MEDICAL Newsletter

SINGAPORE MEDICAL ASSOCIATION

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EDITORIAL

A NEW ERA OF CONSULTANCY PRACTICE?

Since the dawn of higher education in our region with the setting up of the King Edward VII College of Medicine in 1905, the medical profession has led a chequered existence. The first international recognition of local graduates was accorded in 1916 with the recognition of the Diploma of L.M.S. (Singapore) by the General Medical Council of U.K. Despite this, the colonial administration had a parallel and separate scheme for local graduates, and they were given substantive appointments as Assistant Surgeons. Only a handful were promoted to the Malayan Medical Service as full medical officers. In spite of this handicap and the undeclared policy of not encouraging higher degrees for local graduates till the early fifties, the local graduates distinguished themselves by service to the State and the public. The history of our medical profession is replete with examples of L.M.S.s who had rendered distinguished and invaluable service to the State by providing some form of a consultancy service in their time.

The first local graduate to secure a higher qualification of an M.R.C.P. (London) was not accorded adequate recognition initially and was for some time actively discriminated against. Indeed, the discrimination was so marked that as soon as this local graduate secured his London Membership, he was posted to the Government Medical Stores where there was no opportunity to exercise his specialised clinical skill and knowledge.

The Japanese Occupation provided a unique opportunity for some of the local graduates to exercise the functions of a consultant and many distinguished themselves in their new role.

The British Military Administration was indeed a turning point in the hitherto exclusive domain of fulltime expatriate consultants. The acute shortage of expatriate consultants in the Government Service and the proven quality of local doctors who creditably manned the hospitals during the Japanese Occupation forced the authorities concerned to appoint, for the first time, Asian consultants. What is perhaps more important is it started the practice of appointing sessional consultants. Brigadier Marsden came on a sessional basis to do orthopaedic surgery and had a few beds on his own to admit patients. The army also provided psychiatrists who did sessional work for the Government Hospitals and the Medical College.

Thus, from time to time since the B.M.A. administration, sessional consultants were appointed on an *ad hoc* basis by the heads of units depending on the needs of the times.

In 1962, the need to regularise and study the practice of part-time consultants was undertaken by a committee. The gist of their report was that it would be difficult to implement it on a broad and regular basis.

At about this time the Medical Services were undergoing rapid and dynamic expansion, and the remaining few consultancy posts held by expatriate staff were being filled by local staff. In addition, there was an unprecedented expansion of the outpatient services in the early sixties. The late sixties witnessed an exodus of top and middle grade specialists into the private sector of medical practice due to the increasing demands of private specialised medical care by the rapidly growing affluent society.

In 1969, a past president of the S.M.A. expressed the desirability and feasibility of appointing specialists on a part-time basis.

At the 12th Annual General Meeting of the S.M.A. in 1972, the general body considered, the recommendation of the Yeoh Kean Seng report and indicated that a further detailed study be made. A glimpse of the new detailed report shows that it is essentially the same as last year's.

On 27th January, 1973, the Minister of Health and Home Affairs announced the first **official** plan to utilize the talent and skill of the private specialists in the Government hospitals. He gave three reasons for this decision:—

(i) The loss of top and middle-class Government specialists to the private sector because of the demands of an increasingly affluent society requiring private care.

(ii) The unprecedented expansion of the Medical Services with sophisticated expensive instruments may result in the under-utilization of these facilities. Further, the skill and expertise of the top specialists in the private sector may not be fully utilized in the private sector as the cost of purchasing these sophisticated instruments by the private sector will be prohibitive.

(iii) To utilize this highly skilful and expert brain drain for public good so that the poor man can obtain the highest possible skill and expertise which he could not otherwise obtain and also to fully utilize sophisticated and expensive equipment bought out of public funds.

The Minister clearly stated this policy was merely to **complement** the work of Government specialists, and **fill shortages** when and where they arise and to make available to the public **expertise** which they would not otherwise afford. He also reiterated that the main burden of running the specialist services will rest mainly on the shoulders of the Government and university specialists, and every effort in a concrete way will be made to retain their services, particularly the top ones (as noted in the recent increase in the salary and perks schemes for them).

As no details are as yet available as to how this policy will be implemented, it is in the interests of the medical profession to discuss the main practical problems involved and to obtain the views of both Government and private consultants.

We welcome the move to strengthen the Government Medical Service primarily for the public good. However, the manner it is implemented has to be carefully considered. The experts in the Ministry of Health, no doubt, will consider the pros and cons before devising a scheme to implement government policy. Nevertheless, in the interests of our profession and the public, it is worthwhile discussing it.

The problem can be considered:—

(a) from the Government consultants' point of view;
(b) from the private consultants' point of view;
(c) from the point of view of public policy and the ultimate interest of the patient.

Without doubt, public policy and the interest of the patient must ultimately prevail.

I. In an opinion survey, there were no serious differences of opinion on honorary and visiting consultants. The main point of note on visiting consultants is that care should be taken in evaluating them as it was not unknown in the past to have got men of questionable skill and efficiency. Further, they should be noted for their expertise and/or knowledge in teaching, research and consultancy. They should be appointed for short periods of time to stimulate local ideas, cross-fertilize them, and to train local personnel in skills, techniques and management.

II. **Part-Time Consultants**
It is in this area that there were significant differences of opinion, mainly because the idea appeared new to many and because of uncertainty that personality problems may arise with part-time consultants in the running of Units. In general, most hospital consultants welcomed the part-time consultants, provided they worked under the general framework of the unit and were accountable to the head of unit.

On the other hand, private consultants were anxious that their exact duties should be spelled out so that no misunderstanding arises. It was felt that they should not be relegated solely to outpatient services but should take part in some of the other activities of the Unit so as to feel that they are an integral part of the Unit. At the same time, they should not be allowed to pick and choose which type of work they wish to do in the Units. Problems of study, research, teaching, keeping of sessional appointments in time, management problems will naturally arise for part-time consultants, but these with a little effort could be overcome, given goodwill and sincerity on both sides.

It was felt by the majority that part-time consultants were welcome provided that they were fully responsible for the care of their patients and made themselves available for continuous patient care in an emergency or otherwise.

The terms and conditions of part-time consultants should be so designed that it would not cause an exodus of serving officers into the private sector and then coming back as part-time consultants.

The scheme should be such that it is not the best of both worlds for the consultant but primarily in the best interests of the patient and the general public. Perhaps, it would be timely, at this juncture, if a accreditation committee of the Singapore Medical Council defines what a specialist/consultant is, for there are practical implications for such delineated consultants in both the Government and private sector.

The Social Duties of the Professions

A talk delivered at the Singapore Professional Centre. **by Dr. Gwee Ah Leng**

I have chosen to join the fashionable band-wagon in choosing the topic, for it is the current fashion for people to talk about service and duties. Actually, such a fashion is indicative of a lack rather than a profusion, for we generally highlight what we do not have. Hence, we talk about clean air only because we have polluted the atmosphere seriously, and similarly, we talk of democracy and human rights because we are undermining them all the time. If this is so, then the mushrooming of service clubs and organisations in Singapore in the last twenty years must mean that there has been a serious decline in the dedication to social duties locally.

More than just fund-raising

It is of interest to analyse the activities of these organisations and clubs, because the analysis will shed light on what is the average concept of social work. Most of us sitting in meetings of this nature will inevitably find that 90% of the time is taken up with the question of fund raising, and the energy of the members is to a large extent diverted to the search for money. It is undoubtedly true that in a social structure stressing free enterprise and private ownership such as Singapore, lots of social stresses and strains can be ameliorated by the liberal use of money: the man too poor to afford medical treatment, the child born handicapped, and nobody cares about, the dropouts of an educational system changing so fast that experimental victims became numerous, and I can go on for the next hour enumerating more examples. However, an affluent society is not synonymous with a good or healthy society, and clearly, social service has other facets.

Purpose & Direction

A thriving society must have direction and belief besides wealth, physical health, and enjoyment. It must have a purpose which should generate further thriving societies to come. This is normally ensured by tradition and culture often closely associated with religion. The absence or wavering of these prerequisites will inevitably give us a sick society.

Similarly, a profession has more facets than knowledge, which can be equated with earning power. The medical profession learns to heal the sick, and is financially rewarded. The legal profession learns to uphold the rights of man, and is likewise financially rewarded. So too others like architect, engineer, accountant and so on. The rewards are at times handsome, and at others poor – I know of doctors who were given handsome legacies in their patients' wills, and also of these whose patients never paid their bills. Nevertheless, if a profession has no more than knowledge to sell, then it is a sick profession, for a thriving and respected profession like a thriving society must also have a direction and belief which are equally engendered and ensured by culture and tradition.

Homogenity & Stability

The difference exists however, between the two in that society has a very diverse membership comprising old and young, weak and strong, upright and the deviant, and just and the unkind; whereas a profession by virtue of its rigid selection has a much more homogeneous membership with much the same training, and ability, cultural indoctrination and traditional background. It must be obvious that under normal circumstances, the latter will be more stable and less liable to be eroded by extraneous factors.

Mere Technocrat

It is this stability that makes professional duties to society much more than fund raising. The profession must contribute by its ability and its ethical stability so that society can have a healthy direction. The medical profession is only worth its name if it gives the cue to the society about the concept of physical and mental health, and about the inviolate value of life. Otherwise, it will become just a medical technocrat whose activities in fact may be harmful. He can easily treat and operate unnecessarily, kill or endanger at his whim, and even spread the drug cult which is plaguing a good number of societies.

What applies to medicine, can apply to all other professions. The lawyer that does not interest himself in the rights of man, or the teacher who has no passion about the nurture of human mind are perhaps technocrats a society may be better without, for I have always believed that a trained and capable man without principles is the worse man to have around – give me a stupid rogue anytime!

Professional Values

A professional man's social duties are thus of many dimensions: he can firstly contribute his particular expertise as an item of service; he can contribute his earnings and time much as other civic-minded citizens are doing; but most important of all, he can and must see to it that the professional values and dedication give lead to social thinking. And if only the medical profession assumes to itself the duty to see that the value of life and the concepts of health are upheld, and legal profession ensures that no injustice or tyranny may jeopardise human rights, and the teaching profession undertakes to see that all educational endeavours will produce enlightenment and happiness in learning, the Singapore society will have no survival problems.

GALLOWAY MEMORIAL LECTURESHIP 1973

The Academy of Medicine, Singapore, invites applications for the above lecture to be delivered in August 1973 in Singapore. The subject must be one pertaining to Medical Sciences and consist of original work. An honorarium of S$100/– will be paid to the Lecturer. Applicants must submit personal curriculum vitae and an outline of the subject matter embodied in the lecture. Applications should be sent to–

Dr. Beatrice T.M. Chen,
Scribe,
Academy of Medicine, Singapore,
4A College Road, Singapore 3.

not later than 30th April 1973.

Memorandum on the Misuse of Drugs Bill Submitted by the Singapore Medical Association

15th February 1973

The Honourable Minister for Health
through the Permanent Secretary (Health)/
Director of Medical Services
Palmer Road
Singapore.

Dear Minister,

On bahalf of the Council of the Singapore Medical Association, I submit for your kind consideration a brief memorandum regarding the proposed Misuse of Drugs Bill 1972. The Singapore Medical Association will be ready to make more detailed comments when the occasion arises.

Yours sincerely,
Dr. Gwee Ah Leng
President

The Council of the S.M.A. supports the Government in its intention to control drug abuse. It wishes to submit the following general comments:

1. Drug addicts should be treated as ill persons rather than punished as criminals.

2. Trafficking should be punished severely.

3. The circumstances in Singapore are not identical with those of Britain in relation to the problem of drug abuse and its control. Hence certain legal provisions while eminently desirable in Britain may not be applicable locally.

The Council hopes that ample time for public study of the proposed Misuse of Drugs Act 1972 will be permitted before its final reading in Parliament.

The Council meanwhile submits the following observations:

1. **Section 2**, a definition of "drug trafficker" is needed so as to discriminate between trafficking and addiction. There is the difficulty of an addict being a trafficker at the same time, but serious attempt must be made to ensure that addiction – an illness, will not be confused with trafficking – a crime.

2. **Section 6 and 7**,possession and administration can apply equally to addicts and traffickers. The latter is a criminal committing an offence, but the former should be otherwise regarded. Some compulsion, however, is necessary for the addicts to seek treatment.

3. **Section 33, para 1 and 2**, the Council observes that this will give the Director of the Central Narcotics Bureau specific judiciary powers. Since the local Director as at present is not necessarily judicially trained, this would be an undesirable situation. The Council feels that a suspected addict after being medically examined, should be left to the doctor to decide whether or not he should undergo treatment, and not to the Director as in the draft. The judgement to compel treatment is based on mostly medical and some judicial grounds, and would be beyond the province of the Director.

The Council also feels that the release of a case should be subject to the satisfactory report and recommendation of the institute where the treatment is carried out.

4. **Section 34, para 1 (c)**, the Council recommends that Section 14, para 2 of the Dangerous Drugs Act (1970) be included under Section 34 to read as follows:

"Nothing in this section shall be deemed to render unlawful the administration of any such drug by or under the directions of a registered medical practitioner or a registered dentist or a medical or dental officer of any naval, military or air forces who is resident in Singapore on full pay and, acting in the course of his duty."

5. **Section 34, para 2 (d)**, the Council recommends deletion of "and make returns", as it is of the opinion that there are inadequate qualified personnel to make valid use of the returns.

Para 2 (c). the Council recommends the deletion of this paragraph as it represents an encroachment of professional ethics of confidence. **Para 2 (f)**, Council recommends addition of the following: "..... provided that this will not disallow the use of controlled drugs for the purpose of the treatment of addicts".

6. **Second Schedule**, the Council reserves comment in the introduction of corporal punishment. While it supports the concept of punishing the trafficker more severely, it is unhappy about corporal punishment in general.

DR. GWEE AH LENG
President
Singapore Medical Association

Society of Nephrology

The Singapore Society of Nephrology was officially inaugurated on November 28, 1972. The objects of the Society are:–

1) the advancement of knowledge concerning the Kidney;
2) the promotion of research in Nephrology and of improved standards in the treatment of renal diseases;
3) collaboration with international and other regional societies interested in Nephrology.

Those interested in joining the above society, please contact:–

1) Dr. Lim Cheng Hong (President)
c/o Medical Unit II
Outram Road General Hospital
Singapore 3.
2) Dr. Feng Pao Hsii (Hon. Secretary)
c/o Medical Unit
Thomson Road General Hospital
Toa Payoh Rise
Singapore 11.

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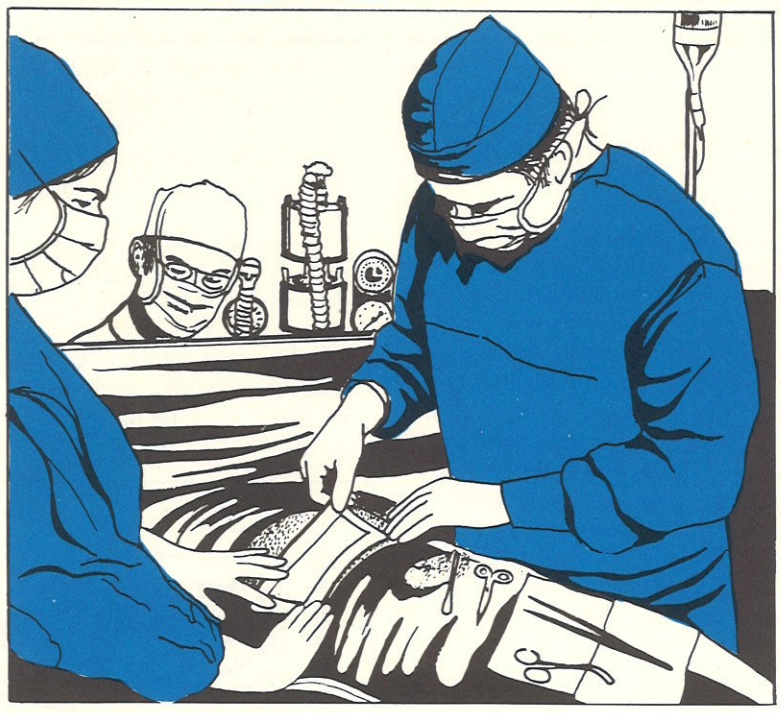

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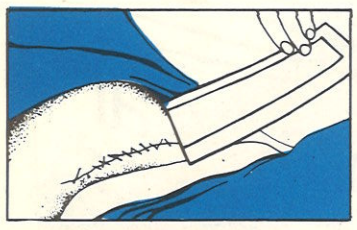

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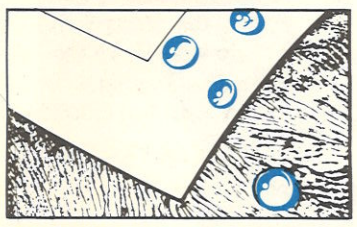

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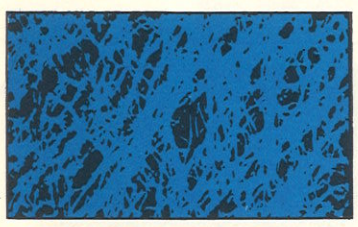

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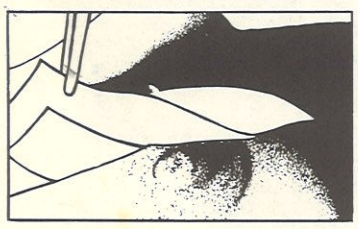

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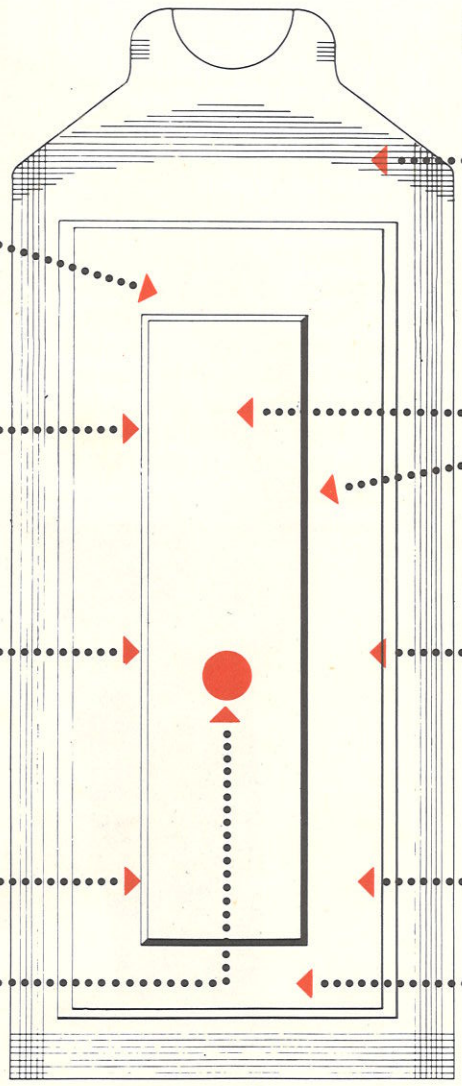

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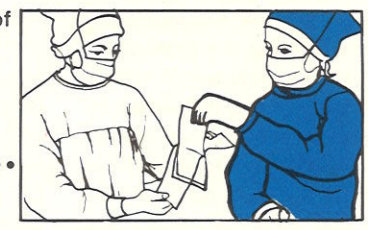

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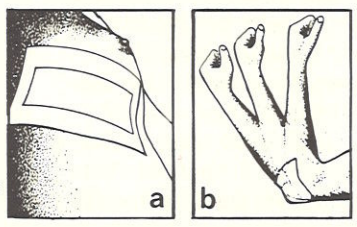

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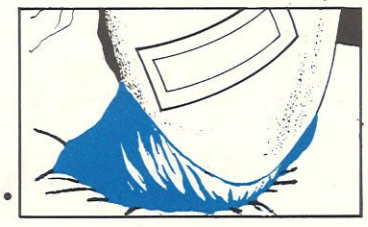

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Practical Problems in Medicine

ANAEMIA

by Dr. Toh Keng Kiat

Anaemia, by definition, means a reduction in the haemoglobin concentration in the peripheral blood below the normal for the age and sex of the patient. It is a common problem and iron deficiency anaemia is perhaps the commonest disease in the world. Anaemia is as often a symptom as it is a cause of disease and detecting it in a patient is but touching the tip of the iceberg for greater dangers lie submerged.

Classification

Classification of the anaemias is difficult as the causes are multiple and the morphology diverse. A practical approach is one based on aetiology and pathogenesis.

I. Blood Loss:

Acute massive bleeding is an obvious cause of anaemia and usually presents no problems as chronic occult blood loss does. Pathological bleeding from an ulcer or malignancy of the gastro intestinal tract is an important cause of insiduous blood loss in the male and the post-menopausal female whilst menstruation and childbirth play a greater role in the female of reproductive age. An inapparent and factitious cause of blood loss anaemia is through too frequent blood donations.

The anaemia caused by blood loss is due to iron deficiency and is characterised by a hypochromic microcytic blood picture with mild reticulocytosis. In the more severe cases, changes in cell shape and target formation may be seen.

II. Excessive Destruction:

Excessive red cell destruction (haemolysis) may be due to intrinsic corpuscular defects (e.g. congenital spherocytosis, elliptocytosis, haemoglobinopathies, G6PD deficiency), presence of abnormal antibodies (e.g. as in Rhesus incompatibility, lymphomas, systemic lupus erythrematosus) or hypersplenism (e.g. in portal hypertension, Felty's syndrome). Some defects as in paroxysmal nocturnal haemoglobinuria cause intravascular haemolysis.

The blood picture of a haemolytic anaemia depends upon the cause. Spherocytosis and elliptocytosis as their names imply are characterised by the presence of spherical and elliptical cells respectively. But spherical cells are also seen in other hemolytic anaemias. Cell fragments, a more intense reticulocytosis and sometimes even nucleated reds are also common features. The leucocytes may show a shift to the left. Other changes are hyperbilirubinaemia with acholuric jaundice. In intravascular haemolysis, haemoglobinuria is present.

III. Impaired Production:

Impaired production of the red cells may be due to :

(a) deficiency of protein, vitamin B_{12}, folic acid, iron or other minerals. Malnutrition, malabsorption and increased demands from growth or pregnancy are the commoner causes. The anaemia due to B_{12} and folic acid deficiency is described as megaloblastic and is characterised by the presence of well haemoglobinised macrovalocytic red cells. There may be mild anisopoikilocytosis and Howell Jolly bodies or Cabot rings are sometimes seen. Hypersegmentation of the nuclei of polymorphs may occur as may platelet deficiency and mild leucopenia.

(b) inherited disorders of hemoglobin synthesis. These may be due to decreased formation of normal globin chains resulting in thalassaemia or to formation of abnormal chains with aminoacid substitutes giving rise to the abnormal haemoglobins e.g. HB S, Hb E, Hb C. Thee blood film shows moderate to severe hypochromasia with prominent target formation, cell fragmentation and reticulocytosis. Punctate basophilia, polychromasia and normoblasts are also present. In Hb S disease, the red cells assume a peculiar sickle or holly-leaf shape.

(c) disturbances of marrow function. This is seen in chronic infections, malignancy, renal failure or endocrine hypofunction (e.g. hypopituitarism, addison's disease, myxoedema). It may also be suppressed by drugs, irradiation or unknown causes. In chronic disease, the blood picture is characteristically normochromic and normocytic and the anaemia mild. Renal failure and uraemia causes burring of the red cells while myxoedema may cause a macrocytic anaemia. Drugs often cause a pancytopenic depression due to suppression of all cell lines in the marrow.

(d) infiltration by malignant disease. The blood picture is variegated as the anaemia may also be due to blood loss, infection and hemolysis. Of note is the leucoerythroblastic type with presence of both early white and red cells.

While it is desirable to classify anaemia as above, it should be emphasized that in any one patient several factors may be present at the same time producing several types of anaemia.

Clinical Features

The signs and symptoms in an anaemic patient may be due to the anaemia itself or to the underlying disease. Very often the manifestations of the causative disorder are mild and escape detection while those of the anaemia predominate. The level of haemoglobin at which symptoms develop depends on the age of the patient and the rate at which the anaemia develops. The younger patient usually tolerates a lower level of haemoglobin better than the elder and has a different set of symptoms. Older persons often present with cardiovascular and cerebrovascular features due to the increasing incidence of degenerative vascular diseases with increasing age.

Generally the most common symptoms are tiredness, easy fatigue, lassitude, and muscular weakness. Other more striking symptoms are angina, intermittent claudication, palpitations, exertional dyspnoea, dizziness and tinnitus.

Palor is the most prominent and characteristic sign, best detected by examining the conjunctivae, mucous membranes of the mouth, nail beds and skin. Sometimes the skin colour may betray the underlying cause as with the sallow skin of uraemia, and the lemon-yellow tint of myxoedema and pernicious anaemia. Integumentary changes may also be diagnostic, such as koilonychia (spooning of the nail) in severe iron deficiency anaemia.

Heart failure is common in the elderly anaemic patient. Less severe degrees of anaemia cause tachycardia, haemic murmurs and a high pulse pressure due to an increased cardiac output. Oedema is seen with cardiac failure but may sometimes occur in the patient without a failure heart.

Numbness, coldness and tingling may also occur, but more severe changes like mental dysfunction and neuropathy should lead one to suspect vitamin B_{12} deficiency, lead poisoning, porphyria, and alcoholism as possible causes.

Mild proteinuria and a loss of concentrating power may occur in severe anaemia. Infertility may be seen in megaloblastic anaemia while in the male priapism has been reported in chronic myeloid leukaemia and some types of hemolytic disease. Menstrual disturbances result from, as well as cause anaemia and amenorrhoea and menorrhagia are commonly reported.

Anorexia, flatulence and nausea may also occur as may mild pyrexia.

Management:

The approach to the management of the patient with anaemia involves (i) making the diagnosis (ii) determining the type (iii) detecting the cause and (iv) treating the patient.

A careful history and the above signs and symptoms suffice for making a diagnosis of anaemia in most patients and of the cause in some. But simple screening tests like the Hb estimation, a full blood count, the blood indices and a peripheral blood film are invaluable. This last is particularly useful as most diseases

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ANAEMIA

have a characteristic blood picture, vide supra. Special investigations are confirmatory and include Hb electrophoresis, enzyme studies, serology and bone marrow aspiration.

The cause of anaemia is often influenced by the age and sex of the patient. Iron deficiency anaemia, for example, in infancy is due mainly to prematurity, shortened gestation, delayed weaning or perinatal hemorrhage; in childhood, to poor diet or increased demands; in reproductive females, to menstruation, pregnancy and childbirth and in adult males and postmenopausal females, to insiduous pathological blood loss. In this last group one should always suspect malignancy and ulcer of the gastrointestinal tract as a possibility and direct investigations along these lines. Repeated tests for faecal occult blood and barium studies of the gastrointestinal tract are often indicated. Other factors like faulty dietary habits, low socio-economic status and cultural and religious taboos are contributory and should not be neglected.

Treatment may be preventive, curative or symptomatic. Certain anaemias like aplastic anaemia and drug-induced hemolysis may be prevented by avoiding drugs known to cause aplasia of the marrow and hemolysis (e.g. phenylbutazone, chloramphenicol, sulphonamides, quinine, antazoline or phenacetin) unless the indications are specific and alternatives unavailable. Anti-inflammatory agents (e.g. salicylates, prednisolone) cause erosions of the gastrointestinal tract while some like salicylates invariably cause blood loss if orally ingested.

Anaemia due to deficiencies of iron, B_{12} or folic acid arising from faulty dietary habits, poor nutrition, malabsorption and food fads are easily cured by replacement of the required hematinic. It is important to remember that in the malabsorping patient, these may need to be given parenterally. Treating infections, renal failure and endocrine diseases leads to an alleviation of the symptomatic anaemias whilst one of the most rewarding anaemias to treat is congenital spherocytosis by splenectomy.

The chronic anaemias due to haemoglobinopathies are only symptomatically relieved by periodic blood transfusions. Splenectomy may be helpful in reducing the frequency of transfusion requirement. The hypoplastic anaemias are treated by fresh blood transfusion or specific component (i.e. platelet, leucocyte or red cell) replacement. In females with anaemia due to menorrhagia from thrombocytopenia a beneficial effect may be derived from the oligomenorrhoea induced by cyclical hormone therapy. Prednisolone and androgenic stimulants may also induce resumption of haemopoiesis.

Lastly, a group of patients is encountered who through self-inflicted wounds and phlebotomies produce a factitious anaemia for manipulative purposes. These patients present as severe iron deficiency anaemia which is easily amenable to treatment but which relapses just as easily. The treatment apart from iron replacement is pyschiatric.

(Not to be Quoted in the Press)

An Informal Affair

by H. H.

On the 6th Jan. '73, over three hundred doctors with a sprinkling of guests attended the SMA dinner at the Crystal Ballroom, Hyatt Hotel, to honour Professor Sir Gordon Ransome.

In spite of the assurance that the dinner was to be an informal affair, only a handful took up the challenge by appearing in short sleeves and open collars. However, what years of habit and good breeding inhibited, a free flow of potent 'Punch', served generously before dinner, easily succeeded in loosening stuffy collars and unbuttoning constricting jackets.

Add to the heady effects of the 'Punch', the tantalising music by a lively band – and you soon have the incredible sight of doctors of all ages packing the slippery aluminium dance floor long before the third course had even been served.

The toast to our Guest of Honour was proposed by the President of the SMA. In a neat little speech, he said that try as he did, he just could not think of something uncomplimentary to say about Professor Ransome. For once the President was not being controversial.

More dances and songs followed. Then Dr. Evelyn Hanam was invited to go up to the stage to present a memento to our guest. Miss Hanam's short trip to the stage provided the only touch of pomp and pageantry for the evening. For, marching solemnly behind her, at a respectful distance, rigid in posture and severe in mien, was none other than Dr Kho. His role in the general scheme of things become apparent only when, as the procession treaded its way back, he was seen ceremoniously carrying a bouquet of flowers, while maintaining the same respectful distance, the same rigid posture and the same, same straight face. Intentionally or otherwise, it was a neat parody on the pomp and ceremony complete with liveried attendants and drum roll to attention, that have characterised all our previous social functions.

Professor Sir Gordon Ransome, in accepting the present, said that in honouring him, we were in fact honouring ourselves. Like all great teachers, he said that he derived his greatest satisfaction in the success and achievements of his old students, many of whom have made their mark not only locally but in foreign lands as well.

More dances and songs followed. As expected, no evening at a Singapore night club can be complete without the inevitable floor show. This was provided by none other than Dr. Wong Yip Chong. He started by waving a wad of lecture notes before his audience. He got everyone so fixed on his notes that when he finished his performance, no one had thought it odd that he should walk away with all his clothes still on – a tribute indeed to his power of hypnosis. Perhaps our sisterly association should learn from the Great Wong that a consumate night club performer can be just as entertaining by merely teasing without stripping.

By 12.30 p.m., as the Crystal Ballroom began emptying itself, there were still weird figures desperately struggling to maintain their bipedal posture on the ice-rink mistakenly called the dance floor.

This is the kind of scene that makes organisers of dinners feel that all their time and energy spent in putting up the function have not been in vain.

Chess Notes by National Master Lim Kok Ann

Scooping the Match of the Century

Fischer v. Spassky: Reykjavik 1972. C.H.O'D. Alexander. Penguin Books £1.00.

Fischer v Spassky: The World Chess Championship Match 1972. S. Gligoric. Collins/Fontana. 50p.

How Fischer Won: World Chess Championship 1972. C.J.S. Purdy. Publ. E.J. Dwyer, Sydney. A$1.25.

Spassky versus Fischer. P.H. Clarke and W.J. Welch. Publ. Hexagon, U.K. 50p.

World Chess Championship: a History. L. Horrowitz. Macmillan, N.Y. US$6.95.

Der Titelkampf Fischer-Spasskij. L.Pachman. Publ. Walter Rau Verlag, Dusseldorf. D.M. 9.80.

Long before Fischer sat down to play Spassky at Reykjavik, publishers all over the world had made plans to scoop the match of the century. The result is that chess fans have a surfeit of books on the match, the above being the titles published in English with one in German, representative of those in other languages.

I give the English titles in the order of merit, taking each book as a whole. Penguins came out with an unusual size of 20 cm x 20 cm (7¾ in. x 7 ¾ in.). Beautifully produced, giving, I quote the blurp, "An account of the struggle for the World Chess Championship with illustrated biographies of the players, their previous encounters and an anaylsis of each game, a report from Reykjavik by Francis Wyndham and drawings by Michael Foreman."

Gligoric's book (by Fontana) gives much the same thing, but one might prefer Gligoric's comments to that of Alexander. Fontana's paper is, however, inferior to Penguins. Whereas Alexander depended on Wyndham's reporting from Reykjavik for "local colour". Gligoric was on the spot to comment on both the games and the action, telephoning to London after each game.

In the event, Fontana rather scooped Penguins, for Gligoric's book was on the bookstands in England a few days after the conclusion of the match, and on sale in Australia soon after that (Fontana's flew the plates out). The latter would have been a clean sweep but for Purdy's enterprise in matching Gligoric's industry for "How Fisher Won" appeared almost simultaneously.

I have each of the three books mentioned and I thoroughly recommend Purdy's book which has a rather intimate style, bringing the reader, as it were, into the game. I don't have Clarke's book, which I think has missed the bus, and I don't think we would have much use for Horrowitz's book too. I saw a copy of it in paperback in Skopje and it appears to be a reprint of Horrowitz's articles in the New York Times. I was told by the USIS Library in Singapore that they do not have plans to acquire the book. The price given above seems to be for a hard-cover publication, and I don't know the paperback price.

Local bookshops still have Gligoric's book. Penguins are sold out, but will re-stock soon. I am ordering Purdy's book for the benefit of local chess fans (price S$4.50). I'll order Pachman's book, too, for anyone interested, but it's dear.

Here is a game I won at Skopje, just to let you know I did win one or two. We beat Guernsey 4-0 in Fina s Group D and they finished 13th place out of 15 teams in this group.

Lim – Le Marquand (Guernsey).

1 d4 Sf6 2 c4 e6 3 Sc3 Lb4 4 a3 Lc3 5 bc3 c5 6 e3 0-0 7 Ld3 d5 8 cd5 ed5 9 Se2 Te8 10 0-0 Sc6 11 Sg3 c4 12 Lb1 Sa5

I have good results with this opening against weak players. In this instance, Black loses time on the Queenside and succumbs to a Kingside attack.

13 f3 Sb3 14 Ta2 Ld7 15 Taf2 Lc6 16 Sf5 b5 17 e4 Sc1 18 Dc1 de4 19 Dg5 g6 20 Sh6 Kg7 21 fe4 Se4 22 Tf7 Kh8 23 Th7 Kh7 24 Tf7 Kh8 25 Dg6 Black resigned. Mate was threatened in several directions.

SMA CONGRATULATES

Mr. Choo Jim Eng – Elected Member of Singapore Medical Council.
Dr. Oon Chiew Seng – appointed external examiner for M.R.C.O.G. examination
Dr. Chau Sik Ting – DIH (Eng.), DIHSA (Lon.)
Dr. Goh Yong Siah – Smith & Nephew Medical Fellowship
(Not to be quoted in the Press)

The Office Bearers of the **Academy of Medicine**, Singapore for the year 1972/1973 are as follows –

Master	Prof. Seah Cheng Siang
Assistant Master	Dr. Chew Chin Hin
Scribe	Dr. Beatrice Chen Tsung Mong
Bursar	Mr. Choo Jim Eng
Bedel	Mr. V.K. Pillay
Censors	Mr. N. Balachandran
	Mr. Yahya Cohen
	Mr. Leong Hin Seng
	Mr. Robert Loh Choo Kiat
	Mr. Tan Ngoh Chuan

WHAT'S THE FUSS, DOC?

What's the fuss, doc?
Over an editorial,
Where to wish is not to commit,
Where a thought is not a deed,
And a desire not an act.
Editorial Fantasy?

What's the fuss, doc?
Over a sub-committee,
Where opinions are solicit,
Where to cross swords is a good deed,
And contrary views are no artefact.
Teratogenic Fantasy?

L. V. C.

Medik Awas Q and A on Allergic Reactions

(Dr. Yeoh Teow Seng, Associate Professor of Pharmacology, answers some questions on allergy posed to him by MEDIK AWAS. Prof. Yeoh is specially interested in the mechanism of anaphylactic shock.)

Q1. The terms anaphylaxis, allergy and hypersensitivity have been loosely used. What is the distinction between these terms?

Ans. To answer this question it is pertinent to look into the origin of these terms and some basic concepts of allergic reactions.
The term allergy was originally proposed by von Pirquet to refer to the concept of a "changed reactivity". He did not take into account whether the change was in the nature of clinical hypersensitivity (i.e. enhanced sensitivity) or clinical immunity (i.e. enhanced protection). However the term (allergy) is now popularly used as synonymous with clinical hypersensitivity.
Allergic reactions have been classified by Gell and Coombs (1963) into 4 types as tabulated. It is important to bear in mind that more than one of these allergic reactions as tabulated below can occur in a patient.
With this background, differentiation of the terms, anaphylaxis, allergy and hypersensitivity can be made as follows: anaphylaxis refers to Type 1 or "immediate" type of reaction; allergy and hypersensitivity are used synonymously to include any of the 4 types of reactions.

Q2. What is the basis of allergic reactions?

Ans. The basis of allergic reactions is the response of our body to any substance it detects as foreign to the body. Thus allergic reactions are but one aspect of the manifestation of our immune response.

Q3. Why are allergic reactions commoner with certain drugs than with others?

Ans. Drugs vary in their antigenic capacity. Drugs that are strongly antigenic, e.g. naturally occurring "foreign" large molecules like the antitoxins present in horse serum or organ extracts are more liable to cause allergic reactions. On the other hand, relatively simple chemical compounds of small molecular weight can also become antigenic if they combine with some other substance in the body, thereby functioning as a hapten. The antigenicity of penicillin is believed to be due to its breakdown product penicillinic acid which acts as a hapten.

Q4. What is the incidence of allergic reactions to penicillin?

Ans. Penicillin is reported to be the major cause of anaphylaxis in man. The incidence of allergic reaction to penicillin among patients receiving it ranges from less than 1% to 10% in various studies.

Q5. How safe and reliable is the intradermal skin test for penicillin hypersensitivity?

Ans. The intradermal skin test for penicillin hypersensitivity is not a safe procedure. In a hypersensitive patient the test itself can precipitate a reaction.

Q6. How much safer is oral administration of a drug compared with parenteral administration?

Ans. Generally speaking, administration by the oral route is less liable to cause sensitization of a patient compared to other routes of administration. If a patient is already sensitised to a drug, oral administration of the drug will also cause allergic manifestations although the reaction is not likely to be as severe compared to administration by the parenteral route.

Q7. How good is the correlation between the speed of onset of a reaction to the gravity of the reaction?

Ans. I am not aware of any studies having been done to correlate these two factors. I presume that the term "reaction" in the question refers to anaphylactic shock. The speed of onset of anaphylactic shock will depend very largely on the route of administration.

Q8. Apart from patients prone to bronchial asthma and atopic dermatitis, are there other groups more liable to drug reaction?

Ans. Special caution should also be taken with patients having a history of hay fever, allergy to certain foods or drugs, or with a family history of allergy.

Q9. Is there any danger of drug sensitization by topical application of drugs on the skin?

Ans. There is no doubt that topical application of drugs to the skin causes sensitization, especially

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Type	Clinical manifestations	Time required for signs/symptoms to manifest	Mediated by
1 (anaphylactic)	Urticaria, angioneurotic oedema, hay fever, bronchial asthma, anaphylactic shock	within	IgE type antibodies
2 (cytotoxic)	incompatible blood transfusion, haemolytic disease of the newborn, drug induced haemolytic anaemia, purpura	several hours	IgG, IgM anti-bodies and complement
3 (damage by toxic complexes)	Arthus reaction, serum sickness	several hours	Toxic antigen-antibody complexes
4 (cell mediated)	delayed hypersensitivity reaction, e.g. tuberculin-type allergy, contact dermatitis	two days	specifically sensitized lymphocytes

M.C.G.P. Examination - Reflection by a G.P.

The College of General Practitioners of Singapore held its first examination in November last year, admitting seven diplomate members, who having survived a gruelling examination, had the previlege of writing M.C.G.P. after their names. The examination was held in two parts, a written and a clinical part. They were held on two successive Sundays for the benefit of G.P.s who were considered to be perhaps not free during the week-ends. The theory part comprised of three papers, two of which were of multiple choice questions and one of the standard essay type questions. Being relatively unaccustomed to answering multiple choice questions, having had little experience of such in my time at the Medical School, I found these most taxing to the mind. The answer to most questions were so close that I felt tempted many an instance to toss a coin. The clinical session, which comprised examination of long and short cases and discussions with examiners on E.C.G.s, X-rays and laboratory results, was less unfamiliar. At least during this part of the examination, one was required to go through the same procedures, both mental and physical, that one would normally do so in one's clinic. The only difference (and what a difference!) was that one was required to vocalise one's thought process in front of the examiners and that was certainly not easy to do, what with a pounding heart and a dry mouth!

Now that the examination is over with, one can sit back and ask – is it worth one's while as a G.P. taking the examination? Precious spare time which can be spent on one's favourite hobbies has had to be sacrifised either reading textbooks or attending classes. There is also the curtailment of one's social life and for what purpose? To read textbooks again after so many years of not having read anything besides the newspapers and magazines! What about failing the examination? The possibility of failing is always there, for everybody. Why then risk it?

I suppose when one looks as it from the point of view of continual medical education, then sitting for an extra examination, years after one has been granted the licence to practise medicine becomes revelant. The examination is only one part of this education. The lectures, discussions, clinical sessions held during the months before the examination form the other part. Both are just as important. The teaching sessions, the reading up before and after provide the education. The examination gives the added incentive, the stimulus to attend a class when one would rather watch T.V., the stimulus to read a page from a book when one would rather roll over and sleep. Without a goal, at least for myself, I would find it difficult, if not impossible, to make myself read.

As one who has gone through the mile, so to speak, I would encourage all G.P.'s, young and old, to have a crack at the examination, the next one I understand is scheduled in September 1973. Whether one gets through or not is of secondary importance. The preparation for the examination has brought together G.P.s of different years standing. The comradeship is there. The side discussions that go on are no less illuminating. I have found the whole process educational and rather enjoyable, though many a time I developed cold feet and felt like withdrawing from the examination.

Dr. Chang Ming Yu

● FROM PAGE 8

with drugs like penicillin, sulphonamides and even antihistamines. In this case the allergic reaction is of the delayed type (Type 4) mediated by specifically sensitized lymphocytes. Subsequent topical application in a sensitized patient leads to dermatitis. However, the reactions to systemic administration vary from the trivial fixed eruptions to widespread and fatal exfoliative dermatitis.

Q10. How efficacious is the prior administration of an anti-histaminic or steroid drug to forestall a drug reaction?

Ans. The acute anaphylactic shock is mediated through the release of certain pharmacologically active substances. Among those that have been identified are prihistamine, slow-acting substance of anaphylaxis, prostaglandins and bradykinin. An antihistaminic or steroid drug does not prevent the antigen-antibody reaction but only acts subsequently to antagonise some of the chemical mediators released. They cannot forestall the allergic reaction but only modify it somewhat.

The Facts of the Case

It was reported in the Press that Dr. Fong Kim Heng has been struck off the Medical Register. The fact is that Dr. Fong himself has asked that his name be removed because he has ceased to practice medicine.

Published by the Singapore Medical Association, 4A, C

Views expressed by