道。

國內、國外——
「讀萬卷書，不如行萬里路」

友

今年暑假，多位同學曾到外地遊覽，尤以二年級的同學（現在已是三年級了）爲數最多，其中十數位爲了交流在旅遊中的見聞，在八月下旬時作了一次非正式的座談，在輕鬆愉快的氣氛下互相傾吐在旅途中的際遇和感受，筆者有幸叨陪末座，現就當日傾談內容簡述一遍，希望藉此與其他同學一同分享旅遊的樂趣。然而因爲在每一地方逗留的時間甚短，所見都是一鱗半爪，因而可能只是片面的認識，所以就此拋磚引玉，希望其他見聞更多更深的同學，不吝賜教。

醫療

（國內）：在用藥方面以西藥爲主，中藥爲輔，現在的趨勢是中西醫結合治療。

在逗留期間，曾有機會接觸到赤脚醫生，原來所謂赤脚醫生，只是指他們不脫離生產，即在治病之餘亦參加勞動。他們約受半年左右的基本醫學訓練，全部以實用爲主，一般工農都可以「小病不出隊，大病不出社」（隊和公社都是農村的單位），因爲赤醫的學習精神很好，雖然基本理論少，但對一般農村常見的病也能應付裕如。

有很多藥房是看病賣藥，如頭痛便給頭痛藥，脚痛則賣脚痛藥，但都只是Symptomatic Tr-eatment，作用相信是減輕診所醫生的負担。

在參觀上海第六人民醫院時，很高興見到斷肢再植的病人，他們通常要數個月才可康復，但痊癒得很徹底，細微的動作都可以做。

回溯斷肢再植的手術始於十數年前，當一班醫生接觸到貧下中農時，了解到四肢對工農的重要，所以在六三年時，有某一工人意外斷手，醫生們便考慮到要爲他保存手部，經過多次努力，克服重重困難，最後終於得到重大成就。例如最初的病者很容易發生水腫，經過研究，發現原來因爲動脈血壓比靜脈大，而當初接駁動脈的數目多靜脈數目少，因而引致Venous Return受阻礙，同時淋巴系統又未能充分接駁成功，所以形成水腫，因此在以後的手術中便儘量接駁多些靜脈，以便血液循環得以暢通。

醫學制度採用三年制（這是在文革後制定，現時還在摸索階段），注重對病的診斷和醫治，畢業後而並非在醫院服務的，隔一年左右便要回醫院學習一段時期。

國內人民甚喜歡閱讀醫書，每每在書局都會見到很多人購買，可見他們的醫學衞生知識水平甚高。

在街道上會見到有教導預防疾病的大字報，對提高一般人的衞生情況很有帮助。

（台灣）：有很多私家醫院，大部份規模都很少，只佔三幾層樓，有些醫院甚至沒有醫生駐診，因爲有些醫生在出洋前將醫院轉讓，而接手者未必是醫生，所以造成有醫院而無醫生，在該等醫院，診病由護士担任。

有些公立醫院的病人雖不多，但工作人員效率則甚低，往往塡寫一張表格也要多重手續，診金是按病情而定，我們有位同伴病得頗重，結果花了三十元，另一位比較輕微的，收費只是十二元。

我們曾見在路旁有由高班醫學生担任的晨早健康檢查；如替老年人量血壓、心跳等，相信是免費服務的。

醫學院大多是六年制，另加一年實習，在低年班有輔助科目如哲學、歷史等。

醫學生在暑假時受三個月軍訓，據說畢業後要當兩年軍醫才可以執業，雖然醫生外流的情形頗嚴重，但又不覺有醫生荒的情形。

（星加坡）：有很多診所是由數個醫生共同開設的，看病的人很多，不過診症頗詳細，公立醫院設備比香港差得多，在星只得一間醫學院，但因人口少，所以醫生比率高於香港。

（馬來西亞）：醫學院制度和香港差不多，第一年讀完Preclinical Course，第二年讀完Paraclnical Course，第三至五年讀完Ceini-cal Couise。

可能因爲華僑子弟多能勤奮向學，所以華人習醫的很多，最近的政策是儘量錄取多些本地人，但他們水準低，External Examiner不滿意他們的成績，所以馬來西亞現在的醫學生不爲英聯邦醫學會所認許？至於有志學醫的華僑子弟，現在很多都赴英攻讀。

（菲律賓）：有很多醫生出口，可能是因爲大學太普遍，所以形成醫生過剩。

（下轉第二版）