SINGAPORE MEDICAL ASSOCIATION

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New Dimensions in Health Care

Dr. Toh Chin Chye, Minister for Health, speaking at the SMA Annual Dinner & Dance said:

I was intrigued by an article on the Pauper Hospital in Early Singapore (1850 — 1859) written by Prof. Lee Yong Kiat and which was published in the December 1975 issue of the Singapore Medical Journal. The Pauper Hospital was the Tan Tock Seng Hospital located not in the present premises at Moulmein Road but at Pearl's Hill.

The hospital's annual report for 1853 commented on the increase in admissions from 478 in 1852 to 752 in the following year. The mortality rates were high being 24.4 per cent and 33.5 per cent respectively. The principal causes of death were cholera, debility, diarrhoea, chronic dysentery, elephantiasis, rheumatism and ulcers. The report not only reflected the art of medicine 120 years ago but also suggested that Singapore could not have been a healthy place to live in. The causes of death a century ago have been kept under control by effective public health measures so that to-day these diseases do not terrify us in modern Singapore. Tan Tock Seng Hospital is no longer a hospital devoted to treating diseases which are present in an impoverished society but nonetheless it faces the same pressure for admissions. With population growth the number of in-patients has been increasing steadily from 8,663 in 1971 to 13,019 in 1975. In spite of the pressures placed on the hospital staff and its facilities I am reassured that mortality rate has remained constant at about 9 per cent over the last five years.

WHERE THE PATIENT REALLY GOES

An international study on health expenditure prepared for WHO in 1967 revealed that on an average each individual spends two hospital days per year in the developed countries. Singapore does not belong to the category of developed countries but patient attendances in 1975 at specialist clinics in all the hospitals administered by the Health Ministry was 1,116,300 giving a ratio of 0.5 hospital attendance per capita. However, there were 2,457,700 attendances at government outpatient dispensaries and if these are added to hospital attendances we have a total of 3,574,000 patient attendances at health institutions run by the Ministry of Health alone giving a ratio of 1.6 patient attendance per capita per year.

It has been claimed by the President of the College of General Practitioners that 9 out of 10 patients are treated by private practitioners. Assuming that he is correct and the number of visits made by a patient to a private practitioner does not significantly differ from the pattern seen in the Ministry of Health's institutions, the arithmetic would suggest a total number of 35,740,000 patient attendances for Singapore. This is a staggering figure for a population of 2.25 million as it will mean a ratio of 16 patient attendances per capita per year. I find it hard to believe that people in Singapore are that sickly or obsessed with ailments that they must go to seek medical treatment at this frequency. It conjures up immediately the social and economic costs borne by the patient directly and the community in general, the loss of earning power, the reduction in work efficiency and last but not least the impact of sickness on the academic performance of school-children.

ESTABLISHING OVERALL PATTERN OF DISEASES

The primary function of the Health Ministry is to oversee the total health status of Singapore. Unfortunately, its task is hampered by the lack of reliable statistical data. Mortality statistics and the causes of death are obtainable from the Registry of Births & Deaths but mortality statistics alone do not indicate how widespread ill health occurs among the population. Mortality statistics do show changing patterns in the causes of death but do not alter the fact that life is finite. Fear of death is inherent in most human beings and the playing up of mortality statistics by medical practitioners in their different areas of speciality — usually at a publicized conference or even in a luncheon speech — can only heighten this human fear and make the weak minded neurotic or hypochondriac. Rushing into print stories such as a recent one that curry causes kidney diseases may be sensational but savours a lack of common sense when it is well known that Indians flourish on a diet of curry and India's population has grown to over 600 million people.

What we need to do is to inquire systematically into the prevalence of different types of illnesses. Because of advances in chemotherapy many diseases which one hundred and twenty years ago would have been fatal are no longer so. This does not mean, however, that such diseases no longer exist. Only small-pox appears to be on the verge of eradication by 1977. Just a little over 5 years ago malarial patients were hard to come by as clinical material for undergraduate teaching. Malaria is now endemic, 417 cases were reported in 1974 and 443 in 1975. The total number of deaths among tuberculosis patients has plunged to a low figure of 472 in 1974 but we still have an average number of 3,100 new patients treated annually for tuberculosis in spite of vastly improved housing conditions. Because tuberculosis and malaria are notifiable diseases we are in a better position to assess their prevalence in the population and to allocate resources to combat their spread. However, there are other illnesses which do not come under the notifiable list of diseases. They are non-glamour diseases and do not catch the public eye but nonetheless they are debilitating and their socio-economic impact is considerable.

V.D. IN OUR MIDST — NOT NOTIFIABLE!

Singapore is an open port and as an open port it has its fair share of red light districts. Sailors and tourists either bring veneral diseases to Singapore or catch them here and go home. It is not possible to screen the one million tourists who visit Singapore annually for veneral diseases. If we do this it will be the end of the tourist industry and as the economists will put it, there will be a multiplier effect leading to the collapse of several service sectors of the economy. Sexually transmitted diseases are notifiable in other countries but not in Singapore. Official figures for 1975 give a rate of 19 infectious syphilis cases and 133 gonorrhea cases per 100,000 population. These figures are only the tip of the ice-berg as private practitioners do not report the incidence among their patients. In fact a sample survey carried out in 1969 would suggest that the official figures need to be multiplied by a factor of 2 for syphilis and 4 for gonorrhea. It is not flattering to be told that the figures for syphilis are higher than European figures.

MORBIDITY STATISTICS

In order that we can plan for future demands for medical facilities and medical manpower we need to have data on morbidity statistics which will help us to discern any change in the pattern of diseases in the population. The Ministry of Health is making an effort to compile whatever statistics we have on morbidity. The project bristles with difficulties as some doctors do not wish to be bothered with form filling, while even among hospitals reporting by doctors show a variance. This latter problem can be solved if a standard procedure is followed by reporting the diagnosis on a

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INSIDE

VIEWPOINT

A PURVIEW OF CONTRACT PRACTICE

The great shift towards urbanization and industrialization in the past decade has brought in its wake many problems — industrial accidents, occupational diseases, mental ill-health as well as pollution of the environment. Great strides have been taken by all concerned with regard to occupational safety and occupational health. Employers are obliged by legislation to provide medical benefits for their employees by contracting the services of general practitioners on specified terms. While in the past the only vital feature of medical care was the personal relationship between the doctor and his patient, to-day we have the employer and the trade union — a third party — that has encroached on this relationship with the advent of contract practice.

Recently, there have been disturbing reports in the press by the Singapore Industrial Labour Organisation (SILO) drawing our attention to some purported problems connected with medical treatment by company doctors.

The care of the worker has become economically essential and not just a moral or legal obligation. Our national prosperity depends in no small measure on speedy industrialization in which the worker's health and his environment are especially important. The emphasis is on the maintenance of good health and the prevention of illness rather than on the treatment of injury and disease. All employers should therefore be selective in the choice of their company doctors.

The company doctor, cannot achieve all the goals of occupational health himself — he needs the support and co-operation of all concerned — the employer, the Union, the Government and the Worker.

The employer or union should not place unreasonable restrictions and limitations on the company doctor — limitations that would impede optimal investigations and management of the worker-patient and thereby hamper the professional efficiency of the company doctor.

The company doctor however should at all times

(a) provide primary health care for the worker as well as immediate treatment for medical and surgical emergencies,

(b) examine applicants for employment and advise management on their fitness for particular jobs,

(c) help management to avoid hazards to health and maintain healthy working conditions,

(d) maintain good standards of health care,

(e) accept high moral and ethical values in his day to day activities.

All this may sound idealistic to the over-worked practitioner under increasing pressure, both economic and social. The task of maintaining standards of work often places a great strain on the physical resources of the doctor. Nevertheless, his job as a doctor is to care for people, to cure and prevent disease, both of body and mind, and to help rehabilitate his patients. The continuing challenge is to command the support of the public and our government by demonstrating that we have a distinct contribution to make to the welfare of the Nation's health.

V.L.F.

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patient on his discharge from hospital. This is more reliable than reporting the diagnosis made on admission. A major lapse in the collection of morbidity statistics is the absence of documentation from the private sector. If 9 out of 10 patients do indeed consult private practitioners the private sector is an important source for collecting morbidity data. Whatever co-operation private practitioners can give in forwarding this data will improve the accuracy of the profile of diseases current in Singapore.

The compilation of morbidity statistics is not an exercise in curiosity. Such data if assembled annually can give us an indication of disease trends which will help us take measures to contain them and prevent their breaking out into epidemic proportions. Are some of the diseases imported or brought back by our own residents as facilities for travel have become so much easier? Are there high risk factors linked with certain diseases because of changes in occupation, the environment or the living habits of the population? Is there a correlation between the greater incidence of certain diseases and ethnic origins, a point which merits especial attention in a multi-racial society. Morbidity data can put us on the alert or prevent us from getting into a panic when we read of diseases appearing in other countries. For instance the incidence of embolism in the veins among Caucasian women on contraceptive pills was sufficient to cause the United States Congress to set up a committee of inquiry but in Singapore the Family Planning & Population Board did not receive reports of this side-effect among Singapore women.

IATROGENY INFLICTED ON A POPULATION

Iatrogeny is a word in the medical lexicon. It means an abnormal state or condition produced by the physician in a patient by inadvertent or erroneous treatment. A study of the growth of many cities in other parts of the world show the disastrous impact on human ecology caused by lack of calculation or human misjudgement in treating their economic and social ills. It is iatrogeny infliced on the population but on a larger scale. Japan has risen from an impoverished nation at the end of 1945 to become the world's third largest industrial state. The social costs to reach this status have been considerable. Hazards to health from environmental pollution such as Minimata disease are the consequences of a headlong single-minded purpose to achieve a high GNP per capita. We in Singapore could do no better than to learn from the experience of other countries as the margin between success and failure is too small for us to make mistakes which in years to come may well be labelled as the Singapore syndrome. By 1990 within our own life-time 400,000 more people will be added to the existing population of 2.25 million giving a population density of 4,537 per square kilometre as compared to the existing figure of 3,839. There will be changes in the population pyramid which will show an increase in the number of people aged 60 years and above. What will be the disease pattern, how cost-effective will be our future health programme and what will be its effect on Singapore's socio-economic development in the next 15 years?

NEW DIMENSIONS

Advances in medical technology have been directed more at the curative aspects of medicine than the preventive. Sophisticated equipment are invented which require skilled manpower to operate and maintain. The irony of it all is that modern curative medicine has transferred the patient from a person to person relationship with his doctor to a system where the patient is delivered into the hands of a team of specialists. This is a major factor in raising the costs of medical health care in industrialized countries. In order to cut down the costs per capita and ensure that hospitals have a more rapid turnover of patients, the trend is towards ambulatory care in Western countries. This works out to an average stay of 3 days in some hospitals in the United States.

As Singapore does not belong to the World Bank's Division One league of countries, we will be foolhardy to keep on shaping our health care system after the Western model even though we have largely followed the practices of the West in medical education. The solution is to apply medical knowledge to a system more suited to our economic limitations and social mores. This means innovation and instilling new attitudes in the medical establishment.

(a) The first and obvious line of approach is to promote preventive medicine. This includes not only immunisation against infectious diseases, improvement of our working and living environment but also educating the public on how to stay healthy. The Ministry will launch a national health campaign in September this year to start this movement for promoting public health consciousness.

(b) Our experience has shown that on a per capita basis the outpatient services have been most cost-effective in delivering medical treatment. Plans are now being worked out to extend these outpatient services to caring for patients in their homes instead of in hospitals. This scheme will initially be confined to the old and infirmed, mentally ill patients who have been discharged and the chronic sick. For home treatment to succeed community participation is essential. It means acceptance of responsibility for the elderly by the family and upholding the concept of a 3-generation family which will include grandparent, parent and grandchild. There are economic and social advantages in the concept of the 3-generation family. When parents are at work it will be the grandparent who will look after the child, values will be transmitted and alienation of the young from their elders will be prevented. In order to encourage community participation in this scheme, a Nursing Foundation will be started. Funds collected by the Foundation will help to pay for part of the costs of the scheme. I am glad to report that the Singapore Nursing Association has expressed their support for this project. It will take several years for this system of medical care to develop and mature but a start needs to be made.

It is not the intention of the Ministry to secure a monopoly over the delivery of health care. Private practitioners too have their own part to play. We have come a long way since the days when Tan Tock Seng founded his hospital for paupers. Singapore will continue to flourish by ingenuity and adaptation but we can exist as a cohesive society only if the roots of social conscience as shown by our forebears grow deep among the population. The medical establishment can help to nourish this conscience.

PROGRESS IN MEDICINE

Dr. Ho Guan Lim, Director of Medical Services said at the opening of the 7th National Medical Convention that:-

There seems to be an avid interest in the progress of medicine. For the medical practitioner this is important to keep abreast of knowledge. For the lay person this is in part curiosity. Perhaps it represents an unsaid wish to know what is new in treatment or in the prevention of disease which may be needed at some later time in life.

New gains in knowledge in medicine are so great that there are numerous publications devoted to cull what is significant. Experts review, select and summarise the gains in knowledge, digesting them for the busy, the lazy or the postgraduate student swotting for examinations. One medical annual frankly states that it is "to provide a reference book for those sitting for higher examinations".

Often accounts of progress are exercises in self-congratulation; paens to past achievements and a tendency to survey the field of medicine through rose-tinted glasses.

It may perhaps be useful if we take the opportunity, such as this, to take stock of our position. To give perspective to our proud record of progress, it is well that we paint in some of the darker hues and attempt to explain the meaning of the picture of medical progress.

(1) Despite the great strides in knowledge there are large gaps in knowledge. For example, there has been no significant progress in understanding or effectively treating the rheumatic diseases or mental illnesses. Yet they are so common and have afflicted man since he walked this earth. They are large pockets of unconquered diseases which have been bypassed in the advance of medicine. They are a challenge to medicine. Not only are they reminders of our failures to solve the mysteries but they represent also a challenge posed by the faith healer and the charlatan. Stripped of any superior knowledge and without impressive gadgetry medical men compete with the quacks on equal terms. This is the test of the true physician. It is a test of his own abilities to give comfort, to relieve pain and to support patients and families through their long and trying period of suffering. The fact that there are so many claims of cures, so many different methods of treatment, is an indication that medical science and medical men have been bested in their primary function which is the alleviation of pain and suffering.

(2) The literature on new discoveries pouring out is so vast as to literally and figuratively bury us under its sheer volume. In 1800 there were about a dozen journals, now there are about 40,000 scientific journals. Knowledge is said to double every ten to fifteen years. It is so large that even specialists find it difficult to keep abreast of new knowledge in their own field. Information systems using librarians to catalogue, statisticians and systems analysts using computers seem just able to keep abreast of all publications. The paradox is that new discoveries coming in such a large flood tide is in danger of choking progress rather than accelerating it. Information may be available but it is not being made use of.

The medical man will continue to be concerned with making new discoveries and to ensure that he assimilates new knowledge as it becomes available. In this pre-occupation of the first two objectives the third and, possibly the more important, is sometimes forgotten. This is that all this new knowledge must be used wisely; that the right conclusions are drawn and applied with understanding and wisdom for the advancement of the welfare of mankind.

The saying that the beginning of wisdom is knowledge may be illustrated in the next following points.

(3) The growth of knowledge inevitably leads to specialisation. A familiar problem consequent to this trend is how the specialist can apply his deep knowledge and high skills in the care of the patient as a whole. A solution would perhaps be realised by having general physicians who will orchestrate the work of specialists and other members of the medical team.

A less discussed problem is that increasing numbers of the most able in the profession are becoming specialists. 40 per cent of all practitioners on the Medical Register in Singapore have higher medical qualifications. The reasons are easy to understand: specialisation is challenging, has glamour and often is more lucrative. This centrifugal movement away from the central function of medicine represents an internal brain drain. Only a few, perhaps, the foolish dedicated ones, elect to remain to provide primary care services or to work in the promotive and preventive health services. The imbalance is to be decried for there must always be able and well motivated persons who will continue to provide the important basic health services.

(4) The vast growth of knowledge in medicine also accounts for the dominating growth of the hospitals. No longer are they quiet havens for patients to lie in peaceful comfort. They are now filled with bustling staff and impressive gadgetry. Vast sums of money are spent on the large army of staff and for the latest technological equipment for the hospitals. Hospital services together absorb more than 65 per cent of the budget for health. Hospital buildings cost fabulous sums of money. In Singapore it is estimated to cost $100,000 to establish one additional hospital bed. But this is not all. The operational cost for maintaining one bed a year is $25,000 or one quarter of the capital outlay. It costs nearly $70 to care for each patient a day in hospital. In contrast the cost for attending one outpatient in the Government Outpatient Dispensary is 50 times less.

Little wonder that questions have been raised whether we have our priorities right. Extreme views have been expressed, such as, "the Hospital — is threatening to de-humanise society to a frightening extent". "The future of — the new world may well become a fight to prevent hospitals from taking control". The pertinent point is whether we can afford the ever higher investments in hospitals and if these have been matched by improvements in service or quality of care.

(5) Advances in knowledge have been reflected in increased investigations, an increase in the number of operations and in prescriptions. Laboratory investigations have increased 100 per cent over the last 10 years, diagnostic X-rays taken have increased by 50 per cent, and prescriptions given to patients by 25 per cent. It is hard to believe that these increases have resulted in any extra benefit or improved the standard of care given to the patients subjected to these investigations or medications. Perhaps, this is a reflection of a basic failure to give time to patients. For it is easier to treat a condition than to treat the patient. Over investigations and over treatment are perhaps a substitute for the inability to deal with a patient as a person. The pill and potion has become a panacea. It is used for every and any condition, so that it has become an ingrained expectation that treatment is not complete unless some form of medicine has been obtained. Yet discerning physicians have warned against over pre-

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Family Medicine in Singapore

The Past, The Present and The Future

A PAPER PRESENTED BY DR WONG HECK SING AT THE 7th NATIONAL MEDICAL CONVENTION

The Past, the Present and the Future — one tends to relate these time periods to one's own life. I studied medicine when antibiotics were first used in Singapore i.e. just after the Second World War. I shall therefore speak of the Past as the pre-antibiotic era, and the Present dating from the Post Second World War period. For the Future I can only speak in terms of presently existing trends and offer a few suggestions that may modify them.

General practice before the advent of the antibiotics was in some aspects a much more demanding vocation. When we think of the helplessness of the doctor faced with a case of pneumonia or of typhoid or of peuperal sepsis we realise how much faith and confidence patients and their families needed to have in him. Often the general practitioner acted as a therapeutic agent — his assurance was their hope and comfort. Most general practitioners were loners.

The relationship between patient and doctor was intimate and personal, and to achieve this time was needed to develop trust and confidence. More time was spent by a doctor to come to a precise diagnosis, for that was where his reputation lay. He had to know the natural history of the disease. He had to predict as to when the crisis would come. To do all this, he had to know what the illness was.

Except among the affluent, a doctor was rarely consulted for minor or early illnesses. Private medical care was on the whole more costly. A great number of cases which by present day practice would have been hospitalised were treated at home, owing to the prevalent fear of hospitalisation. The general practitioner often followed a case throughout the whole course of the illness. Except for those cases requiring surgical intervention, the pattern of diseases seen in hospital practice and in general practice was similar. Obstetrics was done by general practitioners. In fact many of the people in my generation were delivered in their parents' homes.

House-calls too were more common. As I have mentioned earlier, cases were not usually seen in the early stages, and by the time they decided to consult doctors, many had become bed-ridden. I know of a doctor, now deceased, who averaged at one time more than 10 house calls each day. General practitioners in those days had more opportunities to practise medicine in the patient's natural environment, and were thus better able to observe the implications of human interactions on health.

Few doctors then were engaged in contract practice. These few were mainly situated in the city looking after the employees of a handful of large trading firms in the commercial area.

Practically all general practitioners in the past were confined to a 3-mile radius from the General Post Office. There were hardly any doctors in the rural areas. In such areas, primary health care was more often than not provided by practitioners of "traditional" medicine.

Today, progress of medicine has brought many changes to health care in our country. The most significant change is the overwhelming acceptance of Western medicine by the people. This was triggered off by the discovery of the antibiotics.

The advent of penicillin and other antibiotics, with their miraculous cures, overcame the resistance of even those most biased towards Eastern traditional medicine. Almost overnight every medical practice became immensely successful. The need for painstaking consultation appeared to be no longer necessary as broad spectrum drugs seemed to solve most of the doctor's problems, and almost always at the first consultation.

As further medical developments increased the acceptability of Western Medicine, the load on the medical services in the country began increasing. General practitioners had to cope with larger crowds and were often unable to spend as much time as they would have liked with their patients.

Patients carried away by reports of dramatic cures often expect too much of their doctors. If there is no quick response they change doctors. "Doctor-hopping" is a common phenomenon now. It is encouraged by two factors. Firstly, medical charges are on the whole relatively cheap, and secondly, doctors are plentiful. Patients think nothing of discarding their medicines after two or three doses if they are not better, to seek treatment elsewhere as other doctors are within easy reach.

A change in the nature of General Practice has emerged in Singapore over the last decade. With the rapid development of industrial and commercial enterprises, employers are obliged by legislation to provide medical benefits for their employees. Thus we have seen a tremendous increase in a contract type of medical practice, where firms employ general practitioners to look after their workers on specified terms. If we add all the employees in the public sector including those in the statutory boards and uniformed services, to the nation's privately employed workforce of over 800,000, the percentage of people having subsidised medical care in the country would be in the region of 40. I have not included in this figure members of the public who can receive outpatient care at the Government outpatient clinics at reduced costs.

Contract medical practice has encouraged the formation of group practices. The members sometimes share the work so that they may not always provide the continuity of care which is found in lone practices. On the other hand cross consultations are possible and usually some free time is available for each member to pursue other interests. The doctors in group practices are in a better position to undertake continuing medical education.

Another advantage is, the patients remain captive, and if this arrangement continues long enough a comprehensive medical dossier on each patient can be built over the years which might not have been possible in a different situation.

The number of present day general practitioners involved in contract practice is considerable, and in some cases their practice is confined almost entirely to it. This type of practice is sometimes subjected to pressures from parties with vested interests, causing job dissatisfaction or frustration to the practitioner.

A further development has taken place in present day General Practice. It has been brought about by the massive movements of population. Between 1965 and 1975, 700,000 people were resettled in the Housing and Development Board flats. New housing estates are peopled by new inhabitants and new doctors. Primary health care tends to be episodal and discontinuous in such instances, and time is needed before a lasting doctor-patient relationship can be built up. Similar problems are faced by older doctors in established practices when old surrounding homesites or buildings are replaced in the process of redevelopment or urban renewal. Their patients of

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Family Medicine in Singapore

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many years standing and consisting perhaps of members of families spanning several generations are relocated, and are later replaced by new people. Again time is needed to build up rapport and confidence.

At this juncture I wish to mention the role of the outpatient clinics in general practice in Singapore. A Ministry of Health Report said that the main role of outpatient clinics was to provide a "general-practitioner" type of service to the public. In addition, they maintained follow-up treatment of long-term cases discharged by hospitals, and acted as referring agencies for patients who required hospital treatment.

They do not however provide service after office hours, and no house calls are made. The Government outpatient services until the late 1950's, played a relatively minor role in the primary health care of the country. Since then this role has increased and is significant if one views their total current work — in our population of 2 million, there were approximately 2 million attendances in 1975 at the 26 outpatient clinics on the island.

Let us now look at the following statistics indicating some of the trends regarding the future of general practice, which is being increasingly recognised as a separate and distinct medical discipline, more aptly called Family Medicine.

Infection is no longer the main worry in medical practice, and neither is the problem of under-nutrition, as on Charts 4 and 5.

We see a rise in degenerative diseases (Chart 6). The answer here lies in preventive medicine, which also include the control of over-nutrition.

With decreasing birth (Chart 2) and the trend to a two child family, every child becomes a precious child. Genetic counselling, preventive obstetrics, preventive pediatrics and child development become increasingly important in the practice of family medicine.

The care of the terminally ill, if we can use the graph of the malignant deaths as a guide (Chart 7), is an increasing responsibility of the family doctor.

And if we look at the decline in total deaths (Chart 3) we see that people are living longer. So Geriatrics is an area which family doctors cannot ignore.

From cradle to grave, or if you prefer to put it, from conception to the death-bed — that is the span of total care in family medicine.

Besides the above trends, we foresee a rise in socio-psychological problems, resulting from difficulties of adjustment of some of the people to the rapid changes and new life styles in society.

Also, increasing industrialisation will bring forth new problems in industrial health and occupational medicine.

These are some of the challenges of family medicine in the future.

The expectations of the public in health care are rising. This mood is brought about by increasing affluence and a rise in the literacy rate of the population. 10 years ago, 68 per cent of the population was literate. Now this has risen to 76 per cent. 10 years ago, there were 23 persons to one T.V. set, now there are 7. 10 years ago, there were 20 persons to one telephone, now there are 7 to one. These figures are indicative of the rise in the standards of living.

The public is aware of the advances and newer facilities in the medical services provided in the public hos-

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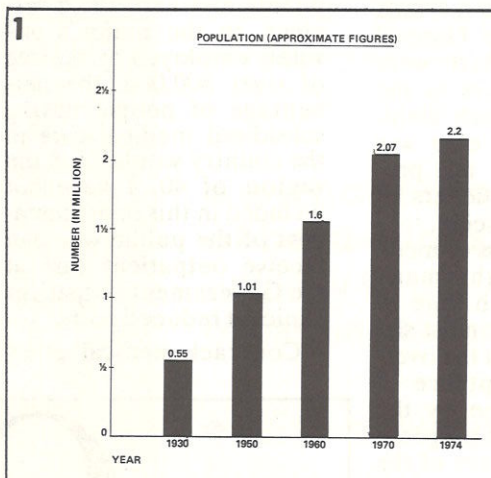

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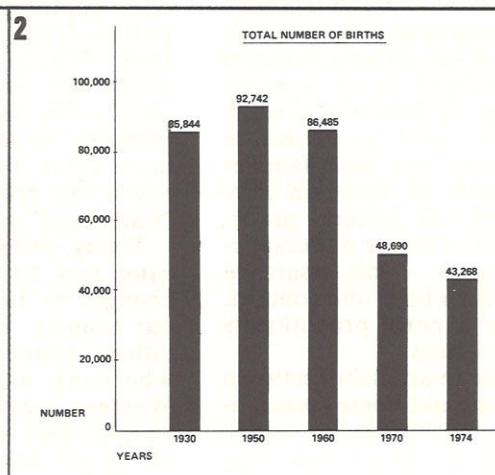

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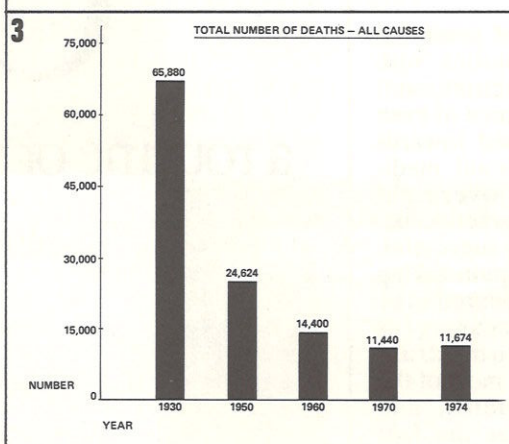

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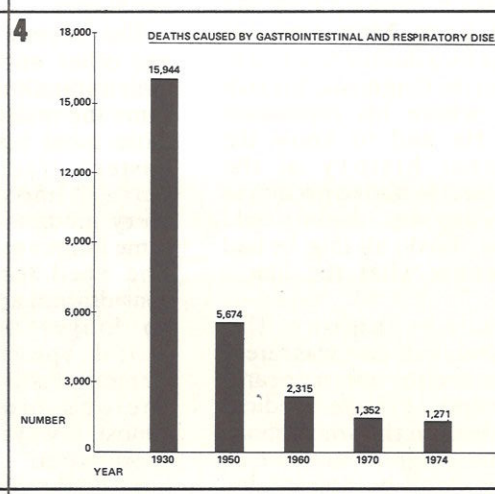

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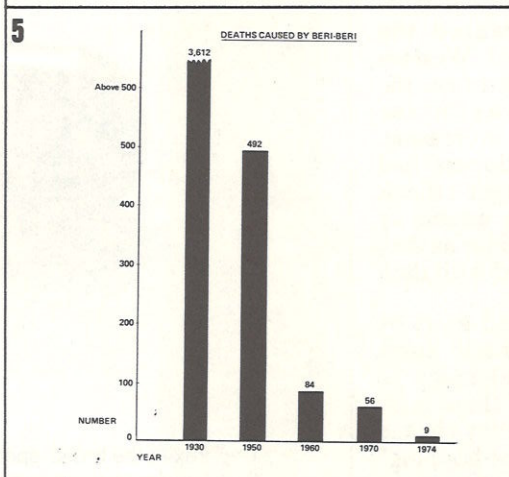

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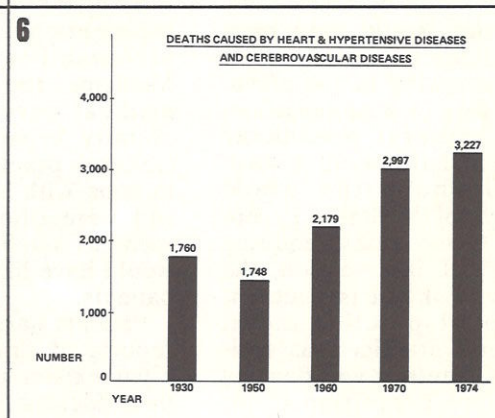

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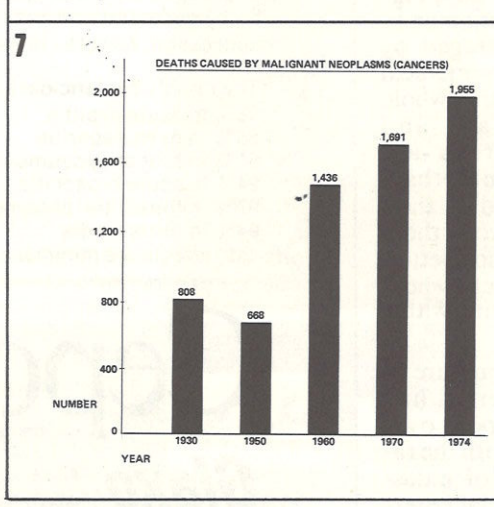


What may we surmise from these data?

Medical Progress

RECENT ADVANCES IN OBSTETRICS & GYNAECOLOGY

HYSTEROSCOPY -

A new Diagnostic & Therapeutic Tool

Hysteroscopy is one of the latest developments in gynecology. It consists of a lens system for visualising the uterine cavity. Select areas of the endometrium can be biopsied, cauterised or operated on. Foreign bodies can also be removed easily.

It was first used in 1869 by Pantaleoni who used a crude tube to visualise the endometrial cavity. In 1963, Silander used a transport rubber balloon to keep the uterine walls apart so that visualisation was possible. Unfortunately, distortion of endometrial features occurred. In 1970, Edstrom and Fernstrom, using a modified urethroscope, pioneered the development of the modern hysteroscope. They used a viscid transparent media (dextran 40) to distend the uterine cavity. A whole new vista of endometrial pathology was opened up. Whereas previously, only blind curettage was possible, it was now feasible to see and classify abnormal uterine pathology.

For the past 3 years, the hysteroscope has been used extensively by us and found to be a safe, simple and efficacious instrument if properly utilised.

Uses of the Hysteroscope

1. Diagnostic visualisation and biopsy of the uterine mucosa or wall, e.g. polyps, carcinoma, submucous fibroids, vascular malformations, subseptate or cornuate uteri.

2. Removal of fragmented intrauterine contraceptive devices which may be partly embedded in the uterine wall. This can be done very easily with the hysteroscope.

3. Aid to Tubaplasty, e.g. cannulation in cases of interstitial blockage.

4. Tubal studies, e.g. collection of tubal fluid for biochemical analysis and recordings of tubal motility and pressure.

5. Sterilisation either by electrocoagulation of the tubal orifices or injection by sclerosant substances or tubal plugs.

6. Contraception with removable tubal plugs.

At present, the hysteroscope is of undoubted value in 1 and 2. In areas 3, 4, 5 and 6 intense research activity is going on.

Method

The procedure was done on an outpatient basis, with only paracervical block for anaesthesia. Following dilatation of the cervical os, the hysteroscope was introduced and the uterine cavity distended with 5 per cent dextrose. Visualisation and biopsy of any abnormal areas were then undertaken.

All patients were observed for an hour after the procedure. Any side-effects were noted and blood pressure and pulse recordings were taken. The patients were then discharged if they were considered fit.

We have used the hysteroscope on numerous occasions and have seen uterine polyps, septums, submucous fibroids and vascular abnormalities. We have found it to be a safe and efficient method to diagnose any uterine mucosal abnormality in the absence of severe bleeding which would make visualisation difficult.

Discussion

Hysteroscopy can be used in place of blind dilatation in almost all cases except those where bleeding is heavy as this makes visualisation difficult. It has the advantage of direct vision and selective biopsy over blind curettage which may miss significant abnormal areas of endometrium.

It was also used to remove fragments of retained I.U.C.D. without resorting to X-ray in 8 cases where the fragments could not be removed with the Novak's curette.

Hysteroscopic sterilisation either by electrocoagulation or the injection of sclerosants has many advantages in ease of performance and safety (peritoneal cavity is not opened) but its great disadvantage at present is the tendency of the interstitial portion of the tube to remain patent and an intense search is going on at present for a suitable sclerosant electrode.

It can thus be seen that Hysteroscopy, even in its infancy, has distinct advantage over blind curettage and, when fully developed, may replace many standard procedures, e.g. abdominal sterilisation and certain types of tuboplasty.

COLPOSCOPY

Colposcopy is a relatively new technique for detecting cervical abnormalities by examination of the cervix with a magnifying lens. It is used for the detection of a variety of abnormalities such as chronic cervicitis and cervical erosion but its main value is in the early detection of carcinoma-in-situ of the cervix.

Cytological studies (i.e. studies of cell smears taken from the cervix and vagina, e.g. Pap smear) have been undertaken for many decades and is the most practical method of mass population cervical cancer screening as it is less time consuming than Colposcopy.

However, numerous studies have shown that a combination of colposcopy and cytology increased considerably the pickup rate of cases of carcinoma-in-situ. Also in many instances where the Pap smear is equivocal of cancer, e.g. Pap III dysplastic smears, colposcopy is of undoubted value in the selection of cases for further investigation and treatment. In cases not colposcoped, unnecessary cone biopsies have been done for chronic cervicitis or mild dysplasias.

The colposcopist usually examines the cervix with a magnification of between 3 to 15 times. He looks for certain features which, if occurring together would be highly suggestive of malignancy.

1. Leukoplakia or white plagues of squamous cells which have proliferated and heaped up.

2. Vascular abnormalities, e.g. large tortuous vessels and punctuate spots (vessels seen and on).

3. Abnormal epithelial patterns, e.g. mosaic patterns. These abnormal areas are punch biopsied with a biopsy forceps and the results confirmed by histology

The condition is then treated accordingly, e.g. chronic cervicitis by cautery and carcinoma-in-situ by punch or cone biopsy or hysterectomy according to the circumstances of the case.

Using the above criteria, we have colposcoped more than 400 cases and have found it to be very useful and reliable particularly in those cases with Class III Pap Smears and in some instances of Class II smears. The cone biopsy rate (with all its attendant complications of haemorrhage, infection, cervical stenosis or incompetence in a subsequent pregnancy) has been reduced and cases of carcinoma-in-situ have been picked up which would have been otherwise missed.

DR. ALLAN Y.H. NG

Annotations

1. **Prevention of Rhesus iso-immunisation**

One of the most exciting advances in the field of preventive medicine is the achievement of success in the prevention of Rhesus iso-immunisation by the giving of anti-D gamma globulin to Rhesus negative mothers with a Rhesus positive baby soon after birth. The success rate is 95 per cent. Thus the scourge of Rhesus iso-immunisation which has resulted in stillbirths, neonatal deaths and brain injury will be substantially reduced and prevented in the near future.

2. **Improved prognosis in patients with malignant trophoblastic neoplasia (choriocarcinoma):**

Methotrexate was first used in 1956 for choriocarcinoma by Li and Hertz. With the addition of other chemotherapeutic agents and improved regimes coupled with sensitive monitoring of disease activity by measurement of beta sub-unit of HCG the prognosis for these patients is now nearly 90 per cent relative cure compared with 10 per cent previously.

3. **Safety in termination of pregnancy**

As more and more countries in the world have legalised and liberalised abortion as a means of population control, much effort has been expanded to achieve safe methods of early pregnancy termination. This can now be said to have been achieved by the application of vacuum aspiration, prostaglandin administration and Karman syringe aspiration. However, termination of pregnancy is not a good method of family planning or population control. Pregnancy prevention is to be preferred from both the medical and ethical points of view.

4. **Improved methods of monitoring the foetus in utero:**

(a) Congenital malformation and disease can now be detected early at about 14-16 weeks gestation by the examination of a sample of amniotic fluid; viz. sex linked diseases (haemophilia, Duchenne muscular dystrophy), chromosomal diseases (Mongolism, Turner's syndrome), in-born errors of metabolism (Tay Sach's disease, Gargoylism), and C.N.S. abnormalities (spina bifida, anencephaly). Therapy of such conditions once diagnosed will have to be individualised.

(b) Fetal growth and welfare can now be followed serially by measurement or urinary or serum oestriols and the ultrasound measurement of fetal skull bi-parietal diameters and fetal weights. Fetal well-being can be assured and intra-uterine growth retardation detected.

(c) Intrapartum care of the fetus during labour can be monitored now by continuous cardiotocography and fetal blood sampling for pH determination. These have helped a few fetuses who would otherwise have asphyxia undetectable by conventional means. However, medical costs and care have increased with these measures and priorities have to be worked out for their use.

DR. LAWRENCE K.C. CHAN.

IN KEEPING WITH OUR TIME ...

Specialist: "Could you pay for an operation if I find one necessary?"

Patient: Would you find one necessary if I couldn't pay for it."

Family Medicine in Singapore

(Continued from page 6)

pitals. They know that more and more doctors manning these hospitals are upgrading their standards and skills. As a matter of fact 40 per cent of hospital doctors presently have postgraduate qualifications. It is natural that a similar upgrading of standards and facilities will be expected by the people in primary health care delivery, to satisfy their changing medical needs.

The present day general practitioner should no longer be content to offer the limited outpatient type of service to his patients. He must learn new skills and be retrained in certain areas if he is to be able to meet the challenges in future primary health care. He must accept his full role as a family physician. He must provide preventive, primary and continuing care. He must be able to mobilise for the care of his patient, all the resources and specialist personnel that are available, if and when necessary. In other words he must be able to assume his full responsibilities as a practitioner of Family Medicine.

What do I mean by Family Medicine? Family Medicine is the primary and continuing health care of an individual in the context of his environment both immediate i.e. his family, and removed i.e. his society. Family Medicine also recognises the dynamics and interactions of this environment which will affect or influence the individual's well-being. This concept of medical practice for the private general practitioner is in many ways desirable as it helps to define his role more precisely. The term Family Physician gives rise to less ambiguity than General Practitioner, and is acceptable to, and understood by, both the public and the medical profession. Of course the Government Outpatient doctor will not be able to play the role of a family physician fully, as his care of the patients is confined within the outpatient clinics, and is not extended to the patients homes. However for convenience and brevity's sake, I will use the term Family Medicine to cover both types of primary health care.

There is at present considerable under-utilisation of the general practitioners. This state of affairs will not affect them economically as long as the patient-doctor ratio remains high so that enough of the present type of work is available to keep them occupied. However, over the last decade, the population — private practitioner ratio has dropped from 4,000 to 1 to 2,600 to 1 presently. The number of private practitioners has nearly doubled since 1966 while the population has increased by only one-sixth. The time may come when some general practitioners may face the problem of economic survival unless they enlarge their present role.

What has been done to upgrade the standard of family medicine and to train the future family physician? Upgrading standards prior to 1971 had hitherto been a fortuitous affair. There were programmes organised by specialist bodies and medical institutions, but family doctors or general practitioners participating in them were often disappointed by the lack of material relevant to their practice. As for providing vocational training for the future practitioner, nothing has yet been done.

The attempt to correct this situation prompted the founding of the College of General Practitioners in Singapore in 1971. With very limited resources and little academic experience, the members of the College have over the past 5 years studied the role of the family doctor and the needs and requirements to fulfill such a role. The College is providing continuing education and regular periodic assessments for primary health care doctors. It is expanding its role in other directions to fulfil its objective of upgrading and maintaining the standard of family medicine. It is studying schemes to provide vocational training for the future practitioners. It is helping to create new challenges and job satisfaction for family doctors by providing teaching and research opportunities. It is trying to train suitable teachers to teach the hitherto neglected discipline of Family Medicine.

While the College can contribute towards the upgrading of primary health care by providing continuing education for those in practice, it has been unable to do much for the future practitioner. Herein lies the root of the problem of providing quality primary health care of the future. Unless family medicine is recognised and accepted as a separate discipline, meriting undergraduate and more important, postgraduate training, no significant advance can be made in this field of medical practice.

The University and the Government will have to assume a major role in this direction.

There is a valid case for including family medicine in the medical curriculum in the University. General practice or what we prefer to call family medicine, encompasses a very substantial and distinct area of medical practice. In defining and managing the problems of this large area of practice, certain skills are evolved and developed by the family practitioner which may not be known or taught to the medical student. Also, the main philosophy of family medicine is the whole-patient approach which is often not appreciated by the medical student. To further support the case that family medicine qualifies as an academic discipline, there is as much research potential in it as there is in the other recognised clinical disciplines.

To go a step further there are certain objectives in medical education which are not often stressed to the medical student. The family physician being placed in the situation where he is better able to understand the importance of these objectives, would be the most suitable person to teach them to the student.

These objectives are:

(a) the development of an attitude to medicine which is a blend of the scientific and humanitarian

(b) the encouragement of high ethical standards

(c) the understanding of the effects of environment on health

(d) the preventive role of the doctor

and (e) the obligation of a doctor to continuing education

There is therefore a place for the family physician and for family medicine in the undergraduate medical training.

I now come to postgraduate vocational training. If family medicine is recognised as a separate entity, then like all other special disciplines, further training would be desirable and necessary before one embarks on it as a career. Few doctors these days would practise a speciality unless he has had postgraduate training. The profession has been so conditioned that few of its members would depart from this accepted procedure. If we do not accept the same rule of further training for family doctors, we should then be prepared to accept the varying standards that prevail in family medicine today.

Vocational training in family medicine is the responsibility of the government in many Western nations like the U.K., Australia, Canada and the U.S.A. Their training consists of specified periods of attachments to hospitals in the disciplines that are relevant to the practice of family medicine in their local context, and to approved general practices outside the institutions. The programmes in these countries appear to have achieved the objective of producing family physicians who are more effective and competent as compared to those who did not have the benefit of such training.

There are no such programmes in Singapore. To provide them we need trained teachers. Next we need training centres both in the hospitals and in private general practices. Unless the Government is able to participate in not only providing their facilities, but also in contributing towards the costs of such a programme, vocational training cannot be developed to any significant level. We will remain as we are, with new practitioners having to learn to practise family medicine by trial and error.

The medical products of today are the results of the selection and training of yesterday's medical students. It is the concern of all doctors to determine the criteria of selection and content of teaching and training to give the best results.

The theme for this 7th National Medical Convention is "Progress in Medicine". If you accept the role of the College of General Practitioners as meaningful, then perhaps some progress has been made in the field of family medicine.

In the final analysis, progress in family medicine or for that matter in any branch of medicine, lies in the development of self respect among the members of the profession. Without this self respect, standards, both ethical and professional, would fall and progress would be reversed. Without self respect the profession would lose its credibility. Without self respect, the profession can no longer be self regulatory and would perhaps require outside intervention.

Can we afford to lose our self respect?

Dr. Wong Heck Sing, President of the College of General Practitioners stated that impressions and views expressed do not necessarily reflect those of the College of General Practitioners. Ed.

"AN OPPORTUNITY to Upgrade your Practice Standards — Join the College of General Practitioners"

— Says Membership Chairman Dr. Lim Lean Huat

The College of General Practitioners Singapore was officially established in June 1971. In its five years of existence we have endeavoured to attain all of our goals, specially in continuing educational upgrading of practice standards. We have regular programmes held weekly, monthly and yearly in the evenings or Sunday afternoons. To name a few we have:

(1) Refresher Courses lasting for three months.

(2) Seminars on topics very relevant to general practitioners.

(3) Weekly lunch-time Teach-in Sessions at Maxwell Road and Kallang O.P. Government Clinics.

In addition, the College has a Library of books and medical tapes with loaning facilities. The latest trend nowadays is for G.Ps to play these medical tapes whilst driving to and from their clinics, or on their rounds to see patients in hospitals or homes. A Video-Tape Cassette equipment has just been presented to the College, and we intend to start weekly lunch-time Video-Tape Sessions in the near future. Our Library has a wide selection of journals and books and is increasingly being used by members of the College.

The College of General Practitioners is heavily committed in continuing education, our budget is very tight, and, apart from donations, subscription fees are nearly all used up in running the College. We are thus dependent on continued support and increasing membership.

Subscriptions are levied only once a year. As long as you are in institutional practice or attached to any of the hospitals you qualify as an Associate Member and need only pay $50 - as an annual subscription and the entrance fee is waived. Those who have been in private practice for less tha five years also qualify as Associate Members, and pay $50 - annual subscriptiion. The entrance fee of $50 - is applicable to those who leave institutional practice to enter private practice. Doctors in private practice for more than five years qualify as Ordinary Members and have to pay $100 - annual subscription fees.

The subscription fees may appear high compared to the other national or medical societies, but we are not a "social" organisation. We have a College office with staff to maintain; a Library which needs to be equipped, and all the ancillary obligations associated with any educational institution.

We are thus appealing to those of you who have yet to become members to join the College and thus strengthen its existence. Application forms are available on request from The Administrative Secretary, College of General Practitioners, 4A College Road, Singapore 3.

NEWS IN PICTURES — SMA ANNUAL DINNER & DANCE

SMA President in action.


Well looked after.


Ladies man.


"Psychotherapy or Hypnotherapy. . . I'll have none of that"


"Wot! No more food?"

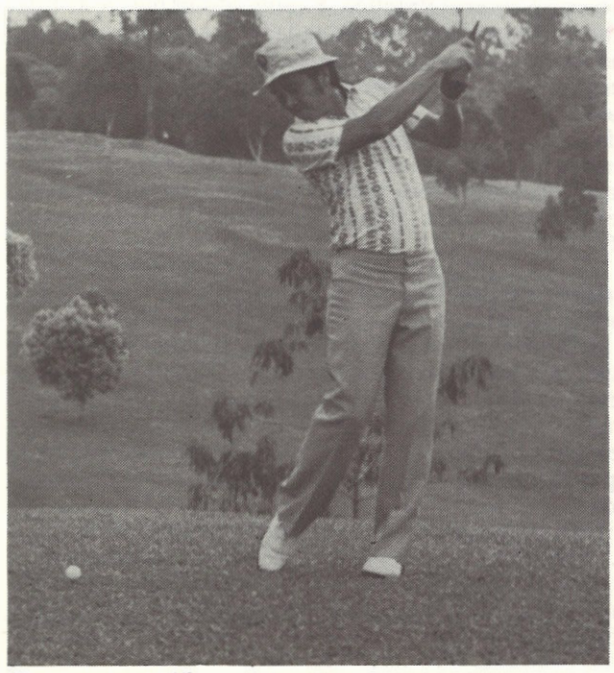

"10 bowls for 9 — I'll take 2"

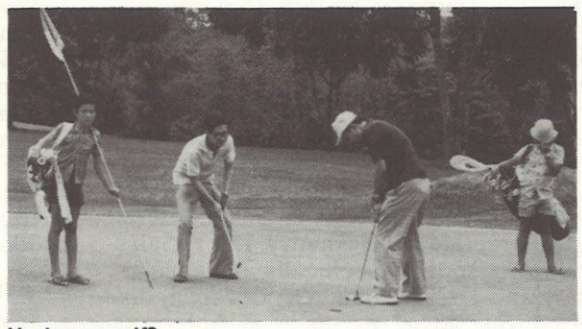

"Cough it up — Support Medik Awas."


"My new bath tub".

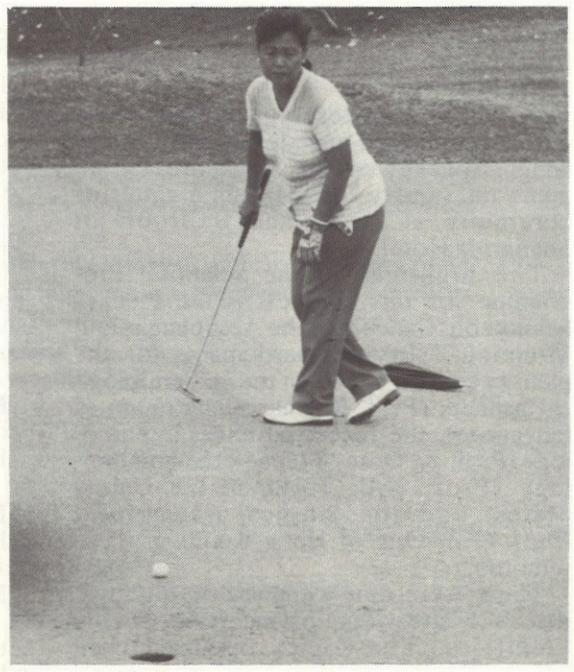

Squash convenor swipes 'em all.

SMA GOLF TOURNAMENT


"Drat — missed it!"


Hockey or golf?


"That's the way to the hole".


"Pray go in".

FOR YOUR INFORMATION

Recent Events

1ST INTER-CONGRESS — A 'MAXI' CONGRESS!

The 1st Asian Federation of Obstetrics & Gynaecology Inter-Congress was held in Singapore on 27 to 30 April 1976. The Congress was organised by the Obstetrical & Gynaecological Society of Singapore. The term 'Inter-Congress' was chosen at the last Asian Congress of Obstetrics & Gynaecology in Kuala Lumpur in 1974. The idea was to hold a 'mini' Congress or Symposium between the main Congress. However the 'mini' Congress turned out to be a 'maxi' Congress by the time it was held in Singapore in April. Altogether 571 delegates and associates attended the Congress of which 437 were from overseas and 134 from Singapore.

The three themes for the Congress were:-

(1) Control of Fertility
(2) Prostaglandins
(3) Trophoblastic Disease

All the three themes were especially chosen as they have a relevance to this region. As a developing country, we are very keen to know the advances in fertility control and also to tell the world of the success of our family planning programme. Prostaglandins have been widely researched in the Department of Obstetrics & Gynaecology, University of Singapore since Professor S.M.M. Karim joined the Department as a Research Professor. Trophoblastic disease has been studied in detail in Singapore especially in the Department of Obstetrics & Gynaecology, University of Singapore. There were 15 invited speakers for the three topics and they came from 8 countries. Altogether there were 102 scientific papers presented at the Congress over 3½ days.

The Congress was a great success as evidenced by the large turnout of overseas and local delegates. Representatives from important Obstetrical & Gynaecological organisations were present at the Congress including the President and Secretary-General of FIGO (Professor B.N. Purandare and Professor De Watteville respectively), the President and Honorary Treasurer of the RCOG (Professor C.J. Dewhurst and Dr. George Pinker), President and Secretary of the Asian Federation of Obstetrics & Gynaecology (Dr. A.B. Marzuki from Malaysia and Dr. J. Fuentes from Philippines) and also the representative from the RCOG in Australia, Dr. P. Elliot.

The Congress was opened by the President of the Republic, Dr. B.H. Sheares and it was held at the Hilton Hotel. Apart from the scientific programme, a very comprehensive social programme was provided for the affiliates including home hospitality entertainment

This enabled the visitors to meet and get to know Singaporeans in their homes.

The Techno-Commercial Exhibition was also held at the Congress and many representatives of scientific instruments and drug firms were present to show their goods.

The Organising Committee is to be congratulated for the success of the Congress and credit must go to the Congress President, Dr. C.S. Oon, the Chairman Professor S.S. Ratnam, the Secretary-General Dr. K.M. Seng and the rest of the Organising Committee for their hard work. Most of the foreign visitors remarked that this was one of the best Congresses they have ever attended and they will come again.

COMBINED ASIAN-PACIFIC CONGRESSES — A GREAT SUCCESS

The Fifth Asian-Pacific Congress of Gastroenterology and the Second Asian-Pacific Congress of Endoscopy were held in Singapore from 23rd to 29th May 1976. The combined registration was 920 (inclusive of 114 social registrants).

Dr. Benjamin Henry Sheares, President of the Republic of Singapore, was the patron for both Congresses which were held under the aegis of the Asian-Pacific Association of Gastroenterology and the Asian-Pacific Zone of the International Society of Endoscopy. The Congresses were organised by the Gastroenterological Society of Singapore, under the Chairmanship of Prof. Seah Cheng Siang, president of the Society.

The Gastroenterology Congress was officially declared open by Dr. Yeoh Ghim Seng, Speaker of the Singapore Parliament, on Sunday 23rd May, in a glittering ceremony at the Island Ballroom of Shangri-la Hotel.

The highlight of the Scientific Programme for this congress is the Plenary Session on 'Cancers of the Aesophagus and Stomach." Invited participants for the plenary session spoke on the epidemiological aspects (Prof. K. Shanmugaratnam of Singapore), the recent advances in pathology (Prof. K. Oota of Japan), the immunology (Prof. K.B. Taylor of the United States) and the Surgical management (Prof. G.B. Ong of Hong Kong) of these tumours.

There were nine symposia on digestive diseases prevalent in the Asian-Pacific Countries. The topics discussed were "Management of Peptic ulcer disease", "Recent advances in Viral Hepatitis", "Immunology in Gastrointestinal diseases", "Surgery of biliary tract disease", "Diarrhoea in infancy and childhood," "Recent advances in diagnosis and management of Pancreatic tumours," "Malabsorption" and "Radiology in Immunology."

The endoscopy congress was officially opened by Dr. Ho Guan Lim, Director of Medical Services, on Friday 28th May in a well-attended ceremony at the Shangri-La Hotel.

In the Plenary Session five eminent endoscopists were invited to speak on "The Present Status of Gastrointestinal Endoscopy." Prof. K. Kawai of Japan and Dr. P. Cotton of England gave a general outline of the current status of this relatively new field in Gastroentecology. Dr. G.S. Nagy of Australia emphasised the application of endoscopy in Gastroenterological practice in his country. Dr. Y. Sakai of Japan spoke specifically on Colonoscopy and Dr. Y. Hara, also of Japan, discussed the advances made in fibreoptic instrumentation.

Symposia were held on "Therapeutic Methods in Endoscopy", "Early Detection of Gastric Cancer" and "Endoscopic Retrograde Cholangio-pancreatography."

A Reception at the Istana was hosted by Dr. Toh Chin Chye, the Minister for Health, and the Official Banquet was attended by President B.H. Sheares and Mrs. Sheares as the Guests-of-Honour.

The Social activities also included a Cultural Night at the Victoria Theatre and a Ladies Programme.

Forthcoming Meetings/ Conferences

● **British Medical Association — Annual Representative Meeting** will be held from **15th — 17th July, 1976** in the **Bloomsbury Centre Hotel, Coram Street, London WC1.** The meeting will deal with important questions of policy affecting the Association and the profession. The Singapore Medical Association will be represented by Dr. Victor L. Fernandez, a member of its present Council.

● **4th World Congress on Medical Law** to be held from **16 — 19 July 1976.** The group discount return air-fare, Singapore Manila is $693 - per person The stipulation is 5 days minimum and 30 days maximum stay in the Philippines.

Please obtain from the President of the Medico-Legal Society, Dr. Chao Tzee Cheng an introductory letter enable you to get this discount. You must make your own travelling arrangement. Please note that this fee does not include hotel and conference fees. For information on the congress, please write to the General Secretariat, Apotheekstraat 5, B-9000 Gent, Belgium. Incidentally the conference fee is US$120 - for registrants and US$50 - for accompanying persons.

● **The Second Week-End Medico Legal Seminar** will be held at the **Shangri-La Hotel** from **July 31 to August 1, 1976.** A medical and legal book fair is being organised in conjunction with this seminar and will be held in the foyer of the hotel.

The topics to be discussed at this Seminar will cover a wide spectrum of medical and legal subjects of particular interest will be the reconstruction of the Mimi Wong Trial. The doctors and lawyers involved in this trial will discuss the medical and legal problems faced by them in the trial. Other topics to be covered are 'Sexual Offences', 'Firearms' and 'Criminal Ballistics', 'The Expert Witness' and 'Scientific Evidence — Narcotics and handwriting analysis'. The speakers, discussants and Chairmen of the various topics will include senior members of the medical and legal profession.

Members of the S.M.A. are welcome to participate in this Seminar. A fee of $35 for non-members and $20 for medical and law students will be charged. This will cover conference materials, lunch and teas.

Registration for the Seminar can be made either through the Society, 4A College Road, or through Dr. Chao Tzee Cheng, Department of Pathology, Outram Road, Singapore.

● **Practitioners Seminar on Drug Abuses:** A Seminar organized by the Singapore Anti-Narcotics Association for Doctors on the present trends and management of Drug Abuse will be held on Sunday, 15 August 76 from 2.30 p.m. to 6 p.m. at the Bougainvilla Room, Hotel Equatorial. We have invited a Panel of eminent speakers to deal with the various aspects of the problem. The Seminar will be opened by Dr. Ho Guan Lim, Director of Medical Services, Singapore. Speakers: Prof. O.T. Khoo, Prof. C.S. Seah, Dr. T.S. Yeoh, Dr. T.C. Chao, Mr. J. Hanam and others.

● WONCA Summit Conference: **7th World Conference on General Practice Family Medicine** from **1-8** October, 1976 at Toronto, Canada.

The purpose of the Conference is to present new concepts, current techniques and recent research applicable to family medicine, dealing with medical care from conception to old age.

Further details relating to registration, travel costs, etc. are available from the College of General Practitioners, 4A College Road, Singapore 3, Telephone 70606.

● **Commonwealth Medical Association's 8th Council & Scientific Meetings** to be held on **5-10th December, 1976** at **New Delhi.** The main themes of the Scientific Meeting will be: Population Control — Role of Medical Profession; Reforms in Medical Education and Scope of Traditional Medicine in Delivery of Health Care.

Members of the S.M.A. are cordially invited to present papers at this Meeting and to take part in the discussions.

Further details of the meeting are available from the Hon. Secretary of the Indian Medical Association, IMA House, Indraprastha Marg, New Delhi-110001, India who are the organisers for the CMA Scientific Meeting.

OPOSED SMA DIRECTORY

e Council of the SMA is care-
considering the advisability and
ility of a Directory of medical
itioners in Singapore. There
een several requests from its
ated bodies and individual
ers to look seriously into the
r.
e following are some of the pro-
l principles governing such a
tory:-
All registered medical practi-
rs in Singapore, whether mem-
or not of the SMA, shall be
d to submit data for listing,
is free of charge.
The Directory shall include
about a medical practitioner, as
vs:-
Name
Degrees /professional qualifi-
ns with dates of acquiring these
Address of office/home
Telephone number
Speciality (if any)
Hobbies and publications
Honours and awards
Public activities
The listing of the speciality of a
cal practitioner shall be deter-
d as f ws:-
The speciality for listing will
bmitted by the medical practi-
r himself
Such submission shall be
npanied by a signed, solemn
witnessed declaration that he
indeed confine himself to the
ice of such a speciality
The procedures under 3(a) &
hall be repeated during the
collection of data for each subse-
quent edition of the Directory
(d) If the SMA Council receives substantiated evidence that the medical practitioner contravenes his declaration of 3(b), the name of the said medical practitioner shall be removed from the speciality listing and placed in the "general" listing instead. The SMA Council shall reserve an absolute discretion to do this.
(e) No medical practitioner shall be permitted to have more than one speciality listing against his name in the same edition of the Directory.
4. The SMA shall point out, in the Directory itself, that it shall not be responsible in any way for the veracity on accuracy of the data therein.
5. The Directory shall be distributed free to SMA members. A fee for copies of the Directory shall be levied on doctors who are not SMA members. The circulation of the Directory shall be restricted to registered medical practitioners only in Singapore.
6. Complimentary copies may be sent to associations affiliated to the SMA.
The SMA Council shall be very grateful if as many members as possible would write to the Hon. Secretary concerning their views on the proposed Directory. Any suggestions will be welcome and all points of view carefully considered before the Council embarks on any action in this matter.

ETHICO REPORTS

cently, there has been a lot of
spondence in the press regard-
ne issue of medical certificates
the role of company doctors.
Singapore Medical Association
s Committee recently met over
mportant issue and have pro-
d the owing rules and guide-
for all practitioners. All doctors
d read these guidelines care-
especially those employed in
rivate sector who countersign
cal certificates. The rules pro-
d by the Ethics Committee are:-
A doctor can differ from
ner in opinion.
In disagreeing, it would be a
er of courtesy for a doctor to
some personal discussion with
ther doctor. However, courtesy
ot be compelled.
A patient who feels ill-used by
loctors' disagreement can take
n against one doctor basing on
pinion of the other.
A doctor certifying a patient with the knowledge that the certificate is going to be scrutinised by another doctor will be wise to have a medical report accompanying the certificate.
Company doctors can face risks of being sued by either private doctors and or employees in refusing to countersign medical certificates and they are therefore advised to exercise great care and integrity in doing so in order to avoid possible trouble. It would be important not to impute professional incompetence when disagreeing. If the company doctor certifying the medical certificate has not seen the patient at the time of his complaint when he visited his own private doctor, it would be prudent for him to contact the other doctor to find out the grounds for which the medical certificate was issued to avoid misunderstanding and possibility of being sued by the employee for negligence or by his private doctor for defamation.

17TH S.M.A. COUNCIL

President	Dr. Frederick Samuel (re-elected)
Vice-President	Dr. Choo Jim Eng (re-elected)
Hon. Secretary	Dr. Toh Keng Kiat (re-elected)
Hon Treasurer	Dr. Loh York Siong
Council Members	Dr. Allan Ng
	Dr. V.L. Fernandez (re-elected)
	Dr. Charles Ng (re-elected)
	Prof. Phoon Wai On (re-elected)
	Dr. Geoffrey Chiam (re-elected)
	Assoc. Prof. Chia Boon Lock
Editor, SMJ	Assoc. Prof. Lim Pin (re-elected)

Increased Subscription Rate

Effective from 1st June, 1976 the annual subscription rate for membership of the Medical Defence Union has been increased from £25/– to £40/– for medical practitioners who have been qualified for more than one year when applying for membership.

The rate of £5/– for newly-qualified doctors (within 1st year of qualifying) remains the same.

Although we have not, to date, received any official notification from the Medical Protection Society about the increase we understand that the M.P.S. will follow suit.

The rate of conversion as at the time of writing is S$4.50 to a £1/–, and £40/– is equivalent to S$180/–. The conversion rate is adjustable at the beginning of each month because of the fluctuation of the pound sterling.

Free Parking for G.P. s!

Copy of letter to our President Dr. Fred Samuel from the Port of Singapore Authority relating to the free transport facilities offered to S.M.A. members attending to patients on board ships at the Container Terminal.

Dear Sir,

I would like to refer to the very congenial meeting we had with the Vice-President, the Secretary and Treasurer of your esteemed Association, and would like to place on record the matters discussed and the decisions arrived at.

It was kind of the SMA to signify its ready appreciation of the hazards at the Container Terminal operational areas, and agreement that rather than seeking parking facilities at the Container Terminal, medical practitioners would be encouraged to make use of the free shuttle service available at the Container Terminal. In cases of extreme medical emergencies, the PSA's ambulance service would be available on request by dialling the PSA telephone exchange (76021 or 914755).

With reference to Pasir Panjang Wharves, which was also discussed at the meeting, I am pleased to inform you that in view of the different safety considerations applying to this gateway of the port, PSA is prepared to permit entry of vehicles displaying the "Doctor on Emergency Call" car label (form NP 171).

I would like to take this opportunity to thank your Association for agreeing to circularise its members on this matter.

JAMES AU
Officer-in-charge, PSA Police

S.P.C. Insurance Scheme

Dear Sirs,

The Insurance Scheme of the Singapore Professional Centre (S.P.C.) since its establishment in 1972 has continued to serve the interest of its members. It has retained the service of S.F. Leow & Co (S) Pte Ltd, an established Insurance Broking and Consultant Firm, to provide professional advice on the insurance requirements of the members of the Singapore Professional Centre and to ensure that more favourable terms than can normally be obtained and secured for members individual insurances.

The S.P.C. Insurance Scheme offers special rates for insurance on a group discount basis and provides a comprehensive range of insurances such as:—

Motor, Fire, Burglary, Money, Golfing, Houseowners, Householders, All Risks, Professional Negligence, Fidelity Guarantee, Employers' Liability, Public Liability, Personal Accident, Surgical Expenses, Life Assurance.

In addition the S.P.C. has now decided to share its annual commission with the subscribing members and with the member associations. Fifty per cent of its annual commission which amounts to a third of the profit obtained from the scheme by S.F. Leow & Co, will be given to the subscribing members and twenty per cent to the member associations. With the introduction of this policy which is beneficial to all concerned, it is hoped that member associations will give the scheme their fullest support.

Thank you.

(Lim Chan Yong)
Chairman, S.P.C.

Association of Surgeons of South East Asia Inaugurated

The Association of Surgeons of South East Asia was formed at the inaugural meeting held on 23rd May at the RELC, Singapore. There were 17 overseas delegates from Hong Kong, Indonesia, Philippines and Malaysia and 22 from Singapore.

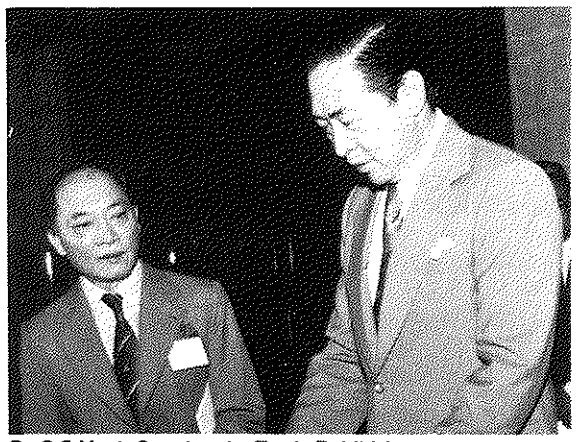
Prof G.B. Ong of Hong Kong was elected President and Dr. T. Oposa (Philippines) as President Elect. The following Surgeons were elected to the Council.

G.B. Ong and F. Cheng (Hong Kong)
T. Oposa and F. Caujunco (Philippines)
R. Sjamsuhidajat and R. Koestedjo (Indonesia)
M. Balasegaram and P. Vanniasingham (Malaysia)
T.Y. Lin (Taiwan)
Lim Koonvisal (Thailand)
R. Nambiar and J.E. Choo (Singapore)

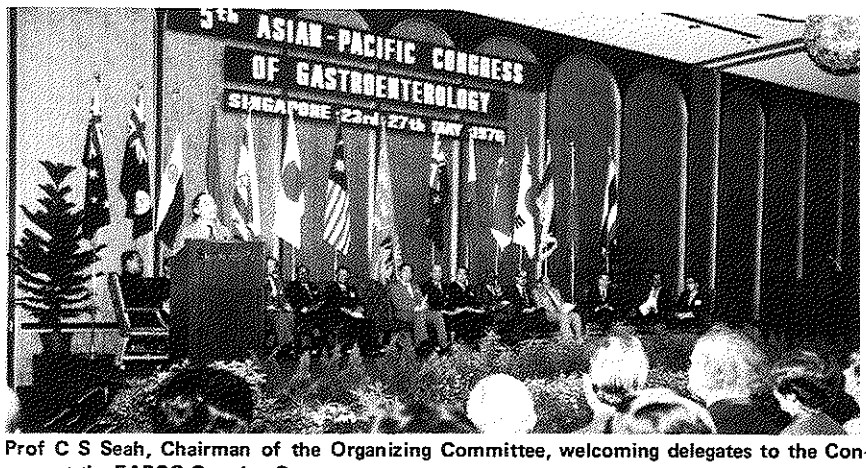
The 1st Scientific meeting of the Association will be held in Hong Kong in September 1977 and the next one in Manila in 1978.

Ordinary membership will be open to all qualified Surgeons in the S.E.A. Countries over the age of 30 years. The registered office of the Association will be in Hong Kong.

5TH ASIAN PACIFIC CONGRESS OF GASTROENTEROLOGY



Dr G S Yeoh Opening the Trade Exhibition.

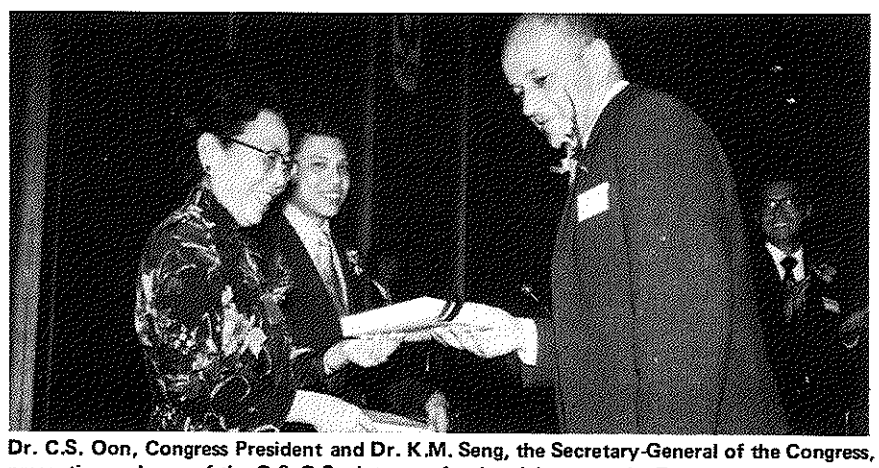


Prof C S Seah, Chairman of the Organizing Committee, welcoming delegates to the Congress at the 5APCG Opening Ceremony.

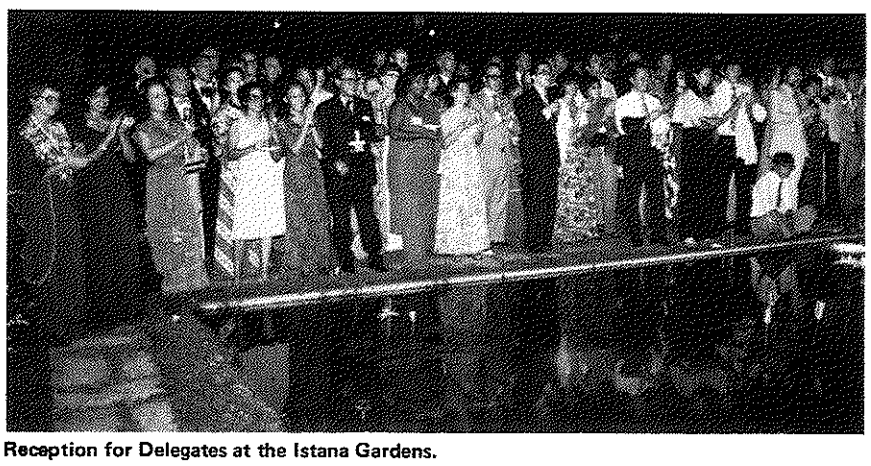
The large distinguished gathering at the 5APCG Opening Ceremony.

1ST INTER-CONGRESS — ASIAN FEDERATION OF O&G

Professor S.S. Ratnam, Chairman of 1st AFOG Inter Congress, addressing the Opening Ceremony.

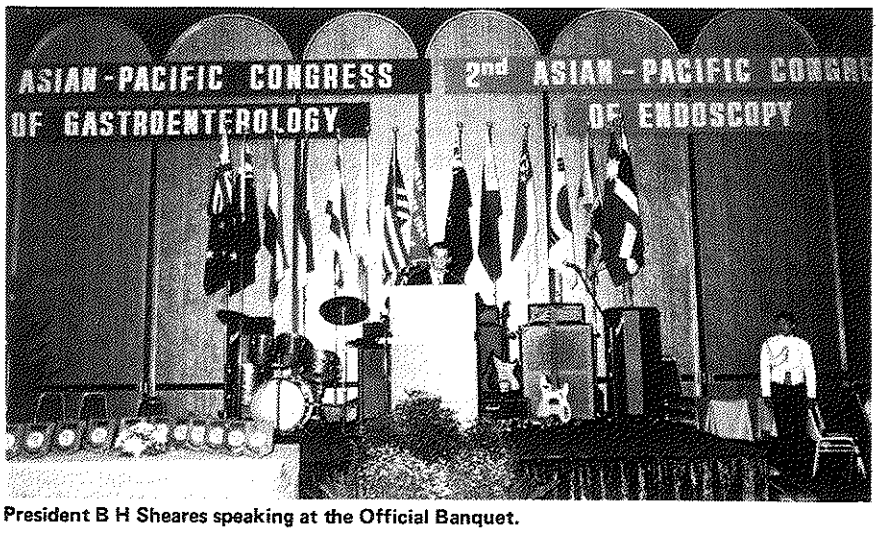


Dr. C.S. Oon, Congress President and Dr. K.M. Seng, the Secretary-General of the Congress, presenting a plaque of the O & G Society to a foreign delegate at the Banquet.

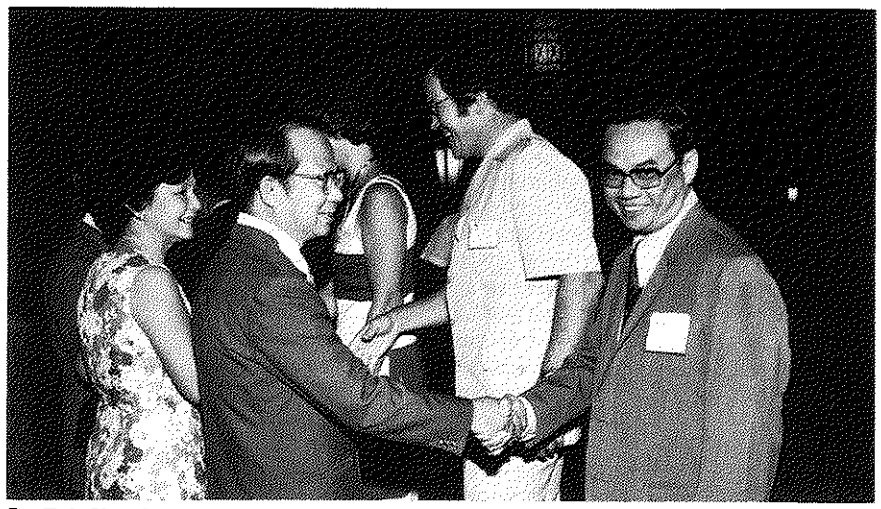


Reception for Delegates at the Istana Gardens.

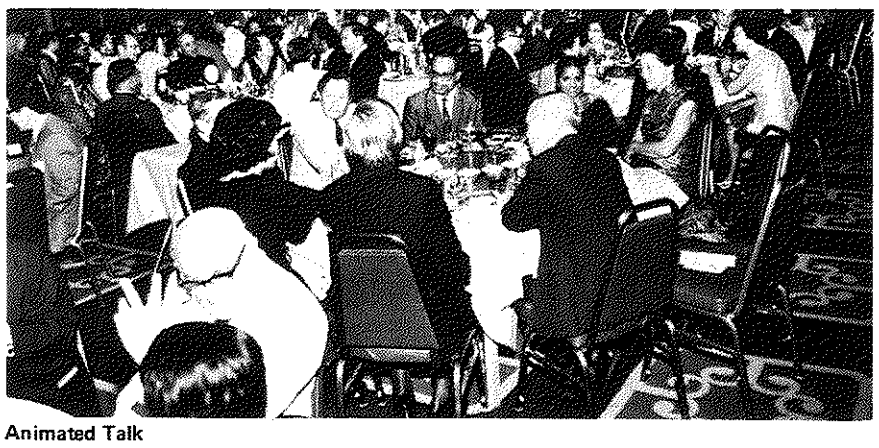
OFFICIAL BANQUET — 5th APCG & 2nd APCE — ISTANA RECEPTION



President B H Sheares speaking at the Official Banquet.



Dr. Toh Chin Chye, Minister for Health, and Mrs. Toh welcoming registrants.



Animated Talk

Mmm ... A Gastrognomical Delight.

RATIONAL DRUG THERAPY

Use and Misuse of Corticosteroids in Bronchial Asthma

Corticosteroids are invaluable agents in the management of serious bronchial asthma and they are usually effective in helping a great number of patients with this distressing disorder. However corticosteroids are a double edged weapon and should not be used until other more conservative measures have been tried. Misuse or indiscriminate use of corticosteroids will result in many serious adverse reactions and some of them can be fatal. There is no justification at all in using corticosteroids in the treatment of mild and episodic asthma. When bronchial asthma cannot be adequately controlled by hyposensitisation, disodium cromoglycate (Intal), and bronchodilators, it will be necessary to use corticosteroids as bronchial asthma is potentially a very disabling and even fatal disease. Refusal to use or delay in the use of corticosteroids in these circumstances will lead to unnecessary sufferings for the asthmatics who will eventually end up a respiratory cripple or invalid.

Selection of Patients

As corticosteroid therapy is often accompanied by many serious side effects, a proper selection of patients is most important. Patients with bronchial asthma are suitable for corticosteroid therapy if 1) a life threatening episode has occured in spite of adequate use of bronchodilators i.e. status asthmaticus, or 2) the asthma has become chronic and is severe enough to produce serious limitation of physical activities leading to financial loss due to frequent absence from work among the adults and loss of schooling and growth retardation among the children. However the therapeutic approach to these two clinical situations is quite different.

Status Asthmaticus

In status asthmaticus, a very high dose of corticosteroids should be used over a short period of time to tide the patient over the crisis without necessarily committing the patients to long term corticosteroid therapy. The dose can be reduced rapidly and withdrawn over a few days without giving rise to any complications of pituitary-adrenal axis suppression. As soon as the diagnosis of status asthmaticus is made, it is imperative to give hydrocortisone 200 mg intravenously sending the patient to the hospital. After arrival in the hospital, the hydrocortisone should be continued at the dose of 200 mg two hourly. If the patient was on long term corticosteroid therapy before, higher dosage of hydrocortisone may be required because the metabolic clearance rate of cortocosteroids is few times greater in the steroid-treated asthmatics than in the untreated asthmatics. This difference is mainly due to enzyme induction in the liver by previous corticosteroid therapy. However, the clinicians must realise that it may take up to 8 hours or more before the patient shows any response to the corticosteroids and other therapeutic measures need to be taken if the patient's condition deteriorates during this period of time. There is no question now that the massive dose of corticosteroids used in the treatment of status asthmaticus is life saving and no patient should be denied this valuable drug.

Chronic Asthma

In severe chronic asthma, the therapeutic objective is to find a lowest maintenance dose capable of controlling the symptoms because the therapy is invariably a long term process. Many patients with chronic asthma which is causing continuous respiratory disability can be kept tolerably well with corticosteroids. As long term use is frequently unavoidable, some side effects which may be serious are only to be expected. Therefore its proper use demands an objective assessment of the patient's response to corticosteroid therapy. This can be done by giving the patient a seven day course of prednisolone 5 mg four times a day. The response should be assessed daily by recordings of forced expiratory volume in 1 second (FEV_1) or peak expiratory flow rate (PEFR) with a simple Wright's Peak Flow Meter. An increase of 25 per cent or more in the FEV_1 or PEFR can be expected if the airways obstruction is responsive to the corticosteroids therapy. It must be realised that not all chronic asthmatics respond to steroid therapy and the subjective improvement is most unreliable and cannot be used as a criterion for continuing steroid therapy. When the objective improvement after a seven day course of prednisolone is observed, the patient can then be given daily maintenance dose of prednisolene. In most patients, 5 mg to 10 mg of prednisolene will be adequate to reduce the number of acute attacks and maintain a fairly long symptom free period. If more than 10 mg of prednisolone is required, some complications will soon follow. The recent introduction of topical corticosteroids, beclomethasone dipropionate aerosol (Becotide), has made it possible to control steroid-responsive chronic asthma without exposing the patients to serious side effects of corticosteroids since only a very small dose is used. The standard dosage is 100 ug i.e. 2 metered doses four times a day. Every attempt should be made to substitute beclomethasone aerosol in patients taking a maintenance dose of prednisolone in excess of 10 mg per day.

DR. TEOH PEK CHUAN

What is the CHECK Programme?

It is an unique system whereby at your leisure, in the convenience of your home (or bed if it needs be), that assists you in an exhilarating, refreshing and candid assessment of your core and current knowledge without the embarrassment of making a public admission of your dificiencies.

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Apply directly for further information to:

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or to The College of General Practitioners Singapore, who will do all the paper work for you and get a handsome discount. Telephone 70606.

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ALUMNI ASSOCIATION ELECTS NEW CHAIRMAN

The new Office Bearers for the Alumni Association (Southern Branch) for the year 1976 — 1977 are as follows:

Chairman	Dr. Choo Jim Eng
Chairman-Elect	Dr. Moses Yu
Hon. Secretary	Dr. Fred Yeoh
Hon. Treasurer	Dr. Lim Ban Siong
Committee Members	Dr. N. Balachandran
	Dr. Djeng Shih Kien
	Dr. Lee Chee Onn
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	Dr. George Tay
	Dr. Wong Kwok Yun
	Dr. Yeoh Kean Hong
	Dr. Yip Wing Kong

S.G.M.D.O.A. — NEW OFFICE BEARERS

The new Office Bearers for the Singapore Government Medical & Dental Officers' Association for the year 1976-1977 are the following:—

President	— Dr Michael Yap Hock Leong
Vice-President	— Dr Wong Kai Peng
Hon. Secretary	— Dr Wu Dar Ching
Hon. Asst. Secretary	— Dr Walter Roland Chen
Hon. Treasurer	— Dr Nei I Ping
Hon Asst. Treasurer	— Dr Lee Choy Leng
Committee Members	— Dr Goh Beng Teik
	Dr Lim Shun Ping
	Dr Wong Saw Yean
	Dr Chan Yee Wing
	Dr Tan Ser Kiat

FIRST COLLEGE DINNER

The College of General Practitioners held its First College Dinner recently to honour those who had helped or supported the College over the past year. The President, Dr. B.H. Sheares and Mrs. .Sheares were the Guests of Honour. Among the guests were those who had helped in the teaching programme and some generous donors of the College. Leading people from the Health Ministry, Medical institutions and Societies — the Director of Medical Services, Dr. Ho Guan Lim; the Chairman of the Singapore Medical Council, Prof. Seah Cheng Siang; the Dean of the Faculty of Medicine, Prof. Wong Poi Kwong; the Acting Master of the Academy, Mr. V.K. Pillay; the President of the Singapore Medical Association, Dr. Fred. Samuel; the President of the Society of Occupational Medicine, Prof. Phoon Wai On were also among the invited guests.

The President of the College, Dr. Wong Heck Sing, in his address, paid tribute to the teachers who had helped in the teaching programme of the College. He said "the teachers not only had to spend considerable time in preparing material relevant to the practice of Family Medicine but had to deliver them at the most inconvenient times. All this was done without reward of any kind. This dinner is a small but sincere token of our gratitude to them."

ACUPUNCTURE - A NEEDLING PROBLEM

Sir,

In 1975, I asked the SMA through these columns about the position of qualified medical practitioners learning and using Acupuncture. So far no reply has been forthcoming from the SMA Council or the Ethical Committee. I would now like to ask again the SMA to state its position for the guidance of members.

(1) Does the SMA accept Acupuncture as a form of treatment, albeit a limited one? Perhaps we can compare it with medical hypnosis. The profession in Britain and America took quite a long time to accept hypnosis as a recognised form of therapy. Acupuncture has now become popular and topical among many doctors. I understand some have learned it and used it in their practice. Some of us had the opportunity to observe it working in China. There is no doubt Acupuncture deserves our serious study. I believe SMA should take a lead in this, thus guiding the profession.

(2) If the qualified medical practitioners are allowed to learn and practise Acupuncture, will they be infringing the Ethical Code on Association when they learn from acupuncturists outside the profession? So far the avenues available to us are:

(a) Self-learning through reading,

(b) learning from other medical practitioners who have been trained in acupuncture in China or Taiwan,

(c) attending a course in Taiwan (as advertised in the SMA Newsletter),

(d) learning from a Chinese Physician Acupuncturist in Singapoore, or perhaps

(e) applying to go to China to learn.

May we hear from the Council and the Ethical Committee please?

Yours faithfully,
RICHARD YUNG

ETHICO REPLIES...

A doctor is free to acquire any knowledge in any manner to extend his knowledge provided he pays attention to the ethical code especially with regards to personal advertisement, and association with unprofessional people, and also provided that the effort in the acquisition is lawful and not contravening any statutes of the country.

Hence there is nothing objectionable ethically in all the 5 methods stated, but he must sure that the people he associates with do not advertise him, or make use of his professional status to carry out practice permittors.

As regards S.M.A.'s attitude to acupuncture, this is not an ethical question, and should be referred to the Council of the SMA please.

DR. GWEE AH LENG
Chairman
SMA Ethics Committee

THE SMA COUNCIL'S VIEWS WOULD BE PUBLISHED IN THE NEXT ISSUE — EDITOR.

EXAMINATIONS

Part I & Part II Examinations for the Diploma of Fellowship of the Royal College of Surgeons of Edinburgh will be conducted in the Faculty of Medicine, University of Malaya, as follows:-

Part I Examination:
Written Section — Friday, 29th October 1976
Orals — Commencing Monday, 1st November 1976.

Part II Examination:
Written Section — Friday, 29th — Saturday, 30th October 1976
Orals — Between Monday, 1st November — Saturday, 6th November 1976 or thereabout.

Applications for admission to these Examinations and requests for further information may be made to the Assistant Registrar, Board on Postgraduate Medical Education, Faculty of Medicine, University of Malaya, Malaysia. The closing date for applications for admission to the Examinations in Kuala Lumpur is

Friday, 30th July 1976.

The fees for these Examinations are:-
Part I — M$589.20
Part II — M$736.50

Society meetings

The Society, in conjunction with the Department of Neurosurgery & Neurology, will resume the series of Wednesday lunch-hour clinical lecture/tutorials after the completion of the Advanced Course in Medicine and the M. Med (Internal Medicine) examinations.

The topics and speakers for the Month of July, are:—

Wednesday	Topic	Speaker
July 14th	A Practical Approach to Disorders of Gait	Dr S.C. Loong
Wednesday July 21st	Cerebral Edema	Mr James Khoo
Wednesday July 28th	Functional Psychoses	Dr W F Tsoi

These will be held as usual in the Department of Neurosurgery and Neurology Conference Room on the 2nd Floor, TTSH at 1.15 p.m.

The Saturday morning case presentation sponsored by the Society will continue as usual at 11.30 a.m. at the Dept of Neurosurgery & Neurology Conference Room, TTSH; and at 11.30 a.m. at the Hospital Conference Room in Woodbridge Hospital for Psychiatry.

The Concept of Brain Death - Definition & Diagnosis

BY DR. S.C. LOONG

Introduction

Recent explosive developments in medical science have shaken the traditional definition of death and necessitated its re-evaluation. This re-evaluation involves the concept of brain death.

My purpose is to present to you our current knowledge about this new concept of death — in particular, its necessity, significance, definition and diagnosis.

Necessity & Significance of the Concept of Brain Death

Traditionally it has been held that the heart is the seat of life. Thus, one speaks of "the heart of the matter", "Heart and soul" or "to die of broken heart". Traditionally, therefore, life simply ceases with the cessation of heart beat and respiration. Today, with improved medical care, the inability to detect such vital signs as heart beat or respiration cannot always be taken to indicate irreversible cessation of life. Moreover, science has shown that the brain and not the heart is the seat of consciousness and the mind. It thus becomes both necessary and logical to re-define death at the brain level.

It is important to emphasize that brain death is an extension and not a replacement of the traditional concept of the diagnosis of death — an extension which has been made necessary by the modern technology of resuscitation. With such technology, brain death would not have been an issue today, for if there were no means of maintaining artificial respiration and blood circulation, there would have been no question that death had occurred. Therefore, in clinical practice, the question of brain death only arises when, in the course of an acute illness, respiration and or cardiac function suddenly stops; the resuscitation team restores and maintains these functions but the patient remains deeply comatose and the attending clinician is confronted with the dilemma of whether or not to turn off the respirator.

It is obvious that with rapid advancement of medical care at the borderline between life and death, this is going to be an ever-increasing problem. The dilemma created is not just a medical one — it has far reaching legal, religious and philosophical implications. From the medical point of view, however, it is of immediate importance to at least 4 groups of people connected with the patient:

1) Firstly, it is of importance to the patient's family who may be subjected to an unnecessarily prolonged period of psychological trauma and considerable expense.

2) Secondly, it is important to the hospital staff for it is wasteful of high-trained medical personnel and critical specialised bed space to attend to a patient whose brain is dead.

3) Thirdly, it is of importance to other patients who may need life-saving intensive care but who may be denied this because the bed and equipment are being taken up by a patient with no hope of recovery.

4) Finally, it is of importance to those who may be the recipients of transplantable organs as brain death patients are a valuable source of donor organs.

Definition and Diagnosis

Granted that brain death has become a necessary concept, how shall we define it?

Before I attempt to answer this, I would like to say a few words about the living brain for death is a negation, complementing the concept of life which is presupposes.

Although once described as a modest bowl of pinkish jelly, the brain is probably the most complex structure in the universe. It is made up essentially of 12 billion nerve cells. While consisting only 2 per cent of the body weight, the brain demands more than 25 per cent of its blood supply.

As an electronic system, its complexity and efficiency would put all computers to shame. It operates on less than 25 watts, receives about 100 million impulses per second from some 4 million sensory receptors. Some of this electrical activity can be recorded on the scalp as EEG which, as will be seen later, has relevance to the question of brain death.

Unfortunately, for all its wonderful versatilities, the brain cannot reproduce its components. Moreover — and this may come as a shock to some of you — between the ages of 20 and 80, 36 million of our brain cells die each year.

The concept of brain death is based largely on the view that intrinsic quality of life is the ability of the brain to support the body so that if that quality ceases to exist, so does life. In this connection, I would like to point out the uniqueness of the brain as an organ. You may ask for a kidney transplant, a heart transplant, or a liver transplant, but you cannot really ask for a brain transplant even if it were technically possible one day .. because the transfer of the brain could only be looked upon as providing it with a new body. The recipient of a brain transplant could only end up as the donor of a body.

The ultimate cause of brain death is anoxic damage to the brain i.e. damage through ultimate lack of oxygen; this in turn may be due to either (a) structural disease of the brain such as haemorrhage or infection or (b) an anoxic state induced by drugs, toxins or other organ failure.

It is well recognized that the brain is the least tolerant of all organs to a lack of oxygen — it can be destroyed by as little as 5-6 minutes of total anoxia. What follows after a severe anoxic insult is that the brain swells with edema which further aggravates the brain anoxia by impending blood flow, the brain cells degenerate and, depending on the duration the 'cadaver' has been on the respirator, the brain liquifies, producing a condition referred to by neuropathologists as "respirator brain".

There is a descending order of sensitivity to anoxic insult within the nervous system itself. With the arrest of circulation the cells of the brain cortex would die within 5 minutes, the cells of the other parts of the brain within 15 minutes while the spinal cord and the peripheral system continue to function for longer periods. From this it is clear that while the exact moment of death is a concept well fixed in popular imagination and duly recorded in legal documents, it is biologically speaking a fiction. Death is a gradual process which occurs over a period of time and not at a fixed point in time. All the cells of the brain do not die simultaneously (except in rare instances of death by explosion) i.e. the brain dies in a piece-meal fashion so that at a particular point in time death may be only a relative state with some cells dead, others dying and still others living.

It also becomes clear that the definition of death is an extremely difficult matter. However, since one of the undisputed criteria of death is its finality, its irreversibility, it has been generally accepted that, in practical terms, brain death may be defined as the IRREVERSIBLE CESSATION OF BRAIN FUNCTION. In other words, the question of brain death is not one of the exact time of occurence of cellular death but that of the point of no (functional) return.

The signs of brain death are basically simple and include:-

TABLE I

Clinical Criteria of Brain Death

Deep coma — failure to respond to even most intense stimuli

No spontaneous respiration

Absence of brain stem reflexes
dilated and fixed pupils
absent corneal reflexes
absent ciliospinal reflexes
absent gag reflex
absent occulocephalic reflex
absent oculocaloric reflex
absent tonic neck reflex

Above conditions present for 12 — 24 hours

A prerequisite to the application of these criteria in the diagnosis of brain death is that all appropriate diagnostic and therapeutic measures have been performed — this eliminates the possibility that the criteria might be applied to comatose patients with reversible conditions, such as drug intoxication or intracranial haematoma.

A number of laboratory tests have been found to be useful in the confirmation of brain death.

TABLE II

Laboratory Criteria of Brain Death

The most useful of these is the EEG. The essential EEG characteristic of brain death is electrocerebral silence. Some centres do not consider an EEG necessary. It is my opinion that, laboratory tests such as the EEG, where available and practicable, should be performed, especially in cases of potential organ donors. The objective laboratory findings relevant to the determination of brain death can go a long way towards allaying the universal deep-rooted fear of premature announcement of death or mutilation. As Professor Daube has aptly said, "Death, like justice, should not only be done but seen to be done."

It may be quite sometime before the general public accepts unreservedly the medical concept and definition of brain death as an extension of the old traditional heart of the matter. It is important to remember that this new concept is being adopted not for the convenience of the attending physician, but for the protection of the living and the dying whose right to live and right to die all of us should consider.

Tests	Result
EEG	Flat
ENG	Flat
Echo	No echopulsations
Atropine test	No tachycardia
Cerebral blood flow	No significant flow
Brain scanning	Cold brain

Congratulations

Mr. Yahya Cohen, until recently Head of Surgical 'B' Unit, Singapore General Hospital and now a Consultant Surgeon in Private Practice, was recently elected to the Fellowship of the Royal College of Surgeons in Edinburgh. This award of election is made to registered practitioners of not less than 20 years' standing whose professional status is of a high order and who are deemed to have rendered special service to surgery in general. This is the first time that this singular honour has been awarded to a Surgeon from Singapore.

Professor Phoon Wai Onn, Head of the Department of Social Medicine and Public Health has been recently elected to the Fellowship of the Royal College of Physicians of London. He is also a Fellow of the Royal Colleges of Edinburgh and Glasgow and the Faculty of Community Medicine of the Royal Colleges of Physicians of the United Kingdom.

Dr. Chew Chin Hin, Senior Chest Physician of Tan Tock Seng Hospital, has recently been elected Overseas Member of the Association of Physicians of Great Britain and Ireland. This honour is restricted to 20 at any one time.

Dr. R. Sivasamboo, until recently Senior Consultant and Head of the 'O' & 'G' Department of the Toa Payoh Hospital and now in Private Practice was recently elected to the Fellowship of the Royal College of Obstetricians and Gynaecologists of London.

Associated Professor Lim Pin of Medical Unit II, Singapore General Hospital has been elected a Fellow of the Royal College of Physicians of London.

Progress in Medicine

(Continued from Page 3)

scription and dependence on drugs for treatment. Osler writing in his text book on medicine constantly expressed little faith in the value of drugs. He is credited with a statement that the difference between man and animal is that man has an insatiable appetite for drugs. Cochrane has pointed to the numerous statistics which demonstrate the influence of suggestion in treatment and the total ineffectiveness of a large number of forms of treatment. Cynically, he says there is much value and importance of the effects and benefits of placebos and faith healing.

It is estimated that about 20 to 30 billion US dollars is spent on medicines annually throughout the world. Expenditure on drugs represents 1 per cent of the GNP in the developing countries and this amounts to about $20 to $60 per capita per year in these developed countries. It is also estimated that this expenditure is increasing at the rate of 10 per cent a year. It cannot however be said that such high and increasing expenditures are due to deteriorating standards of health. Rather it is the increasing appetite for drugs abetted by the medical profession.

I would be loath to place the entire blame on the medical profession. Like Osler, I believe that it is part of our nature or constitution to crave for some form of stimulation or soothing agent. Every society in time and space has had its stimulant — coffee and tea, are examples. The point at issue is whether the profession should encourage such a practice which is both costly and pernicious. Worse still we could be responsible for the "drug culture", the rise in drug addiction throughout the community!

(6) Medical progress has also created moral problems. Enormous powers have been placed in the hands of medical men, the effects of which can be surmised even at this early stage.

Medicine has been mainly preoccupied with death control, less with birth control. It must, accordingly, accept some responsibility for the explosive growth of population we witness throughout the world today.

Prolongation of life also raises the question whether the increase in longevity adds to the quality of life. For it will be of no benefit if people are kept alive if living has no meaning, and the person is prey to a host of illnesses wracked with pain or dependent on others.

The moral issue is whether because we have the technical ability it has to be applied. Technology has run ahead of the means to carry through these procedures universally and before the moral issues have been settled. There is now the technical ability and skill to maintain the vital functions of the heart, the kidneys and the lungs. The technical skills have extended to replacement of certain parts of the body, in the press known quaintly as "spare-part surgery", and extending to transplants of kidneys and the heart. Not every person suffering from these conditions can benefit from these advances. Thus, less than 10 per cent of all persons with end-stage kidney diseased are placed on a kidney dialysis machines and 1 per cent of these only are able to obtain transplants, 90 per cent therefore are left to let the disease run its course and eventually die.

It is fashionable to be critical of the great physical and social sciences. Medicine, no less than the other sciences, comes in for its share of criticisms. There is a need for a social conscience. There is perhaps an even greater need for rethinking the preceptions of our functions. As we record the great achievements in medical science we must be aware of the implications in applying such knowledge. We should have the humility to know that there are different solutions and different approaches to the problems which confront us. There is more than ever a need for cooperation by all persons of different disciplines and professions, to advance the well-being of the humankind in the preventive and healing art of medicine. The human animal is still imperfect and mortal. Our role is to support this person, with all his imperfections, to our best ability. Now that we have achieved some measure of control over nature, our next task is to be able to control our own nature, to be less aggressive, cruel and selfish.

A new lot of attractive **neck ties** made of 100 per cent polyester (in navy blue & maroon) has arrived and is available from the S.M.A. Secretariat at $8 - each.

SCC Sports Medical Research Grants Awards

The Singapore Sports Council (SSC) invites applications from interested persons and organisations to undertake relevant Sports Medical research projects in conjunction with and in line with the research aims and aspirations of its Runme Shaw Centre for Sports Medicine & Research (SM & RC) in the National Stadium.

1. **Number of Grants Awards:** Up to 4 per annum.
2. **Amount tenable:** Up to $10,000 – per successful grant award (including equipment costs).
3. **Aims & Objectives:** To stimulate, encourage and undertake Sports Medical research projects which are of relevance and practical application to Singaporeans, preferably as a whole.
4. **Applications:** Interested applicants should submit, in triplicate, a brief resume of the aims and objectives of their proposed research projects; how they are to be conducted; duration of study (with 6 – monthly reports if it exceeds 12 months); equipment and manpower requirements and costs; and their practical application.

All applications should be addressed to:

The Secretary
Advisory Committee to the Runme Shaw Centre for Sports Medicine & Research
Singapore Sports Council
National Stadium, Kallang
Singapore 14.

Applications for fiscal year 76/77 must be received by 31 Aug 76. The Advisory Committee to the SM & RC will screen all applications, decide on the merits, number and amount to be awarded. All equipment purchased, data obtained and papers produced shall remain the property of the SSC.

For further information and enquiries, please contact the undersigned (Tel. 467111).

DR. GIAM CHOO KEONG
Medical Officer I/C
Runme Shaw Centre for
Sports, Medicine & Research.

Institutional Treatment of Drug Addicts

Dr. Naranjan Singh
Senior Medical Officer
Changi Prison Hospital

DRUG ABUSE

The abuse of drugs often lead to dependence, which is a state arising from frequent or continuous administration of the drug, resulting in harm to the individual and to society. If the drug is withheld, emotional and physical illness is felt.

The number of addicts, especially heroin addicts, is increasing at an alarming rate. Since large sums of money are needed to support a "habit" there is often a direct relationship between addiction and criminal activity. When the addict is desperate, because of withdrawal symptoms, he may commit crimes in order to obtain his drug. That the humanity at large will ever be able to dispense with "artificial Paradise" seems unlikely.

CLASSIFICATION OF DRUGS ADDICTION

Drugs used for this purpose are often divided into two groups. (1) Hard (2) Soft.

1. **HARD DRUGS** are those that are liable to seriously disable the individual as a functioning member of society by inducing severe emotional and, in the case of cerebral depressants, physical dependence. This group includes opium, morphine, heroin and cocaine.

2. **SOFT DRUGS** are less dependence-producing. There may be emotional dependence, but there is little or no physical dependence, except with very heavy doses of depressants e.g. alcohol and barbiturates. This group includes sedative and tranquillizers, amphetamines, cannabis, hallucinogens, alcohol and tobacco. This classification does not recognise individual variation in drug use. Barbiturates can be used in heavy doses that are gravely disabling and induce severe physical dependence with convulsions, on sudden withdrawal i.e. for the individual the drug is "hard". But there are many middle-aged people, mildly dependent on them as hypnotics and sedatives, who retain their position at home and society. Similarly, amphetamines can be used in ways that cause doubt whether they should be described as "hard" or "soft".

TREATMENT OF DRUG ADDICTS

This consists of withdrawal of the drug, followed by attempts at mental and social rehabilitation to prevent relapse. In this direction authorities and organisations in Singapore have been working hard. Unfortunately they have not yet been able to achieve the desired results. There is a minority of cases who need psychiatric treatment. There is another unfortunate group of cases who suffer from painful and distressing diseases e.g. arthritis, neuralgias, peptic ulcer, peripheral vascular diseases like Burger's disease and even bronchial asthma; they resort to opiates in search of relief from their symptoms, thus falling prey to the addicting properties of the drugs. These cases must have their illnesses attended to as a part of their treatment.

In the case of drugs which cause physical dependence, withdrawal may be done by the judicious use of the same drug, but some prefer to use alternative drugs, generally, though not always, of similar kind; for instance a heroin addict can be given methadone, an alcoholic can be given chlordiazepoxide.

Marijuana does not lead to physical dependence. Chronic users become psychologically dependent upon the effects of marijuana. Sudden cessation of the use provide restlessness and anxiety which can be relieved by tranquillizers.

Withdrawal from large amounts of barbiturate is usually much more severe than heroin and must be done under medical supervision. Such addiction to barbiturates is hardly ever seen here.

WITHDRAWAL SYNDROME

Quite a large number of cases are occasional users of drugs. They hardly suffer from serious withdrawal symptoms. The typical withdrawal syndrome in opium, morphine and heroin addiction is seen only in heavy users. It consists of effects which are opposite to their normal action. When the addict misses his first shot, he senses mild withdrawal distress, but this is more psychological then physiological, for fear plays a considerable role in the withdrawal syndrome. At this stage a placebo may give relief. During the first 8-16 hours of abstinence the addict becomes increasingly nervous, restless and anxious. Close confinement tends to intensify these symptoms. Within 14 hours he begins to yawn frequently, he sweats profusely and develop running of eyes and nose comparable to that accompanying a severe head cold. These symptoms increase in intensify for the first 24 hours after which recurring waves of goose flesh occur. Severe twitching of muscles occurs within 36 hours and painful cramps develop in the backs of the legs and in the abdomen. (This is the origin of the term "kick the habit"). All body fluids are released copiously and there is vomiting and diarrhoea; there is little appetite for food and the addict is unable to sleep. The illness reaches its peak within 48-72 hours after the last shot of opiate, gradually subsiding thereafter for the next 5-10 days. The withdrawal syndrome proper is self limiting and most addicts will survive it with no medical assistance whatsoever. This is known as kicking the habit "Cold Turkey". Complete recovery requires three to six months.

Abrupt withdrawal is harsh, the addict undergoes the agony described. With the use of drugs, such as mist opii et chloral, methadone and largaetil it is possible to reduce the distress of withdrawal considerably.

CHOICE OF DRUGS USED FOR WITHDRAWAL

When I was posted to Changi Prison Hospital in the early sixties, the practice then was to treat opium and morphine addicts with mist opii et chloral or methadone. Both the drugs were tapered off in ten days. I found the dose of mist opii et, used, inadequate to control the withdrawal symptoms, whereas methadone, though very effective in controlling the withdrawal symptoms, was addicting enough to pose a problem. As a result other drugs were tried and largactil was found to be the most satisfactory.

ADVANTAGES OF LARGACTIL (CHLORPROMAZINE)

1. It is neither addicting nor habit forming. The patient under withdrawal treatment is allowed to continue it for as long as he wishes. It is interesting to note that the patient volunteers to discontinue it after about 10 days by which time he has overcome his addiction.

2. It is a powerful tranquillizer, the patient under withdrawal does not suffer from the usual restlessness.

3. It has a powerful antiemetic effort and controls vomiting which is often seen during the withdrawal period.

DOSAGE OF DRUGS USED FOR WITHDRAWAL

1. **Mist opii et chloral:** Patients under treatment with this are put on 10 ml of the mixture three times a day for the first three days, followed by twice a day for the next three days and once at night for the last four days. If insomnia is troublesome, amylobarbitone 200 mgm or seconal sodium 100 mgm is given at bed time.

2. **Methadone:** Patients treated with methadone are put on 5-10 mgm of the drug three times a day for the first three days, twice a day for the next three days and once at night for the last four days. Amylobarbitone or seconal is given for insomnia.

3. **Largactil:** Addicts under treatment with largactil are given 50-75 mgm of the drug three times a day. This dose is continued till the patient feels that he no longer needs it. For insomnia, an additional dose of largactil is given at bed time.

COLD TURKEY TREATMENT

The withdrawal treatment with the help of drugs is the "soft line" of treatment. Due to the disappointing results obtained by this line of treatment, as indicated by a very high incidence of relapse, the present attitude is to subject the addict to the "hard line" of treatment, which means the addict is given no medication whatsoever to relieve his agony resulting from the withdrawal of the drug. The purpose behind this line of treatment is to inflict a psychological trauma on the addict, in the hope, that he may give a careful thought before relapsing into the habit.

'Cold Turkey' treatment was introduced in Changi Prison Hospital in June 1974 and in Queenstown Remand Prison in January this year.

All addicts are medically examined before subjecting them to cold turkey treatment. Addicts above the age of 50, and those sufferings from serious diseases, are exempted from this treatment. The number of addicts that received cold turkey treatment are as follows:-

CHANGI PRISON

1974 (From June to December)	64
1975 (From January to December)	110
1976 (Up till end of February)	24

QUEENSTOWN REMAND PRISON

In January 1976	90
In February 1976	107
Total:	395

There were no cases whose life was endangered with this treatment.

Amusing Minutes

A doctor who had just started practice examined his first patient. He could think of no diagnosis of the symptoms, so he said "Have you ever had this before?"

"Sure," the patient replied 'I've had it twice before?"

"Well," advised the doctor with more assurance, "You've got it again.

●

A psychiatrist thought he was making progress with a patient who had split personality. "I was optimistic" he confessed, "Until the patient called and demanded to know why he had received only one bill."

●

A doctor was so busy tending to rich patients that he had no time for the poor who sat daily in his waiting room and went back.

A man who wanted his urgent help rang him up at his home at midnight. When the doctor replied in a weary voice, he said "I've been trying to see for three days. Can't you give me an appointment?"

"Fix it up with my secretary" replied the doctor.

"I did" said the patient. "I took her out to dinner last night. Now I want to see you."

●

A doctor says he can cure a woman of just about any complaint simply by telling her it a sign of old age.

●

The class of student nurses at the General Hospital were studying pharmacy and the professor was giving them a lecture on the various plants that are used for medicinal extracts.

"Now you take this 'Cinchona' twig from which quinine is made", the professor said and held up a small piece of wood. "The twig you see here is made of bark, hard wood and pith. I am sure you all know what pith is."

The student nurses were silent.

"Come now", the professor demanded, "Don't any of you would-be nurses know what pith is?" He turned to a girl in the front row.

"You there, Miss Chang, you know what pith is, don't you?"

"Yeth, thir?" said Miss Chang.

CHESS NOTES by Lim Kok Ann

JIMMY SNG BLITZ

Seven entries were received for the National Convention Lightning Chess Championship, a poor return for the Social Committee's enterprise. Each competitor played two games against his opponents, the main rule being: check mate your opponent within five minutes.

Results: 1st, Dr. Jimmy Sng Ewe Hui, 10 points; 2nd, Dr. Daniel Chua, 8½; 3rd, Prof. Lim Kok Ann, 8½; also played, Drs. Allan Ng, 7½; Gwee Ah Leng, 5½; Siak Chong Leng 1½, Albert Wee, ½.

Jimmy Sng well merited the first place. He placed a sound positional game and waited for his opponents to make mistakes. I was somewhat lucky to get the better of him in our encounter.

Daniel Chua has a good eye for combinations. I thought I could chicken him but the bird was too tough. In our first game I had a winning position when I lost on time; in our second game, I overlooked a wily trap and allowed my King to be captured (permitted in Blitz).

Allan Ng was a bit erratic otherwise he might have finished higher up. Gwee Ah Leng does not ratiocinate as rapidly as he used to and he lost several games by simple blunders. Siak and Albert need more experience.

I hope that more entries will be received in the next championship. I was so confident of winning this one that I told the Organising Committee I did not want to take part. The Committee, however, insisted that I played to show how good I was. Well, you know now how good.

Our thanks are due to the Singapore Chess Federation who supplied equipment with a tournament director, Mr. Bay Sit Thong. At the conclusion of the event, Dr. Fred Samuel presented the Ho Guan Lim Challenge Trophy to Jimmy Sng and souvenirs to prize winners.

Tripoli v Haifa

Politics intrudes in chess as it does not in other sports. Our latest crisis arises from the award by FIDE of the 1976 Olympiads to Israel against strong resistance from the Arab nations in FIDE and their sympathisers.

For two years FIDE had looked for some hospitable country to organise the Olympiads which are international team tournaments, for men and for women. By tradition, the General Assembly of FIDE also meets during the Olympiad, though Delegates to the FIDE Congress pay their own board and lodging whereas full hospitality is provided for teams.

Last May, when the Chess Federation of Israel remained the sole bidder of the 1976 Olympiads, FIDE President Dr. Euwe called a postal ballot: Should the Olympiads be held in Israel or should there be no Olympiads?

52 of 88 FIDE affiliates responded; 34 voted for Olympiads in Israel, 16 voted for cancellation and two voted "abstain". Presumably, some countries who did not reply would also have voted abstain.

The result of the ballot was confirmed by the Central Committee of FIDE meeting last October when Israel gave details of the organisation of the Men's and Women's Olympiads as well as of the Congress.

Before the Central Committee met, a telegram was received from the Libyan Chess Federation, which was then not a member of FIDE, protesting against the proposal to hold the Olympiads in Israel and suggesting that they should be held in a "neutral" country where all teams could attend, e.g., Algeria.

There was no Arab representative at the Central Committee, the President of the Afro-Mediterranean Zone, Mr. Belkadi of Tunisia, being absent. No word was received also from Algeria, but a representative of the Libyan Chess Federation turned up after the meeting had ended.

What was discussed by the late-comer with Dr. Euwe is not known, but he announced later that he had provisionally admitted Libya to FIDE membership for ratification by the 1976 General Assembly. This is unlikely to take place for reasons that will follow.

Last month, the Libyan Chess Federation sent an invitation to the Singapore Chess Federation to send a team to take part in an event entitled, "Against Israel Chess Olympic".

The Libyan Chess Federation offers free air transportation, full board and lodging, as well as US$8.00 per day pocket money and "entertainments". The rub is, the event is to take place on the same dates as the official Olympiads in Haifa, Israel.

The Libyan Chess Federation says it is organising the event on behalf of the Arab Chess Federation, naming 17 countries as members, including seven who are members of FIDE. It is on the cards that FIDE will question the propriety of FIDE members supporting an event in confrontation of the official event, though I suppose the seven FIDE members involved could not avoid it. It is significant that though one or two of them have good experience in organising chess competitions the event is to be organised in a country that has not, as far as I know, organised any international chess competition.

Our own position is clear, as FIDE members we cannot support a counter-attraction. In any case, the Singapore Chess Federation had decided not to send a team to Haifa because of the continued uncertain Middle East situation.

O & G CHINA TRIP

by Y.H. LIOK

Organising a trip abroad for oneself or one's family, although comparatively simple and easy, entails quite a lot of preparation. But organising a group tour of doctors whose temperaments are as variable as they are individualistic takes a heavy toll on one's organising ability and leadership qualities.

And so it was with some trepidation that I accepted the post of leader of the O & G Society Tour Team to China when elected. Fortunately it turned out that all the 21 members of the Team cooperated so well that there was hardly any hitch during the whole of the tour. For this to come about was no sheer luck.

From the outset, I knew I had to get a small but efficient committee. For some unforseen circumstance, Dr. S.O. Lim, the Hon. Secretary of O & G Society, could not be included in the Team. So I looked at the 21 names and picked out Dr. Richard Yung, a most far-sighted choice, for he was efficient, diligent and bilingual (acting as a very polished interpreter when the subject became too technical). Then too a senior member of the Society must be picked as Dy. Leader. If the leader was indisposed, he must be able to take over leadership at a moment's notice and make a good job out of it. Such a person was Dr. W.C. Cheng. Last but by no means least, a good treasurer was absolutely necessary and we have none other than the thrice elected Hon. Treasurer of the SMA, Dr. C.Y. Lim.

Once this good Committee was formed, we proceeded to acquaint members of the team as to what to bring for the trip, what to wear, as it would be late autumn and early winter, custom and immigration formalities etc. Above all we laid down certain rigid rules like punctuality, mandatory attendance at all functions except on a Medical Certificate, blameless behaviour and careful conversation.

Consequent upon all this detailed preparation, the tour itself unfolded smoothly and one and all enjoyed the trip immensely. We left for Hong Kong on 12.11.75. Visa on 13.11.75.

We visited a total of 8 places in 21 days. However in this short article I can only mention the main places we visited. On 14.11.75, we managed to see the Autumn Trade Exhibition opposite our Hotel (2nd last day). On same day we visited Chung San Medical College Hospital, a children's kindergarten & hostel and a orchard commune.

We left Canton for Hangchow by air on the evening of 16.11. The next day, we visited a Flower Park and the famous Westlake where we were taken for a boat ride. Then to a Chrysanthemum Flower Exhibition where we saw hundreds of varieties of this species in full bloom and in all hues and colours. A ½ day visit to the Hangchow Silk Factory and another ½ day to a Tea Commune, where the famous Dragon Well Tea is cultivated.

On 18.11 we left for Shanghai by air (Boeing 707) where we stayed for 3 days taking in tours of the famous City and visit to the Children's Palace O & G Hospital, a vegetable commune and even a Nanking Road Neighbourhood community where we were told how the Government eliminated opium smoking, gangsterism and prostitution. Many of us, who did not have friends in Hong Kong to treat us to the fabulous hairy crab, sold in Hong Kong for HK$25/- each, treated ourselves to this delicacy at less than HK$2.50 each. Many of these crabs were full of golden yellow orange or red rose, which raised our cholesterol and tigliceride levels so high that some got sick the next day and had to be confined to the Hotel. However, the level was soon reduced by our joining the early rising, Shanghai residents in TaiChi or jogging along the Banks of the Whampoa River.

I must say our tour team was very fortunate in having the 1st Vice President & 3rd Vice President of the Singapore Joggers' Association in our midst and they set excellent example by rising early in the morning (5.30 a.m. or so) to jog, and ably assisted by military trained Hon. Secretary (cross-country veteran) and others like once S'pore's Shot Putt Champion, nicknamed in Shanghainese the Big Head. Even the Tour leader did a lap round the Sports field in Nanking's Middle School with the Sports Master. In this manner, most of us were kept fit for the arduous climb up the Great Wall, where 17 out of 21 succeeded to the top.

Left Shanghai for Soochow on 21.11 and stayed for 1 day. We toured 2 famous gardens and also the Soochow's Research & Training Institute for Embroidery & Tapestry. Very impressed with the double-sided embroidery of Cats, which were so life-like.

Reached Nanking by train on 22.11. The highlight of this City are the long Bridge over the Yang Tze River (we were told the history of the difficult conditions under which it was built) the Mausoleum of Dr. Sun Yat Sen, and the 13th Middle School, where we were told the children not only studied in the classrooms, but also did daily exercises and worked in their schools' own gardens planting vegetables.

We flew into Peking on 24.11 and stayed at the newly completed wing of Peking Hotel. Attended banquet hosted by China International Travel Service. Next day visited the enormous Tien An Men Square, the Imperial Palace (Purple Forbidden City) and an under ground shelter. The whole of the 26th was spent in visiting the Great Wall (where the Temperature was $-5^{o}C$) and the Ming Tomb. Next morning we took in the Museum of Chinese History, in the afternoon the Peking Medical College and in the evening, the return banquet. The next day, we toured the Peking O & G Hospital and watched the complete induction of Acupuncture Anaesthesia on a female patient for tubal ligation. Our tour guides took us to the Summer Palace (where the lake was mainly frozen) in the afternoon and topped off with a visit to the Peking Zoo where we saw 3 Pandas.

On the 29th, we had to get up at 5 a.m. to arrive at Peking Airport at 6 a.m. to fly to Wuhan, which is made up of Wuchang, HanYang and Hankow. Here a visit to the first bridge and the Yang Tze River (2nd at Chungking and 3rd at Nanking) gave us a chance to compare with the much longer Bridge in Nanking, which has 2 decks, the upper deck for vehicles and pedestrians and the lower one for a double rail track for trains.

30th we visited the Wuhan Iron & Steel Mills and the East Lake (including boat ride). P.m. 1st of December saw us visiting the Wuhan University (Arts & Science courses only). In the afternoon we entrained for Changshe. On 2nd Dec. we visited Shao Shan and Han Tomb, where we viewed the corpse of a woman excavated recently and who was estimated to have been buried about 2,000 years ago and well preserved. We then took an overnight train to Canton, arriving on the morning of the 3rd Dec., where we spent the morning visiting the burial place of the 72 Martyrs and another Chrysanthemum Flower Exhibition.

We left Canton on the morning of the 4th for Kowloon and home. All in all, the tour was well planned and well conducted. In each of the places visited, especially the big cities like Canton, Hangchow, Shanghai & Peking, we were given the opportunity of doing some shopping at the Friendship Departmental Stores.

The stress made in the welcoming speeches in each place was friendship between the peoples of Singapore and China. But the amazing thing is the success of their Family Planning Programme of limiting the size of their families to 2 children only (whether boys or girls, for they treat males and females as equals nowadays) by methods like delivering the contraceptive pills to the doorsteps by "barefoot" doctors, abortion (termination of early pregnancies) and ligation of tubes under acupuncture anaesthesia.

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