MEDICAL

SINGAPORE MEDICAL ASSOCIATION

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EDITORIAL

Should the Singapore Medical Association have representation in the Medical Council of Singapore?

It is not surprising that most doctors have a vague notion of the constitution, membership and functions of the Medical Council of Singapore. If pressed, they will broadly recollect that it has something to do with their registration and maintenance of professional conduct. Yet, it is of vital importance if one is to follow with interest this discussive editorial, to understand why it was formed, how it is formed, what its functions are and, its shortcomings, if any.

What is most surprising is that it took human society so long, 2,258 years to be exact, after Hippocrates laid down a code of ethics in early 400 B.C., to realise that medicine can only be practised to the advantage of society if it is practised ethically. To effect this, the British were the first to pass in their Parliament in 1858 the Medical Act to enable persons requiring medical aid to distinguish qualified from unqualified medical practitioners. The General Medical Council was constituted consisting of members of **repute** and **competence** of the medical profession whose duty was in the words of Sir Donald MacAlister, "to admit the worthy and to expunge the unworthy". The worthy were admitted on academic grounds and the unworthy expunged on ethical grounds. The grounds for erasure from the Register are conviction in England or Ireland of any felony or misdemeanour, or in Scotland of any criminal offence, or if, after due inquiry, the practitioner is judged by the General Medical Council to be guilty of infamous conduct in a professional aspect.

Infamous conduct in a professional respect was first defined by Lopes L.J. in the case of Allinson v. General Medical Council (1894) as follows:

"If a medical man in the persuit of his profession has done something with regard to it which will be reasonably regarded as disgraceful or dishonourable by his professional brethren of good **repute** and **competency**, then it is open to the General Medical Council, if that be shown, to say that he has been guilty of infamous conduct in a professional respect".

This definition and the spirit and content of the Medical Act of U.K. have formed the basis of Medical Acts in our region. Further, from time to time, rules of natural justice like,

(a) Accusers cannot act as judges,
(b) Due inquiry in all cases of infamous conduct, and the practitioner has the right to be heard though not necesasarily by Counsel, were added to impart a sense of equity to these proceedings.

In our region the first Medical Registration Ordinance was passed in 1907 for both Malaya and Singapore and it incorporated the main ideas of the U.K. Medical Act, with the slight difference that the right to be heard by counsel and the right to appeal to the High Court was enshrined in this act as early as 1907, whereas in U.K., the provisions were made only in 1950. In 1953, a new Medical Registration Ordinance was enacted to replace the previous one. One of the highlights of this ordinance was the provision of a majority of elected members by ballot to this council. The main idea behind this was that in matters of discipline nad professional conduct one should be judged by one's peers, high in repute and competence.

In 1971 this ordinance was amended with significant changes and is now known as Medical Registration (Amendment) Act 1971. (Caps 218) It is not the purpose of this editorial to discuss the wider issues and implications of this amendment as they are still being considered by the committee of medical registration and Council of S.M.A.

However, it will be pertinent to review its composition with particular reference to its earlier discussed functions and to enquire into the possibility of seeking S.M.A. representation in this Medical Council of Singapore.

Briefly, the new Council consists of 13 members, made up as follows:

1. Director of Medical Services (one person)
2. A medical officer in public service appointed by the President (one person).
3. Two registered medical practitioners appointed by the President on nomination of the Council of University of Singapore. (two persons)
4. Six registered medical practitioners resident in Singapore to be elected by registered medical practitioners of Singapore. (six persons)
5. Three registered medical practitioners in Singapore to be appointed by the Minister. (three persons)

Since the twin main functions of the Medical Council of Singapore is to deal with the registration of medical graduates and the regulation of their professional conduct and matters related thereto, and since it is generally accepted both in U.K. and elsewhere that only people of the highest repute and competence in the opinion of their colleagues should sit on this council, especially to judge on disciplinary matters, it would theoretically follow that all or a majority should be elected by their fellow doctors, after due deliberation. However, it is acknowledged and generally accepted both in U.K. and here that special interests have to be represented in this council, like the two representatives of the University Council appointed by the President and one representative in the public service appointed by the President. If it is acknowledged that special interests have to be represented it is not inconceivable and not unreasonable to think in terms of a direct representation of the S.M.A., sitting on the Medical Council of Singapore. One must not forget that the Singapore Medical Association is **the professional organisation** representing the whole spectrum of medical practitioners in Singapore (1200 out of a total of about 1500 registered medical practitioners). Such a representative can effectively voice the considered opinion of the professional body in the highest medical council of the land.

Although the British Medical Association in U.K. does not have direct representation in the General Medical Council in U.K., a study of sister professional organisations in Singapore is very revealing. The Singapore Dental Association have two representatives sitting on the Singapore Dental Board. The Professional Engineer's Board have 8 appointed by the Minister of whom 3 shall be appointed on nomination of the Council of the Institute of. Engineers, Singapore; one member appointed by the Minister on the nomination of the Board of Architects, Singapore. In the Singapore Society of Accountants constituted under the Accountants Act (Caps 212), 8 members from public accountants are nominated to be appointed by the Minister to the council, and 8 member from registered accountants are nominated to be appointed by the Minister. The Architects Board constituted under the Architects Act (Caps 213) has one representative of the Institute of Architects appointed to the Architect's Board. The Board of Legal Education constituted under the Legal Profession Act (Caps 217) has 3 Advocates and Solicitors nominated by the Law Society of Singapore. Thus it will be noted that professional organisations are almost universally represented either by election or nomination or both in their statutory governing bodies in Singapore. Why can't we?

Further if the S.M.A. obtains representation on the S.M.C. its hand will be immeasurably strengthened and its prestige enhanced in dealing with minor infringements of the Ethical Code.

On the other hand, a good case can be made out that S.M.A. as a body should not be represented in the S.M.C., as there is a basic conflict of interests. The gist of the argument is that the S.M.A. is a body that represents collective interests of the members and is protective in nature, whereas the S.M.C. is a adjudicative body dealing with disciplinary charges against members. Second, if a non-member of the S.M.A. is charged before the Medical Council for a disciplinary offence if may be alleged that the S.M.A. representative on the council, if present, will be biased in judging the case, in view of the fact that the accused is a non-member of the S.M.A. These arguments can be countered if it can be understood that they represent special interests on nomination or appointment, but, in actual practice of judging in disciplinary matters they represent the **ultimate truth** and themselves alone and not sectarian interests. Hence the importance even in representatives of the S.M.A. to be men of high repute and competence.

Some would advance the argument that a non-S.M.A. member if accused and appearing before a S.M.C. with direct S.M.A. representation, could object to the presence of the S.M.A. representative on similar lines that an accused objects to the composition of a jury. This analogy or argument is not valid as the S.M.C. is a legally constituted statutory body with functions of a tribunal. Further, in the case Leeson v. General Medical Council (1889) where there was a suspicion that the Medical Defence Union was an interested party by the fact that two of its members sat in the General Medical Council, L.J. Bowen concurred with the majority view expressed by L.J. Cotton that the fact that two members of the General Medical Council were subscribers to the Medical Defence Union, by whom the charge was made against the plaintiff, did **not** invalidate the decision of the General Medical Council. However to avoid suspicion and to be above board, those rare cases where a non-member of the S.M.A. is being charged, the S.M.A. representative can forthwith retire from that particular case.

Lastly, it may be said that there is a potential danger that a particular group might seize control of the S.M.A. and send their particular nominee into the S.M.C. The best way to ensure that this does not happen is for all members to take an active interest in the affairs of the S.M.A., and to vote the right people into the S.M.A. Council, with the same care and deliberation as they would when they choose their elected members of the S.M.C.

JUST BETWEEN US — BY E.K.

Medical Aparthied

The idea is a good one. I think it is about time we dusted some cobwebs off antiquated ideas concerning specialists and consultants in private practice, but we have to go about things very carefully and avoid charging like a bull in a china shop.

Some people feel that specialists should not see patients "off the streets" and should only see those who have been referred to them.

Here I believe we are confusing the role of the specialist and the consultant. All consultants must be specialists, but not all specialists need be consultants. To be a consultant, one must be recognised in the medical world as such. The specialist is simply the medical man who restricts his practice of the profession to only one specialty. I think it is immaterial whether he has a higher degree or not to do this, provided he has shown a reasonable competence to do what he wishes to restrict himself to. A consultant sees only referred cases, a specialist sees any case in his specialty.

If we accept this idea of the specialist as a doctor with specialised or restricted medical interest, then it follows that specialists are not superior medical men, but merely doctors with special interests.

I don't think this is behind the idea of the S.M.A. "Specialist Accreditation" move. To accredit someone as a specialist would mean to officially recognise him as a specialist and perhaps place him one rung above his other colleagues.

I am sure many of my friends who are specialists do not believe themselves to be professionally superior to the non-specialists. They are more knowledgeable without a doubt in their respective specialist fields, but I don't see any of my friends behaving like super doctors or know-alls. What a specialist gains in depth of vision he frequently loses in width, and most honest specialists will readily admit this.

A specialist accreditation scheme would bring on a two-tier structure within the profession resulting in a form of medical apartheid. This we must studiously avoid because any kind of medical apartheid would means factional interests within the profession leading to a loss of cohesiveness and sense of unity amongst our doctors.

What we need perhaps is a **vocational register** in this country. A vocational register does not imply any superiority of one type of doctor over another. It only registers doctors under the various vocations or specialist fields which they themselves opt to follow.

There is no great virtue for instance for a GP to be classified as a great-toe specialist in that a person classified as such in the vocational register has to limit his medical practice to ailments of the big toe.

A vocational register however is useful in that it will keep out the quacks, and members of the profession will know also who's doing what and where.

It is not a good idea for the general public to pick their own specialists and see them without first consulting a G.P. or as he is nowadays known, the doctor of primary medical care. It is obvious that the G.P. would be better placed than the patient to know whether or not he requires specialist care, and if so, what type is best for him.

Whenever we introduce change, we must first ask ourselves whether the change would benefit and enhance the status of the profession as a whole, or would it only bring advantage to a minority in the profession.

ACUPUNCTURE

I think those of us who have seen it, have no doubt in our minds that acupuncture anaesthesia really works. Acupuncture anaesthesia should not be confused with ordinary acupuncture. It is a recent development of an ancient art and the first case was done only a few years ago during the Chinese cultural revolution.

The Chinese themselves are not clear as to how it really works, and here perhaps is a wide and exciting field for research not only into acupuncture itself, but into physiology and the other basic sciences as well.

We have everything we need in Singapore to take a closer look into the subject. We have the surgeons, the anaesthesists, the physiologist and the clinical scientist. We also have the acupuncturist, and most of us can read and write Chinese. But we have done little thus far.

It is a pity that other countries outside China have stolen a march on us. Operations under acupuncture anaesthesia have already been done in Northville, Michigan and in New York.

Maj. Gen Walter R. Tkach, physician to President Nixon and who accompanied him to China had this to say on acupuncture.. "It does work. And there was no evidence to support the belief that hypnosis is used. Acupuncture is not the work of charlatans, nor should it be left to be played with by those who populate the half world of quackery."

In Singapore we have to be careful not to overplay the significance of progress in Chinese Medicine, but we must also not be blind to the door that conceivably could open out to new therapies not only in anaesthesia but to a host of other ailments as well.

(Not to be quoted in the Press)

BIG SPECIALIST

Ah Wun, He say ...
Smart specialist, him see big opening in small hole.

TOGETHERNESS

Ah Wun, He say ..
Medical man, him if not hang on together,
Him sure hang separately.

The Deaf Child

Mr. E. H. Goh

Too many people describe the deaf individual with the contemptuous phrase "Deaf and Dumb", with all the implications of the "Dumb", and do not appreciate that many of these individuals have the same intellectual potential for development as they themselves. Unlike blind individuals, the deaf do not evoke spontaneous sympathy because few understand the problem a deaf individual faces.

It is easy to place oneself in the position of a blind individual – all one has to do is to shut one's eyes. As for the deaf – well, we have often heard people wish they could be deaf on occasions. The importance of speech in everyday life can only be appreciated if one had to communicate by non-oral methods – by signs and gestures, by writing, drawings and similar methods.

Our activities would be slowed down to the level of a go-slow strike! More important is the role of speech in education, for normal educational systems the world over depend a great deal on speech and hearing. A deaf child would require at least three times if not more, the normal 12 years of Primary and Secondary education if he is sent to a normal school, to complete the normal educational process.

However, if special educational facilities are provided some can attain this even within the 12 years of normal school-life. Basically it requires a more concentrated educational effort. For example, in schools for the Deaf, classes should not exceed 8 children. Special apparatus and teaching methods may be a great help, but are basically not essential.

What is often not appreciated is that the congenitally deaf child usually has peripheral damage to his hearing apparatus, and is otherwise normal. He has the same potential for development of his mental facilities as other children, and given the chance many even attain tertiary education. Deaf children rarely suffer from a total loss of hearing – they often have some residual hearing, but this may be inadequate for them to understand speech unless aided by other means, ex. lip-reading.

I have been referring above to children who suffer from malformations of the inner ear. Children who have anomalies of the middle ear or external ear can of course be dealt with surgically and if the inner ear is normal they should be able to hear after operation.

Children suffering from infections of the middle ear can also be dealt with by appropriate operations. As for children who suffer cochlear damage later in childhood, ex. from viral or bacterial infections, the problem though serious is not as bad because they have already received some education.

The problem of the congenitally deaf child initially rests with us, for the earlier the diagnosis is established, the better the chances for rehabilitating the child. Apart from diagnosis and prescribing a hearing aid, we should make every effort to ensure that the parents do not reject the child.

All too often the parents adopt the attitude that the doctor or teacher or social worker has to solve the problem for

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LETTERS Not to be quoted in the press

Dear Sir,

The Newsletter doesn't contain any more news, nor a "leader". No idea can be obtained on reading the newspaper, or happenings within S.M.A. or Council. Is nothing happening?

The newspaper has a pseudo-academic trend (vying S.M.J.?). The articles are more befitting a journal, for example, for the College of G.Ps. Alas, decapitation of editorial comment is now complete!

I remain,
Yours etc.
Lim Kuang Hui.

(Ed. Note.)

Thank you for your letter. Every attempt will be made to incorporate some of your suggestions. However, it should be noted that the first and second issues of the Newsletter had 'leaders' on Cholera and Influenza respectively, which were very topical at the time they appeared, as there were widespread epidemics in our State at the material times. The third and fourth issues have editorials on matters which are of interest to us as they could potentially affect our members in one way or another.

Regarding the nature of articles appearing, a survey of the type of articles readers would like indicated that most readers preferred articles of an informative nature. This is further supported by the fact that most of the articles received by us are of an informative and educative content. We on our part are also cognisant of the fact that this is not merely a Newsletter but a **medical** *Newsletter of S. M. A. whose aims and objectives we have adopted as our guidelines, and whose membership consists mainly of general practitioners.*

With reference to your allegation that there is a paucity of pure "news", a careful perusal of the four issues so far will show that activities of the S.M.A. have been suitably covered at relevant times. However, matters still pending or being currently deliberated either at the Council level or standing committees will be eventually published once the final reports are out.

Thanking you once again for your suggestions.

Progress in Human Ecology

– Prof. Phoon Wai On

The words "Human Ecology" have well-nigh become a battle-cry all over the world. The disillusioned young people in many developed countries treat Human Ecology as a favourite cause for demonstrations, protests and sometimes even riots. Big businesses in the United States of America and some other countries have been frequently thwarted in their expansion schemes because residents in those areas earmarked for their expansion have been fearful of pollution, adamant in their opposition and powerful enough to affect the seats of power. It seems as if suddenly everybody is worried about the environment, and everybody wants to get in on the business of saving it.

In 1969 the Council of Europe launched its European Conservation Year. In the same year Nato's new Committee on the Challenges of Modern Society held its first meeting. Also in 1969 the United Nations voted, without one single dissident vote or abstention, to hold a very large and comprehensive Conference on the Environment. After very thorough and extensive preparations, including several regional conferences (like the one held in Bangkok), the Conference was held in Stockhom in June 1972.

Human Ecology in the Commonwealth

The Commonwealth has not been slow to play an active part in promoting the cause of Human Ecology. In 1969 there was formed in the United Kingdom a body called the Commonwealth Human Ecology Council (CHEC). A highly successful First Commonwealth Conference on Development and Human Ecology in Malta was held in 1970, under the joint auspices of the Maltese Government, the Royal University of Malta, and CHEC itself. Delegates from several Commonwealth Countries attended. Subsequent to that Conference, the Government of Malta has established a permanent Human Environment Council, to study and apply ecological principles in national planning.

I think that the growing realisation of the importance of exploiting, developing, and cultivating our natural resources in the best possible way – not only the most financially profitable way, but also the way whereby the least penalties to human health and unhappiness are exacted and whereby wanton destruction of flora and fauna is avoided so that our unborn generations will not suffer from their want – is one of the most exciting and mementous developments of our age.

Need for objectivity

Nevertheless, there is a need for the maintenance of objectivity in promoting Human Ecology. While development may (and has) caused suffering to millions of people – the answer is not in stopping all developing schemes. The answer, surely, is in development with proper regard to all ecological factors. In development schemes, such as irrigation schemes, the building of airports, etc. due regard must be given – not only to the technical aspects – but also to the study of possible implications on plants, fish, soil, agriculture, public health, sociology and other ecological aspects. Whenever and wherever possible, teams of experts in all these fields should be working right from the start and side by side with their engineering, architectural and quantity surveying colleagues.

An example of air pollution. The air is so polluted that the features are hardly discernable.

The ideal vs. the practicable

Moreover, in this very imperfect world of ours, we must always strike a sound balance between the ideal – on the one hand, and the practicable – on the other. In other words, we may often have to choose the lesser of two evils. For instance, in developed countries like Sweden, D.D.T. has been banned. In fact, those countries do not really require D.D.T. However, it will be foolhardy for countries, where malaria is still rife, to ban D.D.T. at the present time. The number of people made very ill or even killed by malaria is great in such countries. In comparison, whether and what ill-effects D.D.T. causes in human beings are controversial. It is true other insecticides are available as substitutes for D.D.T. but they are so expensive that most countries cannot afford them on the large scale needed to carry out an effective anti-malarial programme.

The "holier than thou" attitude

Again, there is a tendency on the part of some scientists in some disciplines to regard their disciplines as more "ecological" than others. I fail to see how they can labour under such a delusion. If we accept the definition of Human Ecology as the study of the relationship and interaction between Man and his environment – all sciences (whether in the physical or behavioural fields) should be of equal importance and relevant.

Need for team-work rather than a "Super-science"

Some universities and colleges have started courses and qualifications in Human Ecology. Some have departments devoted to that. The Chair in Human Ecology, Cambridge, England, however, became extinct after a few years. It is my conviction that Human Ecology is a concept – a philosophy – an inter-disciplinary and inter-professional team approach and not so much a single subject. As such, I cannot quite see how one can become an expert in Human Ecology as a whole even though he may be a Confucius or a Leonardo di Vinci. Rather, in Human Ecology, I think we have a good example of the axiom that sometimes the sum is greater than its component parts. The united and co-ordinated efforts of different professions and disciplines will be far more effective than the isolated efforts of any profession or discipline alone.

Need for education of Public

It also stands to reason that no matter how enlightened governments become and no matter how hard the academic world and the professions work as regards Human Ecology – their plans will come to nought without the fullest co-operation from all sectors of the population. From childhood upwards, all people should have inculcated in them the great need to use their resources properly and to safeguard their environment. Education is vital to the cause of Human Ecology. In the higher institutions of learning, more integration of the teachings of different disciplines should take place – so that students will see beyond the narrow confines of their own specialities. In other words, they should see only the trees and miss the wood.

A.P.A.O.'s Successful Congress

The 4th Congress of the Asia Pacific Academy of Ophthalmology held in Auckland, New Zealand was attended by about 370 ophthalmologists (including their spouses) from more than 20 countries.

Drs. Robert C.K. Loh, Lim Kuang Hui, Arthur S.M. Lim, Wong Kin Yip and Oh Thiam Hock of the Society of Ophthalmology attended the Congress which lasted from April 9 – 14, 1972. Members who attended the meeting agreed that the Scientific Sessions were perfectly well run, and that the social functions were excellently organised.

Dr. Robert Loh's paper entitled "Cryoextraction of Senile cataracts" was the opening paper of the Congress. Dr. K.H. Lim read a paper on "Epidemic Conjunctivitis in Singapore in 1970 and 1971."

The Council of the A.P.A.O. has decided to depart from the traditional 4 yearly meetings, in preference for bi-ennial meetings. The next two Congresses will therefore be held in 1974 in Colombo (Sri Lanka) and in 1976 in Indonesia.

Dermatology: Past, Present & Future in Singapore

BY "CUTIS"

Dermatology has in the mid-twentieth century changed from the art of description and tongue-twisting nomenclature to a science that seeks to understand skin diseases. This new science of dermatology was born 25 years ago when Stephen Rothman, a Hungarian scientist-dermatologist working in the University of Chicago, began his investigations into the physiology and biochemistry of the skin.

In Singapore, Dermatology is a much younger science and only in the past 5 years has it acquired the status of a speciality.

History:

Before the war, the Senior Physician of the Student Hospital (Tan Tock Seng Hospital) Dr. Landor conducted regular skin clinics. After the war a regular skin clinic was run at Medical Unit II, Outram Road General Hospital. This was initiated by Prof. Khoo Oon Teik, then lecturer in medicine. In 1951, the leprosy outpatients run by the skin clinic, Outram Road General Hospital was transferred to Tan Tock Seng Hospital and subsequently to Irrawaddy Road Skin Clinic. Increasing pressure on the skin clinic at Outram Road General Hospital in the sixties led to Middle Road Hospital, (started after the 2nd World War as a Venereal Disease Hospital), taking on the treatment of skin diseases as well.

A further thrust was given to the speciality when Middle Road Hospital obtained its first fully trained dermatologist in 1966. This was an important milestone, as it laid the foundation for improved undergraduate and post-graduate training. In the ensuing years this hospital has become the main centre for the investigation and treatment of skin disorders. About this time, specialist facilities became available in the private sector, when two local doctors trained abroad in the speciality returned.

Existing Facilities:

Presently patients with skin problems can choose to be treated in the private sector or be seen at Government clinics. There are now a handful of dermatologists in the private sector performing consultative services. The skin clinic at Medical Unit II, Outram Road General Hospital continues to function for one afternoon per week. Irrawaddy Road Skin Clinic is the screening and follow-up centre for all leprosy patients in Singapore and also has clinics for general skin diseases four mornings a week. This is run by two specialists who had training abroad in dermatology and leprosy. Middle Road Hospital sees the main bulk of skin cases in Singapore and provides consultative services to other Government clinics, hospitals and general practitioners. This hospital is also the national centre for the treatment and control of Venereal Diseases which forms 35% of the total work load of the hospital. Sophisticated investigations available in reputable overseas dermatological centres are available in this Hospital. It is the main centre for undergraduate and post-graduate training in dermatology and the Institute of Dermatology of the University of London has recognised it as a centre for its student's elective posting in Dermatology.

Status of Speciality:

It is interesting to pause and critically evaluate the prestige and respect the speciality enjoys in Singapore. On reflecting it is heart breaking to note that Dermatology is the Cinderella of not only the profession, but also the university and medical administrators. Walking along corridors of hospitals and clinics, remarks such as "Skin patients never die nor get better"; "once your patient, your patient for life" are often heard. It is sad but nevertheless true that such remarks are made by doctors who make a blanket diagnosis of "Dermatitis" for any skin rash, unaware of the fact that about 1,600 skin disorders have been described.

It is true that psoriasis is not curable, but have chest physicians cured chronic bronchitis and emphysema, the Rheumatologist rheumatoid arthritis and the Cardiologist coronary atherosclerosis? Though we are on the threshold of becoming the Mayo Clinic of the East, the University of Singapore has no department of dermatology, nor has any plans for the immediate future! In the public sector, dermatology has enjoyed very little priority and all too often has been left out of development plans of the Ministry of Health.

Looking Ahead

The facilities and staff of the main government skin clinics are being fully stretched by the ever increasing number of patients. This demand will surely increase with increasing sophistication and affluence. Skin disease will no longer be accepted philosophically but must be treated and if possible cured!

The Ministry should give serious thought to the formation of a department of dermatology, catering for general skin disorders including leprosy. More and more leprosy patients are being treated on an ambulatory basis and it would be sound economics and manpower well-utilized to bring leprosy back to the fold of dermatology. V.D. should be established as a separate department. Its increasing incidence necessitates such a move if control is to be effective. This cannot be successful if left to specialists fully occupied with dermatology.

The establishment of a university department with fulltime lecturers or even an associate Professor of dermatology will strengthen past efforts of the Government dermatologists in the dermatologic training and education of our doctors.

If both University and Government will seize the initiative now, Singapore may well become the centre of dermatologic learning in South East Asia.

Volunteer Doctors needed for V.C.

The S.M.A. Scheme to provide medical coverage to the Vigilante Corps during their training sessions was launched exactly a year ago.

The scheme is however encountering some setback as the number of volunteer doctors is dwindling. We appeal to members who can spare an hour or two a week, to attend to the sick parade at any of these 4 V.C. Training Centres:–

1) Kim Seng Technical School
   Kim Seng Road
   Singapore 9.

2) Dunman Integrated Secondary School
   Haig Road
   Singapore 15.

3) Whitley Secondary School
   Whitley/Dunearn Road
   Singapore 10.

4) Serangoon Garden Secondary School
   Singapore 19.

Training is held every weekday and a doctor is required to attend to the sick parade for one hour from 8 p.m. on each of their duty days.

Members who are prepared to spare an hour or two a week are asked to contact Mr. James Soh of the Singapore Medical Association (Tel: 981264).

Chess Notes by National Master Lim Kok Ann

Some colleagues have kindly expressed appreciation for my literary efforts on the Spassky-Fischer Match, so an account of how they came to be written may be of interest.

When the newspapers decided to run the game scores in full I was amused to see the report of the first game begin with 1 P-Q4 (D4), KT-KB3 (NF6), and so on.

The poor chaps had not realised that Reuters was giving them both the English notation and the algebraic, side-by-side. The fact that the algebraic should have been written "d4" and "Nf6" respectively was a minor point (A gentleman rang up to say, "I am not a chess player, but can you explain what D-for Dog Four means?")

In kindness to the editors, I offered, to go over the game scores for them and rectify any errors in transmission and also to put in a brief note or too. Some of the cabled comments were quite fatuous so I could not really resist the temptation to elaborate a bit here and there and once committed, it was a small step to go further and include a diagram or two which really made the article much more attractive.

The next thing was that the morning paper which is printed just before the game is concluded in Reykjavik, ran verbatim the report that I had written for the previous day's afternoon paper. I just could not allow myself to be repeated, so I offered to write originals for the morning paper as well.

This turned out to have advantages. Due to space limitations I had to restrict comments to only some of the interesting moves in the afternoon paper. Now I could write for the morning paper comments that had not appeared the previous day.

Moreover, in the interval between writing the two articles, I get the opportunity to go over the game and to spot errors in analysis in the first article which I could correct in the second, and to correct the diagrams too.

The actual technique was quite wearing. In order to meet the dead-line of the afternoon paper, I had to have everything ready by 9.30 a.m. After some trial (and error), I evolved the procedure of obtaining the game score from the newspaper about 5.30 a.m., sometimes before the last few moves have come in.

An hour or so is spent on library research, going over the opening and comparing it with recent games from Chess Informant. Critical stages in the game are reviewed and analysed, and a decision made as to what positions should be illustrated. After a quick snack I go to the newspaper office where I convert what's in the head to headlines.

Once the afternoon article is out of the way, the next morning's comes more easily and can be finished during lunch time, especially as the diagrams can be repeated.

The basic material is, of course, the game score, but the background to the match is also given by cables from the news agencies reporting such mundane, but interesting matters as the duel of the swivel chairs – Spassky demanding one the same as Fischer's, the Russian accusation, comments by Najdorr, Gligoric, Larsen and so on.

When some academic colleagues remarked recently, "Oh, you have come back" I thought they were referring to my visit to Kuala Lumpur for the Congress of Medicine, but it turned out they thought I had been in Reykjavik.

Along with my articles on the games, the newspapers usually run cabled accounts of the match environs with the date-line of Reykjavik, and some readers thought that was my date-line too.

Actually, I deliberately wrote on occasion as if I was in Reykjavik to prove my point that chess fans can follow a match from a distance almost as well as if they were on the spot.

To add to the illusion I invoked, on one occasion, the assistance of my telepathic correspondent, Ch'ien Li-Yen. For those not acquainted with Chinese folk lore, let me explain that Ch'ien means 1000, Li is the Chinese unit of distance, equivalent to about half a

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OBITUARY

Dr. (Mrs.) Sybil D. Gunatelaka-Kiani

Dr. Kiani was my first boss in Government service. She struck me as being very active, alert and kind, even at our first meeting. She was always concerned about the feelings not only of the public but also of the staff. I can recall the time she called me to her office two days after I started general school health work. She explained to me that one of her doctors had been selected to attend the D.P.H. Course. "Would I be her B.C.G. and Tuberculosis Officer?" My ready consent pleased her greatly. "Thank you, dear!" she beamed, "I am sorry to have to change your posting so suddenly and so soon", and I knew she meant every word of what she said in as expressive a tone as only she can. Needless to say, such behaviour, so characteristic of her always, earned the undying affection and loyalty of all her staff.

Our school clinic had pretty verses framed up on the walls, reminding us of the kind act that should be done when the chance occurs, and the joy it can give both the donor and the recipient, acts of which she herself was a living example. I have never heard one harsh word from her.

On one occasion, when she invited the staff to her home for dinner, I ventured into her study. There was a large portrait of her mother, a regal lady, almost life-like, breathing elegance, culture and gentleness. She comes from a very well known family in Ceylon, many of whom are holding high offices. The first Ceylonese Governor-General of independent Ceylon, Sir Oliver Goonetilleke, was a close relative of Dr. Kiani's.

Dr. (Mrs.) Kiani graduated from our K.E. VII School of Medicine in August 1925. She was the 7th lady graduate from our Medical School. When her sister, Dr. (Miss) R.G. Gunatilaka, graduated in March 1929, they were the first team of sisters among our graduates.

An inveterate optimist, she was always the life and soul of any gathering. One could never guess her age; she was always young. I sat at her table at a wedding dinner recently. She did not look a day older than when she retired. Impeccably dressed in a strikingly beautiful brick-red saree, spangled with silver spots, she carried a matching silver purse which she had bought in England. I never dreamt at that time that I would never see her again. She was so attentive to my needs at the table, so appreciative of all the little things she could remember about our work together in the service, not forgetting little details which make one realise how genuine her feelings are. She spoke about her brother in England, but her greatest concern was for her sister, Gladys. They live together, and I am sure no one can feel the loss of Dr. Kiani as much as her sister does.

I am still keeping a lovely white monogrammed handkerchief she gave me one Christmas. It was her custom to give gifts to everyone of her staff. It is torn more with age than with use because I treasure the memory of the donor. It was only at her grave that I realised I could have laid that handkerchief on her coffin. If her spirit happened to have be lingering around us then, it may have pleased her. In any case, Dr. Vellasamy's sheaf of large roses took the place of the handkerchief. This was the last gift before the grave was closed – a gift as lovely and gracious as the life she lived, and as transient despite her three score years and ten.

– Dr. S.R. Sayampanathan

Editor's Note: Her younger colleagues remember her best for her warmth, enthusiasm and her unfailing attendance at Conventions, seminars and medical meetings.

Practical Problems in Medicine

The Mild Analgesics

Dr. George Tay

Physicians should "neither be the first to use a new drug, nor the last to discard the old". This statement is particularly apt when dealing with the mild analgesics which may be broadly classified as follows: –

I. **Analgesics with antipyretic and anti-inflammatory activity:**
Salicylates
Salicylamide
Aniline Derivatives
Pyrazolone Derivatives
Mefenamic Acid
Indomethacin

II. **Weak Narcotics:**
Codeine
Propoxyphene
Ethoheptazine

Salicylates

Aspirin, the most widely used of drugs in this group, is still the standard when assessing the efficacy of other mild analgesics. It has a number of side effects:

(1) nausea, vomiting, dyspepsia, occult bleeding or frank gastro-intestinal haemorrhage.
(2) allergic manifestations such as urticaria, angioneurotic oedema, rhinorrhoea, and even anaphylactic shock.
(3) drug interactions viz: –
  (a) small doses decrease renal clearance of uric acid, thereby antagonizing the effects of probenecid and sulfinpyrazone
  (b) because it is conjugated with glycine and glycuronic acid in the liver, salicylates may prolong or intensify the effect of other drugs that are detoxicated by the same mechanism.

Aspirin, despite the side-effects mentioned, is a useful analgesic and antipyretic agent, especially in the treatment of rheumatic fever and rheumatoid arthritis.

Salicylamide

This drug is not biotransformed to salicylates and is inferior to aspirin and paracetamol as an analgesic.

Aniline Derivatives

These are: –
Acetanilide (rarely used)
Phenacetin
Paracetamol

Phenacetin

Phenacetin compares favourably with aspirin but is less potent as an antipyretic. However, it does not cause gastro-intestinal bleeding as does aspirin.

Side effects are: –
(1) methaemoglobinaemia
(2) hemolytic anaemia, marked in patients with glucose -6-phosphate dehydrogenase deficiency
(3) non-specific nephropathy, more so when drug combinations containing phenacetin have been used over a long period. Difficult to assess role of phenacetin as offending agent.

Paracetamol

Paracetamol, a metabolite of phenacetin, is the most popular agent to-day. It is cheap, safe and well tolerated by children. Like phenacetin it does not cause gastro-intestinal blood loss; unlike phenacetin it does not cause methaemoglobinaemia and hemolytic anaemia and only rarely may give rise to renal damage.

Pyrazolone Derivatives

Drugs belonging to this group are all capable of causing agranulocytosis. This alone is sufficient to contra-indicate their use generally as analgesics and antipyretics. The danger here is not so much the lack of knowledge of this grave side-effect, as the unwitting use of these drugs which have been disguised under various trade names. **Dipyrone** is such a drug. It is marketed in Singapore under various names, but its inherent property of causing agranulocytosis is seldom mentioned. The use of drugs like dipyrone should be reserved only for febrile illnesses not responding to safer agents.

Phenylbutazone and **oxphenbutazone** may cause agranulocytosis, thrombocytopenia, aplastic anemia and also skin rash, hepatitis, peptic ulcer, and salt and water retention. They are only used as anti-rheumatic and anti-inflammatory agents.

Mefenamic Acid

Mefenamic acid is an anthranilic acid derivative with analgesic properties. It may produce diarrhoea and gastro-intestinal bleeding. To date, it has not been proved superior to either aspirin or paracetamol.

Indomethacin

Is only used in rheumatoid arthritis, ankylosing spondylitis, osteoarthritis, and gout.

Weak Narcotics

Codeine is still the drug of choice in this group. Tolerance and drug dependence rarely develop after prolonged use of codeine.

Propoxyphene is related to methadone, and has not been proved superior to codeine.

Ethoheptazine is related to pethidine. The usual recommended dose (100 mgms) appears to have no effect at all.

Finally, as drug interactions in this group of drugs can be very complex, it would be prudent to use a single drug, unless there is strong evidence to suggest that a combination may be more efficacious.

(Not to be Quoted in the Press)

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them. Parental love is the key to the child's progress, as only they can give the child the necessary attention for its development.

Pre-school education for deaf children is the vital missing link in Singapore, as the present facilities are woefully inadequate. Attempts are being made to remedy this. Only primary education is available at present in the only School for the Deaf we have in Singapore. However plans are well advanced for the establishment of a Vocational Institute.

Some hard-headed materialistic citizens in our midst may question the need to rehabilitate these children, as it is obviously more costly than that required for normal children. Apart from moral considerations, it is also in the selfish interest of our Society to provide these facilities, for by making them productive and economically independent we will ease the burden on their families and on the State.

It is also in our interest to see that the best possible facilities are available, for this unfortunate disability does not respect racial or social barriers. (For more information kindly contact the Singapore Association for the Deaf, 151, Orchard Road, Singapore 9.)

SMA Congratulates

Primary Fellowship Examination of the Royal Australasian College of Surgeons

Dr. Jimmy Beng Kian Siew
Dr. Chan Chi Chin
Dr. Chan Siew Chee
Dr. Wu Dar Ching
Dr. Yeo Khee Quan

Modified Primary Examination for the Fellowship in Ophthalmology

Dr. David Tan Soo Leng
Dr. Victor Yong

M. Med. (Paediatrics)

Dr. Frances Chia Mei Ling
Dr. Yong Siu Li

Primary F.F.A.R.A.C.S. Examination

Dr. Shenton Oh Min Yueh
Dr. Kwa Bee Hua
Dr. Ngo Eu Guan

Special Awards

Dr. Chan Siew Chee – Howard Eddey Medal for being the most successful candidate for the Primary F.R.A.C.S. Examination.

(Not to be quoted in the Press)

Stop Press

Attention All Members

"At a meeting held on September 6, 1972 Council noted with concern that during the past few months, a number of Press interviews and doctors' photographs have been appearing in the Press in relation to medical matters, and would draw members' attention to Page 24 of the S.M.A. Ethical Code."

Dr. Gwee Ah Leng
President

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kilometer, and Yen means eye.

Ch'ien Li-Yen is quite versatile, one of his nicknames being Seventy-two Transformations, and he has disguised himself variously as the Doyen of a school for physicians, the Master of a dormitory for acolytes, the Leader of wandering patrolmen, the Chairman of a society of woodpushers, a seer of things so small as to be invisible, an Exorcisor of evil spirits that cause paralytic and sanguinary illnesses, and so on.

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