The Singapore Family Physician

The College of General Practitioners Singapore

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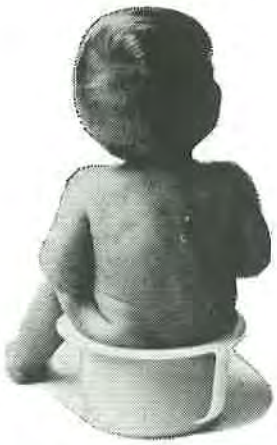

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Editorial
Medical Publications

Recently in Singapore the committees of two of our medical bodies have had to dissociate the parent body from views expressed in the editorials of their journals. Thankfully the College of General Practitioners has never had the need to such recourse.

The editorials of the Singapore Family Physician although not the official voice of the College, none the less expresses views which are not disconsonant with those of the main body. This is because the content of the editorials have in the past been chiefly on matters of academic interest. It is usually when an editorial voices matter with medico-political overtones that it becomes difficult for people sitting on different committees within the same organisation to come up with identical views.

The editor of a house publication should as far as possible express views which are not in conflict with those of the parent body, but he should at the same time be allowed a certain degree of latitude to express his own viewpoints without merely being the mouthpiece of the organisation. How this can best be achieved is something which each organisation has to work out between its committee members and the Editorial board.

Some organisations feel that their primary function is to operate in the medico-political field and their publications will naturally reflect this interest. Apart from medical publications of this nature there are basically two types of medical publications. These have been divided by Sir Theodore Fox as those which are journals of record and those which are journals of information.

Journals of record are primarily scientific journals designed to chart and record the progress of a medical discipline and the British Medical Journal and the Lancet can be said to fall into this group.

By contrast journals of knowledge carry factual information and review articles which seek to update the knowledge of the reader and the Practitioner is a good example.

Publications pertaining to general practice also fall within these two categories. The Journal of the Royal College of General Practitioners having evolved from the Research Newsletter of the college is primarily a journal of record. Up till quite recently it remained the sole journal of record for general practice, but is now joined by an American publication the Journal of Family Practice.

Journals in general practice which update the knowledge of their readers and are useful sources of information are the Australian Family Physician and the American Family Physician.

The Singapore Family Physician like its Australian and American counterparts seeks to provide information for our members. We do however carry original articles from time to time but these occasions are much less frequent than we would really have desired. Even with our review articles most of them have been written by consultants and specialists and we would certainly like to see more written by general practitioners themselves.

Our general practitioners on the whole are either too modest or too indifferent to share with their colleagues their observations and experiences. For those who are too timorous to write an article for publication let us assure them that we do not expect from them articles of world-shaking import. Within the constraints that most general practitioners are subject to it is difficult to come up with scientific papers backed by the logistic support of a plethora of research data. Yet there must be a place in modern general practice where observations and even postulates from those with experience can be gainfully passed on to others in the same discipline.

By keeping their experience only to themselves and not handing them to others, many experienced general practitioners are unwittingly contributing to the emaciation and eventual demise of their own branch of medicine. The Minister for Health Dr. Toh Chin Chye put this across quite well when he was addressing the Chinese physicians. He told them that it was the usual practice of teachers of the martial arts to keep back part of what they know for their self-interest and protection. In time of course less and less was being handed down and soon there would be nothing worthwhile to pass on.

For those who are not interested in sharing their knowledge and their experience there is nothing we can say except that we hope one day they will change their attitudes and be ashamed of their present indifference.

A man is marked by the clothes he wears, and a college likewise is judged by others by the publications it produces. It is true that no person or organisation should be judged by the outer trappings alone, but the world being the way it is, it is inevitable that we will be judged by what we have to show. If we are not to do a bad job of this we will require the help of everyone who has the interest of the College at heart. This is too important a job to be delegated to the few who comprise the Editorial board.

E. K.

(Views expressed in the Editorial are not necessarily the official views of the College).

Opening address at the 6th Convocation & 3rd Sreenivasan Oration

DR. V. FERNANDEZ MBBS, FCGP(S)

Distinguished Guests, Ladies & Gentlemen

On behalf of the College of General Practitioners Singapore, it is my pleasure and privilege to extend a very warm welcome to you and to thank you most sincerely for being with us this evening.

This Sixth Convocation concludes yet another chapter of our continuing education programmes. Our College over the past nine years of its existence has succeeded in constructing the foundations of its activities and establishing its credentials as an academic body. Even our National University has been persuaded that we are collaborators and not rivals. Our active but not-yet-superlative continuing educational programmes have been, in no small measure, a factor in the acceptance of the earnestness of our purpose by the medical profession as a whole in Singapore.

In recent years, our Government has become increasingly concerned with the rising cost of treatment orientated hospital care. Our Minister of Health has placed greater emphasis on out-of-hospital ambulatory care and preventive medicine, as a means of better controlling the cost of health care delivery. This has brought the primary care doctor, both in the public and private sector, to the fore-front of our health care delivery system. If trained by design, the primary care doctor should really be able to completely manage more than 90% of health problems regardless of age and sex. He should also serve as the link between the patient and other specialty services as well as community services. His knowledge, skills and orientation should enable him to apply medical science to the whole patient and his family in a personal way and with the least fragmentation of care.

However, very little, if any, attention has hitherto been paid to the specific training of the primary care doctor at either the undergraduate or graduate levels of medical education in Singapore.

It is now universally accepted that General Practice/Family Medicine is fast becoming a specialty in its own right, possessing an unique combination of elements from the knowledge and skills of medicine. As a medical discipline it has been defined in educational terms, so that it can now be taught as a distinct entity and not as bits and pieces of existing medical disciplines. This means that our medical school should recognize this new area of specialization and advocate the training of a new generation of doctors in the practice of primary medical care. They should recognize the importance of primary medical care and the improved systems of health care delivery to meet the needs of our community. They should redirect their curricula and teaching programmes towards primary comprehensive medical and health care, and reorganize sufficiently to provide substantial exposure to family physicians and family practice at the undergraduate level. This should enable the medical student to learn about the family physicians special attitudes and skills and be taught in the context of the family physician as he applies the discipline in patient care.

The graduate doctor planning to become a new general practitioner or family physician should be trained for the needs of his future practice. There should be a shift in policy in graduate medical education:

(i) from episodic to continuous and comprehensive patient care
(ii) from a disease orientated emphasis to the whole patient and his family
(iii) from rigidity to flexibility
(iv) from an individual physician to the physician as a member of a group and health team.

Vocational training programmes with specified objectives would therefore be necessary if the new general practitioner or family physician is to achieve a standard of excellence in his performance.

There is therefore now an urgent need for special training of the graduate entering primary medical care services. The compulsory period of at least five years service in Government now provides the opportunity for the medical graduate to undergo at least three years' hospital attachments as well as a further two or three years of apprenticeship to an accredited general practice. With the minimum of hospital and primary care experience and training, the graduate trainee would be able to acquire the knowledge and skills in the principles and practice of primary medical care as well as basic clinical training. He would thus be able to serve the needs of his patients and the community better than the hitherto past.

Primary medical care can extend primary, continuing, comprehensive medical care to more people than any other field in medicine and seems the logical foundation for our health care delivery system. The challenge to-day is for our Government to provide for vocational training programmes to enable general practice/family medicine to make an impact on the delivery of health care which is so urgently needed.

To-day, I am pleased to announce that the Tenth WONCA World Conference on Family Medicine would be convened in Singapore in April 1983. At the recent Conference of the World Organization of National Colleges, Academies and Academic Associations of General Practitioners/Family Physicians held in New Orleans, our College was successful in its bid to host the next Conference in Singapore. This is a gigantic undertaking by our College as it would be the largest medical conference ever to be held in Singapore. We need the support of all members of our College for the organization of this Conference, and our efforts shall not be in vain if this World Conference would provide an academic stimulus to establish family medicine as a distinct educational discipline in this part of the world.

Ladies and Gentlemen, to-night we are admitting Four Fellows and Three Diplomate Members. To the three members admitted to the Diplomate Membership I extend my warmest congratulations and look forward to their greater involvement in our educational programmes.

We are also making a few awards to-night.

The Albert Lim Award designed to honour the memory of the late Dr. Albert Lim, a distinguished family physician, goes to Prof Seah Cheng Siang, Senior Professor of Clinical Medicine and an Honorary Fellow of our College. Prof Seah has been our mentor and guide since the inception of our College, and this award is an expression of our kind thoughts, our sincerest thanks for all he has done for us.

Certificates of Appreciation are also being given to selected individuals for services rendered to our College.

The College Shield is being presented to one of our staunchest benefactors, Mr Toh Kian Chui, for his continual support.

Book Prizes are being awarded to the three top candidates who excelled in our G.P. Class examination held this year for the 3rd Year Medical Students.

The highlight of this evening's proceedings is the Third Sreenivasan Oration. This oration is delivered on an annual basis and is designed to honour both our Founder President, the late Dr B R Sreenivasan, and the recipient invited to deliver the oration. I am glad to announce that the proud recipient of the Third Sreenivasan Oration is Dr Leong Vie Chung, a Fellow of our College and currently the Editor of our Journal, "The Singapore Family Physician".

May I conclude by thanking once again all our distinguished guests and members for being with us to-night. To our donors, teachers, examiners and the many, many others who have helped us on our way, I extend, on behalf of the College of General Practitioners Singapore our sincerest thanks for all you have done for us. Finally, I would also like to thank Dr Tan Tian Cho and his committee for organizing to-night's function, and for doing it so well.

Medical Journalism in Singapore
The Third Sreenivasan Oration

DR. LEONG VIE CHUNG, MBBS, FCGP(S)

Preliminaries

First, I must thank the President and Council of the College for nominating me to deliver the Third Sreenivasan Oration this year. I am deeply appreciative of this very great honour.

Although he has unwittingly embarrassed me with so many lavish praises, I must nevertheless thank Dr. Koh Eng Kheng for his gallant attempt to show me in the best possible light.

Lastly, I must thank our distinguished guests, our College members and friends for their kind presence this evening. They have added distinction, grace and colour to make this occasion truly memorable.

The topic of tonight's oration is MEDICAL JOURNALISM IN SINGAPORE. Let me by way of introduction make some preliminary remarks on Female Fashion.

Female fashion, I am told, depends on two clever devices for its attraction. The first is to put the emphasis on certain natural features and the second is to allow partial exposure of others. This deliberate veiling and unveiling according to the nature of attractions desired is always a winner in the highly competitive world of fashion.

An oration is very much like a fashionable female dress. It puts the emphasis on certain features and at the same time allows the partial exposure of others. Alas! what I have to deal with are non-anatomical features. They cannot have the same degree of excitement or attraction for you.

Dr. B.R. Sreenivasan

In 1961, two eminent physicians and medical teachers met socially in the home of Dr. G.O. Horne. This meeting proved to be the beginning of a deep and life-long friendship between Dr. B.R. Sreenivasan after whom this oration is named and Sir Derrick Dunlop of the "Textbook of Therapeutics" fame. Both men had the additional quality of being highly literary and cultured. When they met it was as if each had rekindled the literary flame of the other.

Across the dinner table the two men vied with each other at quoting from the Bible, Shakespeare's plays, Boswell's Life of Johnson and the satires of Alexander Pope. They were so engrossed with these literary works that they became almost oblivious to the normally expected small talk of such a social occasion.

Shortly before Sir Derrick Dunlop died, he recalled with deep feelings his first meeting with the late Dr. B.R. Sreenivasan and lamented that he and his wife no longer enjoyed reciprocal visits between Edinburgh and Singapore.

In a very typical gesture, Dr. Sreenivasan, when he died, left the whole of his library to the College of General Practitioners. This consisted not only of a large number of medical textbooks and bound volumes of local and international biomedical journals, but also a large number of the classics of English Literature. The renowned qualities and professional abilities of Dr. Sreenivasan were as much attributable to his general literary reading and cultural exposure as to his purely medical and scientific training and experience.

It is regrettable that the criteria for medical student selection have swung so much in favour of the purely scientific bent to the virtual elimination of literary ability. Our graduates appear to have less and less literary and cultural background. These qualities are essential in the making of a "good" doctor, especially a good family physician.

Reading a best-seller such as "Kramer vs Kramer" probably tells anyone involved in marriage and family guidance more about at least one aspect of their daily work than half a dozen textbooks could ever convey.

General reading of this type would provide our doctors with a background and understanding of the whole cultural scene to which our professional lives are so closely bound, possibly more rewarding than any number of scientific journals, text-books or seminars.

In 1974 I was thrilled to receive an invitation to tea from Dr. Sreenivasan. He was delighted to see

that in one of my articles in the Medical Newsletter I had quoted from the works of Shakespeare. We spoke of many things. I reminded him how as medical students, we were deeply impressed by his humility in wanting our signatures in his well-treasured leather-covered book which contained the names of all medical students "he is privileged to teach" as he put it. I wonder where this book is now. I am certain the College of General Practitioners will be greatly honoured to have it in its possession.

Let me digress for a moment to explain why this book means so much to us. In a hospital setting, the medical student is considered the "lowest form of animal life". The presence of an isolated pathogenic bacteria is invariably greeted with joy and jubilation. The presence of a medical student on the other hand is tolerated with dismay. Who indeed had ever deemed it worthwhile to treasure the signatures of the "lowest forms of animal life"?

The Singapore Family Physician

Just as it is the vogue of every newly emergent country to start its own international airline, it is also the aspiration of every newly formed medical body to immediately start its own medical journal or at least a "newsletter".

The College of General Practitioners was no exception. It was founded in 1971 and Dr. Sreenivasan, the Founder President, was naturally keen to launch a College Journal as soon as possible. The first issue of the journal named the **GP** was published in March 1973. Some suggested that it was premature as the expertise for running such an ambitious venture was not immediately available. On the other hand, prestige aside, it was obviously essential that such an august body should have as early as possible its own journal. Other important considerations were the need to announce its establishment and objects, the necessity through its medium to recruit membership and the prudence to provide fertile soil for the roots of its academic growth.

Tribute must be paid to the pioneering editors of the chrysalis journals, the Straits Medical Journal and the Proceedings of the Alumni Association which in the fullness of time underwent metamorphosis into the Singapore Medical Journal, a "third generation" journal, in the words of the present editor. It was the first medical journal in this region to gain acceptance and inclusion in the prestigious Index Medicus and the MEDLINE system. It has blazed a trail.

In January 1980, the editor of the Annals of the Academy of Medicine announced with justifiable pride that it too was accorded acceptance and inclusion in the Index Medicus and the MEDLINE system. Our direction of growth has been clearly etched before us.

The contributor to the Singapore Family Physician which is now the legitimate successor to the **GP** need not despair that his article will be lost to medical literature. Since January 1980 it is now indexed under the Family Medicine Literature Index (FAMLI) which is the new index to the world literature in family medicine. FAMLI is a quarterly index with an annual cumulation and is the result of years of work by the Bibliography Committee of WONCA (World Organisation of National Colleges, Academies and Academic Associations of General Practitioners/Family Physicians) in association with the National Library of Medicine of the United States. FAMLI not only provides the references relevant to family medicine from the Index Medicus data base, it also indexes family medicine journals which are indexed in no other source. This combination provides an invaluable resource in family medicine not only to individuals but also to libraries with an interest in family medicine.

The Editorial Column

In discussing the Editorial column we must distinguish between two types of medical publications. Medical publications may come from medical bodies (academies, associations, colleges or societies) or from commercial enterprises.

We don't normally expect a medical publication from a commercial enterprise to have an editorial column. Here the discretion of silence is certainly the better part of business acumen. The whole philosophy of publication is viability. It cannot afford to offend nor to offer out-of-place and thankless views and opinions.

An Editorial column in publications from medical bodies is the vogue rather than the exception. Many doctors believe that the editorial represents the official views and policies of the publishing medical body. Just as many doctors believe that the editorial represents only the views and opinions of the editor or the editorial board.

Any uncertainty as to whose opinions are reflected in the editorial is convincingly dispelled by the history of one of our local biomedical journals and the current practices of three of them.

Our oldest and most revered medical publication, The Singapore Medical Journal (SMJ), started off with a regular editorial column. When the next editor took over the journal, he decided despite strong protests that there would not be a regular editorial column. During his tenure of office, the editorial was conspicuous by its absence. When he

stepped down, the next editor recommenced the editorial.

The decision of the editor, in his official capacity, to omit the editorial would strongly favour the view that the column represented only his views and opinions and nothing would be amiss if he did not choose to write in it. It would be inconceivable that during all the time of the absent editorial, the Singapore Medical Association had no official views and policies on the many and varied affairs then affecting the medical association.

The Annals of the Academy of Medicine makes no reference to the editorial other than stating that "Statements in articles are the responsibility of the authors". Volume 21, No. 5, OCT 1980 of the Singapore Medical Journal prominently displays on its first page this statement, "All articles published, including editorials, letters & book reviews represent the opinion of the authors and do not reflect the official policy of the SMA or Institution with which the author is affiliated unless this is clearly specified." The Singapore Family Physician consistently inserts immediately below the editorial the following statement:— "Views expressed in the Editorial are not necessarily the official views of the College".

The editorials of two medical publications have been highlighted by the Straits Times in October 1980 much to the chagrin and discomfort of the executive officers of the publishing medical bodies. Perhaps there is a genuine misunderstanding of what these editorials represent. In the light of these misunderstandings, there is a clear need to state the exact relationship between the editorial and the publishing medical body to avoid misrepresentation.

If doctors don't dare to speak out on medical matters, who can speak on them? We must forego the comfort of silence in matters affecting the health and care of patients. The constructive and useful role of medical editorials must be seen in this light.

Medical Journals and the Media

Medical topics are news to the media. There is an amazing appetite for medical information, instructive or sensational, which has to be satisfied.

In an informative and authoritative booklet entitled "The Media and You", Canadian Janet Cochran writes: "People **like** to be informed . . .about medicine and health, which in terms of interest rank second only to local news". In Singapore they perhaps take pride of place.

Editors of biomedical journals are sometimes hard put to avoid some degree of conflict with the press over what can be reprinted or summarised from their journals for public consumption. Different local medical journals appear to cope with the problem in different ways. The Singapore Family Physician protects itself in this respect by including in every issue the statement, "The contents of this publication are not to be quoted in the press without permission of the Editor". This of course offers no complete immunity.

News-hungry reporters always have "ways" of getting information, even from closed-door meetings. A very embarrassed Vice-President of an Old Boys' Association whose speech, delivered behind closed-doors, was made public in the Straits Times, posted the usual protest and remarked on "the resourcefulness of . . . journalistic sleuths".

We have always complained that the press does not understand our problems. Do we genuinely understand theirs? A better understanding and relationship can be established between biomedical journals and the press. Our side of the story must be told and their side of the story must be heard. If we strive hard enough and sincerely enough, an understanding can be reached whereby our "ethical principles" are not compromised when medical news have to be given to the public.

In the United Kingdom, many major newspapers employ full-time medically qualified journalists to write and edit original articles of a medical nature for their papers. These men/women understand professional discretion and are able to select and publish suitable abstracts from biomedical journals without offending medical ethics. There is mutual professional trust and few are the occasions which have come to grief.

In Singapore, our English language newspapers employ part-time medical consultants. Their work appears to be confined to writing occasional medical topics and running such popular features such as "Doc's Casebook" and "Doctor in the House". Generally, non-medically and non-scientifically qualified reporters are assigned to the "medical" and "health" beats. Most of them are competent enough in their own sphere but when specialised knowledge and delicate judgement are required they don't seem able to pull it off. A further weakness is that they are allocated the beat for a relative short period of time. As soon as a good understanding relationship has been established, she is transferred to another beat. Like poor Sisyphus, the difficult task of building mutual rapport has to be repeated.

Janet Cochran, referred to earlier, offered this advice to any editor or author who had got into a "tussle" with the media: "When things go wrong do **nothing** until you are over your first flush of anger!"

Copyright

Copyright is a "sensitive" issue in Singapore. Our Republic does not appear to enjoy an enviable reputation especially in international literary and musical circles. However, we can take comfort in the knowledge that the world over, even the most stringent international copyright laws tend to be somewhat loosely interpreted and applied.

In the general literary world, if two or three lines of a poem or the lyric of a song are to be reprinted, then no specific acknowledgement to the author or publisher is expected. If an extensive quotation is made, then formal application is expected accompanied with a copyright fee.

Most biomedical journals take some steps to protect the copyright of the material they publish. The Singapore Family Physician uses a phrase which reads, "The contents of this publication are not to be published in the press without permission of the Editor". The Annals of the Academy of Medicine states, "Permission to abstract must be obtained from the Editor". The Annals of Internal Medicine has formulated an elaborate policy statement on copyright and re-publication which includes a form of assignment to be signed by all authors. The journal enjoys full copyright. Most international biomedical journals including the British Medical Journal will not raise objections if not more than ten percent of an article is quoted verbatim. If tables, diagrams and photographs are included, the matter would have to be cleared with the editor and a royalty expected.

Relationship with the Pharmaceutical Industry

The financial solvency of many local biomedical journals depends to a certain extent on pharmaceutical advertisements and other acceptable ethical advertisements. The matter is not entirely a one sided affair. Such advertisements do indeed boost the sales of the advertised products. On the whole the local biomedical journals enjoy a mutually beneficial and cordial relationship with the pharmaceutical industry.

The Editor of the Singapore Medical Association Medical Newsletter reported in the 10th Annual Report 1979-1980 that "one of the frequent complaints from our advertisers was the infrequency of the Newsletter". He has summed up very neatly the same problems which beset other local biomedical journals. He expressed the hope that successful steps would be taken to avoid this in the future. We certainly would like to share this hope with him.

In the U.K., the "Data Compendium" which is regularly published and updated, gives an accurate assessment of all drugs on the market. This is approved jointly by the Government sponsored Medicines Commission and representatives of the Pharmaceutical Industry and has the force of law behind it.

In the absence of such a relationship in Singapore, the role of editors should at least be some kind of "pharmacovigilante corps" as suggested by two members of the Department of Pharmacology of our university. It has been suggested, not without reason, that advertisement accepted for publication should not include the names of authors who claim to have been involved in investigations, clinical or otherwise, on the drug concerned.

"Vancouver Style"

Since the beginning of 1980, the British Medical Journal (BMJ) along with hundreds of biomedical journals converted from the old-style "Harvard" system of bibliographic presentation to the "Vancouver" style to ensure uniformity in the technical aspects of editing, such as references.

The history of the change-over and the details of what it entails in the submission of manuscripts to these "Vancouver" style journals is contained in a comprehensive paper entitled "Uniform requirements for manuscripts submitted to biomedical journals" prepared by the International Steering Committee of Medical Editors. This was published in the Annals of Internal Medicine, the Lancet and the BMJ. Reprints are available to editors of biomedical journals free of charge and to authors at a cost of 50p (including postage) from the BMJ.

The BMJ in its last issue of 1979 published a touching and nostalgic poem entitled, "Harvard Requiem" by Grace Williams bidding goodbye to the old system.

The Annals of the Academy of Medicine, Singapore has already converted to the Vancouver style or format. The Singapore Medical Journal has given notice that it hopes to convert to this new system entirely in 1981. The advantages of uniformity are obvious and it will not be long before the Singapore Family Physician will conform with this change.

Readable English

The editors of our biomedical journals must ensure that not only their own contributions in the form of editorials, commentaries and so on are of the highest standard in English grammar, style and literature, but also that they insist on an equally high standard from their contributors. This can be achieved in various ways: by rejecting outright badly written papers; by requesting badly written sections to be re-written; or to make the necessary

corrections and improvements themselves where indicated without reference to the contributors.

An excellent standard of proof-reading is essential for the presentation of a high-class article in literate English. We have a very low standard of proof-reading in many current Singapore biomedical journals/publications. A Medical Newsletter short article of less than 150 words was so badly mangled that it became unreadable. There were a total of nearly 40 grammatical, spelling and other unclassified errors. This article is a mute and presbyopic testimony of illiterate proof-reading.

In the criteria for medical student selection we must look for candidates who are good at finding fault. Such a student is likely to be a good proof-reader in subsequent years. One of the most important attributes of a good proof-reader must be an infinite capacity for finding fault and looking for errors in other people's works. I wonder if this attribute is ever looked for by our medical student selectors. I should like to think that at least one candidate in this year's intake of medical students might end up as a local full-time professional biomedical editor in the great tradition of the famous American Dr. F.J. Ingelfinger, who led the New England Journal of Medicine to be acknowledged as possibly the greatest ever journal of its kind in the world.

I wonder what Dr. Ingelfinger's "bedpan aptitude rating" would be if he was an applicant for a place in the medical course of the National University of Singapore.

Sir William Osler's "bedpan aptitude rating" would certainly be even lower. He had a propensity to mischief. In school he was a vandal and delighted in unscrewing desks and putting them up on the loft; he was abusive and fond of shouting insults about the headmaster through a keyhole; and he could be considered antisocial because he once led a flock of geese into the classroom.

We have all along been selecting medical students who are conformists. It is time we choose some who are non-conformists. Out of these there may be one who will wield the pen rather than the knife or the syringe.

Technical Aspects of Writing & Editing

In February 1980, the British Medical Journal lamented that a large number of papers submitted for publication had to be rejected out of hand, many for technical reasons including major faults in presentation. In a fascinating article entitled "The Birth of a Paper", Dr. Alex Paton, Consultant Physician at Dudley Road Hospital, Birmingham, analyses and rewrites in detail a scientific paper submitted to the British Medical Journal for publication. The final rewritten and "polished" form of the paper is published in the same issue. This exercise in editing should be compulsory reading to all potential authors and amateur biomedical editors.

Dr. Stephen Lock, the Editor of the British Medical Journal has very kindly offered to send to this part of the world, at a mutually convenient time, a small team of specialists, led by himself, to organise a "biomedical writing and editing" seminar on quite an elaborate scale, provided there are enough support for the venture. If it is to be viable financially, it will have to be made available to other centres of the region namely, Hong Kong, Malaysia, Indonesia and the Philippines.

An opportunity like this should not be missed and it is worth while to make strenuous efforts to welcome such a visit which will help to upgrade the standard of biomedical journalism in this region.

Book Reviews

For various reasons, two of which are circulation numbers and readership markets, book reviews in local biomedical journals are limited. International publishers rarely send their new books written by authors with international reputation to "domestic" journals unless there is some special reason for doing so.

To stimulate the interest of readers, the editor may direct the review of an important and well-written book in his biomedical journal. He may also employ book-reviewing as a method of soliciting articles from talented writers who would not otherwise have voluntarily contributed to the journal. These two ways of book reviewing have been successfully tried out in the Singapore Family Physician.

Book reviewing is a specialised technique and a general practitioner reviewer must always bear in mind these very instructive lines by Pope taken from "The Dunciad":—

"The critic eye, that microscope of wit,
Sees hairs and pores, examines bit by bit;
How parts relate to parts, or they to whole,
The body's harmony, the beaming soul,
Are things which Kuster, Burman, Wasse shall see
When man's whole frame is obvious to a flea".

A Plea for Standardisation of Chinese Authors' Names

The standardisation of Chinese Authors' Names in biomedical journals is long overdue. In any list of references and bibliographies attached to bio-

medical journals published locally or internationally, Chinese Authors' Names are quoted under a multitude of systems.

A Hong Kong based regional medical journal lists the five Singapore Editorial Representatives under four different systems. Even in the Chinese Medical Journal (printed in English) there is no unanimity in the usage of authors' names.

It may be the inconsistent way the Chinese authors use their names which has contributed to the confusion. This is further aggravated by the following difficulties:—

1) the inheritance of two surnames or more correctly speaking a surname with duplex characters,
2) the inheritance of only one name or a single Chinese character,
3) the use of initials in place of the name or names,
4) the addition of an English Christian name or names,
5) the unconventional way of putting the names before the surname or surnames,
6) the unconventional way of putting initials before the surname or surnames,
7) the use of a hyphen between the two names; and
8) the practice of joining the two names without the hyphen, a practice which is prevalent in Chinese Medical Journals.

It goes without saying that if one has to permutate from eight or more items, the possibilities are utterly confusing.

Singapore as the centre of medical excellence must consider it a matter of urgency to convene a meeting solely for the purpose of standardisation of Chinese Authors' Names in biomedical journals. The consensus of this convention will lead to the acceptance of "Uniform requirements for Chinese Authors' Names submitted to biomedical journals".

Readers' Correspondence

The section devoted to readers' correspondence in a biomedical journal plays an important part in its success. They reflect the digested reaction to the scientific articles published. They offer fresh points of views, opposite views or confirmatory views. In short it is here that intellectual arguments take place. The British Medical Journal and the Lancet would lose a great deal of their interest and merit without their excellent correspondence sections.

Correspondence in our biomedical journals does not appear to be a tradition. Most of the time, most doctors are either too reticent to agree or too polite to disagree.

It must be pointed out that it is not a personal affront to disagree. Samuel Johnson realised the resistance of the ego to contradiction or criticism when he wrote:—

"those who break out into fury at the first attacks of contradiction, or the slightest touch of censure, conceive some injury offered to their honour, some antient immunity violated, or some natural prerogative invaded..."

He considered this attitude essentially irrational.

Obituaries

Obituary notices as a mode of writing are not popular with our local medical writers. They are seldom found in our biomedical journals. The occasional obituary which appears is more often the product of editorial insistence than a spontaneous literary outflow of grief or loss. This is indeed regrettable.

Writing an obituary is as challenging as writing a medical article. Twenty years after writing a medical article, the author may regret what he has written. This is because medical concepts often change with time. Death is of course unchangeable.

I don't believe that Singapore doctors have the gift of immortality. Psalms 89:48 reminds us: "What man is he that liveth, and shall not see death?" I also don't believe that they don't die often enough or in numbers so deficient that they cannot occupy at least a small portion of the obituary page.

The British Medical Journal takes great pride and trouble over the section devoted each week to obituary notices. This is certainly not a case of morbid or pathological curiosity.

The obituary page is a roll of honour — the honour accorded to a medical doctor who had spent the prime of his youth preparing himself for a profession which demanded the prime of the rest of his life. It is but a modest and worthy record of his transit to a higher calling.

Alexander Pope immortalised Sir Isaac Newton when he wrote:—

"Nature and Nature's laws lay hid in night.
God said, Let Newton be! and all was light."

The obituary is a notice of conclusion. In deference, let me give you notice of my remarks in conclusion.

Conclusion

If I have covered the natural features of my subject more than I have revealed them, I take comfort in the knowledge that concealment sometimes attracts more than revelation. The imagination is far more strongly excited by subtle hints

than by vulgar exhibition.

At the end of an oration, it is not unusual to address the new Fellows and Diplomate Members of the College. In keeping with the literary talents of the late Dr. Sreenivasan, it is not out of place to offer them these lines from Pope, taken from "An Essay on Criticism":—

"But where's the man who counsel can bestow,
Still pleased to teach, and yet not proud to know?
Unbiass'd, or by favour, or by spite;
Not dully prepossess'd, nor blindly right;
Though learn'd, well-bred; and though well-bred, sincere;
Modestly bold, and humanly severe;
Who to a friend his faults can freely show,
And gladly praise the merit of a foe?
Bless'd with a taste exact, yet unconfined;
A knowledge both of books and human kind;
Generous converse; a soul exempt from pride;
And love to praise, with reason on his side?"

One of the very few Singapore doctors who fits that description was undoubtedly the late Dr. B.R. Sreenivasan. Let me urge the Fellows and Diplomate Members of the College to strive to excel where he had excelled and to strive to achieve what he had achieved.

Sixth Convocation & Dinner and Third Sreenivasan Oration

A convocation ceremony is always a solemn occasion. It is usually attended with pomp and pagaentry to mark the award of honours to those who have distinguished themselves either in the examinations or in their service to the College.

If you have at the same occasion another very important event in the College calendar – namely the delivery of the prestigious Sreenivasan Lecture, and follow this by the annual College dinner and dance, all on the same night, then there is every likelihood that Murphy's Law – (if anything can go wrong, it's sure to go wrong) will once again prove itself to be infallibly right.

That this was not the case on the night of 16.11.80 at the Shangri-La was due to the good organisation of the team under Dr Tan Tian Cho. Everything proceeded smoothly and there was no visible hitch to the whole ceremony. The College Councilors looked resplendent in their gowns as they solemnly walked down the centre passage-way in a hall filled to capacity. Despite the inconvenient hour that guests were asked to assemble to witness the occasion, it was very heartening to note the number of people present who took the trouble to come early for the ceremony.

The Convocation ceremony began with the President's message, and although short and pithy, the message he gave was loud and clear and that was that the Government should do all it could to help in the training of primary care physicians.

No Convocation ceremony would ever be complete without the conferring of honours to those who have rendered yeoman service to the College. Two Presidents of the College were so honoured, the incumbent President Dr. V.L. Fernandez, and the immediate past President Dr. Wong Heck Sing. Both Dr. Lee Suan Yew and Dr. Koh Eng Kheng were honoured for their work on the various committees in which they served.

Although one would like to see more members receiving the diplomate membership, there is never a dearth of candidates albeit the successful ones are not so many. The diploma of the M.C.G.P. was awarded tp Dr. Chow Yeow Ming, Dr. Hia Kwee Yang and Dr. Loo Choon Yong and they deserve our heartiest congratulations.

This year lady medical students did better than their male counterparts in the yearly general practice examination for medical students. Miss Ivy Lim Swee Lian and Miss Esther Tay Lay Suan were popular winners of the 1st and 2nd book prizes respectively, and Mr Cheong Tuck Hong not to be completely outdone by the ladies came in third.

An institution of postgraduate medical learning like the College of General Practitioners cannot function effectively but for the help and co-operation of our colleagues in the other branches of medicine. It was fitting therefore that they should be honoured for the help they have rendered and certificates of appreciation were given to Prof. Chia Boon Lock, Prof. Lim Pin, Dr. Poh Soo Chuan, Dr. V.S. Rajan, Dr. Tan Bock Yam, Dr. Tan Cheng Lim, Dr. K. Vellayappan and Prof. Wong Poi Kwong for their goodwill and co-operation.

The main highlight of the evening was of course the Sreenivasan Oration, and Dr. Leong Vie Chung did not disappoint his rapt audience. It was good to see Mrs. Sreenivasan present at the occasion to commemorate the memory of her late husband, whose good work has always been a source of inspiration to us all.

Dr. Leong's oration (printed elsewhere in this journal) was masterfully delivered. There was no bawdiness but a subtle humour which kept the interest of the audience alive throughout his talk. His subject on medical publications was a particularly apt one in the light of his experience in the field. It was good that he drew attention to the lamentable fact that students versatile in the arts subjects seem to have a hard time securing entrance to the medical course. For some reason or other best known to themselves the powers that be have decreed that only cold calculating scientists make the best doctors!

The evening was rounded off with a very successful dinner and dance in the adjoining hall. The Chinese food was good and the music provided by Theresa Khoo and her band kept the evening pleasant with old time favourites.

The Sixth Convocation and Dinner of the College was not only an academic occasion to remember, it was a social success as well, as those who attended and enjoyed themselves will readily testify.

E.K. Koh

Looking at death

Dr. Chan Swee Mong MBBS, MCGP(S)
Dr. Lim Choe Lan MBBS

INTRODUCTION

The care of the terminally ill and dying patient as well as the duty of death certification are two very important responsibilities of the family physician. We studied all our registered patients who had died between the period May 1974 and July 1980. These deaths could be conveniently divided into two groups. The first group consisted of all known deaths which were either personally certified or certified by other registered medical practitioners and the second consisted of only deaths which were personally certified. These two groups of deaths formed the basis of our present study.

OBJECTIVES

Our objectives were:—

1) to define the age and sex distribution of deaths in the sample,
2) to ascertain the causes and circumstances of "young" deaths (defined as those who died below 40 years of age),
3) to classify the causes of death into basic pathological entities,
4) to highlight some of the differences between male and female deaths with regard to the major causes of death.
5) to compare our findings with those of a hospital survey[1] and the annual report of the Registrar of Deaths[2] and
6) to discuss the role of the family physician in death certification and the manner his services are utilised by the terminally ill or dying patients and their families.

MATERIALS & METHODS

We studied:—

a) the clinic record cards of all patients who had died,
b) the death certificate duplicates and
c) the relevant newspaper reports of deaths of our registered patients.

We also interviewed family members, relatives or neighbours of all our deceased patients to obtain the circumstances of their deaths.

RESULTS

1) **The Age & Sex Distribution of Deaths in Our Sample**

These are summarised in Table 1 and Table 2.

Table 1
Age and sex distribution of all known deaths (May 1974 to July 1980)

Age Groups (years)	Male		Female	
	Number	%	Number	%
1 – 9+	1	5.95	2	11.5
10 – 19+	1		2	
20 – 29+	2		1	
30 – 39+	1		2	
40 – 49+	5	5.95	2	3.3
50 – 59+	9	10.70	4	6.5
60 – 69+	29	34.50	11	18.0
70 – 79+	19	22.60	19	31.2
80 – 89+	15	17.90	14	23.0
90 – 99+	2	2.40	4	6.5
Total	84	100.00	61	100.0

It is apparent from Table 1 that mortality risks increase significantly with increasing age groups. Young deaths comprise only 5.95% and 11.5% of total male and female deaths respectively. The

Table 2
Age and sex distribution of personally certified deaths (May 1974 to July 1980)

Age Groups (Years)	Male		Female	
	Number	%	Number	%
1 – 9+	Nil	0	Nil	3.8
10 – 19+	Nil		Nil	
20 – 29+	Nil		Nil	
30 – 39+	Nil		2	
40 – 49+	3	4.9	1	1.9
50 – 59+	6	9.8	5	9.4
60 – 69+	21	34.4	6	11.3
70 – 79+	15	24.6	16	30.2
80 – 89+	15	24.6	20	37.7
90 – 99+	1	1.7	3	5.7
Total	61	100.0	53	100.0

greatest mortality risk for males is in the sixth decade and for females, the seventh decade. Deaths in these two age groups accounted for one-third of total deaths in both sexes. This finding is in keeping with the "life expectancy in Singapore which is 65.1 years for males and 70.0 years for females at birth in 1970".[1] From our figures females appear to live longer than males, 60.7% of females against 42.9% of males live beyond the seventh decade.

In presenting the data in Table 1, we are conscious of the following factors:—

a) the smallness of the sample studied,

b) the inevitability of under-reporting of deaths, since it is impossible to keep track of all patients treated by us and to predict their future outcome,

c) the likelihood of patients changing doctors or seeking hospital admissions without reference to the attending general practitioners,

d) the failure in communication between hospital doctors and private practitioners e.g. a patient being certified dead in hospital without the attending general practitioner knowing of it and

e) the absence of statistics relating to the age, sex and racial composition of the people staying in the area of the authors' practice.

In this study, race was not taken into consideration since there were only 4 Malay deaths representing only 2.81% (4 out of 145) of total deaths in a predominantly Chinese suburban community.

It is interesting to note the paucity of young deaths in Table 2. We note that in the 1978 Registrar of Deaths Report, the percentage of young deaths in Singapore was 16.6% (2002/12,065). In a study on hospital deaths, Chan et al[1] found that young adult deaths (which he defined as those dying above the age of 10 years but below the age of 40 years) accounted for 13.2% (128/973) of total deaths in a Singapore hospital medical unit during the period 1972 to 1973.

2) **Young Deaths**

We reviewed all twelve of our young deaths. The results are tabulated in Table 3.

Table 3
A summary of Young Deaths (May 1974 to July 1980)

Type of cases	No. of deaths
Acute Hospital Admissions	3
Emergency Cases	3
Died at Home	3
Police/Coroner's	2
Unknown	1
Total	12

On the paucity of young deaths in our sample, we would like to make the following comments:—

a) There is a preference for direct hospital admission by our patients or members of their families. Three patients bypassed us when they became seriously ill and sought direct admission into the hospitals themselves. The circumstances are worth recording. The first patient was a 26 year old thyrotoxic female who became comatosed at night; the second was a 26 year old male epileptic who had a fall at home and the third was a 3 year old girl who took a turn for the worse while under treatment for "cough and cold".

b) A greater readiness by general practitioners to refer seriously ill or emergency cases to hospital. However, in the three cases classified as "emergency cases", deaths occurred because medical

assistance was not summoned in time. Those who died included an 18 year old Malay boy who suffered from status asthmaticus for 3 days!: a 3 month old baby with respiratory failure from pneumonia and a 4 year old girl with fits and cyanosis. The last case was said to have been ill for some time according to the evidence of neighbours.

c) Care of the Terminally Ill at Home. Patients in this category are those who had been discharged from hospitals as incurable, mostly suffering from malignancies. Gerenal practitioners are approached by members of the family to "oversee" the remaining days of dying patients' lives. Two of our cases came under this category. A 34 year old man was dying of terminal cancer of the tongue and a 36 year old female had advanced cervical cancer. Both these patients had received intensive hospital treatment to no avail. It is sad to record that one death resulted from the wrong notion[3] that traditional medications are more effective for "Moh Tan" which is the local label for pyrexia of unknown origin. A 34 year old female was treated by us for influenza. In her haste to get better quickly, she turned to a "sin-seh" for treatment. We do not know what subsequently ensued. Twelve days later her husband turned up to report her death and sought assistance from us for death certification. This case brings up the point that doctor-hopping acts to the disadvantage and detriment of patients. More so when the next doctor consulted is not even a registered medical practitioner.

d) Coroner's Cases. It goes without saying that young deaths could result from road accidents, suicides and drug or chemical poisonings. These deaths are always investigated by the police and come under the jurisdiction of the coroner. Our records showed one patient, a 29 year old male scooterist who died in a road accident and an 18 year old girl who committed suicide by jumping from a highrise appartment. Both these cases were reported in the local newspapers.

3) **Classification of Major Causes of Deaths**

From the clinical data recorded in the death certificates, we analysed and classified the major underlying causes of deaths in our sample. These are summarised in Table 4.

Our table indicates that there are major differences between male and female patterns of death. In our sample, male deaths from respiratory (including pulmonary tuberculosis), malignant and cardiac conditions accounted for 68.9% of total deaths; female deaths were more likely the result of cerebro-vascular accidents (strokes), senility and malignancies. In both male and female deaths, "other causes" appeared to be fairly similar.

Table 4
Classification of Major Underlying Causes of Deaths

Underlying Causes of Deaths	Male		Female	
	Number	%	Number	%
Respiratory (Including PTB)	15	24;6	1	1.9
Malignancies	14	23.0	8	15.1
Cardiac	13	21.3	4	7.5
Cerebro-vascular Accidents (Strokes & Complications)	7	11.5	18	33.9
Senility	6	9.8	15	28.3
Others (e.g. 'flu, P.U.O., diabetes mellitus, etc.)	6	9.8	7	13.3
Total Deaths	61	100.0	53	100.0

The major causes of death as tabulated in Table 4 are commented upon below:—

Respiratory Deaths (including pulmonary tuberculosis)

These are summarised in Table 5.

Table 5
Deaths from Respiratory Causes as given in the Death Certificates.

Type of Respiratory Disorder	No of Males	No of Females
"C.O.L.D." (bronchitis, emphysema, asthma)	8	Nil
Chronic Bronchitis	3	Nil
Pneumonia	1	1
Advanced PTB	3	Nil
Total Respiratory Deaths	15	1
Total Deaths	61	53

C.O.L.D.: Chronic Obstructive Lung Disease

Table 5 indicates:—

a) that no female had died from chronic obstructive lung diseases or pulmonary tuberculosis Only one death was recorded as primary pneumonia whereas two deaths were recorded as secondary pneumonia which were secondary to hypertensive heart failure and stroke respectively. Since the latter two conditions were not the direct causes of death, they could not be included in the classification.

b) that three males died from active and advanced pulmonary tuberculosis indicating that this disease is still a serious public health problem. These three deaths represented 2.63% of total deaths in our sample and coincidentally came very close to the overall Singapore figures for 1977 and 1978 (see Table 6). There were also three other patients who had a past history of pulmonary tuberculosis which had responded to treatment.

Table 6
TB deaths as a % of total Deaths

	Hospital Survey 1 1972/73	Our Study 1974-1980	Overall Registrar of Death Reports 1977	1978
All TB Deaths	13	3	340	318
Total Deaths	973	114	11,955	12,065
Percentage	1.34	2.63	2.84	2.64

c) the term "C.O.L.D." or chronic obstructive lung disease should be avoided whenever a diagnosis of chronic bronchitis, emphysema or bronchial asthma could be made. This distinction is of importance statistically. It also demands a more discriminating approach to the certification of respiratory causes of death. The term "C.O.L.D." should be reserved to describe:—

i) any severe **end-stage** pulmonary disease where all three elements of bronchitis, emphysema and asthma are interlocked and

ii) in special practice situations when the cause of death has to be certified post-mortem — a term used in the sense "after death" rather than the meaning of autopsy. In such cases, certification as to the cause of death has to be made on the basis of the patient's past medical history or on any information the general practitioner could obtain from the deceased's family with regard to his social, occupational and cultural practices.

d) a regrettable defect in this study is the incomplete documentation of social and occupational histories which would have given a greater significance to our analysis. Details on cigarette smoking for example were not mentioned in the histories. We could only confirm that there were 2 opium addicts and 2 heavy cigarette smokers in our sample of 61 male deaths.

Table 7
Comparative Studies of % of Cancer Deaths out of Total Deaths

	Hospital Survey, [4]Chan et al" 1974, 1975	Our Survey (1974-80)	Overall Datas from Register of deaths. 1977	1978
Total Cancer Deaths	111	22	2,326	2,415
Total Deaths	886	114	11,955	12,065
Percentage	12.5	19.3	19.5	20.0

Malignant Deaths

In our sample, cancer deaths were rated the second and the third commonest causes of death in males and females respectively. In Table 7, we compared our findings with those of other reports. We were pleasantly surprised that our average finding of 19.3% is in keeping with those of the national figures of 19.5% and 20.0% for 1977 and 1978. The different types of cancer which afflicted and caused the deaths of our patients are shown in Table 8.

We reproduce in Table 9 the figures quoted by Dr. A.J. Chen who presented a paper at the symposium of the National Health Campaign 1979 showing the 5 major types of cancer deaths in Singapore. The distribution pattern of malignancies in our sample is not valid because the numbers in it are too small to be reflective.

We correlated the number of lung cancer deaths with the number of all cancer deaths in Table 10. Our figures suggest a 41% relationship which is about twice the national average. We attribute this to the high selectivity of our cases since 90% of them were actually discharged hospital patients who had been let home to die graciously.

In Table 11 we studied the age distribution pattern of the 9 patients who had died from lung

Table 8 Malignancies — A Distribution Pattern		
Type of Malignancy	**Males**	**Females**
Cancer (Ca.) Lung	8	1
Ca. Stomach	2	2
Nasopharyngeal Cancer (N.P.C.)	0	2
Ca. Cervix	0	2
Ca. Larynx	1	0
Ca. Ethmoid	1	0
Ca. Pancreas	1	0
Ca. Bladder	1	0
Ca. Liver	0	1
Total No. of Deaths	14	8

cancer. The high risk age groups were the 60+ and the 70+. We pointed out earlier that elderly males were a highly susceptible group to pulmonary tuberculosis. We feel that it is useful to mount a lung cancer detection programme with special reference to the elderly, the heavy smokers, those with a chronic history of respiratory complaints and those with vague symptoms of ill health. We find it hard to understand the reluctance and resistance of the elderly citizens to submit to routine chest radiography when this procedure is simple and totally devoid of pain.

Cardiac Deaths

These are summarised in Table 12. This table shows that male deaths exceed female deaths from acute myocardial infarction in the ratio of 8 to 1. In a study on hospital coronary deaths, Dr. B.L. Chia[5] found the ratio to be 4.5 to 1 (327/73). Our table also indicates that deaths from heart failure due to various causes do not seem to have a great male:female disparity. Hypertension as an important contributory cause of death is clearly shown in our table being responsible for 46.2% (6/13) and 75% (3/4) of male and female cardiac deaths respectively. We encountered no diabetes mellitus in any of our patients who suffered cardiac deaths.

Lim et al[6] found that the most commonly encountered risk factor in cardiac deaths was cigarette smoking (67% of their patients), while hypertension and diabetes mellitus were present in only 23% and 25% of cases respectively. Also, significant hyperlipidaemia was not common in their patients.

Table 9 Common Sites of Cancer Cases Diagnosed in 1973-1977. (from Dr. A.J. Chen's article)					
Male			**Females**		
Site	**No.**	**%**	**Site**	**No.**	**%**
Lung	1,923	22.5	Breast	839	13.6
Stomach	1,213	14.2	Cervix	670	10.9
Liver	972	11.4	Lung	664	10.8
Naso-pharynx	660	7.7	Stomach	605	9.8
Oesopha-gus	476	5.6	Colon	428	7.0
All Cancers	8,553	100.0	All Cancers	6,157	100.0

Table 10 Percentage of lung cancer deaths out of total cancer deaths				
	Hospital Mortality Survey, Chan et al[4] 1974-1975.	**Our Study 1974-1980**	**Overall Figures, Register of Deaths Singapore**	
			1977	**1978**
Total Lung Ca. Deaths (M + F)	33	9	508	520
Total Cancer Deaths (M + F)	111	22	2,326	2,415
Percentages	29.7	40.9	21.8	21.5

Cerebro-vascular Deaths

In Table 13, we tabulated the effects of age, sex and the concomitant presence of diabetes mellitus

Table 11 Age Distribution of Lung Cancer Deaths	
Age Groups (in years)	**Number**
50+	*1
60+	5
70+	2
80+	1
Total Deaths	9

(*1 female only)

Table 12 Age and sex distribution of cardiac deaths with related causes.						
Type of Cardiac Deaths	**Males**				**Females**	
	Age Groups				**Age Groups**	**Total M/F**
	50+	**60+**	**70+**	**80+**	**70+**	
A) ACUTE MYOCARDIAL INFARCTION (AMI)	4	1	1	2	1	8/1
Previous AMI	2	–	–	–	1	
Hypertension	3	—	–	–	–	
Other/Related Causes	–	'flu	–	–	IHD	
B) HEART FAILURE	–	3	1	1	3	5/3
Hypertension	–	3	–	–	3	
Had stroke before	–	1	–	–	1	
Other/Related Causes	–	–	–	–	1 (Pneu-monia)	

and hypertension on males and females who died of cerebro-vascular accidents (cva). We note that young cva deaths i.e. those in the 4th and 5th decades are invariably associated with hypertension. Our three patients, 2 females and 1 male, had hypertension and all died following a second stroke.

Senile Deaths

We noted previously that senile deaths were the second most common cause of death in females. In males, it ranked fifth. Senile death unlike other causes of death is an imprecise term and can only be made after excluding the major causes of death. Table 14 shows male and female senile deaths with concomitant illnesses and complications.

4) **Male and Female Deaths & their Differences**

We have demonstrated in our cohort of deaths a male predominance in deaths from respiratory diseases, carcinoma of the lung and acute myocardial infarction. The leading causes of death in females are cerebrovascular accidents (33.9% against 11.5% for males) and senile deaths (28.3% against 19.8% for males).

5) **Comparative Studies**

We compare our findings with those obtained by Chan el al[1] from their review of death cases in a Singapore hospital medical unit. Table 15 is reproduced from figures quoted in their article and adjusted for the purpose of comparison with our own figures. The following comments are made:—

i) Chan et al[1] had suggested that "cancer deaths are probably under-estimated" in his survey when compared with Singapore figures as "many of the cancer patients die at home". Our figures apparently confirms this suggestion. Family physicians do play an important role in the management of patients with terminal cancer.

Also the percentage of cardiac deaths is much higher in the hospital survey as expected since this medical department is well-known for its coronary care facilities.

ii) General practitioners like their hospital colleagues treat a fair proportion of patients with cerebro-vascular accidents, malignancies, chronic respiratory and cardiac conditions thereby making a significant contribution to a better utilisation of expensive bed-spaces and facilities in our general hospitals.

iii) Senility, a common cause of death in family practice, is unheard of in hospital practice. Senile patients are certainly not ill enough to merit admission into our general hospitals nor are there enough beds in aged sick homes to cater for them. Many of these senile patients have severe behavioural and physical debility problems e.g. constant shouting and crying, incessant demand for attention, falling at home with bleeding lacerations, urinary and bowel incontinence and feeding problems. Their wives and children are terribly harrassed and so are their family doctors. Many

Table 13
The effects of age and associated diseases or complications on Female and Male Cerebro-vascular accident (CVA) deaths.

	Females							Males			
	Age Groups							Age Groups			
	40+	50+	60+	70+	80+	90+	TOTAL	50+	60+	70+	TOTAL
No. of CVA Deaths (1)	1	1	2	5	7	2	18	1	3	3	7
No. in Table 2 Sample of same Age group (2)	1	5	6	16	20	3	51	6	21	15	42
Percentage of (1) / (2)	100	20	33.3	31.2	35	66.7	35.3	16.7	14.3	20	16.7
No. with Hypertension	1	1	–	3	1	–	6	1	–	1	2
Previous CVA	1	1	–	1	–	–	3	1	–	–	1
Diabetes Mellitus	–	1	1	1	–	–	3	–	1	–	1

Table 14
A summary of the clinical findings in Female and Male Senile Deaths.

	Females					Males				
	Age Groups					Age Groups				
	60+	70+	80+	90+	TOTAL	60+	70+	80+	90+	TOTAL
No. Senile Deaths (1)	1	3	10	1	15	1	1	3	1	6
No. in Table 2 Sample of same age group (2)	6	16	20	3	45	21	15	15	1	52
% of (1) / (2)	16.7	18.7	50	33.3	33.3	9.8	6.7	20	100	11.5
No. with Hypertension	–	1	–	–	1	–	–	–	–	–
No. with Diabetes Mellitus	–	1	–	–	1	–	–	–	–	–

Complications:
1 – Bedsores (87 yr)
1 – Dementia (72 yr)
1 – Head injury (67 yr)
1 – Parkinson's (86 yr)
2 – Fracture hip (72 yr & 89 yr)
1 – Old PTB (60 yr)
1 – GE + malnutrition (84 yr)

Table 15
A Comparison of Hospital and our Clinic Mortality Findings

Causes of Deaths Males & Females Combined.	Hospital Mortality Survey Chan et al[1] (1972/73)		Our Study	
	No.	%	No.	%
Cerebro-vascular Accidents (strokes)	222	22.8	25	21.9
Cardiac Causes	361	37.1	17	14.9
Respiratory (including PTB)	153	15.7	16	14.0
Malignancies	110	11.3	22	19.3
Senile Causes	Not specified		21	18.4
Total Deaths in Sample Studied	973	100	114	100

Table 16
Utilisation of Clinic Services by Patients Prior to their Deaths.

Type of Patient who Died	Male		Female	
	No.	%	No.	%
Regular Patients	38	45.2	34	55.7
Death Certification from "Other sources"	22	26.2	15	24.6
Those Dying after ONE house visit only	14	16.7	7	11.5
Those found Dead or Dying at Home	10	11.9	5	8.2
Total Deaths	84	100	61	100

young adults simply do not have the time to look after their aged parents, having to earn their living. General practitioners face a dilemma when they persist in treating and prolonging the lives of their senile patients without being able to rectify the underlying cause which is cerebral atherosclerosis. Neither can they offer any help from the nursing point of view. The problem of the senile patient will continue to be more pressing in the future unless the government can step in to resolve the difficulties. The answer could be community homes for the care of senile patients under proper medical supervision by the state.

6) **The Utilisation of G. P. Services in Death Certification**

In this final part of our paper, we studied the clinic record cards of all patients who had died to see how our services have been utilised. The results are tabulated in Table 16. Four patterns are discernible.

a) **Regular Patients**

It is satisfying to note that about 50% of patients who had died were our regular patients. Could we take this as a "popularity index" of the doctor in so far as his patients are concerned? It is indeed comforting that a patient or his family would still care to seek the services of his family doctor for succour and relief in the remaining days of his life. This is one aspect of medical practice denied to hospital doctors.

b) **Death Certification from Other Sources**

This group accounts for about 25% of deaths in our table. Death certifications in these cases were performed by fellow medical practitioners in the same area of practice or by hospital doctors in the case of those who were admitted and subsequently died. Some of our regular patients also come under this group. There are many reasons for doctor-hopping; inability to get along with the doctor; the feeling that the medications prescribed have had no effects; inability to pay the fees, etc.

c) **Those dying only after one visit**

About 10-15% of our patients who died come under this category. Many come from the lower socio-economic group and they are usually elderly and very ill with terminal cancer, post-stroke complications, diabetes mellitus, etc. They must have found it pointless to continue further treatment and follow-ups at hospitals and outpatient clinics. The family physician is often called in with the request to make the dying patients as comfortable as possible before death takes its course. Moreover there is the all important matter of death certification.

d) **Those Found Dead or Dying when Seen**

12% of our dead patients were already dead or near-dead when seen for the first time in their homes. Many in this group had been patients of government hospitals, outpatient clinics or other

GP's clinics. In many instances, elderly patients who apparently enjoyed good health had been found dead in bed by their relatives. To certify the cause of death in such cases is really a dilemma. There are often no clues and the Registrar of Deaths would certainly reject the death certificates if the cause of death had been described as "cause unknown – found dead in bed".

SUMMARY

Death is said to be the end of life. This may be true of those who are dead. The general practitioner, however, looks at death not as an end but really as a beginning to learn more about its causes and circumstances. We are not suggesting that our findings are representative of the national figures in terms of mortality risks. We were curious to know how our patients died, where and in what manner they differed from deaths in a hospital or from the national statistics of death. We have satisfied our curiosity with this study.

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Anxiety neurosis and other neuroses

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ANXIETY

ANXIETY

- NORMAL ANXIETY – (physiological) – universal experience
- PATHOLOGICAL ANXIETY – as a symptom of an underlying disorder – organic or functional

NORMAL ANXIETY:

basic human reaction essential for survival

prepares the person for "fight or flight" (Hans Selye)

therapy not required

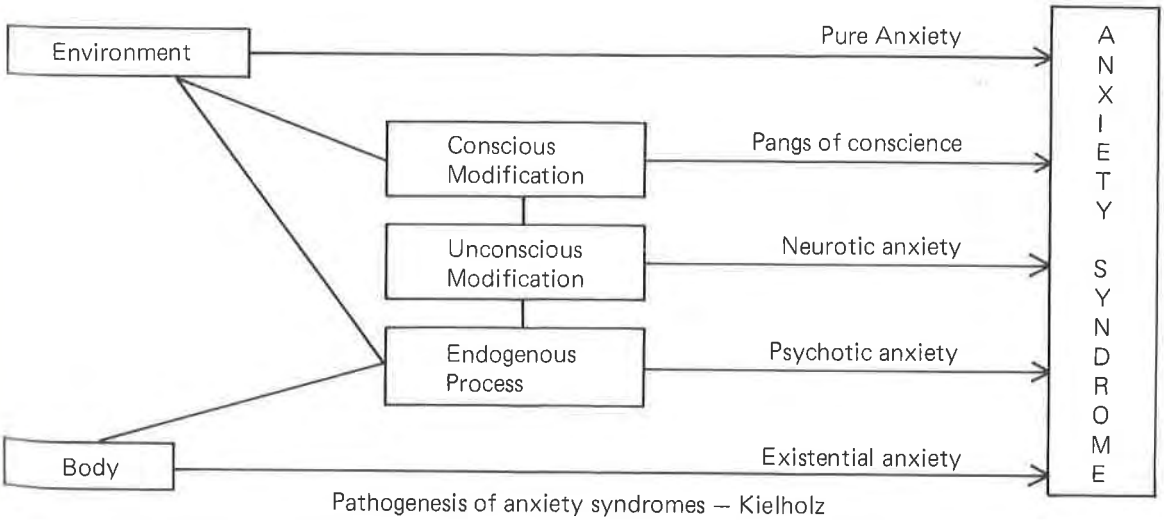
PATHOLOGICAL ANXIETY:

ANXIETY without adequate cause and which persists without good reason

– intensity – disproportionate to the amount of stress

– duration – prolonged, persistent in absence of stress

– severity – interferes with the person's normal functioning and efficiency



Pathogenesis of anxiety syndromes – Kielholz

Pathogenic Classification of Anxiety (Kielholz)

Anxiety states of organic origin – cardiac insufficiency, angina pectoris, myocardial infarction, pneumonia.

Anxiety states of toxic origin – toxic psychosis, alcohol, amphetamine, LSD, endocrine disturbances.

Anxiety states in involutional melancholia) Psychotic
Anxiety states in endogenous depression) Anxiety
Anxiety states in schizophrenia)

Anxiety neuroses)
Anxiety processes) Psychogenic Anxiety
Anxiety reactions)

Pure anxiety due to environment causes – actual threat imaginary.

Some Common Mechanisms of Coping with Anxiety:

The individual has a number of coping mechanisms to alleviate anxiety – to protect himself against trauma and maintain his self-esteem.

These coping mechanisms not only reduce tension which helps to maintain equilibrium but also aids in adaptation.

Everyone of us uses it to some extent.

These are commonly known as defence mechanisms – mental mechanisms.

They do not resolve the conflicts or solve problems.

When used excessively by individual – may become part of the individual's habitual pattern of adaptation and may be abnormal – may work against his best interests.

They prevent him from facing reality, from adopting problem-solving methods.

Knowledge of defence mechanisms provides better understanding of dynamics of anxiety.

Repression:

Process by which unacceptable, unmanageable experiences, feelings, ideas, acts or needs are excluded from consciousness.

They are considered painful, dangerous and best forgotten.

They are pushed deeply into the unconscious part of the mind.

To keep them unconscious requires a lot of energy, e.g., Hysterical Amnesia.

Denial:

Of reality.

Closely related to repression. Some awareness present.

Common example, denial that a loved one is dying

denial that one's marriage is failing

Rationalization:

Helps to justify our beliefs and our actions.

To excuse one's failures, disappointments – make painful experience more acceptable.

"Sour grapes", "sweet lemon" varieties used by everyone.

Reaction Formation:

Sometimes we protect ourselves from dangerous desires by not only repressing them, but actually developing conscious attitudes and behaviour patterns diametrically opposite.

Intellectualization:

The individual turns unacceptable or painful feelings and needs into intellectual activities or discussion.

Projection:

(a) Transfer the blame for our shortcomings, mistakes and misdeeds to others.

(b) Attribute to others our own unacceptable impulses, thoughts and desires.

Displacement:

Process by which feelings are shifted from the original object or person, to another; usually a discharge of strong feelings to a more neutral or less dangerous object.

Sublimation:

Unacceptable needs, desires, impulses are directed into socially approved activities.

Regression:

A process in which the individual returns to a more immature or infantile mode of feeling and behaviour.

THE NEUROSES

Disorders characterised by anxiety which dominates the clinical picture.

Different Diagnoses of a Neurosis:

1. Organic Illness:
   - Thyrotoxicosis
   - Heart disease

- Gastro-intestinal disease
- Neurological disorders, phaechromocytoma

2. Psychosis
   - Manic-depressive – anxiety symptoms appearing for the first time in middle aged or elderly – usually is due to depressive illness
   - Schizophrenia
3. Personality Disorders:
   - Drug addiction
   - Alcoholics, psychopath, delinquents.

Classification of Neuroses:

1. Anxiety reaction
2. Phobic reaction
3. Hysteria
4. Obsessive compulsive neurosis

1. ANXIETY REACTION

Predominant symptom – anxiety extending to panic

Patients complain of being nervous, anxious, tense, irritable, worried, "on edge", "highly-strung"

Anxiety is free-floating.

Onset – sudden or insidious

Acute attacks may occur without warning, more often with background of chronic anxiety. Environmental problems may or may not be present as precipitating factors.

Somatic symptoms:

Palpitations, pains in chest, headaches, respiratory difficulties

Dizziness, weakness, faintness.

Gastro-intestinal symptoms, epigastric pains, gas.

Panic:

Apprehension – fears he may drop dead

Signs and Behaviour:

Very commonly, in severe cases the signs are obvious,

Restless, pacing the floor.

If he is seated, he is fidgety, moves his arms and legs restlessly; complains about his inner turmoil

Pulse – fast, slightly elevated BP – transient.

Fine tremor of hands

In patients with less degree of anxiety – same symptoms, less severe.

CAUSES

Psychological:

Anxiety neurosis is due to the failure in the normal defence mechanism, such as repression to deal with the anxiety coming from within, e.g., forbidden impulses over which he is losing control.

Auxilliary defences such as conversion, displacement, regression are called into play and, through which the repressed drives come out in a disguised form – and is expressed in symptoms of hysteria, phobic neurosis, obsessive compulsive neurosis.

In neurotic conflicts: two important drives
- sexual
- aggression

Genetic:

There is constitutional predisposition to anxiety from:–

(1) Genetic endowment
(2) Personality

Such individuals are prone to develop anxiety when under stress.

Physiological Aspects:

Recent experimental findings have indicated that metabolism of the monoamines in the brain, especially in the limbic system, are related to causation of anxiety.

2. PHOBIC REACTION

Characterised by intense fear of an object or situation, which the patient consciously recognises as irrational.

Anxiety is not free-floating as in anxiety neurosis but attached to a specific idea, object, situation.

Onset
- late teens or early adulthood
- sudden onset in relation to the feared object, situation

Severe anxiety – often mounting to panic – precipitated by the specific circumstances. The more common phobias are:

fears of open spaces

fears of closed spaces, crowded places, streets, vehicles

Depending on the severity of the symptoms and the nature of the phobia, the illness can be incapacitating.

It tends to be a chronic disorder with frequent recurrence of symptoms.

Simple phobias of animals, insects are more amenable to treatment.

Treatment of Phobias:

Pharmacotherapy
- Imipramine – panic attacks
- MAOI
- Minor tranquillisers – anticipatory anxiety

Behaviour therapy
- Desensitization
- Implosion – imaginary, full scale anxiety attack
- Flooding – exposure to stimulus
- Assertive and social skills training

Family therapy

3. HYSTERICAL REACTION (HYSTERIA)

The term 'hysteria' is used to denote psychogenic condition that occurs where there is personal gain to patients – unconscious levels.

- an escape from difficulty
- fulfilment of some wish or
- satisfaction of some desire in reality or fantasy

May occur to anyone under severe stress

Predisposition
- both heredity and upbringing
- hysterical personality

Physical factors – head injury, organic illness

Psychological factors – psychological conflicts, stress

Symptoms:

CONVERSION TYPE
- predominates women, early adolescence, young adults

MOTOR DISTURBANCES
- abnormal movements
- paralysis

SENSORY DISTURBANCES
- anaesthesia
- special senses – deafness, blindness
- hallucinations – visual
- pain

Symptoms simulating physical illness
- identification with symptoms of a person with whom the patient has a close relationship

Symptoms complicating physical illness
- pain due to organic illness may continue unabated
- hysterical fits after a true epileptic seizure

DISSOCIATIVE TYPE
- alterations in the patient's state of consciousness or in his identity – leading to amnesia, somnambulism, fugue and multiple personality

Onset
- usually begins suddenly and ends abruptly.

Symptoms may vary – often complex

Somnambulism
- altered state of consciousness
- patient is out of contact with the environment
- stares blindly or with closed eyes
- emotionally upset, speaks excitedly
- followed by amnesia.

Amnesia
- sudden loss of memory for a period of time – few hours to years

Fugue
- altered state of consciousness
- wandering from home
- amnesia for the fugue state

Multiple Personality
- the patient is dominated by two or more distinct personalities
- often one personality is aware of the other's existence.

4. OBSESSIVE COMPULSIVE NEUROSIS

Obsession
- a recurrent or persistent thought, image, feeling, impulse or movement
- subjective compulsion with desire to resist
- foreign to his personality
- good insight

Incidence
- 5% of all neurotic patients.

Social class
- upper and middle classes.

Previous personality
- two-thirds of patients have obsessional traits prior to their illness

Obsessional personality
- is cautious, deliberate and rational in his approach to life and its problems, reason and logic.
- Steady, reliable, conscientious, scrupulous.

– Neat, orderly, tidy.
– Punctual.
– Believes in morals, honesty, justice.
– Also obstinate and stingy.

Obsessional personality – also commonly linked to depressive illness.

Symptoms:

(a) Obsessional thoughts
Rumination

(b) Compulsions – to jump out of window
– to let out his aggressions
– to shout out obscenities

(c) Compulsive acts – handwashing
– rituals in dressing, praying, etc.

Course:

Chronic illness

After 10 years – 15% of patients are well
– 45% improved – symptomatic
– able to work
– 40% unchanged or worse

Prognosis poor if patient has obsessional traits

Treatment:

(1) Drugs – no specific action on the obsessive compulsive symptoms
– mainly to reduce anxiety

(2) Psychotherapy – limited

(3) Leucotomy – in severe cases not controlled by drug treatment
– can reduce the suffering of the patient

TREATMENT OF THE NEUROSES:

1. INSIGHT PSYCHOTHERAPY
   – REQUIRES SKILLED PSYCHOTHERAPISTS.
   – INTELLIGENT PATIENTS WITH DEEP-SEATED CONFLICTS.
2. SUPPORTIVE PSYCHOTHERAPY
   – BY SYMPATHETIC LISTENING, ENCOURAGE VENTILATION
   – EXPLAIN SYMPTOMS, REASSURANCE
3. CHANGE THE ENVIRONMENT
   – TO REDUCE STRESS
4. BEHAVIOUR THERAPHY
   – RELAXATION EXERCISES, BIOFEEDBACK, SPECIAL TECHNIQUES IN PHOBIC REACTIONS
5. PHARMACOTHERAPY
   – BARBITURATES) CURRENTLY OBSOLETE, NOT
   – MEPROBAMATE) SAFE, TENDENCY TO DEPENDENCE
   – BENZODIAZEPINES
     – REDUCES TENSION AND ANXIETY EFFICIENTLY

     DRUG OF CHOICE FOR ANXIETY, STICK TO 2 OR 3 DRUGS YOU ARE FAMILIAR WITH
   – MAOI) EITHER DRUG MAY BE USED
   – TRICYCLIC ANTI-DEPRESSANTS) FOR ASSOCIATED DEPRESSION
   – MAJOR TRANQUILLISERS (NEUROLEPTICS) – USEFUL IN SMALL DOSES
   – B BLOCKERS
     – USEFUL IN CONTROLLING SOMATIC SYMPTOMS SUCH AS PALPITATIONS
     – LIMITED USE

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Psychiatric emergencies, suicide risks, etc.

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PSYCHIATRIC EMERGENCIES

A disturbance of behaviour, affect or thought requiring immediate treatment. They may do harm to themselves or to others.

SUICIDE

Approximately nine per 100,000 in Singapore.

Ten unsuccessful to every one fatal.

World reports 500,000 annually.

High incidence not due to "jet age" or "tensions of civilisation".

Rate now not substantially different from 1900.

Man is unique in ability to suicide.

Untrue that people who threaten do not. Most give warning, often to doctors.

Previously regarded as a heinous offence – crime against society.

State/religion reacts with vengeance (property to be confiscated/excommunication and no last rights sacrament and no hallowed ground burial).

If successful – a lunatic!

If unsuccessful – a criminal!

Early "causes" included reading trashy, romantic novels, faulty education system.

During 1930's a blue ballad "Gloomy Sunday" was banned from radio because it was said to be responsible for a rash of suicide following its broadcasting!

Generally four groups:

1 Those who believe that suicide is a transition to better life or saves reputation (hara=kiri).
2 Old, bereaved, in pain (chronic or terminal illness) – a release.
3 Psychotic – in response to hallucinations/delusions or consequence of depression.
4 Those who kill out of spite, believing that people would mourn them and that they themselves will somehow be around to witness and enjoy their sorrow!

Others include:

a. friendless children with poor impulse control precipitated by minor frustrations or injuries
b. adults escaping from intolerable real life situations associated with loss – of health, loved ones, money, earning power, job, pride, beauty, honour, status (success), independence and friends – also "empty nest syndrome".

Sociological aspects (social integration)

Intimate involvement reduces suicide.

Thus higher – in married without children than with children
non-Catholics than Catholics
in cities and their centres than rurals
amongst divorced and widowed than married

Note: married state and state of war are associated with low suicides, but high homicides!

Age incidence (U.S.A.)

Rare before four

5-14	0.3 per 100,000
15-19	3rd ranking cause of death
College	2nd ranking cause of death (after accidents)
85+	26 per 100,000 (for whites 70/100,000)

Assessment

Attempted suicide – psychiatric appraisal preferred time, expertise, atmosphere

Regarding it as a "gesture only" is a common pitfall.

Grave risk signs

A. The wish to die expressed
B. Presence of Psychosis – impulsive – suspicious – inappropriately fearful – panicky – hallucinated and deluded.
C. Depression with
Guilt – especially over dead relative
Feelings of worthlessness and despondency
Intense wish for punishment
Withdrawal and hopelessness

Extreme agitation and anxiety
Loss of three appetites – food, sleep, sex.

Moderate risk signs

A. Previous attempts – especially without show + violent methods
B. Previous psychosis
C. Suicide note
D. Chronic disease
E. Recent childbirth/surgery
F. Alcohol and drugs
G. Hypochondriacs – concealing depression
H. Advancing age – retirement – menopause
I. Homosexuality
J. Social Isolations
K. Chronic Maladjustment
L. Bankrupt Resources.

PREVENTION

Early recognition and treatment if diagnosed – may be most effective.

Beware of sudden well-being in a previously depressed patient – may be due to feeling of relief at having decided to die.

If you decide to hospitalise a suicidal patient – do not let him go home alone to get ready.

Do not discontinue anti-depressants abruptly.

Man on ledge – use anything he seems to respond – religion, listening, simple attention, warmth, bringing in relatives, friends, priest, etc.

TREATMENT

Hospitalisation – drugs, E.C.T., general help.

THREATENED HOMICIDE

Not uncommon – especially a mother's fear of leaving her children.

If in response to hallucinations/delusions – should be hospitalised.

Most homicides occur in periods of intense excitement, poor judgement and impaired impulse control, so avoid arguments, controversy, alcohol, drugs.

ASSAULTIVE BEHAVIOUR

From fear, anger, hallucinations, delusions and alcohol and drugs.

In approach remember patient may misinterpret a tendon tapper, or any neutral object as a weapon.

Alcohol may mask a psychotic.

MANIA

Grandiosity, boisterousness, defective judgment, overactivity, over-talkativeness leading to a management problem may have brief spells of control – sufficient to shake off arriving police patrol.

As patient is unreliable, history from relatives necessary.

Do not rely upon them to keep promises however sincere and pleading they can be.

Behaviour may harm physically, financially, or socially.

Admit/treatment with drugs as chlorpromazine 100 mg i/m or more.

May require E.C.T.

Lithium carbonate to follow up as maintenance treatment.

DOMESTIC CRISIS

Breakdown in communication usually present and manifest as: physical abuse, alcoholism or arguments with threats of violence or suicide.

Interview together and separately.

Try not to take sides -- at least at the early stages.

Good try to re-establish communications and verbalise grouses rather than act out.

Expose provocative and sabotage behaviour to both parties.

Follow-up – pressure

ACUTE ANXIETY REACTION

Fear of impending disaster.
Fear of loss of control.
Fear of dying.
Accompanied by autonomic nervous system dysfunction.
Minor attacks common.

The worried executive or the harried housewife syndrome.

There is anxiety, hopelessness, depression with inability to cope with situation – be it a promotion not matched with ability or a housewife in distress – recent removal from family/friends to "new towns", child sick, husband at work, etc.

PARANOID SCHIZOPHRENIA

Fear of being harassed from delusions, especially systematized or from hallucinations – may lead to panic states.

Try avoiding the wrath of paranoids in practice.

CATATONIC STATES

The stuporose state simulates coma, meningitis, encephalitis, non-responsive, flexibilitas cerea eyes closed but with eye "betraying" signs, flushed skin.

Can be persuaded to "show tongue".

The excitement state – beware, unpredictable, frequently assaultive.

Bizarre symptoms, grimacing, mannerism, posturing – confused.

POST-PARTUM CHANGES

"Every woman is abnormal".

A few blow up to acute psychosis – danger to child – a serious matter.

OCULO-GYRIC CRISIS

Devastatingly horrifying to relatives.

i/v Congentin – for miraculous cure!

EPIDEMIC HYSTERIA (MASS HYSTERIA)

Sudden mental disorder affecting a group of people.

Laughing, crying and other irrational and bizarre behaviour.

Generally females of low IQ – superstitious, culture-bound.

Schools, hotels, factories.

Exhilirating abandonment with total inconsequentiality.

Isolate, disperse, close down of institution temporarily, if necessary.

Tranquillise and sedate after isolation invariably helps.

Counter-suggestion may be required in form of religious authority eg. bomoh.

HYPERVENTILATION

Anxious patients start off panting in terror. With overbreathing alkalosis sets in from excessive Co2 output – reduction in consciousness, giddiness, blurring of vision, faintness, aggravate terror. Peripheral vasoconstriction uncomfortable, carpopedal spasms aggravate.

Textbook method is to breathe into paper bag – may be brushed away by frightened patient (note fear of suffocation by bag). Reassurances and explanations may not be helpful as patient may not hear above her loud gaspings.

Give i/v valium 10-20 mg slowly in recumbent position.

MANIA-A-POTU or pathological drunkenness

Past history of head injury with intolerance to alcohol leading to extreme violence followed by profound insomnia with almost total amnesia of violence.

HALLUCINOSIS

Mescaline STP,DMT, LSD.

Dilated pupils reactive to light.

Elevated blood pressure.

Hyperactive reflexes, fever.

Tachycardia sweating.

Psychotic reactions associated with perceptual distortions and hallucinations (trips).

May be suicidal or violent.

Treatment: Isolate, sedate, tranquillise – may require hospitalisation if bad trip is extended.

SCHOOL PHOBIA

Can be crippling emergency without apparent reason – refusal to school – when pressured – panics.

Vicious cycle quickly steps in: longer – more social/educational impairments – more difficult treatment.

Avoid "blaming" teacher whose culpability is exaggerated and if provoked aggravates situation.

Seek her co-operation.

Early return to school.

Seek "ally" or most favoured person to accompany.

Ally to stay for reducing periods.

Child to resume school with gradually extended hours.

If phobic try temporary haven in principal's office, etc.

Tranquillisers: short of drowsiness day and night.

KORO

Seen occasionally under emergency conditions.

Variable presentation to physician – chopsticks – strings – bamboo clamps – clutching by patient or others – in panic state fearing inversion of penis (breast, nipples in females) into abdomen – lead to death based on belief in Yin Yang incompatibility – Penis is Yang organ and inside abdomen is Yin region. May occur in epidemics.

Tranquillisation/reassurance including isolating patient from emotionally charged panicky relatives with more intense beliefs.

Lecture given on 8 August 1980, In-Depth Course in Psychological Medicine, College of General Practitioners Singapore.

The bid for the 10th WONCA World Conference

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At the 8th Wonca Conference on Family medicine held in 1978, the Philippine Academy of Family Physicians offered to host the 10th Wonca World Conference (WWC) in 1983. This generous offer was unanimously accepted by the General Assembly then, as it was thought that such a location for a conference of this nature would help promote family medicine as a definite discipline in South East Asia.

Around the middle of 1980, however, as preparations for the 9th WWC in New Orleans, USA, was in its final stages, the Wonca Executive Committee received word from the Philippines Academy that due to unforeseen circumstances, their offer to host the 10th WWC in 1982 had to be withdrawn.

Shortly thereafter our college received a letter from the Honorary Secretary of WONCA requesting us to consider the possibility of hosting the 10th WWC in Singapore. The College Council debated the issue at length and decided that we could offer ourselves as the host for the following reasons:

1. It would place Singapore very favourably as a centre for post graduate medical education particularly in the field of family medicine;
2. It would help the college to strengthen and emphasise the discipline of family medicine as a specialty in Singapore.
3. It would expose the College as a whole and the family practitioners in Singapore in particular to the trends and advances in family medicine in other more advanced countries to a greater degree than if a few delegates from Singapore were to attend the conference in another country;
4. If properly runned an international meeting of this stature would add prestige to the College and
5. Lastly, there is, with proper management, the possibility of the College benefitting financially from the conference.

The acceptance to host the 10th WWC was then communicated to the WONCA executive committee. Before a reply was received from them, the college learned that a few other member countries were also interested to host the 10th WWC namely India, the Netherlands and Australia. This being the case, the interested countries, therefore, had to make bids at the 9th WWC in New Orleans. A Bids Committee was then set up from amongst council members in the college (6 in number) and the committee got down to working out how best to make Singapore's bid successful. The Singapore Tourist Promotion Board was extremely helpful in this respect. Our initial plans were, however disrupted when we received word from the WONCA Ex-Co that audio-visual aids were not permissible during the bid. Audio visual aids could be used, nevertheless, in hospitality suites which bidding countries could take up at their own expense and outside the official times of the 9th WWC. Our enthusiasm to take up a hospitality suite became more acute when it was learned that the Australian College was having a hospitality suite and was giving a cocktail to all heads of delegates on the evening before the day of the voting for the 10th WWC venue (i.e. on Friday evening, 3 October 1980 and the voting to take place on Saturday 4th October 1980).

In oder to maximise our chances of success in the bid, the Bids Committee decided on the following counter moves:

1. that we would likewise take up a hospitality suite at our own expense;
2. that the hospitality suite would be for breakfast on the morning of the Voting Day and that all heads of delegates would be invited.
3. that we would screen a short filmlet on Singapore and its convention facilities as well as tourist attractions (entitled "Come Share Our World") during the breakfast;
4. that we would decorate the breakfast hall with fresh air-flown orchids from Singapore to New Orleans with the help of the Singapore Tourist Promotion Board;

5. that, after the filmlet and during breakfast we would play a cassette-tape interview given by different persons from different parts of the world, giving favourable responses to Singapore as a convention venue.

The measures planned were thought to be sufficient in our attempt to be successful in our bid. It was also decided that for efficiency of the bidding operations and to maximise person-to-person contact in New Orleans, a team of three or more persons be present in New Orleans. With the help of the Singapore Tourist Promotion Board again, we were able to obtain three return-tickets to New Orleans on the S3 category from Pan American World Airways, to whom we are deeply grateful. Besides the President of the College, Dr Victor Fernandez and Dr Wong Heck Sing, four members in the Bids Committee agreed to go to New Orleans to assist in the bid – namely Dr Fred Samuel, Dr Lim Kim Leong, Dr Paul Chan and Dr Alfred Loh. Dr Fernandez and Dr Wong went at their own expenses and the remaining four doctors decided to divide equally the cost of the fourth ticket, in addition to the 3 free tickets from Pan-Am.

All preliminary arrangements for the bid and hospitality suites were made by telex messages and trunk calls to the Marriott Hotel, New Orleans. Dr Fernandez also departed from Singapore a week earlier to arrive in New Orleans with sufficient time to confirm all hall bookings and facilities needed.

The four-man team left later on Thursday, 2nd October 1980 at 7.00 a.m. to arrive in New Orleans on the same day in the evening after travelling non-stop for 32 hours. The next day (Friday 3 October) was spent getting acquainted with as many of the delegates as possible. Singapore made its formal bid in the General Assembly of heads of delegates that afternoon with Drs Fernandez and Fred Samuel giving the reasons and points as to why Singapore should be the host to the 10th WWC.

The hospitality suite and breakfast on Saturday morning went on quite well despite irritating delays and hitches on odds and ends as a result of poor coordination on the part of the hotel management. The fresh air-flown orchids from Singapore (arranged by Singapore Tourist Promotion Board) arrived at New Orleans Airport in time but were not cleared by the Agricultural Control Unit in good time and so never made any appearance at the breakfast hall. All invited heads of delegates were present with their spouses, and we had about 50 guests for the breakfast. The filmlet on Singapore and the taped-interview were well taken and appreciated.

After breakfast and before noon, was a time of anxious waiting as the WONCA Council (consisting of all heads of delegates) met to vote on the venue of the 10th WWC. When the final count was taken, the voting results were as follows:

India	–	2
Netherlands	–	5
Australia	–	6
Singapore	–	15

Singapore, then, had an overwhelming vote of acceptance as the next venue for the 10th WWC. Keeness to attend the 10th WWC was expressed by most of the delegates that the Singapore team had met – this gave us more encouragement in our determination to host a scientifically productive and socially enjoyable conference in Singapore. The Organising Committee for the 10th WWC will have a mammoth task ahead as this would be the biggest medical conference ever to be held in Singapore but with proper planning, systematic approaches and intelligent use of the 2½ years planning time, there is no reason to doubt the success of the Singapore Conference.

Council News

Tenth WONCA World Conference

Council is pleased to announce that the College of General Practitioners Singapore was successful in its bid to host the Tenth WONCA World Conference on Family Medicine. The Convention will be held in April 1983. This is a gigantic undertaking and the College would need the support of all our members and Sister Organizations all over the world to make this Conference an outstanding success.

Eighth College Examination

At the Eighth College Examination held recently the following were successful:
Dr Chow Yeow Ming
Dr Hia Kwee Yang
Dr Loo Choon Yong

They were inducted as Diplomate Members of the College at the College Convocation held on Sunday, 16 November 1980.

The Sixth College Convocation

The Sixth College Convocation was held at the Shangri-La Hotel, on Sunday, 16 November 1980. At this:

Fellowship of the College was conferred on:
Dr Victor L Fernandez
Dr Koh Eng Kheng
Dr Lee Suan Yew
Dr Wong Heck Sing

The Albert Lim Award was presented to Professor Seah Cheng Siang.

Certificates of Appreciation were awarded to:
Prof Chia Boon Lock
Prof Lim Pin
Dr Poh Soo Chuan
Dr V S Rajan
Dr Tan Bock Yam
Dr Tan Cheng Lim
Dr K Vellayappan
Prof Wong Poi Kwong

The College Shield was presented to Mr Toh Kian Chui, one of our staunchest benefactors, for his continued support.

Book Prizes to three candidates who excelled in our GP class examination were awarded to:
Miss Ivy Lim Swee Lian
Miss Esther Tay Lay Suan
Mr Cheong Tuck Hong

The Third Sreenivasan Oration was delivered by Dr Leong Vie Chung. The theme was "Medical Journalism in Singapore".

MEDICAL NEWS

Vegetarians absorb drugs slowly?

Asian vegetarians are at risk of having a slower than normal metabolism of drugs whose action is terminated by oxidation in the liver, say a team of clinical pharmacologists from Stoke-on-Trent, London and Newcastle-upon-Tyne.

Antipyrine is an indicator of hepatic drug oxidising capacity. The finding that vegetarian Asians metabolise antipyrine more slowly than other people indicates that they may be less capable of detoxifying and excreting drugs that are oxidised in the liver, and that therefore these drugs should possibly be given in smaller than average doses.

The deficiency of antipyrine metabolism appears to be of dietary rather than racial origin, associated with a low protein intake, say the authors. Low rates of metabolism were also found in white volunteers fed a low protein diet and in malnourished children. (Lancet 1980, Vol 11, No. 8186, p 151).

Researchers Studying Longterm Effects of Surgical Glue That Could Replace Stitches

London, on – A surgical glue that could replace stitches is being studied at the University of Western Ontario here.

The plastic compound has several advantages over conventional sutures, but will be tested for three years to assess its longterm effects, according to the project's principal investigator.

The material is a liquid derivative of cyanoacrylate, Dr. K. A. Galil, associate professor of medicine and dentistry, told CANADIAN FAMILY PHYSICIAN last month. When it comes into contact with moisture from the skin, the liquid hardens into a plastic film. When applied to an incision, blood coagulates on the spot and wound edges are held together for five to seven days. "By that time, a new cell layer has built up from below, and the tissue adhesive falls off the way skin layers fall off", Dr. Galil explained.

The hardened adhesive film also protects the area, keeping bacteria from entering the wound and preventing abscesses which can occur when stitches are used, he added.

Incisions closed with the adhesive heal faster than with sutures because no foreign body enters the wound – the glue rests on the skin, Dr. Galil said.

The glue avoids other problems of sutures such as tunnelling and scarring, he added. Applying the material isn't painful, so it doesn't require anesthesia, he siad.

He sees many applications for the adhesive beyond oral surgery. "The beauty of this is that it could be used for plastic surgery, and particularly for the face" because there is no scarring. Microsurgery is another possibility: "When you join nerves together, the needle is bigger than the nerve – you have to do some damage.

"We're also thinking about delivering drugs with it", he added. "For example, if you put medicine on a tongue ulcer, it is washed away by the saliva. But we may be able to put a drop of adhesive on the tongue and lock it into place".

Because of its anticoagulant and protective effects, it could also be sold to the public for use in first aid. Dr Galil has used it in place of a bandage when he cut himself in his laboratory. It should be "very cheap" if produced in large quantities, he feels.

Does Running Avert Coronaries?

(Not necessarily, says a doctor, after studying five deaths.)

They are now in their final frenetic weeks of training, crisscrossing city streets and country lanes, eating special foods, subjecting their bodies to all manner of special exercise. The object of all this self-inflicted agony is the Oct. 26 New York City Marathon, when 16,000 runners will try to pound out 26.2 miles (42.2 km) in the world's largest long-distance race. Few will be able to match stride with the likes of Four-Time Winner Bill Rodgers. But for many competitors, just finishing

is its own special victory: they are convinced that long-distance running protects them from heart disease.

This magic pill theory has long been popular in the running community, particularly among middle-aged males, a group that is at especially high coronary risk. The theory's most outspoken advocate is Dr. Thomas Bassler, an Inglewood, Calif., pathologist. Dr. William C. Roberts, Chief of the pathology branch of the National Heart, Lung and Blood Institute, and Colleague Bruce Waller have provided clinical evidence that Bassler is wrong. They studied the cases of five middle-aged men, 40 to 53, who died while running, including Maryland Congress-man Goodloe Byron, a six-time Boston Marathon finisher.

Roberts found that the men had been running for as long as ten years, averaging from 13.5 to107 miles (22 to 173 km) a week; only one had ever complained of chest pains. Yet post-mortems revealed severe atherosclerosis – the buildup of plaque, or fatty deposits – in the major coronary arteries. Thus, concludes Roberts, heart disease was "the major killer."

Roberts cautiously avoids drawing broader conclusions. He says that no one can say for sure if the men died because of running; on the contrary, they might have died anyway. In fact, he adds, their running may have had some beneficial effects: "I suspect they would have died earlier than they did if they hadn't run."

There is evidence to support such optimism. Studies have shown that running – indeed, all strenuous exercise – can elevate the blood levels of a form of cholesterol called high-density lipoprotein (HDL). This substance helps remove other, more harmful types of cholesterol from the body and presumably reduces the chances of such materials building up in the arteries. Studying 218 marathoners, joggers and nonrunners, G Harley Hartung of the Baylor College of Medicine in Houston found that the marathoners had the highest level of HDL. Other factors may be at work; marathoners tend to be relaxed, eat healthful foods, not smoke and stay thin.

There is still another factor to keep runners off stride. Cornell's Dr. Thomas Pickering, who has also studied HDL levels, reports that arrhythmias – abnormal heartbeat rhythms – occur more frequently during exercise and thus may be the cause of many unexplained deaths among runners. Says he: "A case could be made that the marathon runner is at a decreased risk of cardiovascular death when he is not running, but at an increased risk when he is." So what is a runner to do? Not to worry, says Roberts, who runs five to ten miles (8 to 16 km) a week: "I think that the purpose of running is to make a person feel better." In other words, running a marathon must be its own reward.

Insights into mild hypertension

By Dr Ray W. Gifford
Head, Dept. of Hypertension & Nephrology, Cleveland Clinic, Cleveland, Ohio, U.S.A.

The Hypertention Detection and Follow-up Programme (HDFP) study in the U.S. has given us new insights into the management of patients with mild hypertension. This is the first study that has definitely shown the value of antihypertensive therapy in managing patients with mild hypertension (diastolic 90 to 104 mmHg).

The mortality rate in the group who were aggressively treated (stepped care) was 20 per cent lower than in the referred care group who received traditional antihypertensive therapy. We can conclude that patients whose diastolic pressure is consistently 90 mmHg or more should be treated.

Not only should patients with mild hypertension be treated, but the therapy goal should be lower than we have been accustomed to. When the pretreatment diastolic pressure is between 90 and 100 mmHg, the goal should be to reduce it by at least 10 mmHg.

This means that we should be aiming for diastolic pressures of 85 or less, rather than being content with diastolic pressures of 85 to 90 as we have in the past.

Although it is true that several studies have documented the effectiveness of low sodium diet or weight reduction in reducing blood pressure, most patients will not adhere to the strict dietary regimens required.

Too often, dietary management is simply used as an excuse not to prescribe drugs even though the blood pressure is not adequately controlled. Although I have no quarrel with those physicians and patients who prefer a dietary approach, there should be an understanding at the outset that if diet is ineffective after three to six months, drugs will be used.

Whenever the diastolic blood pressure is more than 104 mmHg at the outset, I feel it is unwise to depend upon diet alone to control it. There is no convincing evidence that exercise programmes or behavioural modification techniques will have any lasting effect on elevated blood pressure.

Therapeutic Tip

Management of Head Lice Infestation in Schoolchildren

Head lice are disturbingly prevalent among

schoolchildren and appear to suggest a decline in standards of personal hygiene and increased promiscuity among adolescents (1) The best prevention is still good hygiene, and parents should be encouraged to check their children's heads at regular intervals.

Once head lice have been detected in a child, all children in that class (or school) should be thoroughly examined by a medical officer or school nurse. To prevent a spread of the infestation the child's combs, brushes, and any headgear must not be used by other children.

Head lice can be effectively treated by applying 1% maldison (malathion) cream or liquid to the scalp or shampooing in for 5 minutes, rinsing well and combing the hair thoroughly [2]. This should be repeated a week later if there is any doubt about elimination of the eggs or lice. Should a secondary, pyogenic infection arise, particularly if associated with swollen lymph nodes, treatment with chlorhexidine lotion or cream and a 5-day course of co-trimoxazole will be effective.

1. Lancet 2: 130-131 (1979).
2. British Medical Journal 280:546 (1980).

Anorectal abscess: early Dx and surgery keys to good outcome

Because of the dangers in delaying treatment of anorectal abscess, patients with this condition should be assumed to have localised pus and should have incision and drainage within 12 hours of admission, according to this five-year retrospective study of 174 patients.

The authors suggest that general or spinal anaesthesia be used with all patients with anorectal abscess because well-hidden loculations of pus are more apt to be found and associated problems, such as haemorrhoids or fissure, can be safely treated at the same time. They advise against extensive unroofing and overzealous attempts at primary fistulotomy for these abscesses.

Since a majority of patients with anorectal abscesses may be afebrile and have minimal leucocytosis, diagnosis must depend on reported symptoms and local findings. Associated pathology, such as diabetes mellitus, inflammatory intestinal disease or carcinoma, should be suspected in patients with this type of abscess. Differential diagnosis must include pilonidal abscess, Bartholin's gland abscess and hidradenitis suppurativa. The authors note that not all perineal abscesses are anorectal.

Contraceptive use here highest in S-E Asia

Singapore's contraception rate of 71 per cent is the highest in South-east Asia, says the latest world population growth indicator released by the Washington-based Population Reference Bureau.

The high rate of contraceptive use is the major reason why Singapore has become the first developing country to attain below replacement level. Replacement level occurs when the rate of births equals the rate of deaths.

The bureau says only 9 per cent of Singapore women practising birth control use the traditional rhythm, withdrawal and abstinence methods.

A high 41 per cent use reversible methods like intra-uterine device and pills, and 21 per cent sterilisation.

The high percentage of women accepting sterilisation is attributed to the incentives offered them, one being preference in schooling for their children.

Asean rates

Says the bureau: "Sterilisation has become the world's most popular single method of birth control."

Thailand comes in second among Asean nations in contraceptive use, with a high 52 per cent rate.

Among Thai women practising birth control, 27 per cent opt for reversible methods, 17 per cent opt for sterilisation and 8 per cent for traditional methods.

The Philippines, with its strong Catholic influence, is a far third with 37 per cent acceptance of contraception. A good 21 per cent of Filipina acceptors prefer the traditional contraceptive methods, 12 per cent use reversible methods and only 4 per cent, sterilisation.

Malaysia has a 33 per cent acceptance rate, and Indonesia 26 per cent.

In Malaysia, 20 per cent of women acceptors opt for reversible methods, 9 per cent use traditional methods, and 4 per cent sterilisation.

In Indonesia, 23 per cent of acceptors opt for reversible methods, and only 3 per cent use traditional methods. No figures are available on sterilisation.

The bureau also said that women in Singapore marry at a later age compared with those in other Asean countries.

BOOK REVIEW

SELECTED PAPERS from the Eighth World Conference on Family Medicine Occasional Paper Number 10 of the Journal of the Royal College of General Practitioners.

This Occasional Paper of the Journal of the Royal College of General Practitioners contains 13 papers presented at the Eighth World Conference of Family Medicine, held in Montreux in 1978 by the World Organization of National Colleges and Academies Associations of General Practitioners/Family Physicians (WONCA). The papers were chosen and edited by Dr D J Pereira Gray "to reflect the wide variety of ideas discussed at the meeting".

Variety there is — the papers cover the areas of care provided by the family physician (child care, care of the elderly, dealing with behavioural problems and family counselling), his problems with decision-making, prescribing and trying to provide continuous care and his relationship with specialists as well as his spouse. The authors come from five continents and include two from Singapore, both stalwarts of our College.

The care of children in family practice by Dr S Carne of the U.K. (and President of WONCA 1976–1978) extensively describes several practical problems arising in child care in general practice. Dr Carne compares the role the family physician with that of the paediatrician, and calls for further education of general practitioners in paediatrics (by paediatricians) and of hospital-based paediatricians in primary-care paediatrics (by general practitioners).

Primary Health Care for the Elderly by Dr F J A Huygen of the Netherlands and **Some Problems of the Elderly** by Dr M R Polliack of Israel. Both deal extensively with the comprehensive care of the elderly (with their increased incidence and multiplicity of disorders with prodominence of chronic and life-threatening illnesses and psychosocial problems) and the pivotal role of the family physician in the health care team for the aged.

The place of the primary health care vs. that of the organised mental health care in patients with behavioural problems is discussed by Dr H Lamberts of the Netherlands in his paper, **Problem Behaviour in Primary Health Care,** while Dr E K Koh of Singapore in **Family Counselling in the East** points out that the closely-knit family ties, and the less open and frank exchange of ideas in the east as compared with the west makes family counselling even more important and challenging.

Dr Pereira Gray must have included Dr Joseph H Levenstein's **The Emergency Treatment of Crescendo Angina,** from South Africa in this publication to exhibit two aspects of general practice:— First, that of preventive medicine (in this case the prevention of myocardial infarction and/or its consequent mortality) by patient-education and active intervention; and second, the birth and sharing of new ideas, regimes and innovations by family practitioners just as by other specialists.

Dr I R McWhinney's paper on **Decision Making in General Practice** from Canada describes very comprehensively how the diagnostic process differs so much in general practice as compared with that in hospital practice. Perhaps if the "specialists" would read this paper they could begin to understand why general practice is a separate entity and specialty in its own right.

The difference between the treatment of patients in the hospital setting and that of those in the general practice setting is emphasised by Dr F Frølund of Denmark in his paper on **Better Prescribing.** He calls the prescribing that we are taught in medical school and that used in hospitals as "rational" ("rational" prescribing considering prescribing to be synonymous with treatment) but feels that Family Physicians need "realistic" prescribing, which takes into account many other factors which influence the probability of prescribing ever becoming treatment.

The other paper with the same title by Dr M W Heffernan of Australia reiterates the need for con-

tinuing medical education of doctors about new drugs and new knowledge of old drugs, and goes on to suggest what physicians might do to improve patient compliance – suggestions which younger practitioners will find extremely useful.

Assessment of patient/doctor continuity in Primary Medical Care by Dr G Ejlertsson of Sweden describes how the continuity index (which indicates the number of doctors seen by a given patient in a given time) can be improved by reorganisation of the practice and better patient health education. An interesting finding in his study at the Dalby Community Research Centre is that although there is a high correlation between the continuity index and the actual number of hours the doctor is on duty, even with 100% hypothetical attendance by the doctor, it is not possible to obtain more than a 64% doctor continuity. Some of our own GPs in Singapore who work extremely long hours week after week without leave or vacation would do well to make note of this.

Dr D Bruusgaard of Norway recommends the policy of encouraging specialists to consult through referral in primary medical care in **"Specialists visiting rural general practices in Norway".** Such consultation, discussion and teaching would increase personal contact and co-operation between the specialists and the GPs with a rational sharing of medical work. Although Dr Bruusgaard refers only to rural health centres, his comments on the relationship between the G.P. and specialist are applicable throughout the world.

Do doctors really make bad spouses? and why? Psychiatrist Dr S B Nelson of U.S.A. attempts to answer these questions in **"Some dynamics of medical marriages"** and goes on to offer some solutions to the problems of medical marriages. This paper is the most readable in the whole publication, and it would be amiss not to reprint here a quote Dr Nelson uses from "The Little Prince" (Saint-Exupery, 1943): "The only really important time in our lives is the time we waste with those we love".

Local family physicians will probably find Dr Wong Heck Sing's paper on **"The Family in 1978"** a bit trite, but the article contains very useful information about family practice in Singapore – its problems of communication because of a multi-racial population, the effects of urbanisation and industrialisation, and the increasing place of health education and disease prevention. However, I am confident all GPs in Singapore will back Dr Wong in his call for the establishment of Family Practice as a distinct discipline both in medical education and in health care planning. The Word Conference has heard Dr Wong make his plea – will the local authorities listen?

This collection of papers presented at the Conference makes superb reading, both for the general practitioner and for anyone else interested in the role of the family physician in providing total and continuous care.

Dr Moti H Vaswani.

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Effective treatment of acne vulgaris

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References:
1. Kligman, A.M., Mills, O.H., Leyden, J.J.: Acne vulgaris – a Treatable Disease. *Postgrad. Med.* 55, 99–105 (1974).

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Naturally the best nourishment a mother can give her baby is breast milk

And she should be given every encouragement to breastfeed her baby for as long as she can.

There are times when a mother is unable to breastfeed as much or for as long as she would like. If a baby is less than 4 months, the doctor may feel that the formula to be introduced should not yet differ markedly in protein content from the protein in breast milk except to compensate for differences in absorption.

In such situations, recommending LACTOGEN WITH HONEY is one way of making sure that her baby's nutritional needs are fully met.

A well-balanced food

Composition of LACTOGEN WITH HONEY at recommended reconstitution, g/100 ml

Milk Proteins	2.1
Milk Fat	2.3
Lactose	3.0
Sucrose	1.3
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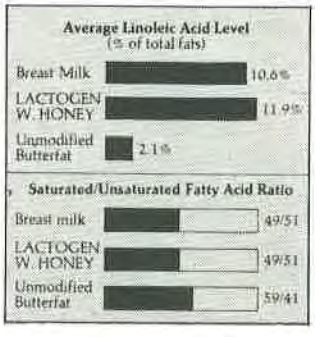
Soya Oil	0.6
Mineral Salts	0.4
Calories per 100 ml	64

LACTOGEN WITH HONEY is made from the finest quality full cream cow's milk, modified to meet the nutritional needs of normal, healthy infants. It is further enriched with organic iron and 11 vitamins.

An improved fat mix

The fat content of LACTOGEN WITH HONEY is made up of 80% milk fat and 20% soya oil, which is rich in polyunsaturated fatty acids. This soya bean oil addition balances the fat mix in terms of the linoleic acid content and the fatty acid composition in a way that is broadly similar to breast milk fat.



Amongst other things, this fat mix supplies the infant with optimal levels of essential linoleic acid. It also means a fairly broad spectrum of fatty acids. All this results in improved digestibility and better fat absorption by infants.

NESTLÉ

Specialists in infant feeding

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The Tenth WONCA World Conference on Family Medicine will be held in SINGAPORE in 1983

Hosted by: The College of General Practitioners, Singapore.

WONCA

WORLD ORGANIZATION OF NATIONAL COLLEGES, ACADEMIES AND ACADEMIC ASSOCIATIONS OF GENERAL PRACTITIONERS/FAMILY PHYSICIANS

The objective of this Organization is to improve the quality of life of the peoples of the world by:—

(a) Promoting and maintaining high standards of the General Practice/Family Medicine through education and research;

(b) Fostering communication and understanding among general practitioners/family physicians the world over;

(c) Representing the academic and research activities of the general practitioner/family physician before other world organizations or forums concerned with health or medical care;

(d) Stimulating the development of educational and research organizations of general practitioners/family physicians.

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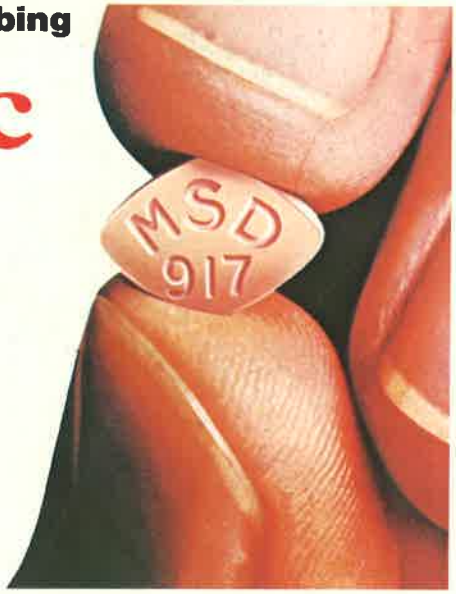

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and lower overall tablet intake combine to promote patient compliance

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