MEDICAL

SINGAPORE MEDICAL ASSOCIATION

Newsletter

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Child Psychiatric Services in Singapore [1]

by
Wong Sze Tai [2]

1. Need for Child Psychiatric Services

Surveys carried out in different parts of the world on the extent of psychiatric disorders in children in the population have shown that about 5 to 12% of school-going aged children suffer from psychiatric disorders sufficiently serious to warrant psychiatric attention at any one point in time (Rutter et al, 1970).

Although we do not know the exact extent of psychiatric disorders in children in our population, it is unlikely that it will be very much different from the generally accepted rate of 5 to 12% of school-going aged children.

Calculated on this basis, with our population of 2.2 million of which nearly ½ is under 21 years old, there will be around 100,000 of school-going aged children who are in need of psychiatric help.

If we include the pre-school children and the mentally retarded children with behaviour problems, the number will rise to about 110,000. This is by no means a small number.

According to the World Health Organisation assessment, **rapidly developing countries tend to have higher rates of psychiatric disorders in their populations compared with the rates of psychiatric morbidity in the developed or underdeveloped countries.** As a rapidly developing nation, Singapore will, no doubt, have to face more and more increasingly complex social and human problems in our society. In such a situation, social incompetence and behaviour problems may be less tolerated.

Already there are signs of increasing mental health problems in children and adolescents in our Republic. There is enough publicity given to the problem of drug abuse in school children, to the increasing rate of juvenile crimes and to the large number of school drop-outs every year. I need mention no more on this point.

Look at it from another angle, Singapore has no natural resources and has to rely on its manpower and brainpower for survival and progress. It is imperative that we should pay more attention to child rearing practices and to the type and quality of services for children and adolescents so that we can ensure that they grow up sound in body and mind. The Government emphasis on children and youth is therefore a very sound one. Provision of child psychiatric services in this context is an investment that our Government cannot afford to ignore. In a report submitted to the President of United States, the Joint Commission on the Mental Health of Children (1970) stressed the importance of such an investment for the Government to undertake, for without it, and I quote: "it will be more costly in the long run in mental illness, human malfunctioning, and under-productivity. In this aspect of our economy, we are far behind many countries which give priority to the proper shepherding of their most important resources, their children".

Child Psychiatric Services is an essential medico-social service and forms an integral part of the Mental Health Services in our Republic. The value of preventive work carried out by the Child Psychiatric Service is clear. With growing affluences and the emphasis on planning small families and on quality, our nation has reached the stage where it cannot afford to ignore the necessity to provide for psychiatric care of emotionally disturbed children.

2. What types of facilities needed

Thus, we know the rough extent of serious psychiatric disorders in children in Singapore. The next question is how should we deal with them.

In the first place, child caring is the responsibility of everyone. I am using the term 'child caring' in a very broad sense here to cover the physical and mental health, education and welfare of children. When deviation from normal occurs in the child's behaviour, emotions or cognitive abilities, the parents may require help. Child Psychiatric Services are concerned with the mental health of children. Milder cases that require reassurances, simple advice, explanation and guidance are increasingly taken on by family doctors, social agencies, teachers, pastors, doctors in maternal and child health centres, out-patient clinics and school health services, paediatricians, etc. This is indeed a healthy sign. Child Psychiatry is more concerned with well-developed clinical entities, that is, with the more difficult cases, complex in the interaction of physical, intellectual, emotional, cultural and social factors, and involving an assessment without which one cannot formulate a plan of treatment for the disturbed child.

It is easy to see why in the course of investigation of a child with disturbed behaviour, it may be necessary to carry out biochemical and pathological studies, X-Rays, audiograms, electro-encephalograms, and chromosomal studies etc. apart from the usual psychological testing, educational and social assessments.

A community Child Psychiatric Service should meet the needs of the pre-school child, the school child and the post-school child.

It should also cater for the family of the child, and in particular the parents. Rarely can it be said that the child will respond to treatment in isolation. It must be remembered that personal relationships are formed in the early years of the child's life, and nearly always are with the parents. Any failure to form the bond, any distortion or disruption of the bond between the child and his parents has significant consequences in the personality growth, intellectual growth, mental health and behaviour of the child later on.

Emotional attitudes of the parents toward their children arise not by accident but are that product of experiences and circumstances in their own lives. Frequently, these circumstances have produced an emotionally handicapped or restricted adult, meriting skilled treatment and management in his own right. Unfortunately, emotional handicaps of this order in the parents rarely respond to simple advice and reassurances. Furthermore, the emotional handicaps of one or both parents have repercussions throughout the family and call for a skilled assessment of the psychodynamics of the family. Indeed, it is often difficult to decide whether the emphasis of treatment should lie with parent or child. This underlines the importance of the family approach in child psychiatry. It also shows the close links with adult psychiatry.

Out-Patient Services

The first and perhaps the most important step in establishing any child psychiatric service is to set up **out-patient psychiatric clinics for children.** These should be located in the community and best be integrated with other medical

(Continued on page 3)

INSIDE

Office Bearers

At the Annual General Meeting of the Singapore Medical Association held on 21st April 1974, the following were elected to the 15th Council of the Association:-

President:	Dr. Choo Jim Eng
President-Elect:	Dr. Frederick Samuel
Hon. Secretary:	Dr. Toh Keng Kiat
Hon. Treasurer:	Dr. Lim Chan Yong (re-elected)
Council Members:	Assoc. Professor Chew Beng Keng
	Dr. N.N. Ling (re-elected)
	Assoc. Professor Loh Tee Fun
	Dr. Loh York Siong
	Dr. Charles Ng
	Professor Phoon Wai on

VIEWPOINT

THE SLIPPERY SLOPE DOWN

One of the more unpleasant and crucial issues facing our young republic to-day is the steady increase in juvenile crime within the past few years. The Minister for Health and Home Affairs Mr. Chua Sian Chin when he disclosed this did not attempt to sugercoat the facts. The figures he gave must have come as a rude shock to many people, but it is always better to look a problem in the face than turn one's eyes in another direction.

Some four years ago when a seminar on mental health held in Singapore disclosed publicly that there were drug takers amongst our school children, quite a number of people found this hard to believe. This was at a time when the emphasis was on the "ruggedness" of our people, and it was unthinkable to us that there could be drug-addicts amongst our children. Yet the truth was there even if we didn't care to see it. If we had taken a more vigorous stand then against drug addiction, we would perhaps have less of a problem on our hands to-day.

We must therefore never relax our vigilance. There are of course many reasons contributing towards the increase in juvenile crime. It is not purely a local phenomenon but a world wide trend these days with the change in life styles and values amongst many of the young in Western societies. Moneytheism, and hedonism amongst the adults have doubtless played a strong part in influencing the behaviour of the young.

Amongst one of the many reasons in this country for the rise in juvenile crime is the rise in the numbers of juvenile drop-outs from our schools. The bulk of these are the failures of the PSLE (primary school leaving) examination. In some schools the rate of failure runs to as high as 70%. Who are these students who don't make the grade? Are they all stupid or educationally subnormal (ESN) children? A University don said the other day that the passing of examinations alone isn't everything in life, and that it is a sin to gauge a child's abilities by his marks at school, yet what does the future hold for the "drop-out" at thirteen? Where can he go to? What can he do?

Illingworth in his book "Lessons from Childhood" gives some interesting examples of drop-outs at school who later became famous personalities. The stories told of Sir Winston Churchill are well known. "He passed into Harrow at the bottom of the lowest form ... he remained perpetually bottom of the class, and did not excel in sport."

Not so well known perhaps was the fact that Albert Einstein was thought a dud in his younger days. His father was distressed by the teacher's reports that the boy was "mentally slow, unsociable and adrift forever in his foolish dreams." At sixteen he applied for entrance to the Swiss Federal Polytechnic School at Zurich, but was rejected.

Thomas Edison is another well known case of the boy thrown out of school who eventually made good, but can any one imagine Beethoven getting a report from his tutor Albrechtsberger which says that he "never has learned anything and never will learn anything. As a composer he is hopeless."

Sir Isaac Newton was for a time bottom in the lowest form but one at the Grammar School at Grantham. He was "inattentive and a bad scholar."

How did the medical giants fare? Osler was expelled from school for his pranks. Sir Ronald Ross who did pioneer work on malaria, was a terrible student who "when he should have been studying medicine, he was writing poetry, stories, plays, composing music, painting or doing sculpture." Carl Jung was thought to be stupid yet crafty, and Sir James Mackenzie while at university had trouble passing his exams. Louis Pasteur was conscientious but a slow learner, and at twenty he finished near the bottom in a Chemistry exam.

Some others apparently fared little better while at school. Oliver Goldsmith was a "stupid heavy blockhead, little better than a fool," and his teachers thought of Balzac as a "fat little fellow in a state of intellectual coma." Tolstoy was regarded as both "unwilling" and "unable" to learn and Charles Darwin was regarded as a very ordinary boy "rather below the common standard in intellect."

It is quite an impressive list and obviously amongst our many school drop-outs there must be some slow developers. It would be unwise to regard all these children as forming the scum of our society. While a fair portion of the dropouts would be ESN children, there are others who have not done well in their exams because of problems of adjustment. With these under-achievers it is not so much a problem of "can't" learn, but a matter of "**won't**" learn.

Why do some of our students refuse to learn their work? Sometimes the fault lies with the parents for not taking an interest in the child's welfare. In other cases perhaps society is to be blamed for giving the child the wrong values in life, so he prefers to be indolent and lazy rather than work. Not infrequently too the school is to be blamed for indifferent teaching, lack of encouragement and supervision. Children who have to 'mug' hard at their lessons can sometimes develop an unconscious mental block to learning, which is in fact a silent mental revolution against pressure of work. Here it becomes a case of the more one knows, the more one forgets. The more one forgets, the less one knows.

The ESN or the stupid child is unlikely to become a dangerous anti-social element in our society. He is not too upset about being an academic drop-out. It's the clever, frustrated child with a chip on his shoulder whom we have to watch for and who could turn into the dangerous criminal. If we wish to forestall this trend we must take steps firstly to reduce the numbers of school drop-outs in our society, and secondly to see that every child who is a drop-out gets a second chance in life.

We must never ignore the problems of our school drop-outs. Every child should be helped to find his or her place in society. Opening more youth and community centres can help to take some of the children off the streets, but it will take more than pingpong games and basketball to solve the rising trend in juvenile crime. We must always try to treat the cause and not merely the symptoms, and until we know why we are having so many drop-outs in our educational system we will not meet with much success.

There are some questions which have to be honestly answered. Are our teachers able to cope with the work? Are we asking too much or pushing too fast in our bilingualism programme? Do we have sufficient facilities at secondary and tertiary level to accommodate all our students? The drop-out child needs more attention than the child in school. He must not be made to feel that society has passed him by. He must be given a sense of belonging, or wanting to belong. He can't feel this by joining a club. He must have an educational institution where he is cared for, given work to do. He must have self-respect, and we have to help him gain this.

What has the medical profession to do with all this? For a start we can be a bit more energetic with our family planning programmes. We must see to it that every child born is a wanted child. We can look to the better nutrition and health care of the children so that they develop in stature both physically and mentally. We have to be aware of the patterns of mental ill health in our community, and know that little Ah Kow's Monday morning colic may not be due to worms, but an unwillingness to go to school.

We are part of society, and we are heir to all the ills of society. To-day's drop-out child maybe to-morrow's drop-dead adult. We can't stand aloof and say that these things do not concern us.

E.K.

Outstanding Young Singaporean Award Scheme

The S.M.A. have been invited to participate in the above scheme organized by the Junior Chamber of Singapore. The objective of this Award is to select and award young men and women who have been outstanding in their personal and professional development through involvement and participation in leadership and community services.

Young Members of the Association who would wish to be nominated are kindly requested to obtain further particulars from the Secretariat, Telephone 981264. The closing date for submission of nominations is 15th August 1974.

AUSTRALIAN MEDICAL ASSOCIATION

The Secretary General, Dr. G.D. Repin, of the Australian Medical Association has advised that the following are the office bearers and members of the Federal Council of the Association:-

President: Dr. K.S. Jones; Vice President: Mr. J.R. Magarey; Chairman of the Federal Assembly: Dr. M.V. Clarke; Treasurer: Dr. L.L. Wilson. Members of Council: Dr. H.L. Thompson, Dr. C.S.H. Reed, Dr. W.M. Maxwell, Dr. A.J. Moss, Dr. J.F. Lee, Dr. H.W.A. Forbes, Dr. M.J.W. Sando, Dr. P.E. Mellows, Dr. R.S.W. Lugg, Dr. P. Kessly, Dr. F.R. Fay and Dr. R. Wall.

Child Psychiatric Services in Singapore

(Continued from page 1)

services for children in a community health centre. In this way it will facilitate easy referrals and frequent consultations between the child psychiatric team and the other doctors from school health services, maternal and child health services, etc.

Modern research all point to the fact that the **pre-school period is the most important formative period in a person's life.** It is of paramount importance to pay special attention to this age group in any service planned to help the child who suffers from psychiatric disturbance. The child is most vulnerable during this period. The early detection and treatment of handicaps – physical, emotional, intellectual and educational – is an important function of the child psychiatric services.

In-Patient Units

In-patient care and treatment are necessary for certain categories of patients, namely neurotic and psychotic children, neurotic and psychotic adolescents.

Children who present problems in diagnosis may require systematic observation and investigation as short-term in-patients, which may range from 2 weeks to 3 months. This step is needed when it is desirable to exclude home influences in clarifying a clinical problem.

Examples of situations calling for in-patient care are:-

Children can present as acute problems and be so ill that immediate skilled attention in hospital is necessary;

For others, distance may prevent adequate out-patient investigation so that in-patient investigation becomes necessary;

Psychosomatic conditions sometimes call for in-patient handling by a psychiatrist;

Neuropsychiatric conditions of childhood may need in-patient investigation and short term treatment;

Psychotic children frequently present as diagnostic problems and a period of observation and investigation is often essential.

In addition to the above children needing short term investigation and treatment, a number of others are found to be so ill and so disturbed as to be beyond the facilities of long term substitute homes and boarding schools. These cases call for a longer period of in-patient care and treatment, often extending to several months or a year or 2.

During the in-patient period, the child's parents will be seen by a member of the child psychiatric team to clarify issues or to receive treatment. Home visits are usually necessary. All these are done so that the child can be discharged eventually to a home that has improved so much that it can cope with the patient.

As the child's education is interrupted when he is admitted as an in-patient, and as he may remain in the hospital for a few weeks or months, it is necessary that school facilities be provided within the in-patient unit. As many of these children are known to be too disturbed or disruptive in normal school, it is essential for the school or class within the in-patient unit to be specially geared for emotionally disturbed children so that they may begin to adjust and start to learn. Assessment of his educational difficulties may become possible for the first time, and special educational programme can then be constructed for each of them.

We should remember that children who are in need of in-patient care and treatment need not be overtly showing disturbed behaviour. The majority in fact do not present in this way.

For the satisfactory functioning of child psychiatric in-patient unit, a close and active liaison with paediatricians is most desired.

Day Centre or Day Hospital

There is a group of children who could not benefit from out-patient treatment and at the same time would not require in-patient management. This group of children are best treated as a **Day Patient** in **Day Centre** attached to an Out-patient Child Psychiatric Clinic or to an In-patient Child Psychiatric Unit.

For the Mentally Retarded

Surveys on disturbed children in the population have clearly demonstrated that mentally retarded children have a significant higher rate of psychiatric disorders compared with the normal population. In view of this, **psychiatric facilities for disurbed mentally retarded children** are badly needed. The facilities should include Out-patient Clinics, Day-Care Centres, In-patient Units and Hostels. There have been a lot of advances in our understanding, treatment and residential care of mentally retarded children recently. With the advent of behaviour modification techniques, special educational methods and drugs, the outlook of many such children has changed dramatically over the last decade. In many instances, before treatment procedures can be usefully applied, it may be necessary to admit the child for short-term stay for observation and investigation purposes.

Forensic Facilities

Another function of the Child Psychiatric Service is to provide **psychiatric examination for delinquents** sent by the Juvenile Court for Court Report. The Child Psychiatric Clinic also takes on cases referred by the Juvenile Court for treatment. Apart from this, there is a need to provide **psychiatric services to remand homes and other residential homes and hostels for juvenile offenders.** In view of the rising juvenile crimes in the Republic, this is all the more important. Serious delinquents on follow-up tend to have poor prognosis. Early assessment and vigorous specialised treatment programmes are very important in the management and rehabilitation of serious delinquents.

Consultation Services

For many years to come, there will be an acute shortage of trained child psychiatric personnel. Such an acute shortage cannot be easily or quickly remedied. It is, therefore, vital that the very limited manpower resources in this field is effectively utilised. In this connection, the child psychiatrist personnel would have to provide **consultation services** to schools, welfare institutions, social agencies, pastors, etc. in the community. For example, the Child Psychiatrist or the Child Psychologist or the trained Child Psychiatric Social Worker can hold regular group discussion with the other professional workers and impart theoretical knowledge and therapeutic skills to them so as to help them deal with their current problems.

The value of Consultative Service of this kind developed by Dr. Balint of U.K. over a decade ago (Balint et al, 1961) is now firmly established and is widely used throughout the world. It is both effective and economical of manpower. Experience everywhere has shown that professional workers in residential schools, children's welfare homes, and hostels function better when they have regular help and support in their management of difficult children and in their contacts with parents.

Other functions – Prevention, Teaching, Training and Research

Up to the stage, I have dealt with Child Psychiatric Services from the clinical standpoint. Space would not permit the delineation of its other functions in any great details. For completeness sake, I shall just mention in passing that other areas of functioning of the Child Psychiatric Services include **prevention** e.g. mental health education, services to kindergartens, creches, etc., **teaching and training** of professional workers from different disciplines involved in child care and **research.**

Evaluation and Surveys

Any planning of child psychiatric services should be based on factual data from research. It is important for example, to carry out proper survey on the extent and nature of psychiatric disorders of children in different areas of our Republic. It is equally important to carry out research on treatment methods in search of more effective and economical treatment procedures. Above all, it is vital to be able to evaluate the delivery of the service, the impact of the service on the community and the pattern of utilisation of the service by the community – in other words, a continuous monitoring system is required (Eisenberg, 1968). The findings of research will naturally be of great help to the Government.

Supportive Services

To a large measure, the success of treatment of disturbed children depends on adequate supportive services in the community. These include special educational facilities, special residential homes or hostels for disturbed children and adolescents and ordinary boarding schools. Our resources in these areas are very limited. Without such supportive services the child psychiatric services will not be able to function effectively.

3. **Local Services**

Before 1970, there were no specialist personnel or facilities to treat emotional or behaviour disorders in children. Inevitably some of the more seriously disturbed children had to be admitted to the adult wards of Woodbridge Hospital, which were really not equipped to deal with them. That was a very unsatisfactory state of affair.

The Government was not unaware of the vast problem of mental ill-health in children. In January 1970, the Minister of Health, in his address to the Regional Workshop for Mental Health, announced the government's intention to develop Child Guidance Clinics as a significant advance in our mental health services.

The first Child Guidance Clinic was opened in O.R.G.H. in April 1970 for the purpose of providing comprehensive assessment, investigations, diagnosis and treatment of emotional disorders in children. In March 1971, it was shifted to its present premises at Block 99, Ground Floor, Old Kallang Airport Road. Initially, for 2 years the Clinic was operating on part-time basis, 2½ days per week. Since mid 1972, it has been operating on a full-time basis, 5½ days per week and became a full unit of Woodbridge Hospital. Since 1973, it has started to admit in-patients and Day-Patients in a very limited way, using beds in St. Andrew's Orthopaedic Hospital (which has a school), in Woodbridge Hospital and in the Mental Defective Home. The results have been encouraging.

The Clinic is directed by a Child Psychiatrist. Its professional staff include one child psychiatrist, one medical officer, two psychologists, two medical social workers and one assistant nurse. In the near future, the staff will need to be expanded, to include more nurses, one occupational therapist, a speech therapist and two or three teachers.

Why a Team?

When a child becomes emotionally disturbed, he is often impaired in several areas of functioning at the same time. For example, a child with learning disabilities may show motor incoordination, speech difficulties, emotional or behaviour disturbances and poor interpersonal relationships together. The causation of emotional disorders in children is often multiple in nature. As no one person or specialist alone can understand or help a disturbed child fully, it is easy to see why a team approach is necessary.

4. **Manpower**

Finally, we have to consider how many more child psychiatric personnel are needed. The generally accepted figure is **one child psychiatric team to 100,000 total population** (Royal College of Psychiatrists, 1973). Each clinical team is best made up of one child psychiatrist, two psychologists and three social workers. For Singapore, based on the present population, we will need ideally about 25 child psychiatrists, 50 child psychologists and about 75 child psychiatric

(Continued on page 5)

News from the College of General Practitioners, Singapore

College Examination:

The next College examination leading to the M.C.G.P.S. will be held in December 1974:

Written exam – Sunday, 1st December 1974.

Clinical exam – Sunday 8th December 1974.

Details regarding the structure and content of the examination may be obtained, on application, from the College Secretariat.

Fees: $250.00.

Please apply early. **CLOSING DATE FOR APPLICATIONS: 31st August 1974.**

Teaching Sessions at Outpatient Department, Maxwell Road:

Teaching sessions are being held at Outpatients Department, Maxwell Road, on Thursday afternoons, from 12.45 p.m. to 2.00 p.m. The sessions are open to all doctors and those interested are welcome. If any doctor wishes lunch to be provided, he could ring the Maxwell O.P.D. and make arrangements.

Refresher Course:

A refresher course will be held from August 30 to November 15, 1974.

Lectures – Fridays from 8.30 p.m. to 10.00 p.m.

Clinical Sessions – Sundays from 2.30 p.m. to 5.00 p.m.

The course is open to all members – whether sitting for the examination or not.

Fees: $100.00

Please apply early. **CLOSING DATE FOR APPLICATIONS: 31st July 1974.**

Medico-Legal Society:

The Medico-Legal Society of Singapore has planned the following series of Seminars and Lectures to be held during the months of July to August 1974.

July – Seminar on "Homicide Investigations".

Aug. – Lecture on "Investigation of Air Craft Disasters" – By Prof. J.K. Mason of Edinburgh University.

Further details will be found in the Singapore Medical Association Circular.

Seminar on Medico-Legal Problems:

The next Seminar run by the College, in conjunction with the Medico-Legal Society of Singapore, will be held on Sunday, 28th July 1974. Details are available from the Details are found on page 8 of this issue.

Convention 75

Dr. John G. Radford, President of the Royal Australian College of General Practitioners, has officially written inviting the Singapore College to attend the Convention '75 in **Sydney**, from **August 25** to **29, 1975**.

The Convention '75 incorporates the Second Joint Conference of the Colleges of General Practitioners of Singapore, Malaysia, New Zealand and Australia, and the 5th Australian General Practitioners Convention. The team of the Conference is **"Caring for People"**.

Members are asked to make a note of this forthcoming important event. It is hoped that many of our members will attend this Convention.

Further details will be made known to members as and when received.

Child Psychiatric Services in Singapore

(Continued from page 3)

social workers. A realistic minimum target should not be less than 75% of the above stated ideal figure – i.e. 18 child psychiatrists, 36 child psychologists and 54 child psychiatric social workers. It is clear therefore that the consultant grade in Child Psychiatry has to be expanded considerably. At present there is only one child psychiatrist in an acting consultant position. To meet the expansion needs, a corresponding increase in trainee or senior registrar posts would have to be firmly and quickly implemented. It is as well to note that the minimum period of training to become a Child Psychiatrist is two years (in most countries abroad it is 3 years, and in a few it is 5 years). Therefore, it would not be before 1976/77 that any additional child psychiatrist can be trained. As a senior registrar generally requires 3 years before he is eligible for promotion to consultant grade, the earliest that the next consultant child psychiatrist can be expected is in 1977.

If two child psychiatrists can be trained each year, by 1980 we may have, hopefully, 6 additional child psychiatrists. By 1985/1986 we may be just getting near to the minimum practical level of consultant staffing. By 1990, a near ideal level may be realised. Three factors need to be borne in mind. Firstly, recruits into child psychiatry usually come from general psychiatry. It is therefore logical that training in general psychiatry has to be expanded as well. Secondly, the increase in population has to be taken into account in any estimate of projected manpower needs. Thirdly, a change in our thinking and attitude about training more psychiatrists is necessary.

In addition, more posts for medical officers to work in Child Psychiatric Services are badly needed. This will provide exposure to child psychiatry to those who have chosen this specialty, to trainees in general psychiatry (who should be given six months' experience in this field), and to facilitate an exchange of experience for doctors in the field of paediatrics, community child health and general practice. Experience everywhere has shown that in this way more recruits would be deflected (e.g. from general psychiatry) into child psychiatry, which is seriously undermanned at present and will still be so for sometime to come.

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7. RUTTER, M., T12ARD, J and WHITMORE, K. (1970): Education, Health and Behaviour. London: Longman. P. 178.

1. Based on a paper of the same title presented by the author at the Public Forum on 'Child Psychology' sponsored by the Paediatric Society on 15th November 1973.
2. Wong Sze Tai, M.B.B.S., D.P.M., M.R.C. Psych., A.M., Ag. Psychiatrist, Child Psychiatric Clinic, Block 99, Ground Floor, Old Kallang Airport Road, Singapore 14.

News About People

Dr. Chao Tze Cheng	M.R.C.P.A.
Dr. Chow Khuen Wai	F.A.C.C.
Prof. Khoo Oon Teik	F.A.C.C.
Dr. Albert Wee	F.A.C.C.
Dr. Robert C.K. Loh	F.R.A.C.S. Elected Member of the Australian College of Ophthalmologists.
Dr. Kevin K.F. Ng	Elected Member by the American Society for Clinical Pharmacology and Therapeutics.
Dr. Michael C.K. Chan	Awarded Heinz Fellow, British Paediatric Association
Dr. V.M.S. Thevathasan	M.F.C.M. (UK) Member of the Faculty of Community Medicine
Dr. Wong Yip Chong	F.R.C. Psych. (Lon.)
Dr. Beng Kian Siew	M. Med. (Surgery)
Dr. Chan Chi Chin	M. Med. (Surgery), F.R.C.S.E.
Dr. Lee Boon Teck	M. Med. (Surgery)
Dr. Yeo Khee Quan	M. Med. (Surgery)
Dr. Ngo Eu Guan	Final F.F.A.R.A.C.S.
Dr. Shenton Oh Min Yueh	Final F.F.A.R.A.C.S.
Dr. Kee Chin Wah, Patrick	M. Med. (In. Medicine)
Dr. Liu Tsun Tsien	M. Med. (In. Medicine)
Dr. Gong Ing San	Prim. M. Med. (Surgery)
Dr. Ng Kang Chin, Andrew	Prim. M. Med. (Surgery)
Dr. Tay Chong Kam	Prim. M. Med. (Surgery)
Dr. Wong Saw Yeen	Prim. M. Med. (Surgery)

Promoted to Superscale Grade 'E'

Dr. Sung Wing Heun
Dr. Poh Soo Chuan
Dr. (Miss) Y.M. Salmon

Promoted to Superscale Grade 'G'

Dr. Tay Leng Kong
Dr. Oon Beng Bee
Dr. Tan Cheng Lim
Dr. Wong Sze Tai
Dr. Ng Boon Keng
Dr. Anthony Heng
Dr. N. Kunaratnam
Dr. Chan Yew Foon
Dr. D. Vengadasalam
Dr. R.N. Perera
Dr. Ong Beng Hock

Acting Appointments Grade 'G'

Dr. Wan Shoung How
Dr. Dhanwant Singh Gill
Dr. Loh York Siong
Dr. Chua Wan Hoi
Dr. Choo Hee Tiat
Dr. Tan Kheng Ann
Dr. Grace Tan
Dr. Khor Tong Hong
Dr. Lee Swee Kok
Dr. (Mdm) Tay Leng
Dr. Santhiramathy Doraisingham

(Not to be quoted in the Press)

News from the Council Table

Tax Relief for Doctors' Telephones

The two Council representatives Dr. F. Samuel and Mr. C. H. A. Hoy met Mr. M. Cordeiro of the Inland Revenue Department to discuss further on this matter. We were later informed officially that the Commissioner did not agree with our views for the apportionment of the cost where a doctor has only one telephone in his house. Following enquiries made we were told that the chances of success were favourable if we make an appeal and Council had thus appointed Dr. Samuel to explore this further. If members have any views please direct them to our representative soon.

Private Limited Companies

We publish below a reply from the Association's Legal Advisers, Chor Pee & Hin Hiong, in answer to our inquiry as to whether members of the medical profession can form private limited companies for the purpose of operating a clinic or surgery:

I have looked all over but am unable to find any law preventing a member of the medical profession or for that matter, a member of any profession from practising through a private limited company.

I believe that like other professions, this is governed by the code of ethics of the relevant profession. As far as the medical profession is concerned, we would have to look into the relevant code of ethics or etiquette pertaining to the medical profession.

It appears to me that there are a number of doctors who are being employed by private limited companies or private hospitals. Another related question is whether a doctor is allowed by his code of ethics or etiquette to be a shareholder or director of a company which operates medical clinics or hospitals.

(Continued on page 11)

(Not to be quoted by the Press)

Health Insurance in Singapore?

by Dr Colin Marcus

I would like to begin our discussion of health insurance in Singapore by quoting a statement in the Government Publication "Singapore '72" which reads:

"In a tropical region where epidemics still prevail, Singapore has a remarkable health record and is relatively free from major infectious diseases. This has become possible through the development of good housing, modern sanitation and excellent public water supply as well as the education of the citizens on the need for preventive health, backed by a high standard of curative services. The low mortality rate of 5.4 per thousand compares with the best in the world."

What then is the need for change in our medical programme some of you may ask? The S.M.A. had previously set up committees to report on 'Hospital Planning' and 'Contract Practice' and these reports expressed some apprehension at the development of our medical services.

To have some background information, I shall review briefly the development of our medical services. Singapore has inherited a system of medical care known as the Social Assistance Pattern, which is mainly the pattern for the colonial and underdeveloped countries. This system is predominantly based on the old charity medical service and in modern society may be considered as the continuation of the medical services provided to the poor by the ancient religious orders and landlords. In this system hospital facilities were owned by the Government and medical personnel were salaried employees and financed out of national income. Private practice existed only for the upper-income segment of the population.

After World War II the increasing pressures for modern treatment coupled with the acute shortage of doctors, led to the expansion of the Social Assistance Pattern with the creation of the Out-Patient Services in 1953 to cope with the situation by mass therapy methods. In subsequent years these services were enlarged to reach in the year 1960 a total attendance of 2.8 million in a population of 1.6 million. The services were offered free of charge up till then, but with the imposition of a token charge the attendance fell and were stabilised to about 2.0 million per annum in the past decade. The attendance for 1972 was 2.2 million.

The position of medical personnel had improved since those years: there were 1,524 doctors on the medical register by the end of 1972; 514 were in Government Medical Services with 87 on the establishment of the Out-Patient Services. The rest were in the University, private institutions and in private medical practice with an estimated 500 in general practice. The development in the Government Medical Services during the past decade has been directed to the higher specialities, with little or no expansion to the primary care units. This led to the setting up of private medical clinics either singly or in group practice to take in the patients which previously attended the O.P.S. Some of these clinics offer services at competitive charges in relation to the Government Clinics. Expansion also progressed in specialist facilities, laboratory investigations and beds in the private sector that it is possible to obtain medical care without recourse to Government facilities, provided there is no economic barrier to pay for such services.

Other expansion in the private sector has been the further development of contract practice by which a doctor or a group of doctors are engaged by an employer to provide medical care to his employees. The terms of contract can vary from a generous cover for all services to rates which are barely sufficient for medical consultation. Under the Labour Ordinance, an employee is obliged to report to the doctor nominated by his employer or forgo medical benefits.

With this brief preamble, an analysis would show that an estimated one-third of the population are still dependant on the Government for their primary medical care, in other words, means on Public Assistance. In the private sector, an employer can dictate where his employees may seek medical advice and limit medical expenditure. Other members in the lower/middle income group have limited means to undergo investigation and therapy and have to revert to Government Services for these facilities. Financial stringency would limit long term surveillance, continuing care and rehabilitation. Widespread screening techniques to detect persons at risk and research in private practice are not practicable.

The socio-economic sphere in Singapore on the other hand, has progressed rapidly with the intense industrialisation and urbanisation now taking place and with it has taken a toll of physical, physiological and psychological disabilities, evident in the changing pattern in our morbidity. The major tropical epidemics have now been controlled and in its place a host of other conditions. It is inevitable that there must be a change in the structure of our medical care programme towards more individual care to meet the new challenge.

Trends in modern medical practice take in all human activities. There is a need to view the patient as a whole in the context of his family, his environment and employment. Colleges of General Practitioners are promoting the concept of a family physician who would be the pivot on whom would rest the responsibility for the health, wellbeing and continuing care of the patient and his family. A prerequisite of such a system is the title to choose one's own doctor. This would lead to a more equable distribution of doctors and the utilisation of the whole profession towards the welfare of the community as a whole. But can the average patient afford such a system unaided?

There are four basic forms in the principles of health insurance, although there are many variations within these forms.

1) **Private health insurance:** This is purely a business insurance for a specific contingency – usually institutional care – medical and surgical costs. There is a limit to indemity and is the predominant pattern in the United States of America.
2) **Social Insurance:** This can be voluntary or compulsory insurance for medical care and para medical services. The main characteristics is that the population covered has to contribute financially to a common fund, either by a fixed weekly or monthly amount or by a percentage of their salaries. The State may subsidise to a varying amount.
3) **Public Service Pattern:** This is the pattern of the National Health in the United Kingdom. In this organisation the nation has formally established complete medical care as a right of all citizens – all services come under systematic Government control. The medical and allied professions are not civil servants, their services are made generally available to the public without economic barriers. General practitioners are paid on a capitation basis, according to the numbers on their panel; hospital specialists of various grades are salaried, full time or part time. The entire organisation is financed from collective funds – a large proportion from national

(Continued on page 9)

DIARY OF CLINICAL MEETINGS / TALKS

20.7.74 8.00 a.m. Orthopaedic Lec. Theatre, O.R.G.H.
Chapter of Surgeons: Academy of Medicine
Monthly Combined Meeting

Depts./Units Presenting: A & C. Chairman: **Assoc. Prof. Chacha.**

25.7.74 4.30 p.m. Brunel-Hawes Lec. Theatre O.R.G.H.
Gastroenterological Society of Singapore

Case Presentations

1. Gastric polypts with chronic atrophic Gastritis and intestinal metaplasia
   Endoscopic aspects – Dr. Fung Wye Poh
   Surgical aspects – Dr. Ho Soon Teik
   Histological aspects – Dr. Lee Swee Kok
2. Ulcerative colitis with intestinal fistula
   Clinical aspects – Dr. T.B. Chi
   Radiology – Dr. Pauline Lui
   Endoscopy & Histology – Dr. W.P. Fung & Dr. S.K. Lee
3. Angiographic studies in Ulcerative Colitis by Dr. Lenny Tan
   Chairman: Prof. C.S. Seah

25.7.74 8.00 p.m. Lecture Theatrette 4A College Road
1974 Galloway Memorial Lecture by Dr. M. Kannan Kutty, MBBS (Madras), MD (Lucknow), FCAP (USA), Senior Consultant Pathologist, General Hospital, K.L.
Subject: "Current Concepts of Rhinosporidiosis"

28.7.74 2.15 p.m. Lecture Theatrette 4A College Road
The College of General Practitioners
Medico Legal Society of Singapore
Seminar on "Medicolegal Problems in General Practice"
The Practitioner and his patient, the patient's relatives, friends and employer
The Practitioner and his colleagues – **Dr. Colin Marcus**
The Practitioner and the Police, the Press, the Coroner and Lawyers – **Mr. Lim Chor Pee**
Medico-Legal Management of Accidents, Poisoning, Sudden Death, Death from Doubtful Causes, Divorce Proceedings, Abortion, Assault, Rape, Drug Addictions, etc. – **Mr. Glenn Knight**
The Misuse of Drugs Act 1973 and the Misuse of Drugs Regulation 1973, and the Problems arising therefrom in General Practice – **Mr. Wong Yip Lung**
Certification, Notification, Witness in Court, Consent– **Dr. Chao Tzee Cheng.**
Chairman: Dr. Koh Eng Kheng
Questions and comments will follow each speaker.
TEA will be served and members wishing to attend are kindly requested to inform the College Office, 4A College Road, Telephone 918968.

30.7.74 8.15 p.m. Lecture Theatrette 4A College Road
Singapore Cardiac Society
Apexcardiogram: its Clinical Value by Dr. Lim Chin Hock.
Chairman: Assoc. Prof. Charles Toh

4.8.74 10.00 a.m. Faculty of Medicine Sepoy Lines S'pore 3
Teaching Seminar on Venereal Diseases
The primary objective of this seminar is to provide an opportunity for medical practitioners to be informed of the latest developments in the diagnosis, treatment and laboratory tests in veneral diseases. An exhibition of the range of drugs used in the treatment of venereal diseases is also planned in conjunction with the seminar.
Registration fee is $25.00, and the closing date for this is 25th July, 1974.
Members wishing to enrol for the seminar please contact Dr. Chan Yow Cheong, secretary of the Singapore Society for Microbiology **or** Miss Kok (Tel: 92681 ext. 13).

Chapter of Surgeons, Academy of Medicine
The following talks will be held at the Orthopaediac Lecture Theatre, Outram General Hospital at 8.00 am.

5.8.74
The Place of Internal Fixation in Fracture Treatment
by Assoc. Prof. Chacha

12.8.74
Management of the Severely Injured by Dr. H.H. Chiu

17.8.74
Monthly Combined Clinical Meeting
Depts./Units Presenting: Cardio-Thoracic and B
Chairman: Dr. N.C. Tan

19.8.74
Management of Burns by Dr. K.L. Wong

26.8.74
Diagnosis and Management of Eye Injuries by Dr. K.H. Lim.

ALL ARE WELCOME

FORTHCOMING CONFERENCES & MEDICAL COURSES

The Ninth Malaysia-Singapore Congress of Medicine

Organized by the Academy of Medicine of Malaysia to be held in **Kuala Lumpur** from **August 23 – 25, 1974.**

28th World Medical Assembly

The World Medical Association cordially invites us to designate a medical delegation to attend its 28th World Medical Assembly being held in **Stockholm,** Sweden, **September 1 – 6, 1974.**

At the forthcoming meeting two and a half days of discussion will be devoted to the International Conference on the Physician and Population Change, sponsored by the World Medical Association, in association with the World Federation for Mental Education, International Planned Parenthood Federation and the World Health Organization.

All expenses will have to be met by every participant-member concerned.

IV Asian-Australasian Congress of Anaesthesiologists

This Congress is being organised by the Singapore Anaesthetic Society, to be held in **Singapore** from **September 22 – 26, 1974.**

For Registration particulars please contact Dr. Tan Seng Huat at the Outram Generál Hospital, Singapore 3.

6th World Conference on General Practice/Family Medicine

This will be held in **Mexico City** from **4 – 8 November 1974.** A total of six plenary sessions, 49 Symposia and free communications are being organized. Among these are "Family Practice at present time", "Family Dynamics", "Culture and Society", "The Professional Formation of the Family Physician".

Members who are interested to attend are requested to contact the College of General Practitioners, Singapore, 4A College Road, Singapore 3.

5th World Congress of Gastroenterology

From **13 – 19 October 1974,** in **Mexico.** For further details please contact Dr. W.P. Fung, Faculty of Medicine, Outram General Hospital, Singapore 3.

Fifteenth Course for Senior Hospital Administrators

This course will be conducted by the International Hospital Federation in the King's Fund Centre, 24 Nutford Place, **London** W1H 6AN, in consultation with the British Council, the Department of Health and Social Security, Regional and Area Health Authorities, and will be held from **5 March 1975** to 30 May 1975. It will consist partly of academic work and partly of attachments to different hospital and health service authorities in London.

General enquiries concerning the course should be addressed to the Director General, International Hospital Federation, 24 Nutford place, London WIH 6AN. *(Continued on page 13)*

HEALTH INSURANCE IN SINGAPORE?

(Continued from page 7)

revenues and the balance from social insurance contributions and tax sources.

4) The fourth pattern is found in **Communist countries** – this pattern is an extension of the Public Service Pattern, but all personnel are civil servants and all facilities are organised by Government. All services are free to the entire population.

There are advocates that recommend the British and others the Australian systems, but there are factors in Singapore that make these systems impracticable. We have no traditional background in the development of Western medicine. There are many adherents to the traditional form of medical care, the many functioning establishments of this nature attest to the popularity of this form of therapy. Again I doubt if there is general acceptance on the principles of insurance, unless this is made as a form of compulsory tax and a large population of casual workers, self-employed, unemployed and unemployables, who would have no mean to make any contribution unless aided by Public Assistance.

Instead, I would suggest that we look to an Eastern country to which we have closer, social and cultural affinities. In Japan, when it embarked on an industrial programme, Mutual Aid Associations were established in factories primarily for industrial injuries and later developed into Health Insurance Societies under the Health Insurance Law. This requires anyone who is employed in an organisation with more than 5 persons to be insured. Contributions are varied with different employments at about 2 to 3 percent of the salary. An employer pays approximately an equal amount. An insured patient is free to choose his own medical consultant from among the doctors who have entered into contracts with the Insurance Society. The medical fee is borne by the Insurance Society except for a token amount of partial liability which is paid at the time of consultation. The organisation is underwritten by a National subsidy. Benefits include medical care, sickness or injury allowance, maternity allowance, funeral expenses, nursing allowance, and medical care benefits to dependants. An interesting feature in this system is the evaluation of services on a point system.

In Malaysia an attempt by SOCSO, an organisation under the Social Security Act to underwrite the cost of industrial accidents. The service is provided by private practitioners and the central fund created by contribution from the employers. It is functioning in major cities, but is expected to spread to the rural areas and its scope is envisaged to extend to non-industrial illnesses.

In Singapore, the possibilities are (1) to introduce a voluntary health insurance as a pilot scheme under legislation in a closed organisation i.e. a statuary body on a contributary basis by both employee and employer which would include the family and dependants, by doctors in private practice who are prepared to enter into contracts with the insurers and allowing free choice of doctors. It is important that data be collected on the sickness rate, the cost per patient and the percentage requiring investigation as well as those on long term and maintenance therapy. This is essential, if the scope of the health organisation is to be enlarged, for our actuaries to work out the costs.

Other advantage is that if this organisation is successfully run, the benefits wound encourage an extension to include other categories of workers and other members of our society, lower the pressure on the O.P.S. and stimulate the increase of hospital beds – which are lacking in Singapore.

(2) A second possible avenue to pursue is to amalgate the present contract practice to integrate it into one organisation with standard fees for consultation and services and a free choice of doctors in the organisation. This I am afraid will not be looked upon with favour by some doctors.

In conclusion, if we view Singapore as a country dependant on trade and servicing as our means of livelihood without natural resources except human, it follows that we should preserve and nurture these resources by a more positive approach to individual health and well-being. Measures have been taken to combat pollution, improve our environment and cultural activities towards better living standards of the community as a whole, what better 'perks' could the profession offer than a personal medical care to our citizens?

Medical Ethics and You*

by Dr. A.L. Gwee

Most people have heard about medical ethics and judging from the letters of complaint I have had occasion to read when I was in the Singapore Medical Council, they must have believed that medical ethics are meant for the protection of the patient.

Indeed, there is some truth in that belief, but there are more to it than meets the eye, and the intricacies of medical ethics are getting more, and even beyond the average doctor in these days of modern medicine.

Medical ethics is actually an agreed code of good conduct, and western medical ethics – confining ourselves today to that alone – is best known in the Hipocratic code which was reputedly to have been formulated more than two thousand years ago. In addition, other than this code, there has been the Geneva code of conventions formulated by the World Medical Association in 1954, with subsequent additions in the form of declarations, such as those on death and on human experimentation. Over and above these, there are also national codes drawn up by various national medical associations for the guidance of their own doctors such as British Medical Association code in Britain, American Medical Association code in United States etc. Further more, there is the most recent Commonwealth Medical Association Code adopted in April this year by twenty six commonwealth nations including Singapore and Malaysia.

Without getting into the boring details of each of these codes, I would state as an oversimplification three points:

1. The medical ethical code is a sort of public declaration of attitude by the medical profession.

2. Medical ethics will change as doctors thinking changes, and the thinking of doctors is affected by social changes.

3. Medical code of ethics does not necessarily always protect the interest of the patient.

When a patient sees the doctor, he or she has literally given the doctor a free hand, for the most intimate information is given, and the bodily examination can be very thorough, and the treatment can have far reaching effects, sometimes of a serious nature. Few have ever the privilege to be so trusted, and fewer indeed would have the foolhardiness to confer such a privilege without serious forethought.

This trust is secure, however, because the doctors have declared their attitude unequivocally in that "whatever they do, it will not injure the patient", and "the patient's life shall be held sacred, and his confidence always respected." This security is further enhanced by the fact that the declaration is no empty promise like those made on some political platforms, but is in fact enforceable by penalty, for a doctor can be hauled up for the breach of these promises.

But medical ethics also ensure that doctors and doctors should not compete indecorously, and in this view, advertisement is prohibited. This will reduce the patient's choice as he is now being deprived of the information to make valid selections, just as he can do when he chooses a new car, or house, or even a brand of soap. He will have to depend on a chanced encounter to pick his first doctor – the family doctor or the general practitioner – as the regulations of doctors ordain that a doctor's name should be displayed only with decorum and without ostentation, and that usually implies a board of about ten by fourteen inches! He will have to rely on gossip of cured patients or his family doctor's advice to go to a specialist or a consultant.

Moreover, the community has its views about life and health – views which change with the thinking of the times. Right now it feels that in general, the minority interest must give way to that of the majority, and an individual must be subservient to the community. Hence, individual freedom can be restricted if he is a threat such as under Drug Misuse and Abuse Ordinance and Infectious Diseases and Quarantine Ordinance, and the doctor in spite of his avowal of attitude is told in no uncertain terms that if he has knowledge of offending individual under the Ordinances, and does not turn informer, he would be severely dealt with by fines and imprisonment like anybody else. The intimate information he obtained from patients under promise of strict confidence receives equally shabby treatment in the Courts, for the magistrates and the judges will tell him quite clearly that he would have to give up the information he possesses when asked or be liable to face dire consequences.

Furthermore, recent advances in medicine makes it necessary for occasions of human experimentation, and for the question of whether a patient still alive by conventional standards should be declared dead already, either because he has no hope of recovery in the doctor's view, or in addition, his organ may be of value to benefit other human beings. The Geneva code has it that a doctor may under certain circumstances of expertise and preparedness experiment on human beings provided the person experimented on

(Continued on page 10)

LETTERS

Dear Sir,

I feel I should add a flippant note to the serious dissertation by Drs. E.K. Koh and H.H. Un in their comments on the 'Future Role of the Family Physician' for I find it strange that doctors, above all things, are now equated with airline pilots – a rather curious analogy?

But be it as it may. Looking back I have been, perhaps, foolhardy in being lulled into complacency by the attractive torsos of the airhostesses, when I should correctly be concerned with the qualifications of the airpilots, whether they have had vocational training, continuing education and a diploma of the College of Airpilots before I ventured to emplane on the hazardous journeys by air to the various parts of the world.

And perhaps we doctors should, as with our counterparts, submit ourselves for re-certification- to undergo a gamut of tests in cardiovascular evaluation, audiometric assessment, visual and colour acuity; X-Rays – the lot, to be re-certified with a clean bill of health, so that airpilots will continue to fly their planes and we to do our doctoring.

Yours faithfully,
Dr. Colin Marcus

Dear Sir;

Re: Conference Proceedings

May I, through your Newsletter, request that Organising Secretaries of congresses, conferences, symposia, seminars, etc., in Singapore send a set of the proceedings to the Medical Library so that it may be made more readily available to anyone wishing to read the papers? Sometimes we are more fortunate in being able to obtain the proceedings in published form but there is the problem of the time lag between the time the meeting is held and the time the proceedings are published.

It might interest your readers to know that the Medical Society has a clause in its constitution for its publications and records of its activities to be deposited in the Medical Library to enable future groups of students to know of the past activities of the Society.

Yours faithfully,
Michael Cheng
Medical Librarian
University of Singapore

Dear Editor,

I forward herewith a photostat copy of an editorial note from WHO sources about the precautions necessary to avoid getting infected with typhoid, locally or abroad, whether due to normal or chloramphenicol-resistant strains (WER No. 23 of 1973 for any action you may consider useful.

Though your readers are not ignorant of the facts in the editorial note, it may be comforting to obtain confirmation from authoritative sources.

Yours faithfully,
Dr. S R Sayampanathan
Senior Health Officer
Quarantine & Epidemiology
Environmental Public
Health Division

W.H.O. The epidemic of chloramphenicol-resistant typhoid fever in Mexico serves to reemphasize advice for persons planning travel to areas of the world where typhoid is prevalent. The traveller's first line of defense is discrimination in his choice of food and beverages. The safest foods are those that are cooked and served hot. Salads, raw vegetables, and unpeeled fruits should be avoided. Commercially bottled or canned mineral water and bottled or canned beverages are generally safe. Ideally, tap water should not be consumed unless first boiled or treated with chemical purifiers. Water which is uncomfortably hot to touch may also be safe for drinking after it has cooled. Ice should be avoided. Eating places with substandard hygienic conditions should not be patronized. These precautions are equally applicable to the prevention of other infections, such as non-typhoid salmonellosis, shigellosis, amebiasis and infectious hepatitis, to which international travellers may be exposed.

Harmful

Typhoid vaccine can provide additional protection against contracting typhoid fever. However, the vaccine is only partially effective and is in no way a substitute for careful attention in the selection of safe food and drink. Prophylactic antimicrobial drugs are of questionable value and may even be harmful.

When the diagnosis of typhoid fever is suspected in a patient, a careful history should be taken concerning possible travel to Mexico or other highly endemic areas. *S. typhi* isolates should be routinely tested for sensitivity to chloramphenicol and ampicillin. Illness due to chloramphenicol-resistant strains should be treated with parenteral ampicillin, which may also be used as the initial drug in patients with a history of travel to Mexico while antibiotic susceptibility tests are pending.

CDC has confirmed resistance to both chloramphenicol and ampicillin in a small proportion of isolates obtained from Mexican patients. No case of typhoid due to the strain resistant to both drugs has been reported to CDC from the United States.

Medico-Legal Society

Dear Sir,

I was very pleased to read the formation of the Medico-legal society. In fact, the organisers have saved me from the trouble of any suggestion from me as to the value of having such a society.

The MMA has already formed one many months ago and I was wondering as to why no initiation has been taken by the SMA. Normally in most medical matters, Singapore sets an example. But in this particular instance it lost the lead. However better late than never.

Guidance

Recently, I visited India in connection with my book on Medical Jurisprudence & Toxicology now in use in the Medical Colleges in India in many provinces. This is the first edition and naturally it will have some defects for rectification in the next edition. Incidentally it is under review by the Editor SMJ. But I hope with the help and guidance of medical associations of both the countries – Singapore-Malaysia the book can be useful for guidance of both professions so that one can look to his own author for references purposes instead of looking to India or England. Incidentally, there is now an Indian Academy of Forensic Medicine. The fellowship is open to all those who are interested. Most of them are Professors of Forensic Medicine of the Medical Colleges of India.

In conclusion, I would like to congratulate the organisers and wish them all success for the development of their undertaking. I venture to suggest that membership should be broad based that is to say eke out those who are interested in the subject not only from the legal and medical profession but also from judiciary and police and specially from the special branch and chemists.

The Society can be of tremendous assistance in the investigation of crime including forgery and juvenile delinquency.

My services are at the disposal of the society at all times should they feel so desire.

Yours Faithfully.
Dr. Rajinder S Grewal.

Medical Ethics and You*

(Continued from page 9)

agrees to it, and the risk, in the doctor's view, is not too great. The Harvard group of doctors has come out with what is known as the criterion of brain death, where it is proposed that if certain amount of brain has died already, the patient can be regarded as dead. A recent conference of leading paediatricians and gynaecologists brought out this cryptic and unchallenged statement: "I take that none of us accept the sanctity of life doctrine ... and instead we have the quality of life doctrine."

With these, you can see why more and more people are demanding a share in the decisions of the formulation of medical ethics, for if a doctor does not necessarily respect patient's confidence, does not always respect life, intends occasionally to experiment on human beings for the benefit of science and at times ready to declare a person dead because the quality of his life is deemed to be not up to mark, then one wonders if the trust that has been originally given should not be reviewed a little more circumspectively and realistically.

*You = the public.

New Office Bearers of

COLLEGE OF GENERAL PRACTITIONERS SINGAPORE

President	Dr. Wong Heck Sing (re-elected)
Vice-President	Dr. Chen Chi Nan (")
Censor-in-Chief	Dr. Evelyn Hanam
Hon. Secretary	Dr. Koh Eng Kheng (")
Hon. Treasurer	Dr. J. Chang Ming Yu
Council Members	Dr. Gordon O. Horne(")
	Dr. Leong Vie Chung
	Dr. Liok Yew Hee
	Dr. Colin Marcus (")
	Dr. F. Samuel

SOCIETY OF OPHTHALMOLOGY

Chairman	Dr. Robert C.K. Loh
Hon. Secretary	
Treasurer	Dr. Lim Kuang Hui
Committee members	Dr. Arthur S.M. Lim
	Dr. H.N. Tong
	Dr. Voon Gone Lin
Auditor	Dr. Peter Tan

OBSTETRICAL & GYNAECOLOGICAL SOCIETY OF SINGAPORE

President	Dr. Oon Chiew Seng
Vice-President	Dr. Liok Yew Hee
Hon. Secretary	Dr. Lim Swee Oon
Hon. Treasurer	Dr. Christopher Chen
Council Members	Prof. Goon Sek Mun
	Dr. Chan Yew Foon
	Dr. Chong Kim Foo
	Dr. Choo Hee Tiat
	Dr. Seng Kwang Meng

A Study of Mental Health Act 1959 (England)

by Rajinder S. Grewal.
LMS (S'pore). MD. (Malaya). FRCP (Glasg).

Introduction

I have read with great interest the articles on Mental Health written by Dr Freda Paul and Dr Tsoi Wing Foo in the newsletters of recent months. My interest in mental health problems stems, from having been a medical superintendent of a mental hospital for over three years in Burma and having taken my MD Thesis in this subject.

Apart from this, I have made a special study of the subject as applied in the National Health Services Act 1946 and the importance of this subject from an angle of Social and Preventive medicine, I have thought fit to review the subject and explain the present day concept of "mental disorders".

The Present Day Concept.

Firstly, the old concept of custody and control of the patients as was customary in the eighteenth and nineteenth century by hook or crook is now out of date. That concept is now replaced by treatment just like any other disease or disorder. Secondly the stress is on voluntary treatment than on compulsory. But if the compulsory treatment becomes inevitable then there are many safeguards against detention. Thirdly where ever possible the care of the patient is to be within the community rather than in the hospital.

Main Features of the Act.

The term mental disorder covers mental illness or disability. There is no administrative distinction between psychosis and subnormal mentality. In the event of compulsory detention four groups are taken into consideration namely mentally ill, severely subnormal – subnormal and psychopathic. Therefore the terms insane or lunatic are now discarded.

Psychopathic disorder is defined as a persistent disorder or disability of mind whether or not including subnormality of intelligence which results in abnormal aggressive or seriously irresponsible conduct on the part of the patient and needs or is susceptible to medical treatment.

Designated Hospitals

There are no more designated hospitals. The hospital authorities may arrange for treatment of any type of mental patients to be provided in any suitable hospital. The admission is informal. All hospitals are free to receive patients informally, without powers of detention.

Powers of Detention and Safeguards.

Here one must note that the emphasis is on medical rather than the administrative. In other words it is a change in the outlook and attitude to the mental illness. This is an essential point to be noted. Because the present attitude of the public need a change and it can be best done by health education by doctors, nurses and others. One has not to go to a magistrate. Instead the mental welfare office has stepped in who is appointed by the local health authority that is the corporation or the medical officer of health in U.K. County Councils.

Procedure for Compulsory Admission

Obviously those cases that are a danger to themselves and the community at large must be admitted in a hospital e.g. a Psychopathic disorder with aggressive or seriously irresponsible conduct.

The procedure is that two doctors should recommend an admission of the case. But one of them must have special psychiatric experience and the other if possible should have a previous acquaintance with the patient (generally speaking the family doctor in the National Health Service Act).

Further, the psychiatric practitioner must have been approved by the Local Health Authority, namely, the medical officer of the Health as having special experience in the diagnosis or treatment of mental disorders. Here it should be noted that this is a great advantage because every one who is seriously mentally ill will be likely to have the benefit of the opinion of the psychiatrist.

It is to be very carefully noted that the doctors act only from the medical angle of the case for treatment. But the application for the admission is made by the nearest relative, if available. Otherwise the mental welfare officer who must try to consult the nearest relative. It will be noted that the position is now quite clear that is to say that the safeguard to the public is now apparent, whereas formerly a magistrate and a doctor could certify a person as one suffering from mental disorder.

The Duration of the Compulsary Admission.

The compulsary admission is only for twenty eight (28) days for the purpose of observation. Evidently it is felt that this period gives ample time for arriving at a diagnosis. Indeed it is thought that even an acute psychosis may recover. After this period an assessment is made and if found necessary further extention can be given as the circumstances of the case may require.

Emergency Cases Admission.

Emergencies as every one knows create a sudden crisis which needs immediate solution of the problem. In such cases which do crop up at times an application can be made on the recommendation of one doctor only. This is valid for 72 hours.

Protection of the Public.

If a competent court (generally a High Court) considers necessary for the protection of the public it can order a mentally disordered person convicted before it or by an another competent court and shall not be discharged without the Home Secretary's consent. In other words one stays at her Majesty's expense and pleasure or here in this country at the President's pleasure or the Agong in Malaysia.

What others say...

A Chinese Daily, The Sin Chew Jit Poh, carried the following news item on 27 May 1974, on the occasion of the opening of Yen Nien Laboratory at Chung Hwa Clinic, run by Central Malaysia Chinese Physician's Association, Kuala Lumpur.

The President of the Council of Central Malaysia Chinese Physician's Association, Yeow See Chuan said today that Chinese physicians using the scientific instruments of western-trained physicians is like western-trained physicians studying the art of acupuncture of the Chinese physicians. This is not at all surprising, because all are progressing towards the combination of chinese and western medicine.

President Yeow was speaking at the 20th Anniversary of the Chung Hwa Clinic and the opening ceremony of the Yen Nien Laboratory. Extracts of his speech are as follows:

"Yen Nien Laboratory is recently established by our Clinic. It has an X-Ray machine and an Electro-cardiograph instrument. It can help in diagnosis and increase curative effect. For poor patients, this is very advantageous. All these equipments have been donated by Mr. Lee Yen Nien after whom this laboratory is named.

"Perhaps some people will query why Chung Hwa Clinic, being established by the Chinese Physician's Association as a charitable institution using chinese art of medicine and chinese medicine, must it use the X-Ray machine and E.C.G. instrument of the western-trained physicians? Our answer is that Chinese and Western systems of medicine, each possessing its own good points and short-comings can complement each other to their mutual benefit. If the chinese and western systems of medicine can be combined together, using the theories, diagnostic methods, medicine and therapeutics together, then this will greatly contribute to the curative and preventive aspects of health.

"In recent years, China has been using this combined method of Chinese and Western systems of medicine, making progress which has astonished the world. This serves as a good example for us. Our Clinic by borrowing the use of scientific instruments such as the X-Ray, E.C.G. and microscopes, can directly prove our diagnoses, and indirectly improve our curative effects. And it will lay a foundation for the ultimate combination of both chinese and western systems of medicine."

"We the members of Central Malaysia Chinese Physicians' Association are willing to play our part in this combination. We hope the chinese and western-trained physicians will co-operate together in this effort and to improve the sacred work of Malaysian Medicine.' We believe the medical organizations of Chinese physicians using the scientific instruments of western medicine is the same as western-trained medical organizations studying the art of acupuncture of chinese physicians. It is not at all surprising because both are progressing towards the road to combination of chinese and western systems of medicine."

(Continued from page 6)

Publication of Medical Matters

The Council of the Singapore Medical Association had discussed with concern the recent appearances in the local mass media of letters and articles touching on medical matters and the profession, sometimes in disparaging and derogatory manner, written by members of the medical profession.

We agreed that such letters and/or articles, especially those that would give rise to controversy or public alarm should most preferably be published in our Medical Newsletter. Council therefore request members to send any such letters or articles that they may write in the future to the editor of either the Medical Journal or the Medical Newsletter for consideration of publishing therein instead of sending them to the mass media.

Thank you for your co-operation and support.

Dr. Toh Keng Kiat
Hon. Secretary, SMA

Ah Wun he say

Early Worm

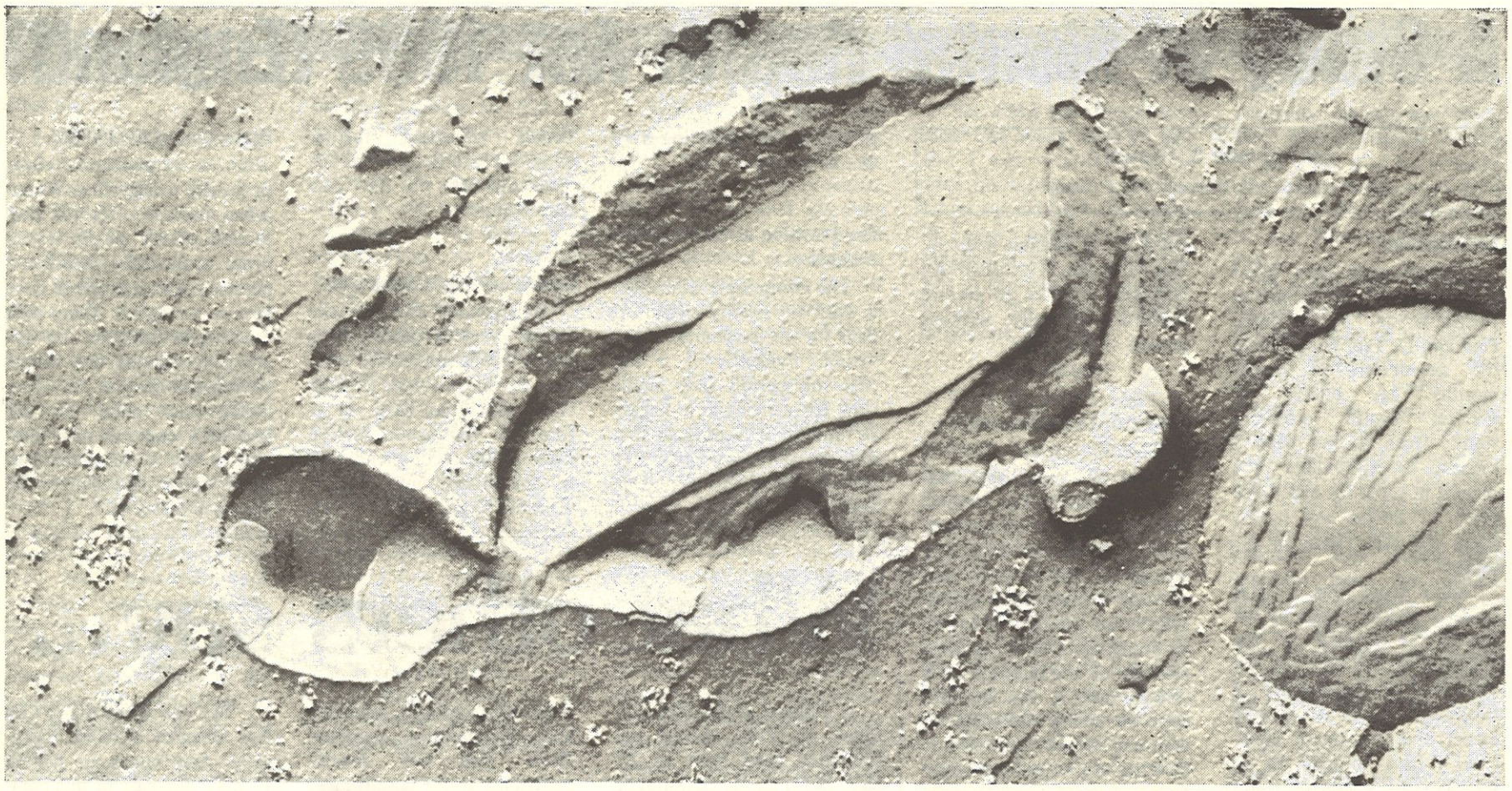
– him

catch the

birds.

National Day Parade 1974

A limited number of Essential Services Car Labels is available on a first-come-first-served basis, from the S.M.A. Secretariat. These labels will enable doctors to get through road blocks set up during rehearsal dates (July 21 & 28) and the National Day Parade (August 9). Please obtain them from Miss Chan O.L./Miss Cynthia Lee (Tel. 981264).

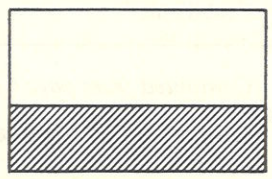
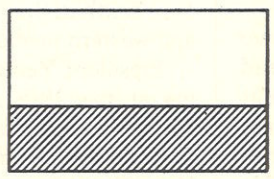
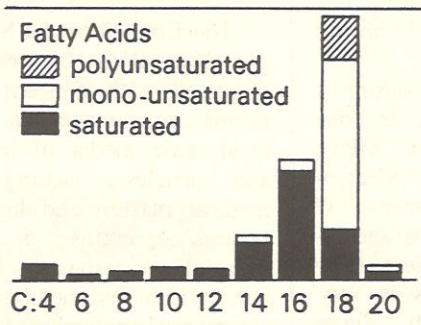
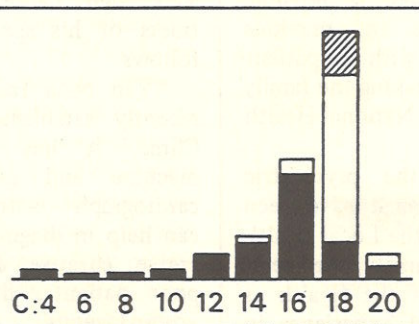
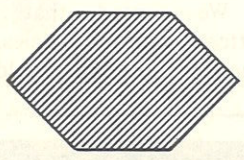
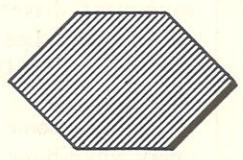
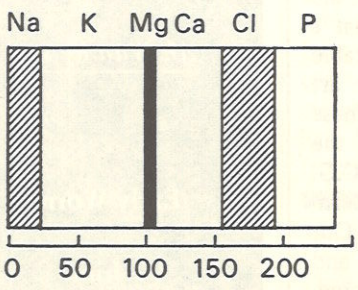
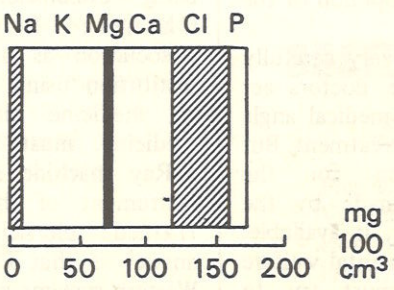


Photograph of breast milk through electron microscope taken in Nestlé Research Laboratories, Vevey, initial enlargement x 20,000.

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.

NAN®	BREAST MILK	
 Lactalbumin / Casein	 60% / 40%	**Proteins** – same amount of protein – same casein/lactalbumin ratio – similar composition of essential amino acids
 Fatty Acids: polyunsaturated, mono-unsaturated, saturated; C:4 6 8 10 12 14 16 18 20	 C:4 6 8 10 12 14 16 18 20	**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
 Na K Mg Ca Cl P; 0 50 100 150 200	 Na K Mg Ca Cl P; 0 50 100 150 200 mg 100 cm^3	**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.

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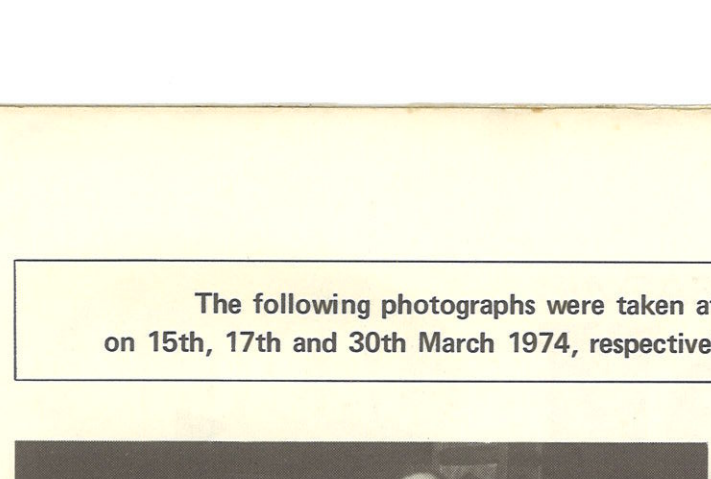
The following photographs were taken at the S.M.A.: Lecture Reception, Golf Tournament and Annual Dinner on 15th, 17th and 30th March 1974, respectively, held in conjunction with the Seminar Week organized by the Association:-

The S.M.A. President Dr. J.E. Choo, sharing a joke with some VIPs. at the Annual Dinner. From left: Mr. Koh Bok Seng, president of the Pharmaceutical Society, Miss P.H. Teo, formerly with the S.M.A. Secretariat and Dr. Chew Chin Hin, master of the Academy of Medicine. Dr. F. Samuel, President-elect of the S.M.A. is also in the picture.



At the Golf Prize Giving Ceremony, from left in the front: Drs. Lo Hong Ling, Robert Loh, Sheng Nam Chin, Ong Swee Law, Chan Ah Kow (partly hidden), Mrs. Chan and Mrs. Foo Chee Guan.

Prof. B.K. Chew planting a big kiss on his wife Dr. Chew Kheng Lian before receiving the beautiful cup for the Best Stableford Score. At the mike is Dr. Lee Keow Seong, the golf convenor.

Singing happily away at the Annual Dinner are from left: Prof. B.K. Chew, Drs. Wong Yip Chong, W.G.S. Fung & Yeoh Kean Hong.

Seen at the Lecture Reception from left are: Dr. Nalla Tan, Mrs. Huang, Mrs. Khoo Oon Teik and Dr. Ivy Chew. Dr. Tan Joo Liang in the background.

Board on Postgraduate Medical Education Faculty of Medicine University of Malaya

(Continued from page 8)

Faculty of Anaesthetists Royal Australasian College of Surgeons Primary Examination

The Primary F.F.A.R.A.C.S. Examination will be held in Faculty of Medicine, University of Malaya, Kuala Lumpur. The written section will be held on Thursday, 29th August and Friday, 30th August while the viva voce on or about 19 September 1974.

Application forms to sit for the examination and copies of the Manual on Training governing the examination may be obtained from the Examination Secretary, Faculty of Anaesthetists, Royal Australasian College of Surgeons, Spring Street, Melbourne, Victoria 3000, Australia.

Royal College of Surgeons, Edinburgh Part I and Part II Examinations

Part I and Part II of the Fellowship Examination for the F.R.C.S. Edinburgh will be held from 28th October to 4th November 1974 in the Faculty of Medicine, University of Malaya, Kuala Lumpur. Formal notices will be issued in due course.

POSTGRADUATE COURSES IN PATHOLOGY, PSYCHOLOGICAL MEDICINE AND PUBLIC HEALTH*

These courses leading to University of Malaya Degrees of Master of Pathology, Master of Psychological Medicine and Master of Public Health will commence on 2nd September 1974 for the academic session 1974/75.

Fellowships are available for candidates from Malaysia and South-east Asia admitted to the courses.

BASIC MEDICAL SCIENCES COURSE*

An eight weeks full-time course in Basic Medical Sciences designed to prepare medical graduates for the Part I F.R.C.S. (Edinburgh) Examination will be conducted from 2nd September to 26th October 1974. Admission to the course is restricted to those who intend to sit for the Part I F.R.C.S. (Edinburgh) Examination.

ADVANCED COURSE IN MEDICINE*

A full-time four weeks Advanced Course in Medicine will be conducted in the latter half of 1974 for a limited number of candidates who has passed the Part I Examination of the Royal College of Physicians, U.K. 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.

COURSE IN SURGERY*

This course, designed for those intending to sit for the Final Examination of the Royal College of Surgeons (Edinburgh) will comprise of four weeks clinical attachment commencing 30th September 1974 to the Department of Surgery, Faculty of Medicine, University of Malaya. Only a limited number of candidates will be accepted.

**Application forms and further information in regards to the above courses may be obtained from: Administrative Assistant, Office of the Dean, Faculty of Medicine, University of Malaya, Kuala Lumpur.*

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Views expressed by writers are not necessarily those of the Editorial Board.