Caduceus

啟思

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啓思＝同學＋老師＋醫生

根據醫生會的憲章，啓思是一份醫生會的學生報。事實上，這名稱有點兒不貼切。啓思每月發行四千份中，除了同學閱讀外，並有送給老師，更有二千份寄給香港的醫生。所以，啓思肩負的工作並非簡單。

啓思應該是醫科同學、老師及醫生交流的園地。誰都不否認，上課時只是老師滔滔不絕地說，學生多正襟危坐側耳恭聽；上輔導課時，或在醫院病房裡，老師同樣滔滔不絕，但同學們多是支支吾吾地（？）回答問題。而啓思，正是一個可以讓兩方面都能暢所欲言的地方。其實，除了醫學上的問題外，每位醫科同學、每位老師和每位醫生，都可能有不同的人生觀，處世態度，對各類問題有不同的看法。與其每個月守株待兔般等待啓思出現，何不拿起筆，或中文、或英文、或中英文，總之寫出心中的說話，就是受歡迎的文章。我們尤其希望看到老師們，醫生們的見聞體會。不知是誰說的：A doctor's life is a dog's life，身爲醫科同學，實在希望能在啓思中得到啓思。

啓思應該在醫學院內密切聯繫着醫學會幹事會、屬會和同學。我們將反映醫科同學的動態，配合幹事會和屬會，鼓勵同學參與有意義的活動，例如社會服務，與其他院系合辦的活動等，希望大家通過活動多交朋友，多接觸問題和認識問題。

我們更希望將醫療界的重要消息以專題形式盡快報導，希望一同關注我們切身的問題，引起同學廣泛討論。

最後，我們希望更多同學能加入編委會工作，共同把啓思變成你的、我的、大家的。

承平洞新運人壽年豐福滿堂

捏筆迎春驗龍吟果喃氣如虹

What is General Practice?

SUCH has been the explosive increase in the volume of knowledge and skills in modern medicine that its practice has demanded an increasing number of specialists in even more narrowly defined fields of expertise. This specialization has resulted in great benefits for the patient and has ensured a continuing momentum in medical discovery and invention. But while the frontiers of medical knowledge continue to be rolled back at a dramatic pact the problems of how to understand the patient as a person and how to mobilize the new medical technology for his care become increasingly important. The patient who presents with unorganized illness, with a handful of symptoms and clinical signs which may portend a viral throat infection, a leukaemia or the somatic expression of an unhappy life situation, requires the help of a broad generalist in medical science.

The clinical task of the general practitioner was not invented by any draftsman of a comprehensive health care system.

Recently, because of the need to define the general practitioner's job in educational terms, the Royal College of General Practitioners published (1972) the following job definition:

'The general practitioner is a doctor who provides personal, primary and continuing medical care to individuals and families. He may attend his patients in their homes, in his consulting-room, or sometimes in hospital. He accepts the responsibility for making an initial decision on every problem his patient may present to him, consulting with specialists when he thinks it appropriate to do so.

'He will usually work in a group with other general practitioners, from premises that are built or modified for the purpose, with the help of paramedical colleagues, adequate secretarial staff and all the equipment which is necessary. Even if he is in single-handed practice he will work in a team and delegate when necessary.

'His diagnoses will be composed in physical, psychological and social terms. He will intervene therapeutically and educationally to promote his patients' health.'

The job definition of the general practitioner *(see above)* states that he accepts the responsibility for making an initial decision on every problem which his patient may present to him. It must be clear that, since the general practitioner is the doctor of first contact, his work takes in the whole spectrum of human pathology—physical, psychological and social.

General practice now claims to be an academic discipline. That is to say, it claims to be more than the description of a particular location in which medical care is given and more than a clinical exercise which is simply the sum of a large number of medical specialties, all of them practised at a less than expert level. Consequently it has become a subject which requires to be taught as a postgraduate (vocational training) subject; it has a unique contribution to make to the undergraduate training of all future doctors; and it poses particular problems in the continuing education of future general practitioners.

In the recent publication by the Royal College of General Practitioners (1972) from which the job definition was quoted earlier, a curriculum for vocational training was mapped out in some detail

Area I. Clinical medicine—health and diseases

a. Health and health education.

b. Diseases:

i. Acute diseases threatening life.

ii. Diseases which may be aborted and of which the complications may be reduced.

iii. Dangerous complications of diseases not otherwise thought dangerous.

iv. Diseases common in general practice which will not require referral or hospitalization.

v. Chronic diseases requiring continuous care.

These are examined in relation to:

α. The natural history.

β. Intervention—prevention;
early diagnosis;
management in general practice.

Area II. Clinical medicine—human development

Genetics.
Fetal development.
Physical, intellectual, emotional and social development from birth to death.

Area III. Clinical medicine—human behaviour

Behaviour presented to the general practitioner.
Behaviour in interpersonal relationships.
Behaviour in the family.
Behaviour between doctor and paitnet.

Area IV. Medicine and society

Culture and class in relation to illness.
Diseases of civilization.
The use of epidemiology.
The organization of medical care in the United Kingdom and comparisons with other countries.
The relationship of medical services to other institutions of society.
Historical perspectives of general practice.

Area V. The practice

Practice management.
Communications.
The management of change.
Practice policy.
The team.
Finance, buildings and equipment.
Medical records.
The family doctor and the law.
Research in general practice.

The introduction of teaching from general practice into the undergraduate curriculum has been relatively recent in the history of medical education.

The most important effect of establishing university departments of general practice is that on medical education. By incorporating the teaching of clinical medicine outside the hospital, in the patient's home and in the general practitioner's consulting room, the student is given not only a more realistic picture of the characteristics of health and illness in the community, but also of the knowledge, skills and attitudes which are part of clinical problem-solving outside the hospital.

The medical student should understand that the patients seen in teaching hospitals represent a highly selected group and that an overwhelming majority of those seeking medical attention are treated in general practice without reference to hospital. In addition to the serious conditions which are often first seen by the general practitioner, many common infections are nowadays seen only in the home and patients with emotional disturbances and minor psychoneurotic illnesses usually go no further than the general practitioner's surgery. Certain aspects of medicine such as domiciliary care of the elderly and the chronic sick, which are becoming increasingly important, are best taught in the context of general practice; students should also learn techniques of preventive inoculation. The student must be given an opportunity to see for himself the impact of illness and death on the family and to learn how the general practitioner meets the clinical, personal and social problems involved. He should see how the doctor patient relationship often differs in general practice from that in the hospital.

The undergraduate medical student should, in our view, learn about general practice, not as a preliminary to training for a career in that field, but as an educational experience whose purpose is to give every student some understanding of problems which are of major importance in themselves and should not be thought of as variants or minor subdivisions of the problems raised in hospital practice. The aim of the teaching should be to afford the student some insight into the nature of the problems and opportunities of general practice.

同學們對啓思的意見

「轉莊」了，為使未來的一年我們做得更好，「啓思」能更代表廣大學生，我們特別訪問了一些同學。希望我們能照著他們的意見去做。不過，他們還只是一部份同學而已，希望將來大家能主動地給我們意見，批評。

☆要主動地請別人投稿才行。
☆多做訪問，設爭論性的專題，以提高同學的興趣。

☆印刷尚算精美，仍待改善。
☆排稿常有錯誤，希望能改過。

☆講醫療界的事應佔三分一，因非醫療界範圍很廣。應有多些思想及哲學性文章。
☆每期專題可使一份報紙有重心，但不應佔篇幅太多，題材應以醫學界為主，但也應是多數人感興趣的。

☆多介紹醫學院各學系的「名人」和他們的事蹟，有很多現任或已退休的教授和講師都是社會上的知名人仕，醫學生對他們也應該有些認識。
☆希望啓思能多介紹香港的醫療制度和其他社會制度
☆希望能節錄其它刊物。內容宜與醫學有關係。

☆以往教導性文章太多。專題方面：是「性與健康」專題，對外界有代表性，所以應該著重類似的題目。

☆因大多數同學都有看「學苑」，所以學生會的活動應輕輕報導。

☆增加散文或新詩等文章。
☆增加文章，圖畫及照片，可使篇幅更充實和生動。

喜讀啓思後感

風馳

當我把啓思第七卷第十二期拿在手的時候，心中有說不出的愉快。這期的封面是非英聯邦醫生有關的報章剪影，底面是中學生採訪與選舉的圖片報導。再翻一翻，總共有十四版，與以往一向的四版、六版、八版，實在是一個大幅度的增加，不由得連聲讚好。

細看之下，感到內容非常豐富。此期以非英聯邦醫生之事為專題，不但提供了有關資料，並讓我們為數不少的老師和同學通過接受訪問，表達了他們的個人意見，在報上相互交流。其他文章如 Effect of smoking on health ——吸烟與健康的關係；Meaning of life ——人生意義與精神衞生，都是一些有實際社會意義的醫學問題，很值得我們關心。近年來，社會醫學 (Community Medicine/Social Medicine) 愈來愈受到醫療界的重視。同學們常提及的「發揚醫務精神」、「關心香港醫療」、「關心世界醫療」都是反映了上述的事實。作為一份學生報，能夠如此敏銳地覺察到醫療界所面臨新的變化，並予以介紹，加强同學的注視，引起討論，實不失為發揮了醫學報的優良傳統。

此外，啓思錄，集外集等散文欄都是反映醫科同學的生活與心聲，雖然這期已經是七五年度最後一期，編委仍保持這種不斷創新的精神，的確令人欽佩。不難看出編委是朝着一個把院報辦成具有生活氣息的園地。縱使在這第一次新的嘗試裏面還未能盡善盡美，但是更具生動活潑的版面是我作為讀者所希望看到的。還有令我為之驚喜的是此期編委之龐大。數一數，竟有十九位之多，與前比較又是一個可喜的進展。

其實，要在這繁重的功課壓力底下，抽身出來，用祇有一個月的時間來籌備像這期豐富的院報，實在不簡單。這個事實祇能是反映了辦報同學的熱誠愈來愈高，而同學對啓思的投入，關懷也愈來愈多。明顯地，編委的熱誠與讀者的支持是互為影响的，就像一個 Feedback System。但往往後者對前者的作用較弱，不是說讀者不歡迎或不擁護該報，祇是未有把這個表達出來，以成一種動力。記得近來有一股不大健康的風氣，就是對出來為同學服務「彈」得多，「讚得少，甚至在彈裏面夾雜着個人攻擊。這些都不是」表達意見的好方法，也不會使其服務有所改進。所以建設一個完整的 Feedback System 是需要的，這就得花點唇舌，用點筆墨，把歡迎的東西讚揚讚揚，把不符合同學利益的東西批評批評。此文雖以讚揚為多，但這是與實相符的，全無過份，亦同時表達了一些自己對院報的想法吧了。七六年經已來到，盼望來屆編委，能夠承先啓後，繼續把我們的醫學報辦得更好，而我們讀者亦能經常地表達我們的要求，完善這個 Feedcack System！

吳敏倫醫生訪問記

每一期的「啓思」我都略略看過一遍，我也相當關心內生活、感想之文章，和一些關於社會問題的；對於學術性的則不感趣，因為平時和學生聊天時，通常都會提及學術問題，很少關於他們的生活。

報導醫療界與非醫療界的比例大約該一比一。非醫療界方面大可着重文藝、及其他科學的認識，如天文、化學等。社會問題和醫療界有很大的關連，可以大為報導一下；但太遠的則不需要，如中東問題等；但中國問題和香港現狀大有關係，故值得一提。報導醫學會應盡客觀，可以輔助「醫學會通訊」，因為「啓思」可以報導得詳盡些。至於學生會裏的活動，很重要的才需報導，因為「學苑」已為我們報導了。英文版可以介紹一些課外書籍、書評和「一些節錄，因為通常同學們都甚少讀課外書。

以前的啓思在刺激同學關心社會方面做得不錯，對醫學以外的卻不夠，如哲學、個人修養、文藝、音樂等，因為醫生也是人，是必須要有一個健全的人格，和各方面的知識，而這一切都不能從學校內學得到。

一般來說，醫學生很少拉稿，「啓思週」雖然不錯，但總未能提高同學們對「啓思」的關心。「啓思」應主動地刺激起同學踴躍投稿。「啓思」的目的是應去溝通同學有百家爭鳴的現象總比祇有單方面思想灌輸好。故希望能盡量投稿，這或許會引起同學們的投稿呢！

「啓思」大可以請一些其他院系的同學、講師、和各宿舍的舍監等寫一些關於對醫學生的認識，感想和期望。

SOCIAL IMPLICATION OF VENEREAL DISEASE AND MEASURES OF CONTROL IN HONG KONG

INTRODUCTION

There is no doubt that venereal and other sexually transmitted diseases are occurring with increasing frequency. Its insidious spread has allowed it to reach alarming proportions. This is particularly so in the more prosperous countries of the world. It is more prevalent in cities than in country districts. Such differential incidence coincides with differences in promiscuity.

Accurate information either of the new infections or of late manifestations of syphilis, gonorrhoea, or other V.Ds. is unobtainable in any country because some people may seek treatment from private practitioners. Anything therefore that can be said on this subject must be treated with reservation.

SEX BEHAVIOUR HAS A CLOSE LINK WITH V.DS.

In relation to a number of behaviour patterns, there are those who refrain from promiscuity for various causes; those who will always seize opportunity to excess; and the vast majority who follow the fashion of the group with which they are in contact. i/e. those who may or may not be promiscuous according to circumstances.

In regard to the promiscuous group we believe that many of them develop this behaviour and other antisocial traits through defective upbringing.

The modern society is more tolerant of sexual promiscuity than before and the youths are less secretive about premarital sexual activities. Such attitude may result in illigitimate births or artificial abortions.

With the knowledge of birth control a number of young people may look upon sex intercourse as a purely personal matter without social implications.

Promiscuity in men can be a matter of irresponsibility and ignorance, which is illustrated by the fact that many men with V.D. admit to further contacts with their wives as well as with other women during the infectious stages. There are others who believe that sexual intercourse is necessary for their health or who have got grown beyond the adolescent approach to sex as a form of "Play".

Some married men turn to the prostitutes because of the indifference or aversion of their wives to the intimate relation of marriage.

As regards the promiscuous women, they act as a reservoir of infection. They may or may not be prostitutes, because many of them will be engaged, or partially occupied in legitimate work. Other come most commonly from broken homes.

SOCIAL IMPLICATION OF VENEREAL DISEASES

The spread of V.D. unlike almost any other diseases is peculiarly personal, passing form man to woman and woman to man in a long and unending chain of contacts, each case being the result of a deliberate intention for enjoyment.

V.D. is a symptom of a wider social malady. It has its consequences in illness, crippling and death, but these are probably of less grave significance to the community health than the background of anti-social behaviour out of which it springs. Promiscuity is the social disease; V.Ds. are the medical consequences. Science may find an answer to the medical disabilities, but not to the social disorder. Such disorder may be roughly illustrated as follows:—

Some women feel resentful on being advised to have routine blood test which is helpful in the early detection of syphilis.

Emotionally rooted prejudice makes it more difficult to secure the attendance of women and men for treatment at clinics.

Occasionally a married woman or the children who contracted the disease is not allowed by the man to accept treatment due to social conditions or ignorance.

Furthermore, though treatment is free, yet the patients may not like to attend the clinics for fear of dismissal from their employment or loss of daily wages.

Besides this, some patients are required to be under observation over a long period.

It must be remembered that the symptoms of the diseases are much less obvious in women, and that those of gonorrhoea are to the lay person indistinguishable from a similar discharge arising from many other causes. The patient cannot diagnose herself and would not willingly first seek advice at a V.D. Clinic.

"Casual" infecting contacts are often very difficult to trace and may not be easily persuaded to attend for investigation. The problems of secrecy and disclosure are complicated

The serious manifestations of late syphilis that appear many years after the original infection, frequently strike during the fourth or fifth decades of life — at the time at which the individual's working capacity is at greatest, and economic liabilities to his wife and growing family are most heavy. Thus the tragedy of late syphilis does not invariably remain a personal one.

The earlier the treatment is commenced, the better the outlook: the syphilitic degenerative process can be arrested, but full restoration to physical fitness and earning capacity depend on the degree of tissue destruction before the recognition of the disease. Destroyed tissue cannot be replaced and only too often, despite treatment, there remains some deterioration of the mental or physical capacity.

The tragedy of congenital syphilis is the greater because such a case would have been entirely preventable: the detection of maternal syphilis early in pregnancy and the application of treatment probably will result in the birth of a healthy infant.

Perhaps one of the most tragic sequels of unrecognized or untreated gonorrhoea in the female is infection of the infant's eyes during the process of birth, ophthalmia nenonatorum. This in the past was a frequent cause of blindness.

Syphilis and gonorrhoea — particularly syphilis — has a social stigma that is common to all disease — the individual becomes a burden to the community.

Since these diseases are transmitted almost entirely by promiscuous sexual contact — an activity condemned by our society and concealed by the participants — the application of methods commonly effective in the control of other communicable diseases is beset with unusual difficulties.

Also many of the characteristics which help to produce promiscuity as mentioned before, make the patient with V.Ds. more difficult subject to guide, and at the same time render the need for guidance many times more pressing.

MEASURES OF CONTROL IN HONG KONG

The control of V.D. lies under 3 categories:—

(a) Health Education about the disease (including publications)
(b) Early scientific diagnosis and adequate treatment and after care.
(c) The tracing and treating of sex partners of the infected.

In Hong Kong the Social Hygiene Clinics provide services for the examination, treatment and prevention of V.Ds.

Patients, contact or suspicious cases are treated and dealt with coordingly.

Because the social stigma adhering to V.D. may easily obscure the simple medical facts, some sufferers still turn to the quack and the charlaton. Therefore the suppression of such quack and charlaton is an important factor in securing effective treatment.

Serological tests for syphilis is done for the pre-natal women, premarital people, other occupational and economic groups, emigrants, blood donors etc to detect unknown infections.

The staff of the Anti-V.D. Section, a sub-department of the Social Hygiene Service, take an active part in V.D. control work.

Health Visiting may be paid to people of all walks of life, with varying background and educational standard. Very occasionally a health staff might be threatened during her performance of home visit duties.

And some of the most dramatic stories of disease detective work are found in the field of V.D. control.

Therefore Public health personnel performing these services should be well trained in interviewing and investigating techniques, and be able to handle skilfully a great variety of personal and social problems related to sex and venereal disease.

The essential qualification, however, is good personality, sound maturity, great tact and humility, all round up-to-date knowledge and a keen sense of vocation.

It is improtant for a health staff to show courtesy when she makes her visits to various places, because nothing can be gained through aggression. She should not disclose the fact that she is a staff from the V.D. department.

In public health work, it is a good practice to put oneself in the other person's place, to try to understand her point of view, difficulties and fears. One step wrongly taken by the staff may cause a complete family disruption or mental suffering of the person she approaches.

Tact is required in obtaining the required information.

Sometimes it may only be possible for the health staff to spend a few minutes with the case, when longer conversation in the home about the patient's condition is inconvenient, for fear of being over heard. If such a patient turns up at the clinic, further advice and treatment will then be given, or sometimes the patient may be asked to go out for a walk to talk things over. In some other instance, conversation may be carried out freely in the home, then considerable time may be required just for one case.

For unsuccessful home visits due to incorrect addresses, notes are usually attached to the case chart stating such. The co-operation of the clinical or clerical staff is then required to check the addresses should the patients happen to turn up in the clinic again.

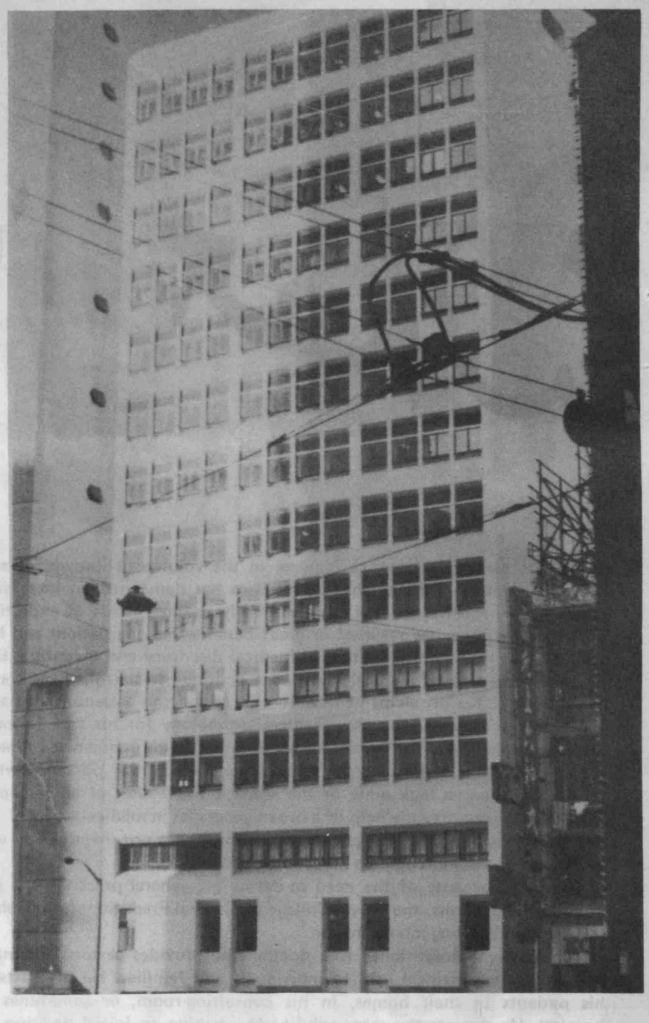
In certain instance, if the patient is willing, she may be accompanied to the clinic by the staff.

Occasionally, people other than the patient may have to be approached and educated, if they try to hinder treatment for the patient, Leaving a message to a patient also calls for the skill of a staff, because even selecting the right person in the house for such purpose counts.

Evening or night visits are carried out to get hold of the cases, who will not be seen during day time.

啓思

醫學院



籌備過程

早於一九七三年十月間，香港醫學會已深覺香港實有設立一全科醫學院之急切需要。該會認為執業「全科」與其他普遍認可之「專科」如兒科及外科應具有同等的地位及水準，但是一直以來，執業「全科」獲得深造進修之機會仍見缺乏，故為彌補此方面之不足，全科醫學院之設立遂成目前急不容緩之要務。

當時醫學會主席李仲賢醫生有鑑於此，故立即成立一研究小組，委任黃超龍醫生為主席，負責調查及研究在港籌設全科醫學院的計劃是否可行；並透過醫學會向多個設有此類醫學院的國家搜集大量有關資料，其中尤以澳洲皇家全科醫學院（The Royal Australian College of General Practitioners）英國皇家全科醫學院 The Royal College of G. P. U. K. 及全科醫院世界組織 The World Organization of National Colleges, Academies And Academic Association of General Practitioners/Family Physicians 幫助最大。

於七五年七月間，該研究小組主席黃超龍醫生代表醫學會赴澳洲作為期一週之正式訪問，參加在墨爾砵舉行之澳洲皇家全科醫院理事會會議，並赴雪梨，訪問該學院總部。澳洲皇家全科醫學院是一個學術機構，主要業務乃利用教育及研究方式，提高基本健康水平，工作重點在於訓練青年醫科畢業生，準備日後從事全科醫務工作。澳洲皇家全科醫學院除積極提供種種機會，與在業醫生進修之外，並與各大學醫院會合作，訓練醫科學生。在此次訪問中，黃超龍醫生搜得大量參考資料，返港後，即向香港醫學會理事會建議，認為在港建立此學院不但可行，而且有此需要。此建議立即被該會理事會欣然接納，並於短期內成立了工作小組，負責研究此事，並開始進行有關籌備工作。同年八月間，香港醫學會又派遣兩位港會會員赴澳洲雪梨參加澳洲皇家全科醫學會理事會會議及第二屆星加坡、馬來西亞，及紐西蘭各國全科醫學院聯席會議。他們且曾與該院各理事及負責人會晤商榷、有關在港創辦全科學院之事宜。

澳洲皇家全科醫學院鼎力支持香港醫學院此舉，並於七五年十二月間，派出由該院院長甘吾醫生，秘書長花勵醫生及進修程序策劃幹事任夏信所組成之代表團，來港協助此學院之成立，並提供了寶貴的意見。代表團在港逗留了個多星期，先後赴往港九新界各地參觀考察本港各項醫務工作，包括各公私立醫院，診所及私人執業全科醫務所，並與香港醫學會及香港全科醫學院籌備委員會負責人作多次正式交換意見並詳盡討論有關在本港設院事宜。

同一時期中，香港醫學會新會址開幕，澳代表應邀參加，甘吾醫生並以「全科本身究竟是否專科」為題，作專題演講，詳述全科在整個衞生工作，涉及範圍及其重要性。

世界各國全科醫學機構聯合會長黎斯醫生特請甘吾醫生藉此次訪港之便，向行將成立之香港全科醫學院致意並希望香港將加入該聯合會，與世界各地其他二十個國家的全科醫學會共同致力於提高全科醫務之工作。在此期間香港全科醫學院籌備委員會（Interim Council H.K. Colloge of General Practitioners）正式成立，

成員包括：

主席：李福權醫生

秘書：雅坤娜修女醫生(Dr Sister M Aquinas)

財務：陳樂彬醫生

委員：麥慶國醫生

招顯洸醫生

Professor M. J. Colbourne

Dr. John Wedderburn

潘廣照醫生

李仲賢醫生

李稚麟醫生

李長智醫生

梁幹芬醫生

杜澄愷醫生

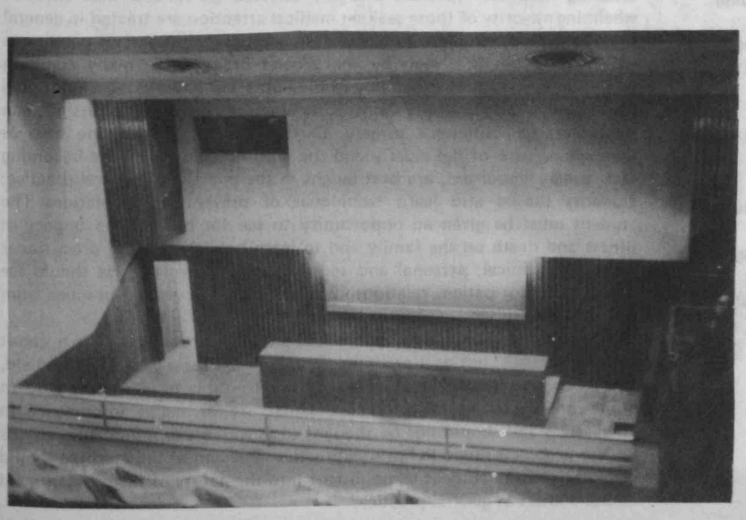
譚世傑醫生

劉亦思教授（Professor Cecil Lewis）

目的

香港全科醫學院並非港大醫學院延展的一部份，實質上將是執業醫生在醫學上再求深造的一個研究院。醫學技術的發展是日新月異的，對那些畢業了很久的醫生而言，熟習這些新技術，繼續進修是必要的。

同時很多時候，醫生行醫時所遇到的病例與他所學的會相差很遠，為了要熟習這些病症，實在有再行進修的必要。另一方面，醫生可能會遇到一些非醫學性的問題，如病人的家庭環境、病人精神心理上的不平穩等。這些對病人有重大影响的問題，都是不能用普通醫學常識和醫療設備所能解決的。但是，如果要徹底地治療好病人，這些都是必需解決的問題。所以基本上，全科醫學院設立的最終目的在於依隨目前世界趨世，將普通全科提高至其他專科醫生再行深造的水準。換言之就是使普通全科本身成為一門專科



香港全科

即將成立的香港全科醫學院是香港醫療事業發展的里程碑，啟思有鑑於此，將盡量在下一期訪問一些全科醫生及有關人仕，希望能對此學院作進一步的認識了解。

會員資格

凡本港的註冊醫生均可申請參加，會員特包括：

學生會員（Student Member）
可能有，暫時未定。

附屬會員（Affiliate Member）
剛畢業註冊之醫生。

贊助會員（Associate Member）
執業三年之註冊醫生。

正式會員（Full Member）
執業五年或以上之註冊醫生。

院士（Fellow）
於日後通過全科醫學院考試，或對學院有功績，或在其他地方之全科院獲得院士之醫生。

榮譽會員（Honorary Member）
Correspondence Member 凡從事專科而欲轉為執業全科之醫生。

暫定之入會費用為港幣五百元，而每年之會費則為港幣二百元。

全科學院成立之初，課程將主要以函授方式進行，暫時將沒有任何類形之考試。但希望會員能保持一個令院方滿意之水準，課程將會非常廣泛，包括普通全科的方面，參加者可以根據自己的愛好選擇進修。上課亦會採用研討會方式，參加者可將資料帶返家中空閉時研究。討論會約每週舉行一次，邀請本港醫科專家及香港大學講師主講。日後將採用視聽（Audio Visual Aids）及小組討論，使在不同區域執業及接觸不同階層病人的醫生交換意見。

經濟來源

香港政府暫時將不會對全科醫學院有任何經濟上之資助，所以經濟來源主要依靠會費及課程所收之費用。不過香港醫學會已允諾承担最初行政方面所需之費用。

院　址

全科醫學院暫時未有一實在之院址，上課將借用香港醫學會在灣仔新會址的課室。

由於香港全科醫學院尚在籌備之階段，有些細則尚未能確定。醫學院將會在本年三、四月間正式成立，屆時本港執業全科的醫生將可利用餘暇進修，更無須遠到外國修讀課程，對提高本港醫生的質素；有極大的裨益。

——更正——道歉——

啓思七卷十二期校對錯漏改正如下：

一、「聽蔡元雪醫生後有感」，「雪」字應爲「雲」字。
二、"Meaning of Life" 作者爲Dr. Bernard Lau Wai Kai
三、"IFSMA" 應爲IFMSA
四、"Commit y Health"一文第一段第八行Coulbnerne應爲Colbourne

Cont. from P. 3

CONTINUING EDUCATION

It was one of the disabling characteristics of general practice in the past that, whatever the quality of the man going into general practice, he was doomed to a professional lifetime of relative isolation. The increasing separation of general practice from hospital practice served only to reinforce this isolation. Whereas the hospital consultant carries out his clinical scrutiny of his peers and his juniors, the work of the general practitioner was scrutinized only at second hand by his consultant colleagues, who did not always understand the nature of his problems or the content of his work, and by his patients, who are for the most part flatteringly uncritical (Cartwright, 1967) or else unable to make their criticism effective.

To improve the situation general practitioners exists a body of peers (his partners in the group practice and all his paramedical colleagues) who observe his work and to whom he is in a sense answerable. Even more critical than a doctor's peers are his juniors; the introduction of increasingly large numbers of medical students to these group practices and the advent of universal vocational training will ensure that the pressure from this informed criticism will continue to exert a beneficial influence on the quality of primary care.

For the future the major problem is to diagnose what are the general practitioner's needs from continuing education and how those needs may best be met.

It is no accident that departments of general practice in the universities have tended to develop in association with departments of social or community medicine. The two subjects have a natural academic affinity.

If the community physician of the future is to make a full contribution to the planning and delivery of health care by the future general practitioner, each group will need a sensible grasp of the professional expertise, range of work and problems of the other.

Reference:
Marshall Marinker, General Practice, A Handbook of Community Medicine

The value of a visit is that the home conditions of the patient can be assessed, so that information given to the doctor will be of great value in creating a sympathetic understanding of the patient's difficulties. Moreover a personal visit makes the patient feel that a real interest is being taken in her case. Sometimes with the patient's consent, parents or husband can be approached and the whole home atmsophere can be clarified.

Contact Tracing

The patient who reports at a V.D. clinic is only one link in a chain. Any one of these contacts not found and examined may develop the disease, pass it on to another people.

Usually a patient, in the clinic, is asked the name, address and description of all his sex partners during the last few weeks or months according to his illness. His co-operation and help is then sought to ensure their attendance. All means of persuasion are used, either in series or as a single exercise. The health staff may ring the contact, write to her or visit her. The same procedure will apply if there are multiple contacts. Once their attendance is secured the process begins again.

It should be understood that no one can be forced to be examined or treated, unless he or she is willing to co-operate. This is the place where Health Education can play its part.

Successful contact tracing, however, requires an organization of workers; public health, aministrative, clerical and social. Many of the details recorded about contacts are slight, though the work entailed and the number of visits necessary for each may be heavy.

Receiving New and Old Cases

The majority of patients, reporting to a V.D. clinic, are frightened and on the defensive. They may be aggressive and cheeky or regressive and reticent.

A kind and sympathetic reception is essential and each case should be attended to as quickly as possible, so that gossiping groups do not gather together in the waiting room to increase the fear of the nervous and the regular attender may waste as little time as possible.

Every effort must be made to render examination and treatment as easy and free from all stigma as possible. They must have respect for, and confidence in, the staff they come in contact, otherwise there will be a high defaulter rate. They should be given an idea of the nature and length of their treatment, and the period of the observation required. Problems like ignorance, fear of the treatment, fear of being recognized or difficulty of attendance owing to work or home ties should be discussed and solved as far as possible.

Efficiency is important in this department, because of the infectious nature of the diseases and these patients are often not too ill to spread the disease. A well-trained and tactful staff with a good memory is invaluable in the office. A friendly unhurried and cheerful atmosphere should be maintained and the staff should take an intelligent interest in the patients and their families.

Each new patient should be interviewed and her confidence gained by speaking to her from the health, not the moral, standpoint. She should be made to feel a person and not merely a case. Much has been achieved by constructive and sympathetic listening. Direct questions can frighten the patient but it is first necessary to get informations such as name, address, age, occupation etc. The patient is made to feel as much at ease as possible and further details of home, important facts of the sexual history, financial position, as it may affect regularity of attendance etc, may be obtained tactfully through a full and frank talk.

In certain instances the information given by patient may be wilfully inaccurate, then a general assessment of the patient as to background, rehability, etc is valuable.

Sometimes several interviews may be required to establish a good staff-patient relationship, which is very important for successful health teaching. If a patient or contact is emotionally upset, it would be best for the staff to say what is considered most necessary in regards to health and care at that moment. Further advice can be given during subsequent visits when he or she may be more calm and lucid.

Furthermore all possible chances should be taken to educate or to influence those attending our clinics, hoping that they in turn will influence others to come.

Although some cases attending our clinics are at first dirty, unsociable and resentful, when kindly treated they are found to be good-natured and friendly. Even the mentally or morally defective case who is constantly getting re-infected, will return spontaneously for treatment if made to feel welcome and given help and encouragement.

Social Therapy and Rehabilitation for V.D. Patients

Obviously few patients with V.D. require medical treatment alone. Behind the infection lies a complex of factors which have singly or together led the patient into his or her present impasse. It is important that these factors should be studied with the long-term object of helping the patient to regain their position as responsible citizens; and with the short-term aim of ensuring that the patient continues treatment until cured, that the risk of infecting others is clealry understood, and that information of the source of infection is secured. As a fair number of patients have become infected through infidelity of the spouse it is necessary to discuss with the patients about the problems caused by venereal infection in married life.

Rehabilitation for most cases is difficult, because they may be either the habitual promiscuous type or they are getting easy money. As for the female, some of them return to earn the easy money after a certain number of years of normal life. Others although already employed in a decent job, continue to get money occasionally with the old method. Only a few got married and become excellent wives and mothers.

Rehabilitation calls for a strong will on the patinet's part and constant encouragement from others. Staff of the Social Hygiene Services should take all possible chances in helping these people to have a fresh outlook on life with new ideals and self-respect.

Prevention

The medical profession, however, has not the entire responsibility. All the social services and welfare services, parents and teachers are involved, particulalry with regard to education, housing, employment and the care of the mentally and morally defective individual.

Health Education must be directed not only at the narrow target of factual knowledge, but also at the prevention of both emotional dwarfism and social and moral breakdown. And the community should be aroused for greater awareness towards the problems of V.Ds. From what has been said it will be clear that education should be aimed more at the young; at potential parents, parents with growing families and especially those preparing to meet the problems of adolescence in their offspring.

Methods employed should be adapted to meet the current needs of our changing society.

Group discussion about V.Ds. with people of the same age, sex and background is useful.

The school, the home and the community all share the responsibilities in bringing up the next generation with good health, a sound and liberal education, and proper use of leisure in the development of hobbies and outside interests. The avoidance of promiscuous intercourse and the maintenance of the sanctity of marriage must be stressed. All these will help towards the prevention of V.D.

Record Keeping

Records must be kept strictly confidential in this service. They should be accurate, concise and serving the purpose required of them. Apart from the routine recording of our daily work, any change in name, working place or accommodation reported by the cases or discovered by the staff is kept up-to-date as far as possible. Special points of the cases e.g. operation scar or mole on face are also noted down. All these facilities our future work.

CONCLUSION

To conclude, it seems that the problem of V.Ds. is with us for the foreseeable future.

Thus it is necessary to maintain an active, well-financed V.D. control programme even when these diseases appear to be satisfactorily controlled. Perhaps we may then hope to eradicate syphilis – the most serious one of the V.Ds. – from the community.

ELIZABETH CHEUNG (LAM)
TANG SHIU KIN HOSPITAL

寫在這新的年頭

霍嘉斌

回顧幾年來健康委員會的活動，在內容和實質方面可以說是有了個大的發展，而形式方面也多姿多彩化了。四年前的健委會只搞了四項活動，一是捐血，二是為ARMSA請藥廠捐藥，三是到喜嶺州麻瘋院參觀，四是到石鼓州戒毒所參觀，還有一個席位在HKAPI（Hong Kong Association of Pharmaceutical Industry）的Drug Abuse Subcommittee。總的來說，當年就只有兩個參觀訪問是有較多同學參與的。全年支出的費用也只不過是$15.05。

72—73年所舉辦的活動多了，只說展覽已有兩個；一個是「中醫周」，第二個是「防癌展覽」。其他還有電影，討論會和工作營等。到了73—74年，活動更大型了，就「健與疾」展覽來說，是醫學會首次在大會堂搞的大型展覽，有百多位同學參與，除此之外，健委會又組織同學幫手香港家庭計劃指導會。到了去年參與活動的同學是大大增加了，就「性與健康」而言，已有近四百同學曾經或多或少地幫過手。另一方面，活動的性質已發展為進一步深入地認識社會。就以去年六月的長洲社訪，親身接觸當地居民，了解當地醫療情況；而一個醞釀了多年的香港醫療問題學習小組亦於去年十一月成立了。從以上的事例可以看到，活動是不斷的增加和擴大，象徵著愈來愈多同學希望走出「拉記」，要求參與活動，有的更希望從而認識到我們身處的這一個社會。

為什麼會愈來愈多同學參與活動呢？參與這些活動是否有價值的呢？在這個問題上有很多不同的答案。

有一些比較高班的同學認為，我們醫學生是應該對病人有感情的。記得有一位同學，他做Introductory Clerk，在醫院裏初次遇到很多病症，其中不少是嚴重的，如癌症等；但在醫院裏，似乎見得多，習慣了，把癌症病人只當作一種病症來學；但後來，當他發覺自己的母親身上有了一硬塊類似惡性腫瘤時，雖然他也是用平時學得的方法去替母親檢驗，但心裏就有一種從未試過的，深切的感情。事後他自我反省一下，眞正的體會到作為一個醫生，對病人就要有著一股如對待自己或自己親人一樣的那麼深切的感情，才能做到全心全意地盡力的替病人服務。而這種感情就只有通過多次接觸和認識我們這個社會，特別是那作為大多數的中下階層，了解他們的語言，了解他們日常生活中的各種問題，在學生時期內逐漸培養出來的。

另外有一些同學認為，現在的教育制度壓制了我們認識社會的機會，我們就要儘量爭取機會去接觸和認識，不要脫離了社會。

又有一些同學認為參與這些活動，是符合神的旨意的。

更有不少同學認為，參與活動，既可學到一些東西，又可對醫學會，對社會有所貢獻，抽些時間出來，是十分值得的。

總的來說，參與這些活動的價值是肯定的，問題只是在時間方面而已，記得有人說過，時間就好像濕了水的海綿一樣，你抓得緊一點，水就會被擠出來的了。我們同學中不是也有的是參與很多活動的嗎？這並不是因為他們聰明些，只是他們能夠把時間抓得緊一點，把一些平時在不知不覺中溜走的時間利用起來而已。

現在是七六年初，很多同學都要準備M.B.試，活動自然是少些了。三月開始，在1st. M.B.之後，各類活動便會逐步發展。今年健康委員會除了一般性的活動外，更準備搞流動性展覽會。至於大型展覽會的可行性與題目，還在討論中。有的同學認為大型展覽會同學喜歡，宣傳容易，效果明顯，又可促進溝通團結，也有些同學認為大型的流動性展覽會在推廣健康常識較有實效，同學又可以親身接觸市民，意義比較深遠。其他的活動有香港醫療問題學習，社會性探訪調查，講座等。希望同學能多提意見，多參與，一同把活動搞得更完美，更充實，替醫學會帶來一股活力。

八十聖誕花絮

醫學會和我班都在聖誕假分別舉辦Social Gathering，皆以跳舞為主，是否正如醫學會宣傳所謂：Soc. Gat.就等於男仔和女仔一起跳舞呢？

一位從美國回來的同學說，美國大學的Soc. Gat.是很長的，下午是「齊齊玩」，跟著大食會，到了晚上才是舞會，歡喜留下的就可以留下，尊隨君便。未知諸君覺得如何？

舞會尚未開始時，最初只有十幾位Single的男同學和自己班的女同學；當第一對couple進場時，十多對眼睛盯著那位小姐，弄得他們怪難為情，急忙「繞瑟」在場地一角。

初時，小姐們比男士人數還多，以至有些被冷落一旁。後來有部份小姐們離開，結果男多過女，最後更出現「你爭我搶」的鏡頭呢！

晚上有營火會，有些同學伴著營火唱歌，竟唱到翌晨五時許。第二天，他們皆謂面皮和手背都被烘乾了。「精神可嘉！」

一星期後，我們又在屏山女童軍營「宿營」。一次飯後，我們的「班代」拿了幾個橙出來和大家分享，結果蘋果、梨紛紛出現，可見一個好榜樣的作用多大！

參加本班Soc. Gat.共有六十多位同學，但只有五位女同學（包括四名班委），不知是否女同學們不感興趣，抑或男同學們唔識做？

有一餐是女同學們親自下廚，飯饌美味非常，個個讚不絕口。看來，未來的女醫生也是好廚師和「賢妻良母」！

在玩紙牌的「捉蟲」遊戲時，一位女同學輸得過度，用手大力往枱面一拍，結果——她手上的一隻瑪瑙介指立刻一分為二，不知破環能否重圓？

一個晴朗的中午，本班的「英雄」們紛紛獻技——在元朗的田畦路踏單車——結果不少英雄掉進路旁的田裏，弄至滿腳泥漿。剛巧附近有間公厠，個個往內洗腳。事後有感齊說：「想此公厠必是市政局為踏單車者而設也。」

想學泰山乎？

困獸鬥！

捉虫？

Health Education— via mass media or the school system

Li Ka Kou

During my second MB Community Medicine viva, I was asked "What do you think is the most effective means of promoting health education in Hong Kong?" I answered then, without hesitation, "Mass media, especially television." After the viva, when I have time to think more about this topic, I have some doubts about my answer.

I have no intention to underestimate the importance of mass media. In fact, when TV is so common in Hong Kong, probably half of the population may easily be reached via TV alone. It may also influence the opinion of society elites, especially decision makers, at all levels. However, health education via mass media has its drawbacks.

Education is a dual process. A successful education is one that induces a CHANGE in attitude. To bring about this change, six stages are essential in an education process: 1) awareness 2) interest 3) acceptance 4) finalisation 5) adoption 6) reinforcement.

Health education through mass media may be divided into "flash media" and "penetrating media". It is apparent that the short "flash media" health education would not be able to achieve the stages mentioned. Whereas a long "penetrating" media would automatically drive away many uninterested viewers. TV viewers usually include the older section of the population, such as housewives, elderlies, who are less able to adapt to new ideas and usually lack the initiative to learn.

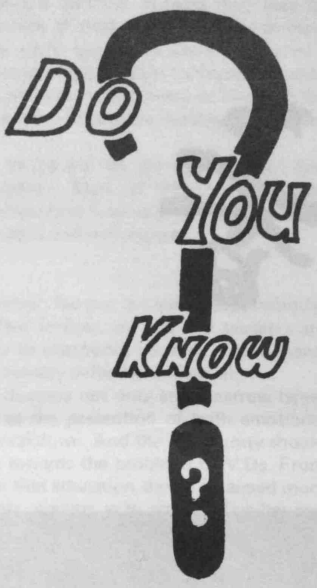
Health education through TV also means a financial burden. How can one compete with the cigarette companies who dump billions of dollars a year in advertisement to promote their sales?

Health education in schools is more deep rooted. If we look at the population distribution in Hong Kong, we would see that in 1973, 2.28 million people, a majority of the population are under the age of 25; and one million of them (a quarter of the population) are between 10-19, the appropriate age group for education. Last year there were 1.3 million students in the community. Thus health education in schools would reach a sizeable number. But more importantly we are now dealing with young people. Young people have the capacity to correct their attitudes and accept new ideas. They are also more socially conscious and have the initiative to build for themselves a healthier environment. They are easy to organise as an established structure of a school system already exists. There is also much less financial involvement compared to mass media.

But most important of all, school health education provides face to face communication. Unlike mass media, face to face communication can get instant feedback. A feedback is essential for correcting mistakes, clarifying confusion, modifying a strategy or reinforcing the motivation. It is a crucial factor that makes me believe that school health education is more penetrating, if not more effective, than health education via mass media.

If I were asked the same question again in the viva, I would feel inclined to choose a well organised school health education programme.

How then could a Comprehensive Health Education program be organised under the present Education System, bound by its various limitations? I think school Health Clubs, initiated and consolidated by the students' own effort are a feasible solution. I shall attempt to discuss this topic in another article.



A HEART WEEK
is going to be organised jointly by
HONG KONG HEART FUNDATION
and
the MEDICAL SOCIETY, H.K.U.S.U.
and the MEDICAL SOCIETY, H.K.U.S.U.

DATE: 22nd to 27th January, 1976.
PLACE: City Hall Exhibition Hall (Low Block)

TOPICS touched upon:

- Basic Anatomy and Physiology of human heart
- Rheumatic heart disease
- Congenital heart disease
- Ischemic heart disease
- Hypertension
- Effect of smoking, alcohol and exercise
- Cardiac investigation

Expert doctor advisors in various fields
from the HONG KONG HEART FOUNDATION:

Dr. W. Y. Wu
Dr. J. Pang
Dr. K. H. Wai
Dr. Bao
Dr. Kwong
Dr. Tse

Artists from HANG SANG BANK also aid in board presentation.

Coordinators:–

1st year NG WAI FU, NICHOL
LO TING NGAH, TINA
4th year WONG KIN MING
HUANG YUE HOI

The Editorial Board wishes to thank the special support of Glaxo Hong Kong Ltd.

新年雜感

風

又是新的一年——小時候，總覺得時間好像蝸牛，甚麼「光陰似箭」、「日月如飛」，都不過是文人筆下誇大之辭。隨着年歲的增長，才體會到個中的感受。

今午在渡海輪上望出去，海水在陽光下閃爍。在如此明朗耀眼的白日下，突然覺得那些日子很遙遠、很虛無。這一年來，彷彿生活在兩個世界。外面看來，一切是那麼正常，每天上課說書、參加課外活動，假期的節目密麻麻。但在那樂天的笑容背後，是一個怎樣惶惑和不安穩的心情。就在這兩個迥然不同的現實生活和內心世界裏，日子一天又一天的渡過。有時覺得快要崩潰，但眞奇怪，我仍是那麼循規蹈矩地做人，比很多人還要清醒、積極！說得清高點，這個世界每個人都有他的負担，我無權勒索他人的同情。說得平凡點，收藏起自己的內心世界，是保護自己的最好方法——遇遭有太多好奇而並不十分友善的目光了！更眞實點，是恆格使然，總覺得與人分享自己的憂慮遠比分享自己的快樂困難，或許因為前者比後者來得「私人」吧！

×　×　×

生命是無數大大小小的事情纍積而成，隨着時間和空間的變遷，新的人事把舊的掩蓋。但我深信，在我生命中每一件事，祇要我曾付出努力或投下感情，又或許我祇是接受而沒有付出，縱使日後回顧，覺得祇是人生旅程的一段小插曲，甚至不復記憶，它都已經在自覺及不自覺中改變了我。蛻變不一定是壞事，相反來說，很多時候是好的——人不能永遠滯留在一個階段，但是對於「變」始終有一點莫名的恐懼。為此，我總是抓緊一些於我而言是恆常不變的基本信念，或許在這日新月異的時代，是太落伍，但我寧可幼稚點！現在看看去年的自己，明年再看看今年的自己，有多少不同？

×　×　×

做孩子的時候，總喜歡立下甚麼新年大計、新年願望，使自己對新的一年充滿信心。現在仍然保留這習慣，不同的是，去年是這個，今年是這個，相信明年也是一樣——勞碌的生活，冷暖的人情，都不會奪去我對生命的「欣賞」和「感激」。我不懷疑生活的價值（雖說生命裏最美好的東西是免費，可惜生存的基本需要往往不是），但在我有這幸運，不必為衣食住行過份操勞的時候，便應抓着這機會，為他人，也為自己，帶來一點超越生活的東西——無論是屬於大自然的、藝術的、或人性的。……突然想起，當我在這裏胡聊之際，同學們都在埋頭苦讀，自己案頭還有堆積如山的「知識寶藏」等待發掘，不禁心頭一沉——這就是生和生命的鬥爭吧！無奈一笑！

七六年一月

MY DEAR FRIEND

By Human-E

I began to know you when
We met in the library
A few months ago.
You smiled upon me,
You talked to me.
And I did likewise.

2　2　2

I began to understand you when
We dined in the restaurant.
You revealed your ideals,
You talked of your past.
And I did likewise.

2　2　2

I began to love you when
I found out that
You are kind and considerate,
You are versatile and helpful.
And I longed to be the like.

2　2　2

I begin to miss you as
I have to leave you.
Yet I can assure you:
Though the world may change and
Time may lapse,
My love for you shall never vanish!
And, will you promise me the like?

歡迎

高班，低班同學，長期，短期工作，漫畫，採訪校對，只要有興趣——請接觸任何一位編輯，一定歡迎你加入工作！

稿例

一、啓思歡迎老師、同學及醫生來稿。
二、用筆名投稿者請附眞實姓名、年級，以方便聯絡。
三、中文稿請用原稿紙直寫，英文稿請打字或書寫清楚，請勿一紙兩面寫。
四、編輯有刪改權，如不欲刪改者請註明。
五、作者文責自負。
六、每月五日截稿，來稿請交任何一位編輯或投食堂內啓思信箱。
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