MEDICAL

SINGAPORE MEDICAL ASSOCIATION

Newsletter

VOL 7 No. 5 JULY 1974 M C (P) 996/74 KDN 7824

What is Community Medicine ?

by DR. NALLA TAN,
Senior Lecturer,
Department of
Social Medicine
and Public Health
Faculty of Medicine
University of Singapore

Community Medicine is a term that is being used over and over again more recently, so much so that many wonder if it is not a new form of medicine and speculate on what it is all about. To look at it from an over simplified point of view, it can be described as medicine practised to community level; and here "community" is taken to mean a group of people who live together, share common patterns of living, common social values and amenities – the practice of medicine being one of these – and where the family is the basic unit of Society.

It goes without much further explanation that individuals make up families, and it is from a collection of families that communities are born. So that, essentially, when we speak of community medicine, we are talking of the practice of medicine geared towards the total health needs of the community and involving everyone from the very young to the old.

Symptoms

This is not anything new. It is only new in the sense that the concept has been revived after a long period during which scientists were engaged making great discoveries, involved in research and in technological advance. Community Medicine is as old as the hills and was practised in the ancient civilisations of China, India and the Middle East. In those days the physician was the philosopher, the priest, the teacher in the community. When people were sick they went to the physician and they were treated according to their symptoms. The physician of old was similar to the present day practitioners; he knew what common ailments afflicted these people. But treatment of illness was not the only thing he did. He advised them on what to eat, and what to do when certain phenomena would follow as part of the course of disease; and he also told them how disease could be prevented. These facets of Community Medicine as practised by the ancients, are known today as Health Education and Preventive Medicine.

Leprosy

We tend to think it is only more recently that treatment, prevention and Health Education have been recognised as the basis of the practice of medicine, in much the same way as we tend to look at the study of the patterns of disease – the discipline of epidemiology – as something of only about 200 years old. We have only to look back into the history of medicine. Again in the histories of the ancient civilisations and in particular in the book of Leviticus of the old testament, we find records on medicine practised on a community basis. The first great public health laws enunciated to protect the community from the spread of infectious diseases, were the laws enforced on people suffering from leprosy, and the principles of isolation, segregation, quarantine and cure was established by the Jews.

And so it was too in the days of Hippocrates. Medicine as practised by the Greeks was definitely on a community basis. The Greek physicians were conversant with the common ailments of that time, and again, prevention received as much attention as did treatment. Some of the tenets of preventive medicine as enunciated by Hippocrates still hold good. For instance, he warned people that eating in excess of their energy requirements led to obesity and early death; that adolescence was a vulnerable period in growth. This he was able to say because he observed people in sickness and in health – and here is possibly the most important aspect of community medicine – not only in sickness but in health – he knew their habits, their troubles. He knew them as families in a community, when they were ill, and when they were not. And right from the times I have just mentioned, the whole practice of medicine was community oriented, aimed at alleviating pain, sickness and suffering of people.

Advancement

Medicine has come a long way since, and at different times in history has taken on different emphasis. We have gone through, as I have said, phases of scientific advancement, the discovery of bacteria as a cause of infectious diseases, the antibiotics, antisepsis, major advances in anaesthesia and surgery – all these have revolutionised our approach to medicine and we have gone on, obsessed with discovery, research, to extreme specialisation where the patient is fragmented according to organs or systems affected. The focus has shifted from the person to laboratory techniques, and much more attention is paid to diagnosis and diagnostic paraphernalia, so that people are just shoved around and forgotten as individuals, human beings, with emotions, attitudes, feelings and reactions. The diagnosis of a case has been over emphasised and everything is geared to this end. Figures are important so research papers can be read at conferences, and the real objectives of medicine pushed aside. Treatment too has become very routine. This has led to a very impersonalised form of practised medicine, and there has been a reaction.

It's a funny thing, but Newton certainly knew what he was talking about when he said "to every action there is an equal and opposite reaction" – and this is where we are today. We are at a point of reaction to what has been going on, in terms of medical care. There is a

● See Page 8

BANGLADESH : Emergency Flood Relief

Dear Sir,

Perhaps you are aware that of the total 56,000 sq.miles area of Bangladesh about 46,000 sq.miles are already under flood water and the remaining area are gradually going to be affected in the same way. Already road communication has been paralysed from one to another part of this country. The collosal damage could not as yet be assessed although loss of lives, damage of crops, huts and shelters particularly in village area is alarming. This gigantic task need be solved with utmost care by the people of all walks of lives of Bangladesh and we are already in service to play our part in medical relief activities.

As already explained above we have extended our services with all resources in hand and with speed at our command but our resources are so limited that we may not be able to continue our services for long to meet the necessity of our people.

We would, therefore, approach your good offices to help us in this national emergency in any way it may be possible. You may also advice your local manufacturers of drugs and medicines to contribute generously for this humanitarian task.

All contributions in coins may be sent to us by way of remittance through Banks to our official address at Dacca and contributions/donations in kind may be despatched either by air (if free flight is available for Dacca Air Port) or by sea at Chittagong Port from where we shall arrange to clear the same on receipt of concerned documents.

We are anxiously awaiting to hear from you and we are sure that you will kindly respond to our humble call to help our distressed people and to overcome our national calamity.

Yours faithfully,

Secretary General,
Bangladesh Medical Association.

★

The above letter was sent to the Commonwealth Medical Association who have circulated it to member organisations. Doctors willing to help can ring SMA Secretariat for details. This is a joint project with the Pharmaceutical Trade Association.

You can give either in cash or in kind.

We have made arrangements for essential medicine to be purchased at cost as below cost from the trade.

INSIDE

Battle of Sexes

Ah Wun, He say,
For woman,
Before marry, first come engagement.
After marry, then come battle.

VIEWPOINT

Carrot Or Stick ?

The 151 page Report of the Committee on Crime and Delinquency is an important document that deserves close study. It puts the finger rightly on the pulse on many issues, it speaks out loud and clear on matters where hitherto there have been only muffled tones. Obviously much homework has been done and it is impressive.

It confirms what was expressed in Viewpoint in our last issue (the Slippery Slope Down), that a "major part of the problem of delinquency" is "linked with that of school drop-outs." It reinforces the argument that unless these drop-outs are given gainful employment and training of some form, the problem of juvenile delinquency is not likely to improve.

On the present school system and the curriculum it says, "We believe that educational failure contributes to personality maladjustment and misbehaviour. Failure in school work may lead these slow learners to react against authority." Once more one could not agree more.

It recognises the pressures our students in the schools are facing to-day, "Our society still places undue emphasis and value on examination success and paper qualifications. Consequently a child finds that school life is highly competitive. Examinations can be a cause of anxiety and nervous tension because of the stigma attached to failures. Behavioural problems may arise as a result of such difficulties in school." This is a refreshingly frank assessment of the problem, but are parents to blame as the Report suggests because they "believe their own children are as good as other children?" If there were sufficient secondary schools and tertiary institutions and no "bar examinations" would not the pressures be much less?

The Report recognises the problems of the slow learners and discusses the need for a review of the age system, retention and automatic promotion. It fears also that a child from an almost vernacular background would "suffer a culture shock" in the first two years, and recommends that every attempt should be made to assist them master the basic language in the first two years at school. This should not go unheeded.

Having done so well thus far, the Report unfortunately falls on its face by recommending in Section 3.3.39 that "teachers enforcing .. standards of discipline should be allowed to administer corporal punishment as they are the immediate authority. **The effect will be greater if the class teacher has the right to inflict corporal punishment.** It is therefore desirable to invest the authority on the teacher."

Surely this is going to be a great leap backwards! One does not deny the fact that in certain recalcitrant cases, corporal punishment is unfortunately perhaps the only way of showing a miscreant that he has done wrong. Whether he will be convinced by this method of physical argument is another matter. But is it fair or wise to allow an irate teacher to assume the roles of prosecutor, judge and executor all at the same time? Is it not possible that the irritability brought by overwork and other forms of stress could cloud his judgement? It would be much better to retain the present system where the principal administers the punishment, thereby serving as the judge and executor, while the teacher makes out the case for the prosecution.

The incidence rate of delinquency in schools is given in Table E 1 as varying between 2.07 to 25.97 per thousand male students. Surely the misbehaviour of a small segment of students is not sufficient grounds for wielding the birch over the heads of the other 975 in the thousand who pose no problems in discipline.

Does corporal punishment ever achieve anything? The weal on the skin heals readily enough, but what about the scar on the mind? Will this not be counterproductive and make big delinquents out of little ones who feel bitterness and hostility towards society? Illingworth recounts the bitterness with which some famous people remember their days at school.

Alfred Lord Tennyson said that as a boy he could not "hold his knife and fork for days after a caning." Gladstone, the British Prime Minister had a headmaster who promised his students that if they were not pure in heart he would "flog purity into you through your hides." Yeats wrote that "he remembered little of childhood but its pains."

Does the punishment always fit the crime? Does forgetting to bring a mug along to brush teeth, or talking during class merit two of the best? Does it always stop at two? There have been instances where doctors have seen students who were not merely caned, but were roundly thrashed by teachers who could not control their rage. Admittedly most teachers will not go on to excesses, but even teachers are human and if provoked it is hard for anyone to contain one's wrath.

Thomas Crammer said that "the schoolmaster had dulled the wits of the scholars in his charge and made them hate rather than appreciate good literature." In his own case "the treatment he had received at school had permanently damaged both the good memory and the natural audacity with which he had been endowed as a child."

Illingworth gives this comment on corporal punishment, "much punishment would be avoided if teachers and parents would realise that children learn far better from praise and encouragement for good behaviour, than from threats of punishment, discouragement and the weapons of fear, sarcasm and ridicule.

Children learn more by being shown the reasons for good conduct, by being treated as individuals who will co-operate if given a chance, and by being given increasing opportunities to exercise decision and self control.

As one writer put in, too many parents and teachers still place great faith on rules and regulations, in demanding unquestioning respect for authority, obedience without question, freedom from annoyance for themselves and still cling to retaliatory theories.

One of the many reasons why punishment is usually wrong is that it is meted out for things which are in **no way the fault** of the child – features such as poor concentration, overactivity, difficulty in reading or arithmetic, or clumsiness.

As George Bernard Shaw once wrote, 'To punish is to injure. You can't mend a person by damaging him."

One has to apologise for culling so heavily from Illingworth. These are not the airey-fairey theorizations of some academician, but the observations of a Professor in Child Health who has devoted a life time to the problems of children.

If we look upon the rod as the panacea for all the ills of juvenile delinquency, and feel we have nothing to learn from Western academics in their "permissive" approach, we would be taking a naive attitude to a complex situation. In the Report "inadequate parental support and guidance" is listed as one of the causes. How much of this inadequate guidance is due to disinterest and how much of it is due to lack of supervision due to the fact that both parents have to work to support the family these days?

We must not always point the accusing finger at the child, or the parents, or even at the teacher, but we have to ask ourselves in every case of a child gone wrong, has society in anyway failed him?

The Report of the Committee on Crime and Delinquency is an excellent piece of work, and we must not allow a few shortcomings to detract from its intrinsic value and merit. Perhaps the final solution has been suggested by the Report itself that we need more counselling centres and more child guidance clinics to look into the needs of the anti-social child. We must recognise the "pre-delinquent" child for here as in all things, prevention and not the stick, is always better than cure.

E.K.

Failure in Adaptation

In the recent SMJ (June 1974), Dr. A.L. Gwee has drawn attention briefly on "Failure in adaptation" making itself manifest in many ways. One of the passive ways is in the form of ill-health of a protean nature which formed the basis of his article.

Manifestations of this failure in adaptation can by implication be divided into 2 main types, the "active" and the "passive" type corresponding to the "fight" and "flight" activity of an organism in an inhibitory situation or environment.

Thus, assault on property or person leading, in extremis, to the taking away of another person's life is active manifestation of this failure to adapt. Other forms of passive manifestation may include drug-abuse, hippyism and self-degradation leading to suicide.

'Ping-Pong'

People adapted to the situation or environment live in a "ping-pong" sort of existence with occasions verging on the edge of one extreme and occasions on the edge of the other extreme.

Are we witnessing the twin manifestations of active and passive maladaptation in our youth with increasing cases of juvenile crime and drug-abuse in society? It was certainly pertinent that "E.K." and Dr. Wong S.T. should draw doctors' attention to some of the symptoms, aspects and problems of the "disease" with suggestions on their resolution in the last Newsletter (May/June 1974).

For a start, the term school "drop-out" should be discarded as it causes more problems, perplexities and unhappiness than any other nosological label. The term "non-adaptor" is neutral enough with no overtones or undertones.

If every child is a wanted child, it is time we go into the reasons and causes of the failure to adapt. Medical (genetic, psychological and physical), educational and socio-economic factors may well be contributory factors. We can as doctors go into the medical factors. Can we count on experts in other fields to make similar contributions?

Our Environment is very much of our own making and concern. Perhaps our "ping-pong" table is substandard in size and when we extend the edges on either side, the number of non-adaptors will be less.

L.V.C.

The Academy of Medicine: Its beginnings and its role in medical specialisation and training of specialists

AN ADDRESS TO THE ROTARY CLUB OF SINGAPORE, WEST

by Dr. CHEW CHIN HIN,
Master, Academy of Medicine;
Senior Physician (Thoracic Medicine)
Tan Tock Seng Hospital

The Academy was founded 17 years ago in July 1957 as the body of medical and dental specialists for Singapore. Amongst the 20 specialists who gathered on that memorable day in the home of Prof. Sir Gordon Ransome, the first Master, were our Republic's President and the Academy's Patron, Dr. Benjamin Sheares, who was then the Professor of Obstetrics and Gynaecology, the Speaker, Dr. Yeoh Ghim Seng, who was the Professor of Surgery, and Prof. E.S. Monteiro, our Republic's Ambassador to Washington.

Right from its inception, the academy was patterned after the Royal Colleges in the United Kingdom and in Australia. However, unlike the Royal Colleges, the Academy has the important advantage in that it embraces all specialities in Medicine. Thus it includes within its number all Medical specialists and consultants in Singapore – the Government Service, the University and the private sector. From a meager beginning of 34 founder members we now have 250 members and 9 honorary members of international pre-eminence.

The major responsibility of this body were also similar to those of the Royal Colleges when taken collectively: these being to advance the Art and Science of Medicine, to maintain and promote the highest standards in professional practice and to foster and sustain Postgraduate Education.

In accordance with these objectives, the Academy immediately after its foundation embarked on a programme of organised teaching for medical practitioners through refresher courses, teach-in seminars and symposia; the first was on Cardiology which was soon followed by other major specialities such as Neurology, Thoracic Medicine, Paediatrics and specialised aspects of Dental Surgery. Many of these lectures were subsequently published in the first series of the Academy's Annals. In the last decade this particular function of the Academy has been greatly promoted through the formation of our Chapters of Physicians, of Surgeons and of Obstetricians and Gynaecologists, and early this year it has been enhanced even further by the formation of the Chapter of Radiologists.

Congresses

On yet another aspect of continuing education, Congresses of Medicine have been organised regularly by us commencing in 1963 and alternating in venue between Singapore and Kuala Lumpur from 1965. These Congresses continue to flourish and the 8th Congress which was held in Singapore last year was a tremendous success. It attracted 300 participants from 12 countries and its special feature, the symposium on Intensive Care with international experts participating, was extremely well received. The primary aim of these Congresses is to provide a local forum for our members to present the results of their research and to invite fruitful and critical discussion. Although these Congresses are finding acceptance in increasing measure well beyond our National borders, they provide an important historical bridge of friendship between us and our sister Academy at Malaysia. I should perhaps add in passing that it was our Academy which was responsible for the formation of the Academy in Malaysia in 1966.

Another of the Academy's early contributions to Postgraduate Medical Education in Singapore was to place this on a formal basis. Thus in 1959 it submitted a carefully prepared memorandum to the Ministry of Health and the University. This led to the formation of a Committee on Postgraduate Medical Education by the University with the representation of the Academy and the Ministry. Organised courses in the Basic Medical Sciences and the Primary Fellowship Examinations of the Royal Surgical Colleges were conducted and since the early sixties courses in Advanced Medicine and Advanced Surgery were held regularly with the assistance through the Colombo Plan of visiting lecturers from the Royal Australasian Colleges and the active participation of the Academy.

Recognised

The next important page in the development was when Dr. Toh Chin Chye in an address just before he assumed the Vice Chancellorship of the University called for the establishment of local postgraduate professional medical qualifications. This was clearly pertinent to the Academy as it had from its beginnings set its sights on training those who wish to specialise and on the conduct of postgraduate examinations. Thus on reading of this in the newspapers the next morning, our Council promptly answered his call. I can still remember vividly the morning coffee we had with him in the Conference Room of the Deputy Prime Minister at the City Hall in 1968. That meeting was of tremendous importance because it led to the formation of the School of Postgraduate Medical Studies in 1969, and the first professional examinations leading to the degrees of Mastership of Medicine in Internal Medicine, Surgery, Obstetrics and Gynaecology and Paediatrics were held the following year. The teachers of the School are mostly Academy Members and the Internal examiners are also of the Academy. To ensure that the standards obtained would be equal to those of the Royal Colleges, external examiners from these Colleges are added to the examining panel. The problem of high standards is of prime importance for it would be futile to have ones own examinations and degrees if the standards are not comparable to those of

● See Page 5

THE ACADEMY OF MEDICINE

● From Page 3

the Royal Colleges. Thus it is indeed a matter of much satisfaction to us that the degress are now recognised by so many of our kindred bodies in the United Kingdom and Australia as equivalent to their corresponding qualifications e.g. the M.R.C.P. or the F.R.A.C.S. so soon after their establishment. Even more important, these were recognised immediately by our own Government.

Since their establishment, about 150 doctors have obtained the degrees awarded by the School. Were we without these examinations all these candidates would have to take leave for abroad sometimes for many years to seek higher qualifications. This was what happened. Thus there is now no waste of time, manpower and much expense as these doctors need no longer be sent abroad just to attend courses and sit for examinations. Much has been achieved and this is laudable.

Register

However, medical specialisation is a continuous process, and the immediate acquirement of a higher professional degree does not make the holder a specialist. Further advanced training will have to be planned. This has been recognised for many years by the States and Canada and more recently by the United Kingdom, Australia and New Zealand. **Thus the Royal Commission set up in London to study this need under the Chairmanship of Lord Todd stated in 1968 that the time had now come to establish a specialist register and it envisaged that holders of higher professional qualifications should be eligible for registration as a specialist after a 3 to 4 year period of further advanced specialist training. Indeed this was what the founders of the Academy of Medicine foresaw 17 years ago for the stringent demands of our Membership are on similar lines as those envisaged in Britain, Australia and New Zealand.** This matter has gathered momentum in recent years and, I feel, should be carefully studied by the Ministry of Health and the medical profession, particularly as our citizens are becoming more sophisticated and increasingly aware of the rapid advances that are occurring in the field of Medicine and our patients are rightly demanding increasing specialisation and quality in their treatment. In this regard, I cannot over-emphasize that within our Academy there is no dearth of qualified persons to fulfil this function of advanced specialist training, although a period abroad in the more advanced countries for our advanced trainees to widen their horizons would certainly be beneficial, particularly in some of the more sophisticated specialities.

Excellence

Indeed the need for medical specialisation was fully appreciated by our Government. In 1970 a Committee was appointed by the Minister for Health to recommend and plan a programme of development of medical specialities which would ultimately result in our Republic being recognised as one of the world's centres of excellence in Medicine. This was a very significant step in the history of our medical services. After careful study, the Academy on invitation, submitted a comprehensive memorandum to this Committee. This was extremely well received and many of our recommendations were accepted; many have been implemented and others are now in the advanced stages of planning. These developments in medical specialisation in Singapore will be enhanced tremedously with the completion within this decade of our new General Hospital Complex – the Singapore General Hospital and the upgrading of the specialised departments in the other hospital.

Enormous sums of money will be required but I am confident that with the total commitment of all those who are involved in the training of specialists and in the planning of our medical services and most important coupled with the full support of the Community and our well wishers, Singapore's place in the forefront of world Medicine is assured.

The Law and Eye Injuries *

by Dr Kuang Hui Lim
Senior Ophthalmic Surgeon, Singapore

Duke Elder (1972) rightly said: "Trauma is one of the Captains of the Men of Death."

In discussing the subject of ocular trauma which has been raised today, I wish to address myself on 2 aspects of prevention about which we have some experience and for which legislation was recently enacted in my country. The Martial Arts Instruction Bill was read for the first time on 4th March, 1974 (Bill No.3/74) in the Singapore Parliament. Moving the second reading of the Bill (Parliamentary Debates, Singapore 1974), the Minister for Health and Home Affairs, Mr Chua Sian Chin, said "..... organisations which teach martial art, be it a Chinese pugilistic art, or karate or taekwondo or judo or bersilat, in effect equip their members with a potential weapon which, if abused, can have serious consequences for their victims and serious implications for the maintenance of law and order." Martial arts, as defined in the Bill, includes karate, taekwondo, judo, aikido, kendo, bersilat, kung fu, jiu jitsu, or a combination of them. These are various forms of unarmed combat mostly of Chinese, Korean or Japanese origin.

The Bill has more than purely local significance for it emphasizes the grievous consequences of injury that may be seen in countries where martial art is becoming popular, introducing thereby a new dimension in the horrors of ocular trauma. The aim of unarmed combat is simply, to hurt (albeit a stylistic hurt as it may appear) and, while exponents may deliver only "simulated blows" in practice, a multitude of injuries are liable to occur. Romantic stories may be told of martial artistes challenging each other, looking for trouble, as it were, like the fast guns in the West but we have seen a number of ocular injuries sustained during practice or in criminal assault cases.

Until a few years ago the term martial art was hardly used in Singapore; then came the popularity of Chinese films especially from Hongkong and Taiwan in the late 60s which glorified martial arts and with it the rapid proliferation martial art organisations in the country. In moving the Bill in Parliament, the Minister said that at the end of 1973 there were 128 organisations in Singapore compared to 32 in 1963, with a number of trainees estimated at between 13,000 and 18,000 The sinister fact was the secret society members and the criminal elements had learnt the art to further their own ends. Apart from criminal assault, the danger of injuries inflicted during training are real, and while on the one hand the Bill was intended to regulate the activities of martial art organisations, on the other, trainees and instructors alike should learn to take added precaution to develop their gaze

● See Page 13

NEWS FROM THE COUNCIL TABLE

(Not to be quoted by the Press)

GROUP TOURS

The Council has decided to organise a third S.M.A. tour to China and request for approval in principle has been sent to the authorities and a reply is being awaited.

We have also agreed to explore the possibilities of group tours to other countries, such as America, Australia etc. to be held to coincide with scientific meetings of the medical associations of these countries, with a view to promote social, cultural and professional activities among members of the S.M.A.

The Council welcomes suggestions and/or views from members of the Association towards these tours.

EDITOR S.M.J.

We publish in this issue of the Newsletter correspondence relating to the election of the Editor of the Singapore Medical Journal at the last A.G.M., which members will find self-explanatory. As a result of the circumstances prevailing, Council of the S.M.A. has appointed Dr. K.K. Tan to be the editor of the S.M.J., who after much reluctance, has accepted the appointment.

TAX RELIEF FOR DOCTORS

Members are advised that we could not appeal against the decision of the Comptroller "in vacuole". We have to quote a specific case in point. A member of the S.M.A., especially one in large group practice, is therefore requested to volunteer for this purpose and he is asked to contact me at Tel. 324926 or Mr. Soh, Tel. 981264. The Association will pay for the necessary expenses incurred in the appeal.

Dr. Toh Keng Kiat
Hon. Secretary, S.M.A.

M.B., B.S. (Singapore)

At the recent Convocation of the University of Singapore, among others, a total of 106 persons (17 of whom are females) had obtained the Degree of Bachelor of Medicine and Bachelor of Surgery. Two of them received awards, as follows :–

Ng Han Seong @ Ng Han Sheng — with honours awarded the Gibbs Gold Medal, the Hoops Medal, the Yeoh Khuan Joo Gold Medal and the Singapore Medical Association Silver Medal

Evan Lee Jon Choon
awarded the Singapore Medical Association Bronze Medal

The Singapore Medical Association wishes to congratulate these newly-qualified doctors and cordially invite them to join the Association to support and participate in its various activities. Particulars and application forms for membership are available from either Prof. Loh Tee Fun, chairman of the membership drive committee or Mr. James Soh of the S.M.A. Secretariat, Alumni Medical Centre, 4A College Road, (Tel: 981264).

NEWS ABOUT PEOPLE

Dr. Tan Kheng Khoo Dr. Loke Yue Nam Dr. Chong Kwang Dick	**Appointed part-time** Consultants in the Government Medical Services
Dr. Aw Swee Eng Dr. Lee Liang Hin Dr. Kevin K.F. Ng Dr. R. Sinniah	Promoted to Associate Professors
Dr. Chan Heng Leong	Promoted to Senior Lecturer
Dr. F.Y. Khoo	Conferred Honorary Doctor of Medicine by the University of Singapore
Dr. Kok-Seah Lee	FAGG Passed American Board of Internal Medicine
Dr. Chao Tzee Cheng	F.R.C.P.A.
Dr. Allan Chong	M.R.A.C.P. (Paed.)
Dr. Catherine Lam Lee Hua Dr. Patrick Kee Chin Wah	M.R.A.C.P. (Med.)
Dr. Goh Lee Gan Dr. Lim Shun Ping Dr. Tan, Tulip Dr. Tein Boh Goh Dr. Teo Seng Kee Dr. Wong Chin Heng Dr. Woo Kin Fatt	Common Part I M.R.C.P. (UK)
Dr. Wee Keng Poh	Dip. in Medical Jurisprudence (Clinical & Pathology)

Awarded National Day Honours 1974

Dr. J.M.J. Supramaniam	The Public Administration Medal (Gold)
Dr. Allan Hong Chee Boo	The Public Service Medal
Dr. (Mrs.) O.R. Gunaratnam	The Efficiency Medal
Dr. (Mrs.) Margaret Loh Tee Fun	The Efficiency Medal

(Not to be quoted by the Press)

MEDITATION

When honour, love, youth, aspiration fled,
With heart-breaking sighs, my gay spirit's dead.
Past lingers in Thought, visioned in sad dream.
O my golden days! alas, Time like stream
Flow on and on, ne'er turns her head and way.
Here, Men have come, lived, and gone, day and day.
So things have changed; strange events have occurred.
Poor Ancient decays; fine New is preferred.
Thus Life's great wheels forever turn.
O God, let me to happy Past return!

(from "Collected Poems" by Dr. C.H. Tay)

Does Preventive Medicine Really Work?

Abstracts of A talk by Professor W.O. Phoon, Head, Department of Social Medicine and Public Health, University of Singapore to the Rotary Club East

To avoid our getting lost in the jungle of semantics, let us define that Preventive Medicine as very simply that aspect of Medicine which aims to prevent, rather than cure, disease. While the term "Preventive Medicine" is of modern origin, its concept of practice is not new. The Court Physician to the Yellow Emperor in ancient China once remarked, "To administer medicines to diseases which have already developed ... is comparable to the behaviour of those persons who begin to dig a well after they have become thirsty, and of those who begin to cast weapons after they have engaged in battle. Would not these actions be too late?" If it is possible, surely it is better not to suffer from a disease than to suffer first and then be treated for it?

Vaccination was first practised about two hundred years ago by a country general practitioner in England called Edward Jenner. Jenner observed that dairy maids who milked cows suffering from cowpox, a disease related to smallpox, got cowpox blisters on their fingers and did not seem to be susceptible to smallpox. He therefore hit upon the idea of deliberately infecting human beings with cowpox, which is quite harmless to Man, to protect them from smallpox. Vaccinations are a good example of the fact that Preventive Medicine really works.

About ten years or less ago, Tuberculosis was the No. 1 killer in Singapore, that is, more people died every year from tuberculosis than from any other cause of death. Now tuberculosis has dropped to about the eighth or ninth place in the "Death League", because relatively few people die from that disease in Singapore nowadays. This change is due to various factors, but not least among them is again Preventive Medicine. The national programme of vaccinating the newborn babies against tuberculosis (or B.C.G. Vaccination as it is called) has helped to build up a general resistance against the disease.

In the case of tuberculosis, Preventive Medicine does not consist merely in giving such vaccinations. Mass X-Ray campaigns, such as those conducted by the Singapore Anti-Tuberculosis Association (S.A.T.A.) are also an example of Preventive Medicine in practice.

All of us must have read, with great interest, the wonderful exploits of such sea-faring horoes as Christopher Columbus, Francis Drake and Vasco da Gama. What is not often mentioned in such stories is the fact that in such long voyages it was usual for more than half the crews to die at sea and that more of these died from illness than from all the onslaughts of pirates or hostile natives. They did not have fresh fruits or vegetables as they were so far from land. They developed bleeding gums and bleeding from other parts of the body, became very debilitated, and died by the hundreds. It was discovered that the drinking of lemon juice would prevent the disease, which was scurvy.

Nowadays, there is quite a lot of publicity about cancer. Cancer cases have hope of cure only if the cancer is discovered early. Hence it is recommended that all women over the age of 30 years should have a cervical smear test done once a year. Of course it is better still to prevent the occurrence of cancer altogether. We know that cigarette smoking increases the risk of lung cancer by more than ten times. To lessen the risk of getting lung cancer, therefore, we shall preferably not smoke cigarettes or cut down on their consumption, because the more we smoke, the greater are the risks of lung cancer.

In the factory situation, there are several substances, such as asbestos, chromate salts and radioactive substances, which may also increase the risk of getting lung cancer. In many ways, it is easier to control the risk of cancer from causes in the working environment than causes in the general community. We can get rid of the cancer risk in the factory completely if we institute occupational health measures early. This is yet another instance of effective Preventive Medicine in action.

But all these developments in Preventive Medicine do not just happen. Medical and other practitioners of Preventive Medicine have to study problems – in order to pinpoint the cause or causes of a disease, and by doing other equally elaborate and painstaking studies to find ways of preventing it.

Even after a new discovery in Preventive Medicine is made, there is usually a long interval between that and the utilisation of such new knowledge. The co-operation of the government and the public needs to be obtained, as without it, no programme in Preventive Medicine can be successful – be it vaccination, mass X-Ray campaign, cancer screening test, or correction of malnutrition. Many communities are too "treatment-oriented". **They willingly allot ninety per cent or more of their "health" budgets to what are really treatment services for ill-health, but are reluctant to spend enough money on the prevention of such ill-health.** This is, perhaps, very understandable – as people seem to be more prepared to pay for cures of diseases which they can see, rather than to pay to prevent diseases which have not yet occurred. **The mass media and the public are usually enthralled by "glamorous" medical procedures such as cardiac transplants, which have to date added only a few years of life to, at most, a few hundred individuals in the world, but seldom pay much attention to Preventive Medicine programmes such as anti-mosquito measures, which year by year are saving millions of children, men and women throughout the world, who would otherwise have died from malaria and other mosquito-borne diseases.**

Let us not belittle the undoubtedly great importance of Curative Medicine, nor forget that one of the worthy aims of Medicine is to relieve human suffering. Moreover, early detection is useless unless it can be followed by proper treatment. Nonetheless, it is necessary for me to point out that Preventive Medicine has an equally important role to play. Specialists in Preventive Medicine are not always given enough recognition, in contrast to their colleagues in the hospitals. Money for research and service programmes in Preventive Medicine is frequently lacking, though **it is often far cheaper to prevent a disease altogether or to prevent it from reaching an advanced stage than to treat it after all the signs, symptoms and complications have become manifest.** There is a lot more to know about Preventive Medicine and how to make it prolong or improve the lives of humankind, but money for research in that subject is often the first to be cut whenever an economic setback hits a nation.

It seems to me that the proverb "prevention is better than cure" is more easily believed by people in any other context except that relating to health, whereas it is precisely in health matters that the proverb originated and is most true.

What is Community Medicine ?

● From Page 1

reaction to the kind of dehumanising procedures people are put through, the detached way in which medicine is practised in institutions and to a fairly large extent in general practice, the expensive specialised medicine that only a priviledged few can afford, we are now turning our sights back to the community and the needs of human beings. And as if it is something new, we hear a Eureka from some modern day medical Archimedes – "The solution to the practice of medicine has been found – Medicine must be community based."

Requisites

In fact a large part of what exists today is still community medicine. The Out-patient clinics, the M&CH clinics, Hospital facilities, public health measures and most important of all, the general practitioner who treats the community, are all part of it. What we have to look at from a new angle, is how we can use all the new advances, knowledge, and techniques we have discovered for the benefit of the community.

There are three basic requisites for the practice of Community Medicine.

1) Doctors in general practice, equipped with knowledge of present day medicine for the prevention, and cure of disease, and the promotion of health. The general practitioner is really the pivot of community medicine – for it is he who deals with people as part of families. The general practitioner must necessarily be conversant with new patterns of disease, and be able to deal with them – the chronic degenerative illness, mental ill health, psychoses, psychoneuroses. He has to be conversant with why people behave the way they do, and be able to counsel, to health educate; to treat and to prevent. Medicine has to be a vocation, not a trade. The doctor has to know his community, what their social ailments are, what disorganises them, what troubles them. Thus the training of our doctors has to be geared in this direction and training must include the behavioural sciences. Only then would they serve the community effectively.
2) The second requisite is general preventive and public health measures, that protect in a collective way, like for example, the services provided for mosquito control, control of noxious agents in the environment, producing herd immunity against certain diseases by immunisation programmes; welfare services to specific groups like women in the reproductive age group, infants, toddlers, school children and the old. This is achieved at present by a net work of out-patient, M. & C.H. and school health clinics. But the quality of this community service can be enhanced by closer co-ordination between these services and the general practitioners, for the benefit of the community. And this can be achieved in a variety of ways, e.g. by allowing GPs the use of simple laboratory facilities, X-rays, and even home visiting facilities provided in public clinics.
3) The last is the community hospital where members of the community requiring very special investigations and diagnostic procedures not available in general practice, can be admitted for this purpose. Practitioners must then be included in the care of these patients in hospital, so that continuity is maintained. The success of Community Medicine thus practised depends on close liason between these three sectors. **If one sector thinks it is more important, more qualified, more knowledgeable, than the others, then team spirit is lost, and we revert back to fragmentation of the individual. There has to be understanding at all levels that the patients, the members of the community, are the most important persons in this set-up and co-operation the key word.**

I must not give anyone the impression that we can do without research and the adoption of better methods of diagnosis and treatment.

What we have to ensure is that

1) these things do not make us forget why we have medical services, and
2) we have a sense of balance in our approach to the practice of medicine.

Disciplines

Again, not only is the problem of co-operation vital; we need to have breadth of mind to understand and accept there are many disciplines which enhance the practice of medicine, line epidemiology, demography, social psychology, and to work with people who are trained in these disciplines. For instance, the general practitioner or family doctor, as he is sometimes called, will be helped considerably in his approach to community care by information supplied to him by the epidemiologist or the demographer. All this in the interests of the betterment of the health of people, physically, socially and mentally.

It is possible that a Central Board of Community Affairs may be the answer, when health personnel work with town planners, educationists, etc., etc., to improve the life of the community in all its aspects. For none of these things stands in isolation or by itself. They are intricately interwoven in terms of human needs and general welfare.

yardstick

A great deal of the quality of medical care given in a community must depend on the kind of facilities available as well as the number of qualified doctors. In other words one yardstick of the measurement of quality (it is not possible to cover all) is the doctor-patient ratio in existence. When we think of Community Medicine in Singapore and its quality, I would like to bring up one of two special points.

1) We are a heterogenous society, from three different cultural backgrounds, and upon whom a fourth culture has left its mark as an incident in history.
2) We are thus faced with a form of medicine that is part of our backgrounds and another superimposed on it, viz., scientific medicine. This means that when we are considering community medicine in this area, we cannot afford to ignore the fact that part of the community, (about 30–40%) still goes for more traditional forms of treatment, and that if we are considering doctor-patient ratios, we must take into our calculations, sin-sehs. They certainly enhance the doctor-patient ratio, but the big issue in this particular aspect, is that traditional Chinese medicine has to be scrutinised closely and re-organised if it is to be included realistically as part of a scheme of community medicine that is of a high order.

● See Page 13

DIARY OF CLINICAL MEETINGS/TALKS

SOCIETY FOR NEUROLOGY, NEUROSURGERY & PSYCHIATRY

21.8.74 4.00 p.m. Tan Tock Seng Lec. Theatre
Clinical Meetings (Neurology & Neurosurgery)

In addition, regular clinical meetings on Psychiatry are held at Woodbridge Hospital Lecture Theatre at 11.00 a.m., on the first 4 Saturdays of every month.

GASTROENTEROLOGICAL SOCIETY OF SINGAPORE

29.8.74 4.30 p.m. Brunel-Hawes Lect. Theatre, Med. Unit II, O.R.G.H.

4th Scientific Meeting

3 Cases will be shown

Chairman: Prof. C.S. Seah

SOCIETY FOR NEUROLOGY, NEUROSURGERY & PSYCHIATRY

4.9.74 5.00 p.m. Med. Unit III Lec. Room, O.R.G.H.

Clinical Meeting (Neurology & Neurosurgery)

The following combined Clinical Meeting and continuing Education Lectures, sponsored by the **ACADEMY OF MEDICINE'S CHAPTER OF SURGEONS** will be held at 8.00 a.m. at the Orthopaedic Lecture Theatre, O.R.G.H.

2.9.74 "A Review of the Newer Antibiotics" Dr. P.C. Teoh

9.9.74 "Management of Root Pain" Dr. C.F. Tham

16.9.74 "Common Skin Lesions of Surgical Interest Dr. V.S. Rajan

21.9.74 Clinical Meeting of Thomson Rd. General Hospital and Eye Units Chairman: Dr. K.H. Lim

23.9.74 "Intestino-Urinary Fistulae" Dr. H.S. Leong

30.9.74 "Immunological Aspects of Cancer" Dr. S.H. Chan

(Speakers may interchange the dates of their lectures. For confirmation, please contact the Academy's Office (Tel. 70606) on the Saturday before the lecture).

Combined Scientific Meeting of SINGAPORE SOCIETY OF NEPHROLOGY AND SINGAPORE PAEDIATRIC SOCIETY

18.9.1974 8.00 p.m. Path.Lec. Theatre, O.R.G.H.
"Glomerulonephritis"

Pathogenesis/Immunology – Dr. Gordon Ku
Acute Nephritis in Children – Dr. Peter Lim
Nephritis in Adults – Dr. Pwee Hock Swee

Chairman : Dr. Lim Cheng Hong

FORTHCOMING CONFERENCES AND MEDICAL COURSES

The 9th Malaysia/ Singapore Congress of Medicine scheduled to begin on 23rd August in **Kuala Lumpur,** has been **postponed** to the **6th to 8th September 1974.**

Annual Conference of Australian and New Zealand Society of Occupational Medicine will be held at **Adelaide** from **16-18 October 1974.** Theme: "Occupational Medicine in the Community Role" Further particulars are obtainable from Dr. Chew Pin Kee, Secretary of the Singapore Society of Occupational Medicine, c/o Industrial Health Unit, Halifax Road (Tel: 50757).

Combined Surgical Meeting of the College of Surgeons of Malaysia and the **Royal College of Surgeons of Edinburgh** to be held in **Kuala Lumpur** from **1-3 November 1974.** Attendance at the Meeting is open to all who are Fellows of any of the Surgical Colleges, or members of Surgical Associations/Societies and to all registered medical practitioners. Participation in the Scientific Session is limited to Fellows of any of the Colleges of Surgeons and to Members of Surgical Associations/Societies.

Further details and registration forms are obtainable from Prof. N.K. Yong, Secretary of the College of Surgeons of Malaysia, Department of Surgery, University of Malaya, Kuala Lumpur.

Colloquium on Nephrology, jointly organised by the Singapore Society of Nephrology, the National Kidney Foundation and the Ministry of Health, will be declared open by the Minister for Health, Mr. Chua Sian Chin, on **15th November 1974** at the **R.E.L.C., Singapore.** The Colloquium is scheduled for three days and is open to the medical world and members of the S.M.A. for participation. For further details please contact any one of the three organisers.

50th All India Medical Conference – The Indian Medical Association is inviting members of the S.M.A. to attend its golden jubilee conference and to participate in the scientific sessions as well, to be held from **25-27 December 1974** at **Calcutta.** The I.M.A. College of General Practitioners will be held simultaneously and the theme for discussion is **"Emergency in General Practice".** Among others the Conference will have scientific symposia, panel discussions, scientific/ pharmaceutical exhibitions and medical films.

Members of the S.M.A. who are interested to attend are kindly requested to submit their names to the Secretariat, 4A College Road, Singapore by 15 Sept. 1974.

88th Anniversary Sessions of Sri Lanka Medical Association to be held at **Colombo,** Sri Lanka, Ceylon, from **26-29 March 1975.**

Members of the S.M.A. are invited to present short papers of scientific interest at the Sessions. The time allotted for a paper is 20 minutes. Those wishing to read a paper are requested to send a copy of the entire script to reach the Hon. Secretary (Dr. K. Maheswaran) of the Sri Lanka Medical Association, 6 Wijerama Mawatha, Colombo 7, before 5th January 1975.

The registration fee is US$15 per person.

Postgraduate course in **Gastroenterology** organised by the British Council, **London** and Leeds, from **19th January – 1st February 1975.** This is open to senior medical practitioners from overseas who wish to become further acquainted with recent advances in this field.

Programme: **Endoscopy** and **GIT Diseases** and the fee is **£195** (inclusive of board & lodging).

Applications should be made to the British Council, 310 Cathay Building, Mount Sophia, Singapore 9, by 15th September 1974.

Courses in **Primary M.Med. (Anaesthesia), M.Med. (Obs & Gyn.)** and **MRCOG** Examinations organised by the University of Singapore's School of Postgraduate Medical Studies to be held on 2nd September 1974 and 23rd September 1974 respectively.

Application forms and further particulars are obtainable from the Secretary of the School (Tel: 92681), Sepoy Lines, Singapore 3.

Board of Postgraduate Medical Education, University of Malaya:

ADVANCED COURSE IN MEDICINE

A full-time four weeks Course in Medicine will be conducted from 4th to 30th November 1974 for a limited number of candidates who have passed the Part I Examination of the Royal College of Physicians United Kingdom to enable them to take the Final Examination in due course. The Course which includes a clinical attachment to the Department of Medicine, Faculty of Medicine, University of Malaya, will consist of case presentations, tutorials and lectures. The Course fee is $100.

The closing date for applications will be *7th October 1974.*

ADVANCED COURSE IN PAEDIATRICS

A full-time four weeks Course in Paediatris will be conducted from 4th to 30th November 1974 for a limited number of candidates who have passed the Part I Examination of the Royal College of Physicians United Kingdom to enable them to take the Final Examination in Paediatrics in due course. The Course which includes a clinical attachment to the Department of Paediatrics, Faculty of Medicine, University of Malaya, will consist of case presentations, tutorials and lectures. The Course fee is $100.

The closing date for applications will be *7th October 1974.*

NOTICE OF EXAMINATIONS

The Royal College of Surgeons of Edinburgh

Examinations for the Diploma of Fellowship

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

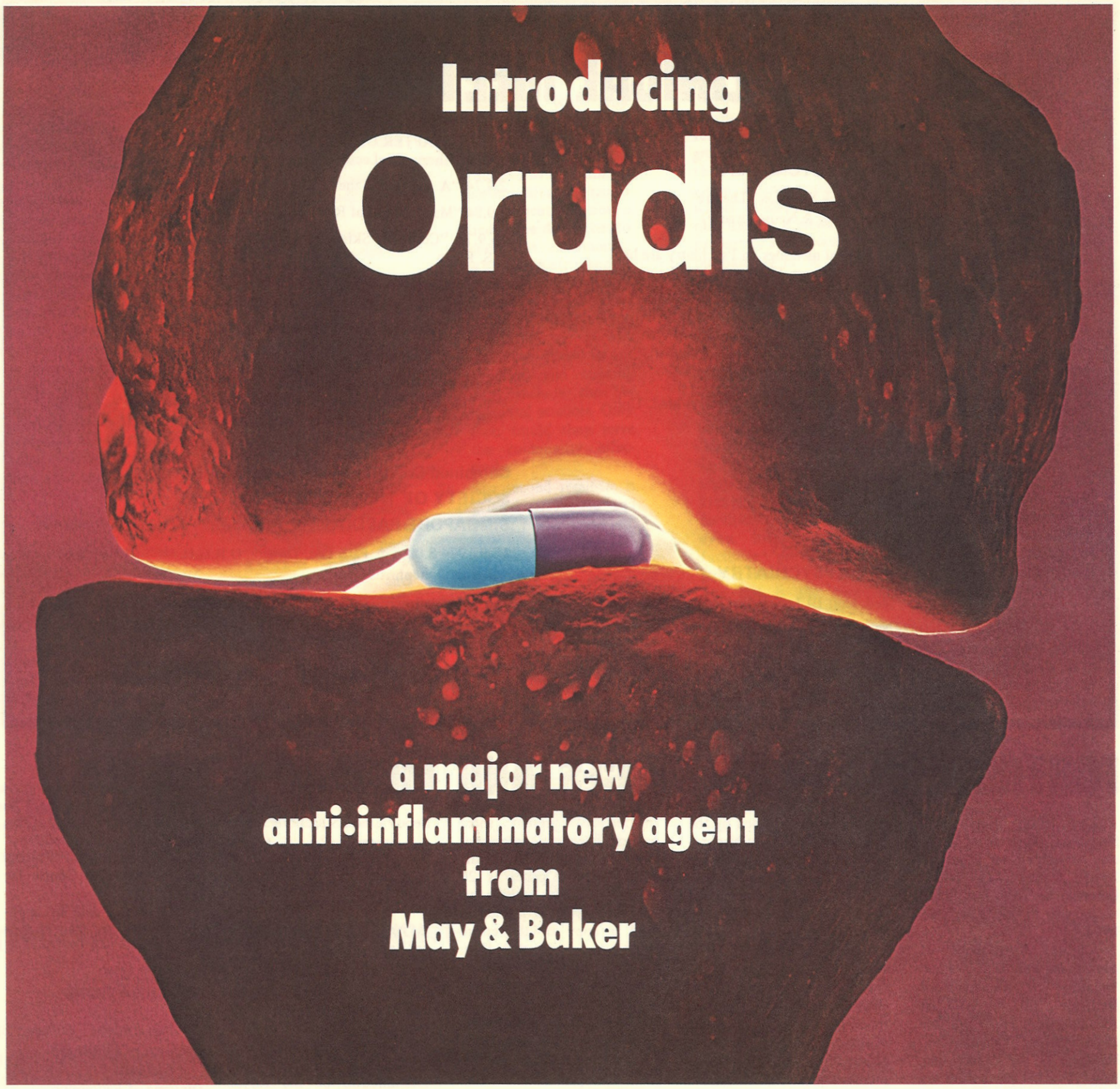
Part I Examination: Monday, 28th October to Wednesday, 30th October 1974.

Part II Examination: Monday, 29th October to Friday, 1st November 1974.

Applications for admission to these Examinations and requests for further information may be made to the Assistant Registrar, Board on Postgraduate Medical Education, Faculty of Medicine, University of Malaya, Malaysia. The closing date for applications for admission to the Examinations in Kuala Lumpur is *Saturday, 14th September 1974.*

The fees for these Examinations are:-

M$481.95. Part I –
M$538.65 Part II –



In both rheumatoid arthritis and osteoarthrosis

Orudis

a new non-steroidal anti-inflammatory and analgesic agent provides the optimal therapeutic combination

high activity with good tolerance.

Controlled UK trials have shown 'Orudis' to be

*Better tolerated than indomethacin ...with comparable activity

"... Orudis—a new non-steroidal anti-inflammatory agent—has been shown to be well tolerated and to have comparable therapeutic efficacy with indomethacin when given in equal dosage. Side effects were less severe with Orudis."
Br. Med. J., **iv**, 398, 1972

*More active than ibuprofen ...with comparable tolerance

"... the present study has shown that analgesic and anti-inflammatory activity of ketoprofen ['Orudis'] is significantly superior to that of ibuprofen, whilst adverse reactions of the two drugs are comparable and not serious."
Br. Med. J., **iv**, 82, 1973.

Orudis

supplied as capsules of 25 mg in easy-to-open containers.
Full prescribing information available on request

'Orudis' is a trade mark of May & Baker Ltd Dagenham Essex RM10 7XS England for its preparations of ketoprofen

S.E.A. Branch Offices:–
HONGKONG – P.O. Box 559 Tel: 712323
MALAYSIA – P.O. Box 150, Petaling Jaya. Tel: 772355
SINGAPORE – P.O. Box 693 Tel: 656244
THAILAND – P.O. Box 693, Bangkok. Tel: 915489

M&B May & Baker

A member of the Rhône-Poulenc Group of Companies

SMA 2431

LETTERS — Not to be quoted by the Press

SMJ CONTROVERSY OVER EDITOR

THE EDITOR OF THE S.M.J. WRITES...

Dear Mr. J.E. Choo,

Few weeks before the 1974 S.M.A. Meeting I spoke to you regarding the editorship of the S.M.J. I told you that I was reluctant to continue as editor because my efforts were not appreciated. It is quite distressing for me to spend so many hours per week on the journal just to be chastised at every A.G.M. I proposed the names of 2 people whom we can approach to take over the journal. You then persuaded me to continue for another year. I reluctantly agreed.

Prior to your first S.M.A. Council Meeting at about 7.00 p.m., you telephoned me to say that you were in a fix. You explained that although Dr. Gwee Ah Leng was elected editor he did not consent to stand as editor. Therefore would I mind helping you out by continuing as editor till the next A.G.M. Although I was adamant about it, and unaware of the full facts, I was willing to help you out and agreed to your suggestion

Having not been at the A.G.M. I did not know the tone and the feeling at the A.G.M. I received the minutes of the A.G.M. held on the 21st today. Having read it and after due consideration I regret that I cannot continue as editor of the S.M.J.

Constitutionally I cannot continue because I was thrown out by a majority of 15 to 11. If Dr. Gwee said that he did not give his consent to stand as editor and now refuses to be editor, then an E.G.M. should be called to elect a new editor. Otherwise at the next A.G.M. (1975) any member can challenge my staying on as editor as I was not elected.

The grounds on which I was not re-elected was purely on the fact that I do not write editorials which should preferably be political in nature. Any member who cares to go to the medical library and browse through all the journals will see for himself that a high percentage of the most reputable international journals do not have editorials. Journals like the B.M.J. and Lancet have full time paid editors and their editorials are all paid for piecemeal to the different specialists in their subjects.

When I took over the editorship, in my first editorial in 1971, I laid out the Editorial Board's policy: as there was then a fully functioning newsletter, all political or medico-political subjects should be aired in the newsletter. The Board's aims were to confine the S.M.J. to scientific subjects, and raise the standards of the S.M.J. in this direction. If the S.M.A. did not agree to this view then a new editor should have been elected at the next A.G.M. I was re-elected for the next two years: I assume then that the general body was agreeable to the Editorial Board's policy.

Now that I have been thrown out by the house on what I deem to be the "editorial" issue, then I must perforce stand down.

If the S.M.A. wants an editor merely to write editorials irrespective of the standards of the scientific papers, then obviously I am not your man. If editing a good quality medical journal is based entirely on whether political editorials are written or not, then S.M.A. must take a second look at its priorities.

Therefore you can see that it is quite improper for me to remain as editor under these circumstances.

As everybody has read the minutes by now I have to publish this letter in the next newsletter.

Yours Sincerely,

(Dr. Tan Kheng Khoo)
10 May 1974

Dear Dr. Toh,

Thank you for the letter regarding Editorship of the SMJ. I regret that the nomination did not have my prior approval, and as I am going to be very busy this year, I am unable to take it up. I gather that the next highest in rating is Dr. Tan, and I would be pleased to recommend that he be requested to continue.

Dr. Gwee Ah Leng

At the A.G.M. on 21.4.74 when nomination for the position of Editor of the S.M.J. were called for, two names were proposed – Dr. Gwee Ah Leng by Dr. Un Hon Hing and Dr. Tan Kheng Khoo by Dr. Choo Jim Eng. Neither of the nominees were present, but the Chair was assured by Dr. Un that Dr. Gwee had agreed to stand and Dr. Choo assured the House that Dr. Tan had agreed to stand, so both names were accepted. Dr. Gwee was elected.

However, when Dr. Gwee was approached a week later, he denied having agreed to stand and said he was too busy to take on the Editorship. The President then approached Dr. Tan, explaining the position to him and Dr. Tan agreed to continue as Editor.

When Dr. Tan read the minutes of the A.G.M. in which Dr. Un's "derogatory" remarks were quoted he wrote the appended letter to the President refusing the post. As the letter was received only after Dr. Tan had gone to America no action could be taken till his return on 17th June 1974. After the President explained that because Dr. Gwee had not at any time indicated that he was willing to stand for the post of Editor, the only valid nomination was that of Dr. Tan. Dr. Tan then very kindly agreed to continue as Editor for the rest of the year.

It was extremely irresponsible behaviour on the part of Dr. Un Hon Hing just to nominate Dr. Gwee and then to assure the House that Dr. Gwee's consent had been obtained, although previously he could not give the same assurance when he proposed Dr. Gwee for Councillor. Whatever his motives, he put the S.M.A. into a very difficult position and it is only because Dr. Tan Kheng Khoo despite Dr. Un's remarks at the A.G.M. agreed to reconsider his decision to withdraw from the Editorship that the S.M.J. still has an Editor. We are very grateful to Dr. Tan for his public spirit.

Mr. J.E. Choo
20/6/74

Dear Mr. Choo,

I understand that Dr. Gwee Ah Leng has decided not to accept the editorship of the S.M.J. on the ground that he had not given his consent to be nominated.

I wish to clarify the situation.

At a lunch at the Alumni Centre, I first told Dr. Gwee that I would like to nominate him to be the President – elect at our coming AGM. He

● See Page 12

LETTERS (Not to be quoted by the Press)

SMJ CONTROVERSY OVER EDITOR

● From Page 11

straight-away turned my proposal down on the ground that he wanted the younger set to take over the S.M.A.

I then told him that I would nominate him to be the editor of the S.M.J., and proceeded to give him the reasons why we need a change in the editorship.

At no time did Dr. Gwee disagree with my views, nor did he turn down my nomination as he had so promptly done with my first one.

At a recent meeting with Dr. Gwee, he himself agreed with me that this was so.

I naturally took his silence to mean consent. Hence I did not think it necessary at all for me to obtain a formal or written consent from Dr. Gwee to the nomination.

Unfortunately silence does not always mean consent. Apparently, it can also mean dissent. The difference in our interpretation of silence probably accounts for the confusion arising from my nomination of Dr. Gwee as editor of the S.M.J.

I would like to express my apologies for the inconvenience caused to the Council.

Yours sincerely,
Dr. Un Hon Hing
24/6/74

Bilingual drop outs

Dear Sir,

I welcome your editorial on school drop outs... mainly because it has made the banning of my own article so much less likely.

My article is more specific. It is about the alarming hordes of Drop Outs that will arise from the Bilingual System. It seeks to identify the faults of the bi-lingual system and to suggest remedies.

The first glaring defect of the new bilingual system is its total lack of preparation. Its precipitate implementation has resulted in mobilising half trained teachers to teach the difficult Chinese language to primary school children. Nothing kills the interest in a subject so easily as bad teaching. Chinese will be just as much mumbo jumbo to the young students. The concession that subjects taught in Chinese will not be presented for examination will only make matters worse. Most students will take this to be an invitation to neglect their subjects. This indifference will inevitably spread to subjects taught in the English language as well. The prospect of thousands of primary school children turning their backs to the whole process of learning must alarm every rational man especially a doctor.

Stages

There is nothing wrong with bilingualism. The fault is with the unseemly haste with which it is being implemented. The remedy obviously lies in introducing the new system in stages, starting first with only the primary one classes. If we were to extend this system to one new standard every year, we will have enough time to ensure that all teachers called to teach Chinese will be adequately trained.

The second most glaring fault with the teaching of Chinese in our English stream is the unrealistically high standard demanded of our children.

It is indeed ironical that after fifteen full years of commitment to bi-lingualism there is still so much difficulty in getting Chinese students to study their own mother tongue in an essentially Chinese society. The reason for this paradox is not difficult to find ... the standard of Chinese demanded is too high.

Prestigious

The easiest way to kill the interest in a language and thereby keep the student population illiterate is to make the subject absurdly difficult. The Roman catholic church did this by insisting on Latin as the official church language. There is a possibility that by insisting on too high a standard of Chinese, we might have succeeded in making most of our students illiterate in that language. A study of our text books and examination questions and results would bear this out. We all should be alarmed by the fact that one of the most prestigious schools in Singapore, with practically every student having private tuition in Chinese, could only boast of a 25% pass in Chinese last year.

Such trauma and wastage is completely unnecessary. Our standard should be tailored to suit the average student and to serve the practical needs of our society. We certainly do not want every student to become Chinese scholars. All we should aim for is to make every child merely literate in his own mother tongue. Those rare gifted freaks who want to quote Confucius and Mencius can easily fend for themselves elsewhere, in a few classes specially arranged for children with such wayward inclinations.

It is said that in order to be literate in Chinese i.e. to be able to write simple Chinese letters and to read the Chinese newspapers, one needs only to master two thousand basic Chinese characters.

Spread over ten years of school life, one needs only to teach a child two hundred new characters a year. Spread over a school year of ten months, a child needs to master only twenty new characters a month or one new character a day.

Realistic

This task is surely completely within the capacity of a teacher to teach and a child to master. If only we will lower our sights and be more realistic and modest in our demands, every child in school should be able to learn Chinese without tears.

What a boon that will be to life in Singapore. Fathers will no longer dread coming home to neurotic wives and rebellious children. They will now be able to come home to happy children actually singing their Chinese lessons as we used to do. Wives who have gone on strike because their husbands have refused to emigrate will now resume their wifely duties with glee. Disgruntled editors who uncharacteristically groan about drop outs in schools will once again be in their elements singing praises to their... ugh... why must every silver lining have a cloud.

H.H. Un

The articles in the Newsletter are included for general interest of our members and do not necessarily reflect the views of the Editorial Board or the SMA

Experience or Examination ?

Dear Sir,

The article on "The Future Role of the Family Physician by Dr. Wong Kum Hoong in the S.M.A. Newsletter of December 1973/January 1974 gives a very good picture of the duties of the Family Physician.

Medicine is a very noble profession and in fact the patients reveal to the doctor as he may reveal to the creator all his troubles and worries. This is a way the Doctor is a living God. Therefore, it should be the duty of the Doctor to see that he deserves all the trust that a patient places on him. The code of Hippocrates is based on this.

Doctors whether they are Family Physicians or in the Government Service must try to give their best service. When a doctor qualifies he is not expected to be thoroughly conversant with the various branches of medicine, as the subject is very vast with increasing advances as years pass by. Therefore a young doctor must know his limitation and consult his seniors when necessary. It is because of this advanced studies have been introduced. We have done this with the best of intention to advance our knowledge so that we could serve Humanity better. But the States and Governments, in my opinion, do not give the necessary credit and recognition for our labours. We have introduced more and more examinations in the various branches of Medicine. In the Government, though one may get his higher qualifications, one is not automatically recognized. He is at the mercy of the Public Service Commission for promotions. I don't think in most other Professions higher studies are required to better their status. I know in the legal service one can become the chief Justice or Lord President with an initial law qualification. Therefore, in a way, we have to blame ourselves, for having to pass more and more examinations.

Practical work is much more important than passing degrees. In my service I had come across a young surgeon with M.S. and F.R.C.S. but his surgery – Practical was awful. After three years in a hospital, he learned operative skill and had become an eminent surgeon. What I am trying to stress is that in the Practice of Medicine, practical knowledge is much more important than passing higher Examinations. The Practical knowledge cannot be had outside the Hospitals. No practitioner can afford to have all the facilities to study his cases. No doctor should be allowed to go into general practice, within, say 10 years after qualification. He should attend courses **suitable to general practice and certified by some authority before he can go into General Practice. Those intending to do specialised studies should similarly attend advanced studies in the hospitals and must be quite competent in their practical work before certified as specialists.** The main issue is the practical work. Theory is necessary but more stress must be placed on Practical work. I really laugh at the **Idea of General Practitioners having Examinations.** What advance and about concentrated study is possible in General Practice. Studies must be had where there is available material and facilities. In general practice one has to make use of the knowledge he had gathered in the wards of the Hospital. As conditions are, general practice is quite simple, if the practitioner knows his limitations. In a hospital, which I know, the outpatients number about 1000 a day and seven medical officers attend to them. There are cases which a practitioner with average knowledge of medicine, can handle. He can easily refer those whom he cannot deal with to the respective specialist or the nearest hospital. There are lots of limitations in General Practice.

Dr. Wong Kum Hoong has suggested some remedies to improve the general practice. This, I think, is the usual way of arm chair physicians and surgeons. If one has to learn anything, it has to be done at the hospitals – Practical post graduate studies for varying periods, on the many subjects. Clinical Meetings organised by the Hospitals – on the various subject. Those interested to improve their knowledge should try to make use of these facilities. I think, we usually and slavishly try to follow what is happening elsewhere. We must study local conditions and the way of life of our society.

C. Subrah Manyam

Editor's Note–

Dr. Subrah Manyam was a former Government pathologist. He is now retired and living in Malaysia.

The present day concept of general practice is not an extension of hospital practice as he suggests, but a field of its own, the field of family and community medicine in which there is primary, continuing and total care of a patient.

SURGICAL JUDGEMENT

In a surgeon there is no quality of mind more to be desired than that of judgement. Judgement is the product of a mind cultured by a liberal and a professional education and matured by experience. It is judgemnt even more than skill that makes a truly successful surgeon.

Judgement is not readily developed during undergraduate training when the academic foundations of a surgeon are being laid. In the comparatively short period of undergraduate training, the student is required to absorb a mass of accepted knowledge, presented to him with a dogmatism characteristic of undergraduate teaching. There is too little time for explanations which would enable him to assimilate it on a basis of physiology and pathology. The intensive teaching dulls any imagination he may have; and the result is that if he is to be academically successful he must form memorizing rather than reasoning habits of mind. Thus, though he may acquire much knowledge, he develops little wisdom and lays no foundation in the art of acquiring wisdom.

Habits

As time goes on, however, the developing surgeon begins to exchange his memorizing for reasoning habits of mind. In this way he begins to accumulate that mature wisdom and develop that sound judgement which is so essential in the make up of a surgeon. He is encouraged in this as he comes under the influence of those who have attained a position in the profession which entitles them to hand on the torch of knowledge and to point the way of wisdom and judgement. The young surgeon becomes sensible of this influence first in the hospital wards, operating theatres, and laboratories, then at surgical conferences, and finally through the medium of surgical literature, in relation to which he must cultivate a kindly critical mind.

Ideal

Chastened by his experiences, enlightened by his scientific association and encouraged by the counsels of his seniors, he develops a changing point of view. He begins to lose his rigidity of mind, to rely less on textbooks and more on his own observations, to have doubts and to develop an open mind, **and above all to acquire a humility of thought – perhaps the greatest sign of wisdom.** And then naturally come an assessment of the clinical value of his experiences; an examination of surgical procedures nd assortment of these for comparison with others of a like nature in the future. Then follow speculations, inferences and hypothesis; the testing of these by further observations; and finally theories and discoveries. All these are milestones in the cultivated march of surgical judgement. If now Nature has been kind to him and his Christian and vocational roots lie deep, the end result should be the ideal surgeon.

H.B. Devine (Australian and New Zealand Journal of Surgery 1950 Vol.20 P 161).

What is Community Medicine ?

● From Page 8

I do not think we can close our eyes to the fact that the practice of Chinese medicine has been put on a scientific basis in China, and is strictly controlled. We can include this as part of community medicine in Singapore if people who intend to practise it have a set minimum in terms of entry educational qualifications, undergo training and pass examinations in established and recognised institutions. Further, an ethical code has to be drawn up to direct and control such practitioners so that baseline quality is maintained, in much the same way as Western scientific medicine is controlled.

There have to be these safeguards but these requisites should not be an obstacle to the inclusion of traditional Chinese medicine into community-medical practice in Singapore. We would, in fact, be meeting the health needs of people as people with cultural and social heritages.

You may feel this is too radical an innovation, but I leave you to ponder over it. Only remember, that community medicine has to be geared to the varying needs of society. It cannot be anything else.

● From Page 5

and reflexes in dodging (as perfected by Mohamed Ali) as the head and face are common targets of blows. Further, spectacle glasses that can shatter should never be worn during practice.

On another matter we have had absolute success; Duke-Elder (1972) said of firecracker injuries, "... practically all such injuries are due to over exuberance or lack of controlling influences and the result of carelessness." Guy Fawkes may not be familiar in Singapore, but addressing Parliament in moving the Dangerous Fireworks Bill (Bill No. 20/72) on 2nd June, 1972 the then Minister for Home Affairs, Prof. Wong Lin Ken, said, "The firing of crackers is an ancient Chinese custom, rooted in beliefs no longer credible among the better educated, but, nevertheless, remaining an enjoyable way of celebrating Chinese festive occasions, such as the Chinese New Year. Other communities have also taken up the firing of crackers but not the beliefs. However, the firing of crackers has always presented the problem of fire hazards, which have increased, as the explosive ingredients are improved by modern scientific knowledge. In addition, hazards of physical injuries also have become a problem." The Minister went on to recount that in Chinese New Year of 1970 there was indiscriminate letting off of fire crackers resulting in 6 deaths. 68 injured and damage to property and a partial ban was then imposed (The Minor Offences Amendment Act, 1970). The ban was lifted during the Chinese New Year festival but this resulted in 9 persons being injured in 1971 whilst in 1972 members of the public, more bold in their disregard, created more havoc, resulting in 26 persons injured and 2 unarmed policemen brutally attacked. As a result of public outcry, and in view of the numerous breaches of the law and, even more important, the injuries and deaths resulting from the indiscriminate firing of crackers, the Government came to the conclusion that the only practicable solution left was a total ban on the possession or firing of crackers.

Thus, what was once commonplace in our casualty units was totally eradicated in 1972.

*From a discussion on the legislative aspects of ocular trauma at the International Conference on the Prevention of Impaired Vision and Blindness held in Paris, May 1974.

REFERENCES

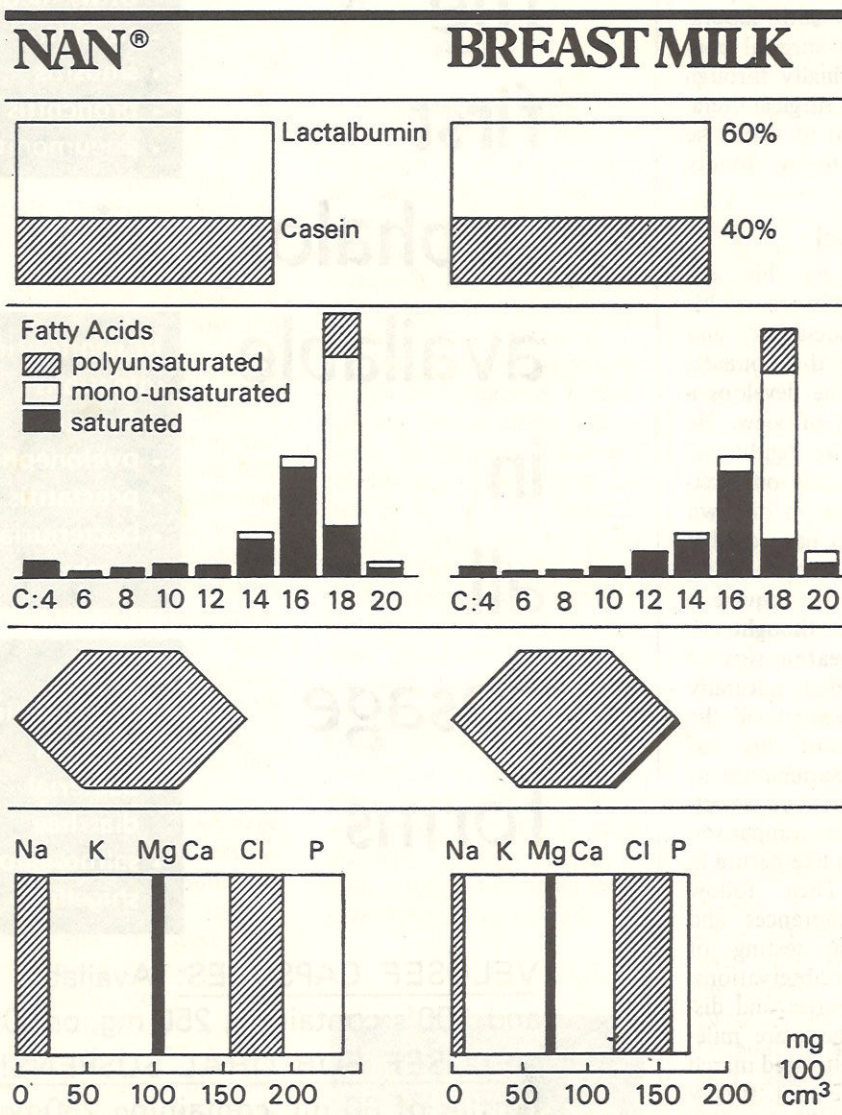
1. Duke-Elder, S.: System of Ophthalmology, Vol XIV, Part I, Injuries, page V and 19, Kimpton, London, 1972.
2. Parliamentary Debates Singapore Official Report, 27th March, 1974.
3. Ibid: 2nd June, 1972.

Photograph of breast milk through electron microscope taken in Nestlé Research Laboratories, Vevey, initial enlargement x 20,000.

We have studied the smallest details of mothers' milk...

We thought you would like to see how it compares with NAN.®

Of course we discovered that it is not possible, or perhaps not yet possible, to synthesize breast milk. Nonetheless, certain of our findings over the years can be applied and in NAN we have brought all our findings together with the specific aim of reaching a composition as close as possible to that of breast milk.



Proteins
- same amount of protein
- same casein/lactalbumin ratio
- similar composition of essential amino acids

Fats
- same composition of fatty acids
- same ratio of saturated to unsaturated fatty acids
- same content of linoleic acid, the essential fatty acid
- same triglyceride structure
- provision of essential phospholipids

Carbohydrates
- lactose only
- same ratio between lactose and lactalbumin

Mineral salts
- no over-supply of mineral salts
- relationship between the different mineral salts maintained (particularly Na/K)
- physiological Calcium/Phosphorus ratio
- identical quantities of organic salts provided.

In addition NAN contains the quantities of iron and vitamins which are needed to cover the physiological requirements of the infant and in normal cases ensure the prevention of nutritional deficiencies (particularly anemia and rickets). NAN has been widely and successfully submitted to clinical trials all over the world.

® NAN is a registered trade mark

PI 2383 GB

Published by the Singapore Medical Association, 4A, College Rd., Singapore 3 and printed by Eurasia Press, 12/14, Kampong Ampat, Singapore 13.