

The Singapore Family Physician



**The
College of General
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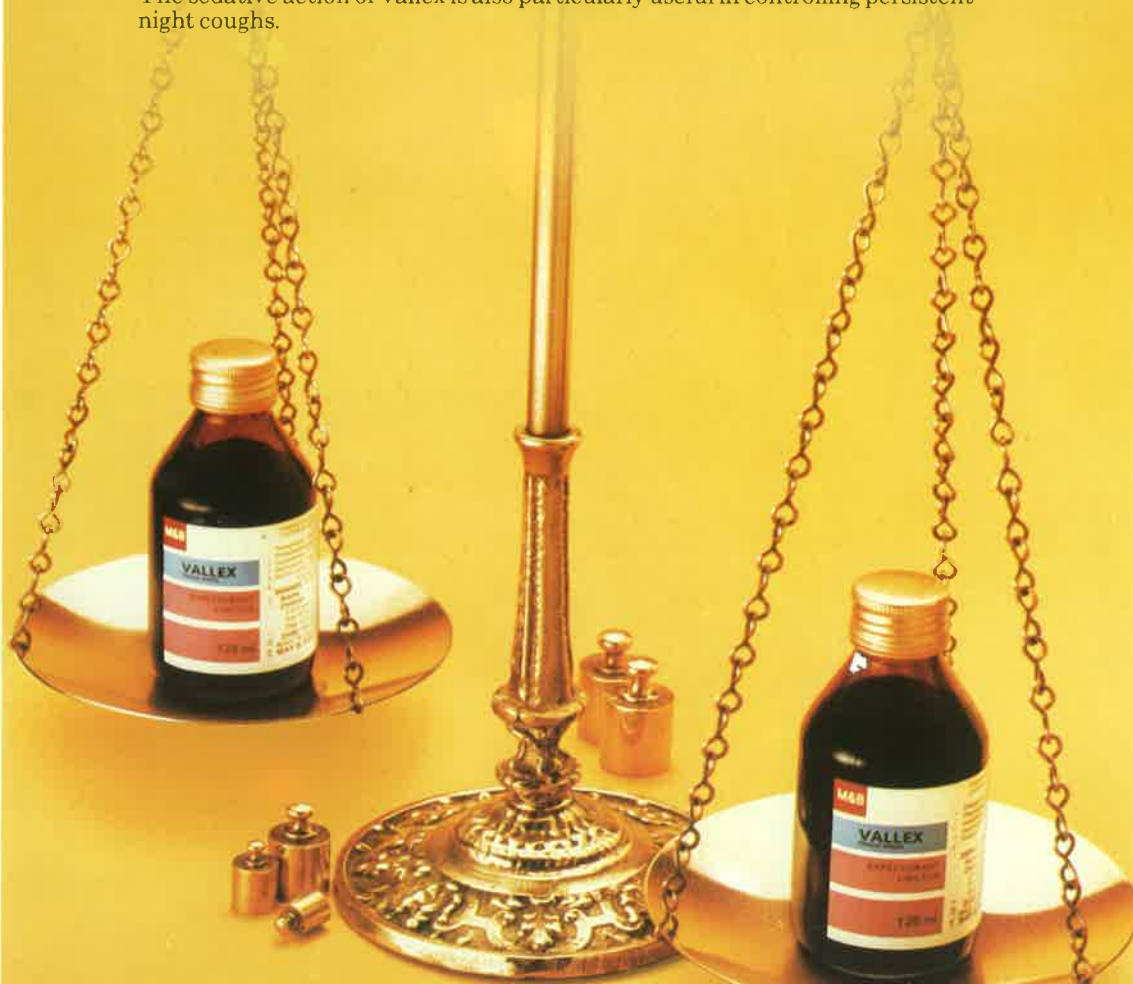
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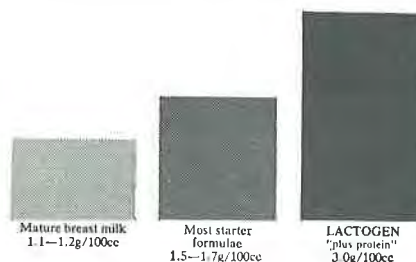
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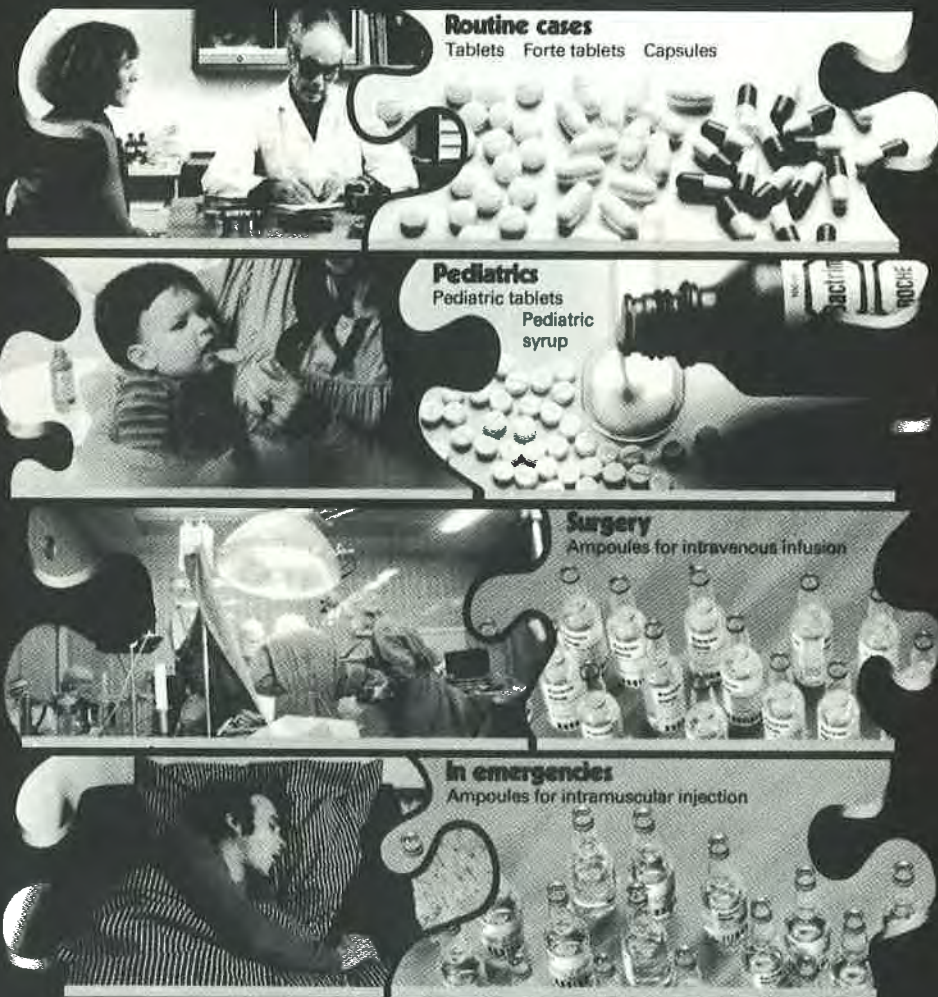
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Editorial

Medical Registration

The introduction by the General Medical Council (U.K.) of an annual fee for the retention of a doctor's name on the medical register in 1972 led to protests. Many doctors in the U.K. considered the imposition of an annual retention fee unjust. They refused to pay the fee. In turn the General Medical Council threatened to have their names removed from the register which would amount to debarring them from practice. Fortunately the Secretary of State for Social Services decided to intervene and announced the setting up of an inquiry into the regulation of the medical profession. By so doing what would have been a grave situation was averted.

The imposition of a similar annual retention fee in Singapore in 1973 was carried out with no public outcry and protests by doctors although there might have been privately expressed but muted murmurings of dissatisfaction. Can it be that Singapore doctors are more aware of the need for such annual retention fees and of the nature and function of the Medical Register? I certainly would like to believe so but such sentiment might be misplaced.

Historical Perspective (U.K.)

The restriction of the practice of medicine and surgery to qualified and licensed persons was made by the Medical Act, 1511 which decreed that no one should practise medicine or surgery unless licensed by the Bishop of his diocese. The Bishop's duty was to summon an expert panel for the examination and approval of the candidate before a licence was granted.

Thus the first Medical Act placed the legal administration of medical practice in the hands of the Church Authorities. It must be recognised that the Church was the only corporate body with the necessary organization to administer the Act. Moreover, it reflected the powerful position the Church played in the secular affairs of the nation. It was said then that the Church was the Nation

and the Nation was the Church. The Church's authority was broken with universal education and new classes were coming into being and growing in importance. The medieval state of things was changing throughout England and the entrenched privilege of the clergy was eroded.

In 1542 an amending Act was passed exempting from the penalties for unlicensed practice "divers honest persons" who were knowledgeable in the use of herbs for the treatment of "customable diseases". This exemption was valid only if they practised without fee.

With the erosion of the Church's authority, several medical societies became established and they provided alternative means of licensing persons to practise medicine. The College of Physicians was granted a Royal Charter in 1518 and its functions extending over seven miles around London were to grant licenses to those who qualified. At the same time it was granted powers to punish pretenders to medicine and others who mal-practised whether they were licensed or not.

In 1540, an Act established the United Company of Barber-Surgeons, bringing together the companies of Barbers who performed minor surgery and of Surgeons into a single company. In 1745, an Act for the dissolution of the United Company was promoted by the Surgeons. In 1800 the College of Surgeons was formed.

The Apothecaries had their own Society in 1617. Because they did not charge for their advice, the Apothecaries claimed that they were exempt from the licensing provisions of the Medical Act, 1511. After many years of conflict with the College of Physicians who exercised an undefined authority over them, they were recognised by the Apothecaries Act, 1815 which decreed that all apothecaries except those already in practice, were to be examined and licensed by their own Society of Apothecaries. There was also the condition that before a candidate can offer himself for examination he must have completed

five years' apprenticeship. The Society also had the right to prosecute offenders against the Act.

The conflicts and petty jealousies of the various licensing bodies and their efforts to safeguard the privileges and interests of their own members slowly petered out and gave way to demands for medical reform. There was increasing desire for an uniform medical qualification. Finally a central licensing authority was created by the Medical Act, 1858. This Act re-affirmed the rights of existing bodies subject to overall control by a new body to be set up under the Act — the General Council of Medical Education and Registration. This body was later known as the General Medical Council. The 1858 Act provided that registered persons should be entitled according to their qualifications to practise either medicine or surgery, or medicine and surgery. The Medical Act, 1886 later made it impossible for any person to become registered on a single qualification and required the passing of a qualifying examination in all three branches of medicine i.e. medicine, surgery and midwifery. However, the Act did not make it an offence for unqualified or unlicensed persons to practise.

The General Medical Council's first duty in 1858 was to compile a register of qualified practitioners, to appoint a Registrar, to make regulations for the keeping of a register, to print and publish a correct register of names in alphabetical order according to surname, with medical titles, degrees and qualifications, with dates so qualified of all persons on the said register on the first day of January every year. Such a register was to be called "The Medical Register". The Medical Register shall be evidence in all courts and before all justices that the persons therein are registered according to the provisions of the Act.

The Singapore Medical Council

The Medical Council of Singapore was first set up in 1905 under the Medical Registration Ordinance. This was amended by:—

1. Ordinance 99 in the 1926 Revised Edition of the Laws of Singapore,
2. Chapter 65 in the 1936 Edition,
3. Chapter 191 in the 1955 Edition,
4. Chapter 218 in the 1970 Edition.

The last was further amended by:—

- a) the Medical Registration (Amendment) Act, 1971 (operative on 14.7.1972),
- b) the Medical Registration (Amendment of Schedule) Notification, 1978 (operative on 1.5.1978) and
- c) the Medical Registration (Amendment)

Act, 1979 (operative on 15.6.79).

The Medical Registration Ordinance of Singapore, following the same pattern of the U.K. Medical Act, 1858 does not make it an offence for unlicensed and unqualified persons to practise medicine as long as they do not represent themselves as registered medical practitioners.

The Medical Register

The primary purpose of the medical register is to make public and legal recognition of the competent medical practitioner. Competence implies the successful completion of an education process which meets the requirements of the regulating body i.e. the Medical Council. Competence also implies the satisfactory completion of a period of experience in clinical practice in an approved hospital.

By virtue of its power to place a name on the register, the Medical Council exerts power over educational institutions which train medical practitioners. Registration is founded on a certain standard of competence and in specifying this standard, the Medical Council is in a position to accept or reject graduates of any educational body be it local or overseas.

By the same token, the Medical Council exerts power over the professional conduct of the registered medical practitioners. Their continued presence on the register is dependent on upholding professional conduct in accordance with the highest ethical standards.

Clearly if the Medical Council has the authority to register a medical practitioner, it has also the right to deregister him if he is found to have defrauded in respect of his qualification and competence and/or conducted himself dishonourably against the accepted ethical code of his peers.

Early this year I asked the first three hundred adult patients whether they had heard of the "Medical Register".

Only four have heard of it but none has in fact seen it, used it or understood the significance of this register. This is indeed strange because the whole idea of the Medical Register is for the benefit of the public. Yet less than a handful have heard of it and none has in fact understood its significance. The Medical Council of Singapore of course does not publicise the Medical Register. Should it be expected to do so in view of the ignorance of the public in respect of its primary function? An added reason would be that if publicity could be given to deregistration, why not to the more important issue of registration. There is a clear need for the public to know. They should be

informed and made aware of the importance of the medical register which is intended primarily to serve and protect them. In fact this is the very reason for medical registration.

Privileges of Registration

The privileges accorded to registration are few. Amongst the more important of these are the privilege of giving valid medical certificates, issuing of other statutory certificates and the prescription and use of dangerous drugs or poisons. Abuse of any of these privileges would, if proven, be sufficient ground for deregistration.

Another privilege is that only registered medical practitioners are entitled to recover fees in any court of law for any medical or surgical advice or attendance or for the performance of any operation or for any medicine prescribed and supplied. Even here, however, Fellows of the Royal College of Physicians are debarred from recovery of fees in a court of law by their Byelaw.

Registered Medical Practitioners are exempted from service in certain offices. The most important and onerous of such duties is that of serving as a juror. With the abolition of the jury system in Singapore, this is certainly no longer a privilege.

Appointment as medical officer in any sea-going vessel is only open to registered medical practitioners.

Importance of Registration

Registration is as important, if not more so than graduation. It means the placement of one's name on the Medical Register i.e. a public and legal recognition of competence to practise medicine and surgery. It also implies that the registered medical practitioner has publicly avowed to practise his profession according to the highest standard of ethics and be prepared to be judged by them.

It is suggested that because registration is such a humdrum affair at present, the significance and dignity of the occasion is often lost. It must be restored to its previous glory and heyday when a Bishop solemnized the occasion, presented the licence and made homilies to drive home the sanctity and high responsibility of the medical profession. It is certainly not suggested that we should bring back the Bishop to do this in future. But there is a place for the Chairman of the Medical Council to address all those who after completing their provisional registration seek and are admitted for the first time into the Medical Register as fully registered.

The Legal Profession lays great stress and importance on the observance of the ceremony of

being called to the Bar. We in the Medical Profession observes no ceremony on being placed on the Medical Register. No wonder then that sometimes (some would say too uncomfortably frequent) doctors don't realise the importance and significance of being admitted and registered as medical practitioners.

Exemption — Why?

Exemption in respect of any provision governing registration should not be made. Yet we see the anomaly that doctors employed in Government and University service are exempted from the payment of an annual retention fee which has been made a precondition for the retention of one's name on the register. This should not be so because exemption belittles the importance of registration. If it is a good thing and a precondition for registration, then it must be made applicable to all without exception. Is exemption an apology or a privilege? In either case why?

What of the Future?

It can be seen that medical registration has a history of more than a century in the U.K. when the General Medical Council was first established in 1858. In Singapore the medical register has entered its 75th year.

The Merrison Report, 1975 noted three important and major differences between what is required of a doctor's education now and what it was in the past.

1. It is now no longer possible to compress into the medical course all that a doctor is required to know in order to be competent.
2. The prime function of the Medical Council which was to maintain a minimum standard of competence in the past is now questioned. The task should now be to promote excellence.
3. The education of a doctor, consultant or family physician, is a complex, lengthy and continuing one and many academic bodies with different roles and responsibilities (e.g. The College of General Practitioners) must play an important role in it.

These three observations presage the things to come in the 80's not only in the U.K. but also in Singapore. It is well and timely that family physicians should ruminate their important implications.

L.V.C.

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

New horizons in primary health care in South East Asia

Dr Victor L Fernandez

President, C. G. P. (S).

Introduction

The past decade has seen the evolution and development of health policies in South East Asia aimed primarily to provide health care to improve the quality of life of our peoples. There has been a compelling need for innovative cost-effective approaches and methods to cope with the vast extent of current health needs aggravated by the sheer magnitude of the rural population. With the shift of emphasis toward comprehensive primary health care for our growing population, current health care delivery systems in S. E. A. with their inadequacies and resource limitations, need to be improved and their health care services extended — the ultimate goal being the provision of high-quality primary health care which is accessible, comprehensive and acceptable to both the patients and the community.

The term Primary Health Care evokes a variety of concepts and definitions due to differences in perception, varying professional backgrounds and cultural norms and also from the particular social and political systems. In recent years the countries in S. E. A. have expressed acceptance and the intention to adapt the primary health care concept for their own respective national health programmes. The philosophy of primary health care is to promote and support basic health care at the grassroot level, with emphasis on community involvement and participation. The World Health Organization has defined primary health care "as essential health care made universally accessible to individuals and families in the community through their full participation, and at a cost that the community can afford. It forms an integral part — both of the country's health system and the overall social and economic development of the community." From this definition, it can be construed that primary health care involves activities undertaken at the level of first contact of people with the health delivery system, namely:

- (1) medical care of established diseases
- (2) prevention of diseases and disabilities

- (3) health promotion through health education
- (4) rehabilitation services.

Obviously an understanding of the current barriers to the delivery of health care service is essential to any efforts to extend available knowledge and health resources to the entire population.

Barriers of Health Care

Consumer Related	Provider Related
(1) Socio economic	(1) Lack of facilities and manpower
(2) Educational	(2) Operational features of service
(3) Informational	(3) Fragmented care
(4) Psychological	(4) Shortage of Funds
(5) Cultural	(5) Organizational inertia
(6) Geographic	

Most of these barriers often operate at the interface between the poor patient and the health provider. Extension of health care to this large part of our population, especially in the remote rural areas, represents the most difficult challenge.

Models of Health Care in Asean Countries

A brief review of the models of health care delivery systems in South East Asia would show that primary health care assumes different forms in different countries. Great strides have been made to reinforce basic services in an effort to provide the total population with effective health care at a price they can afford. The countries of Vietnam, Kampuchea and Laos, although they form together with Thailand, the Indo-China

Paper presented at the 4th Combined Colleges Conference and S.E.A. Regional Meeting of W.O.N.C.A. in Manila, Philippines from 17th — 20th September 1979.

region in the centre of continental South East Asia, have been left out of this review as these countries are now embroiled in political upheaval and are ravaged by War.

I INDONESIA

Basic Country Information

1 Area (in Sq Km)	1,904,569
2 Population (in millions)	145.45
3 Annual Rate of population growth	2.8
4 Population in Rural areas (%)	83.0%
5 Population under 15 years (%)	44.5%
6 Crude Birth Rate	43
7 Crude Death Rate	17
8 Infant Mortality Rate	130

The Indonesian archipelago is made up of more than 13,666 islands, but five large land masses dominate — namely Sumatra, Java, Kalimantan, Sulawesi and Irian Java, the total land area being approximately 1.9 million sq. kilometres.

Administratively, Indonesia is divided into 27 provinces which are further divided into regencies/municipalities. Each regency/municipality is divided into sub-districts and these are further divided into villages. There are 246 regencies, 54 municipalities, 3,350 sub-districts and 60,000 villages.

In 1965, the major health problems were:

- (1) Communicable diseases — malaria, T.B., Cholera, Leprosy, etc.
- (2) Nutrition.
- (3) Hygiene and Sanitation.
- (4) High Mortality Rate $\left\{ \begin{array}{l} 20/1000 - \text{more than} \\ 50\% \text{ were children} \\ \text{Infant Mortality Rate} \\ 130/1000 \text{ live births} \end{array} \right.$
- (5) Population Growth.
- (6) Health Knowledge and Consciousness of People was very low — 41% had no school education.
- (7) Economic Factors — low economical level of the people influenced and caused these poor health conditions.

The First Five-Year National Development Program (1968-1972) and the Second Five-Year National Development Program (1973-1978) and the Presidential Decree of 1975 have resulted in the restructuring of the provincial health organizations — the important focal point being on the community health services. The primary health care approach was suitably adopted and designated Village Community Health Development. The main objective was to develop every aspect of the individual and community resources to improve

their well-being through the improvement of their health status. These Village Community Health Development activities are now in the pilot stages in several provinces as an integral part of community development as well as national development.

II THE PHILIPPINES

Basic Country Information

1 Area (in Sq Km)	229,681
2 Population (in millions)	45.31
3 Annual Rate of population growth	2.7
4 Population in Rural Areas (%)	68%
5 Population under 15 years (%)	42%
6 Crude Birth Rate	28.8%
7 Crude Death Rate	6.4
8 Infant Mortality Rate	53.3
9 Maternal Mortality Rate	1.6

The Republic of the Philippines is an archipelago composed of 7,100 islands and has 3 major island groups — namely, Luzon in the north, the Visayas in the central part and Mindanao in the south.

The country is divided into provinces which in turn are made up of municipalities and cities. Each municipality, with a population ranging from 10,000 — 100,000 — is comprised of the town proper and the surrounding villages called "barangays". There are at present 75 provinces, 61 cities and 1,409 municipalities. The country's economy is primarily agricultural, but during the past 5 years great strides have been made towards industrialization as part of the government's efforts to achieve a balanced agro-industrial economy. Politically, major reforms in the political, economic and social fields, including health, have been instituted.

The leading health problems are communicable diseases, malnutrition, environmental sanitation and chronic debilitating diseases like malaria, tuberculosis as well as a high population growth rate.

The responsibility for promoting adequate health services to the people is that of the government through the Ministry of Health. However, the system of health care delivery is divided between the:

- i) Public Sector — government and government controlled agencies.
- ii) Private Sector — private hospitals, private clinics and private practitioners.
- iii) Mixed Sector — professional, private and other health related organizations.
- iv) International Health Organizations.

The Ministry of Health maintains a network of hospitals at both district and provincial level, with larger Regional Medical Centres for secondary and tertiary levels of health care.

At the Primary Health Care level, Rural Health Units have largely contributed to the improved health status of the nation. Each municipality has at least one Rural Health Unit, staffed by a physician, one public health nurse and at least one midwife and a sanitary inspector. With increasing demands on the Rural Health Unit in recent years, the establishment of *barrio* (*barangay*) health stations increased recruitment of additional personnel, which included the local "herb" practitioner (*herbalario*), the untrained indigenous mid-wife (*hilot*) and support from voluntary organizations have increased the outreach of the health services. This together with community participation, has in no small measure met the primary health care needs of the country.

III THAILAND

Basic Country Information

1 Area (in Sq Km)	514,000
2 Population (in millions)	41.87
3 Annual Rate of population growth	2.5
4 Population in Rural Areas (%)	75.0%
5 Population under 15 years (%)	43.7%
6 Crude Birth Rate	37.67
7 Crude Death Rate	6.4
8 Infant Mortality Rate	26.3

The Kingdom of Thailand occupies about 514,000 sq. Km. in the centre of continental South East Asia. It is bordered by Kampuchea in the South-east, by Laos in the East and North-east, by Burma in the North, North-west and West, and by the Andaman Sea and Gulf of Thailand in the South. It has a population of approximately 41.87 million, 43.7% being under 15 years old. About 75% of the population live in hamlets and villages.

Health services are provided by both the private and public sectors. The private sector provides curative medicine as well as family planning services, mainly in the metropolis of Bangkok and the 126 municipalities. Health services of the public sector are concentrated in the provincial areas. In addition, there is a variegated network of traditional medical practitioners and practices which is part of the traditional Thai cultural pattern. This takes care of more than half the population for its symptomatic problems. This is specially predominant in the rural areas where other health services are neither available or not accepted by the people.

In order to correct the problem of inadequate coverage of health services as well as to encourage community participation, several public health community centre projects have been undertaken. However, in 1975 the Royal Thai Government put forth the Fourth Five-Year Social and Economic Development Plan (1977-1981) and is considered an important milestone in the changing pattern of health care in Thailand. Its main goals were:

- i) an emphasis on "Primary Health Care".
- ii) an emphasis on health services to rural areas.
- iii) an emphasis on increasing manpower at all levels.
- iv) an emphasis on improved health planning and management.
- v) an emphasis on availability of minimum essential medical care for the population.

Primary Health Care schemes will be implemented on a nationwide scale to cover 50% of villages in the country in the next 20 years. District hospitals are also being built to cover all districts during this period. These hospitals also function as health centres and midwifery clinics, which are also being extended. In addition to Maternal and Child Health & Family Planning, health education, nutrition and environmental health promotion, communicable disease prevention, they also provide basic medical care. Primary Health Care will rely on existing organizations set up in villages and will attempt to harness traditional medicine and practices and use community reserves like Buddhist Temples and monks, village health volunteers and health communicators in the approach and solution of the health problems of the villages. Primary Health Care will be eventually a private system developed and executed by rural people themselves with the support of government agencies.

IV MALAYSIA

Basic Country Information (1977)

1 Area (in Sq Km)	329,739
2 Population (in millions)	12.53
3 Annual Rate of population growth	2.7
4 Population in Rural Areas	71.2%
5 Population under 15 years	40.2%
6 Crude Birth Rate	30.7
7 Crude Death Rate	6.2
8 Infant Mortality Rate	30.7
9 Maternal Mortality Rate	0.8

Malaysia was founded in 1963 and is now a federation of 13 States and a Federal Territory. Eleven State and the Federal Territory are located in Peninsular Malaysia and two States — Sarawak

and Sabah — are in the Island of Borneo. Since 1971, the federal government has been wholly responsible for the administration of medical and health services throughout Malaysia. At the turn of the century the private sector comprised **only of estate and mine hospitals set up by the rubber and mining industry**, but as more local doctors became available, the number of general practitioners increased rapidly in the urban areas. At the time of Independence in 1957, the health services were urban — based, curative orientated, with complimentary rural health programmes. There was also an acute shortage of local manpower at both professional and sub-professional levels. However, great strides have been made to rectify the imbalance in distribution of services between the rural and urban areas with greater emphasis on preventive services, stepped-up training of medical manpower locally and organization of national health programmes.

The highest priority has since been given to the Rural Health Service — an integrated service providing preventive, promotive and personal health services. Special emphasis is placed on maternal and child care, basic ambulatory curative care, dental care as well as environmental sanitation. The basic plan of a Rural Health Unit is a two-tiered system with a Main Health Centre (MHC) covering a population of 15 — 20,000, while the Rural Community Clinic (RCC) or Klinik Desa (KD) with two rural nurses will cover a population of 4,000. Patient care is designed on a centripetal system with primary medical care at the periphery, secondary medical care at the intermediate level and tertiary care at centre, with appropriate referral systems. In spite of this health service infrastructure, 25% — 30% of the population are still on the fringes of development and are either under-served or unserved. Primary Health Care or "Community Health Movement" (Pergerakan Kesihatan Masyarakat) as it is known in Malaysia appears to be the answer. As total coverage of the rural population can only be achieved by 1990, Mobile Health Teams in Peninsular Malaysia and the Flying Doctor Service in Sabah and Sarawak serve as an interim measure to cover the unserved population until such time when the permanent health facilities are expanded to provide complete coverage.

V SINGAPORE

Basic Country Information

1 Area (in Sq Km)	602
2 Population (in millions)	2.33
3 Annual Rate of Population Growth	1.17

4 Population under 15 years (%)	28.5
5 Crude Birth Rate	16.8
6 Crude Death Rate	5.2
7 Infant Mortality Rate	11.6
8 Maternal Mortality Rate	0.2

The Republic of Singapore comprises the main island of Singapore and about 50 offshore islands. The population is multi-ethnic, comprising 76% Chinese, 15% Malays, 7% Indians/Pakistanis, and the remaining 2% others. (The crude birth rate is 16.8 per thousand and the crude death rate 5.2 per 1,000; the infant mortality rate 11.6 (12.6) per 1,000, and maternal mortality 0.2 per 1,000.)

The provision of health services by the government in Singapore is very comprehensive and relegated to several Ministries:

HEALTH		ENVIRONMENT
Hospital Curative Services	Outpatient Curative Services	Sewerage Disposal
Primary Health Care	Maternal & Child Health Services	Environmental Sanitation:
	School Health Services	Refuse Collection & Disposal
Dental Services		Drainage
Laboratory Services		Vector Control
Pharmaceutical Services		Control of Infectious Diseases
Control of Tuberculosis		Running of Food Establishments
Control of Venereal Diseases		Running of Control of Hawkers
Control of Drug Abuse		
Health Education		
Family Planning		
LABOUR		NATIONAL DEVELOPMENT
Industrial Health		Control of zoonoses
		Abolition and meal reports
		P.M.'s OFFICE
		Control of Air, Water and land pollution

Personal medical services are provided by private practitioners (both generalists and specialists) and by private hospitals (7). The Ministry of Health is responsible for the overall policy on health matters, maintenance of public health standards, development of health programmes and preventive measures, and the provision of **maternal and hospital facilities**. In addition, the Singapore Family Planning and Population Board provides family planning advice and facilities.

Primary Health Care in Singapore is integrated under one administration to form the Division of Primary Health Care Services, headed by a Deputy Director of Medical Services (Primary Health Care). It comprises of three departments:

- (1) Twenty-six Outpatient departments providing curative services.
- (2) Thirteen full time and 32 part-time Maternal & Child Health Clinics dealing with health and welfare of mothers and children.
- (3) School Health Services promoting health in school children.

In recent years, several polyclinics have been set up in New Housing Estates to provide a wide range of integrated services — health promotive, diagnostic (radiological and laboratory services), treatment (including minor surgery) and home-care services. To meet the growing demand for

services in the outpatient department, a Nurse Practitioner Scheme was implemented in 1975 where specially trained staff nurses provide health care at the intermediate level in simple routine curative service to patients.

With the ageing of the population, the upward trend of chronic degenerative diseases, and the escalating costs of hospital beds, the concept of Home Nursing Services was wisely formalized by government with the establishment of the Home Nursing Foundation. By mobilizing resources in the community and with the community participation, nursing care is now brought to the disabled, chronically sick, mentally ill and geriatric patients in their homes, thus relieving the strain on hospitals.

There is need for special training of the graduate entering primary health care services. The compulsory period of at least 5 years service in Government now provides the opportunity for all medical graduates to have a minimum of hospital and primary care experience and training. The primary care trainee would thus be able to acquire the knowledge and skills in the principles and practice of primary care as well as basic clinical training. He would thus be able to serve the primary health care needs of the community better than the hitherto past.

Recent Progress

From this very brief review of Primary Health Care in the Asean countries it is obvious that the technical knowledge and organization of primary health care are existent and available in all the countries in the region. The models of the health care delivery systems, whether in the planning stage or in actual operation in these Asean countries, offer an alternative solution to the perennial problems of shortage and inadequacies of existing health care services. The overall improvement in the standard of health during the past decade is indicated by the vital statistics covering death rates, mortality rates, etc. The marked improvement of these key indicators reflects the higher standard of health of the general population in recent years. However there is definitive need to further improve the health status and reduce the disparities in health care services that exist in the more disadvantaged rural areas in which more than seventy per cent (70%) of our peoples live.

Community Participation

Great efforts are being made to expand the coverage of health services to the rural areas through community participation. Moreover, the resources within the community should be harnessed and even traditional forms of medical treatment should be incorporated into the health

care system. Whether it is the "dukum" in Indonesia, the "herbalario" in the Philippines, the "wechakom" in Thailand or the "bomoh" or "sin-seh" in Malaysia and Singapore, like the "bare-foot" doctors in China, they should undergo training programmes aimed at improving their techniques and maintaining baseline quality. As health needs and priorities may vary from one country to another, it is essential that the community should participate in decision-making regarding its health services.

Political Aspects

By and large, many health programmes are planned for the community without prior consultation with the local people about their needs and expectations. There is also a dearth of corridors for communication between the community, the medical profession and the health planners. Health policy should be shaped through the combined efforts of physicians, family physicians, economists, epidemiologists, sociologists, health planners, consumers, legislators and community leaders. To a large extent health is a political decision and political support is essential. Nevertheless, changes that are made should be well-planned and responsive to society's needs and policy-making should not be left completely to the politicians.

Undergraduate and Graduate Education

The principal practitioners of primary health care are general practitioners and family physicians as they, and only they meet the criteria of comprehensive and continuing care for all age groups and for both sexes. It is now universally recognized that general practice or family medicine is a specialty possessing a unique combination of elements from the knowledge and skills of medicine. However, very little, if any, attention has hitherto been paid to the specific training of the family doctor at either the undergraduate or graduate levels of medical education in the Asean countries. The founding of Academies and Colleges of General Practitioners in South East Asian countries in recent years, with aims and goals identical to those of Academies and Colleges in developed countries, have helped to define this new area of specialization and to advocate for the training of a new generation of doctors in the practice of primary care. This means that our medical schools should recognize the importance of primary care and improved systems of health care delivery. They should redirect their curricula and teaching programmes toward primary comprehensive 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 physician's 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. These objectives should:

- (i) be realistically capable of being translated into learning experience.
- (ii) be suitable for evaluation by examination.
- (iii) be broad enough to cover the likely roles the general practitioner will be called upon to perform.
- (iv) be flexible enough to prepare him to adapt to unpredictable advances in medical science and technology.

The challenge today is for the developing countries to provide for vocational training programme to enable general practice/family medicine to make an impact on the delivery of health care which is so urgently needed.

The Health Team

The utilization of para-medical personnel in primary health care is probably more important than in any other field, as primary health care involves high patient volume and the most comprehensive range of health services. The physician of today can no longer practise alone. He needs the help of a larger team of paramedical assistants as well as the services of other health facilities and services in the community. He needs specialty consultation for complex problems outside his field of competence. He needs to work in close association with other physicians in order to provide for continuity of patient care which can allow him an opportunity for a normal personal and family life as well as time for continuing medical education. Primary health care relies on allied health personnel, namely, nurses, mid-wives, ancillaries, community workers as well as traditional practitioners, trained socially and technically, to work as a health team and to respond to

the expressed health needs of the community. The primary care physician, as the leader of this growing health team, should provide leadership as to how to best incorporate para-medical personnel into the care of the patient.

In summary, I wish to reiterate, Primary Health Care in South East Asia will require reorganization of the health care delivery systems to deal with much broader problems than in the past — complex problems that need a multidisciplinary team approach to the management of the delivery system. There are many existing barriers to health care which preclude even basic medical care for many people. The development of community health centres — the team approach to health care delivery and the emphasis on out of hospital cost-effective care — health maintenance and preventive medicine — has brought the general practitioner/family physician to the forefront of our health care delivery system. Trained by design, he should be able to competently 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.

The challenges facing medicine today are great. However there is much room for optimism in the South East Asian countries, for we have come a long way. From our present acute sense of awareness of our deficiencies, and the active reappraisal of our resources and methods of practice, will evolve better health care systems. The vigorous development of primary health care seems as inevitable as it is appropriate to our current problems. Primary health care can extend primary, continuing, comprehensive health care to more people than any other field in medicine and seems the logical foundation for health care systems of South East Asia.

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Primary Health Care for all the people

Dr. M. K. RAJAKUMAR

Chairman of Council
College of General Practitioners of Malaysia

We live in an age when expectations of people are high yet their confidence is low on the experts who will be needed to fulfil these expectations. This is most acutely true of medicine and in recent years, physicians have come under scrutiny and challenge in the face of a demand for better health care. These increased expectations on health have occurred contemporaneously in the developed as well as the developing countries.

At the Thirty First Meeting of the World Assembly, in May 1978, an appeal was addressed to the political leaders of the world to make the target of Health for all by year 2000, the social target for the last quarter of the twentieth century. This was proclaimed at the Conference on Primary Health Care held at Alma Ata in September 1978 under the sponsorship of the World Health Organisation (WHO) and the United Children's Fund. This was an inter-governmental conference attended by 134 governments and by representatives of 67 United Nations organisations, specialised agencies and non-governmental organisations in relation with WHO and UNICEF. The Declaration of Alma Ata reads in its fifth part:

"Governments have a responsibility for the health of their people which can be fulfilled only by the provision of adequate health and social measures. A main social target of Governments, international organisations and the whole world community in the coming decade should be the attainment by all peoples of the world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life. Primary Health Care is the key to attaining this target as part of development in the spirit of social justice".

This, you might well say, is the business of all of us gathered here today yet not a single organisation of physicians in Primary Care, general practitioners or family physicians, were present at Alma Ata or contributed to the Declaration. It is a sad and astonishing fact that organisations represented here today were neither invited nor put in anything to a historic Conference that placed Primary

Care on the top of the agenda of social objectives.

Part of the reason, no doubt, is that planning and organisation of health care is very largely in the hands of public health physicians and of health administrators who advise the politicians. Notwithstanding that, it would be letting ourselves off too lightly to accept that as the whole reason.

The sad truth is that General Practitioners and Family Physicians have allowed themselves to be overtaken by events, even as they relaxed in the warm glow of the achievements of the past two decades in giving our discipline its rightful place in medicine. Particularly in the developing nations, where the challenge to the physicians is greatest, the general practitioners have prospered in a professional ghetto and lost sight of the necessity of making their skills relevant to the needs of their people.

The impact of the Declaration of Alma Ata promises to be great on the nations of this region for two reasons. For one thing, as still underdeveloped nations, they are in the line of the main thrust of the WHO campaign. For another, being a relatively better off and better organised group of nations, they are better able to receive and implement the ideas of the WHO. It is therefore important to study these ideas closely and critically.

There are three aspects of the Declaration that I should like to examine. Firstly the term Primary Health Care is used loosely and often appears as a synonym for a form of minimal health care activity designed for poor countries as a substitute for good health care; a basic system planned by public health officials and delivered by lay health worker and using traditional healers where necessary. This seems to me to be a retrograde development. It must be admitted that there are a few nations in the world so poor and so disorganised that very little health care is better than none at all. Nevertheless if not today, then tomorrow, all developing countries can and must aim at delivering modern medical care through trained teams.

This brings me to my second reservation regarding the WHO's Primary Health Care. It appears to give up too easily on the prospects of getting

Opening address delivered at the 4th Combined Colleges Conference and S.E.A. Regional Meeting of W.O.N.C.A. in Manila, Philippines from 17th - 20th September 1979.

physicians to work in rural areas where they are needed most. It seems to me that rural populations need the best trained and experienced physicians because their health problems are more severe and more complex. At the present time throughout the developed world there are no rewards for the physician in the rural areas, neither financial inducements for private practice nor career advancement in government service. Is it any wonder that bright young doctors quickly recognise that politicians do not wish to be taken seriously when they say that rural health is a top priority but do not provide the funds to make that possible.

Finally, there is the use of traditional medicine. It has become politically popular to push the use of traditional medicines or even urge their incorporation into modern medical practice. I am not saying that there are not therapeutically active agents in traditional medicine. On the contrary, it is likely that research will continue to discover therapeutic activity in various herbal preparations. Traditional medicine is part of the historic heritage of modern medicine. A great deal of the modern pharmacopoeia is still of herbal origins, reflecting the traditional medicines of western and other societies. We owe to herbal medicine a good number of our most important drugs, including morphine, digitalis, ephedrine and atropine. No doubt, more active agents are waiting to be discovered. However, this is quite a different matter from advocating the introduction of unknown, unidentified and untested medications and methods into medical practice. Such a development would open wide the doors to charlatanry and the community would be the worse.

Notwithstanding these reservations, the primary health care objectives of the Declaration of Alma Ata are an important development which have the potential for much good in this region. It is up to each country to make what it will of it. As primary care physicians from this region we can help to determine the shape of the primary health care delivery system and to train a new generation of physicians to deliver this care. We can make primary health care in this region a genuine contribution to raising the standards of life and not merely a cover for neglect. The organisation of general practitioners in this region can play a vital and decisive role in determining the shape and standards of the new general practice in this region as a vital part of the movement to achieve health for all.

Regretably we have done very little. Over the past few years, there have been a series of regional workshops on different aspects of primary health

care and there has been no participation by general practitioners. General Practice in our region has become equated with private 'shop-house' practice confined to episodic care of those who pay, irrelevant to the health needs of the community.

I believe that the fault lies with us. General Practitioners in the region have failed to keep up with the advances in primary care and the new concepts that have appeared over the past two decades. There has been neglect of education and a lack of ideas to contribute to solving the health problems of the community. As a result even within the area of our expertise, other specialists have had to do the thinking and propose solutions. The awful standards of primary care in developing nations of this part of the world is a reflection of neglect by the practitioners of primary care. We have failed by default.

We need a strategy to reverse this drift and to rescue primary health care from its deformed existence. There must be many approaches to this task and I give you my own thoughts and a little bit of the directions of my own College.

To begin you need an organisation. The College of General Practitioners of Malaysia was founded in 1973. There is a great deal worth discussing on how to set about forming a College but I need not preach to the converted assembled here today. The College must get recognition. In Malaysia we have found that it was necessary to get an Act of Parliament to establish the College as a body corporate. Many years of persuasion and explanation have at last culminated in a public declaration by our Government that an Act of Parliament is being drafted. We expect that this will be passed in the next few months. We have therefore over five years, succeeding in constructing the foundations for our activities. In the Asean Region, two countries are still without organisations of general practitioners, namely Indonesia and Thailand. These are large and important nations and I hope that they will have their own organisations in the not too distant future.

Then there is the matter of establishing credentials as an educational body. The national medical association is the appropriate body for medical politics, not the College or Academy. The Universities have to be persuaded that we are collaborators and not rivals. The decisive argument is an active and superlative educational programme.

My College has an active but not-yet-superlative continuing educational programme. This has been in no small measure a factor in the acceptance of the earnestness of our purpose by the medical profession as a whole in my country. All the

organisations participating here today have excellent continuing educational programmes and we all envy the Family Medical Programme and the Check Programme of the Royal Australian College of General Practitioners.

The development of vocational training is a milestone. We have put our concepts on training into a report which we have called 'Specialisation in Primary Health Care — Training for the New General Practice in Malaysia'. This Report outlines the objectives, content of training and the mode of examination.

At the same time, our College has joined a Committee of the Malaysian Medical Council to define the qualifications and experience of those who are entitled to be called 'Specialist'. Significantly one of the categories of specialist under discussion is that of "Family Physician".

Finally there is the role of providing expert advice on the future of primary health care in our countries. If general practitioners are the experts in primary health care, then they must provide expertise in that area. We must have expert committees and ensure that our views and advice are sought and used in planning and decision making. We have to be expert and we have to be persuasive.

The developing countries of this region urgently need good systems of primary health care delivery. They have committed themselves to a hospital-oriented system which has shown an infinite capacity to absorb all health funding. Fortunately the developing countries of this region are relatively prosperous and can afford a reasonable investment in health.

The common dilemma of these countries is that they are unable to get doctors to go to the rural areas. As a result some form of compulsory service has been introduced. Young doctors are sent to the rural areas from which they rush back to the cities as soon as their compulsory service is completed.

The problem is a very real one. In developing countries, four-fifths of the population live in the rural areas, but four-fifths of the physicians are in the urban areas. Four-fifths of the morbidity and mortality is in the rural areas, but four-fifths of health funds go into the urban areas. Four-fifths of health problems need primary health care but four-fifths of the health budget goes into hospitals. These proportions are generally true for the developing nations although the percentages may vary from nation to nation and according to the definition of urban and rural.

In Malaysia, my College has addressed itself to these problems. We have argued that primary health care in the rural areas is no less demanding

professionally than hospital medicine. It needs well-trained physicians and not inexperienced ones. Primary rural health care must not be considered an exile or punishment but as exciting and challenging work. It must not be a job in which the physician loses out but one in which he gets rewards and recognition.

The creation of teaching Health Centres is an important part of the solution of attracting primary care physicians to the rural areas. These teaching Health Centres must receive the sort of priorities for funds that are now reserved for teaching hospitals.

The teaching Health Centres can fulfil the following functions.

1. Develop new approaches to the delivery of primary health care.
2. Train and motivate a new generation of physicians and other health care workers.

In primary health care delivery, we are in new and unexplored terrain and we need to try out different approaches. The aim is to develop primary health care teams led by physicians who, expert in their field, can function as a unit and deliver health care of a very high standard.

The expectations of people are high and they will if necessary bypass inferior health providers and trek to the cities for their medical care. These teaching Primary Health Centres must be well equipped centres with skilled staff if they are to win the confidence of the community.

From these centres, we can provide the new generation of health care teams who work well because they know they have been well-trained and that their work is recognised and rewarded.

To plan the programme, you need a National Institute of Primary Care. The National Institute can provide the resource backing, help to develop medical record systems and treatment protocols and summarise the experience of the Centres.

Ultimately success or failure depends on the availability of funds. Good Primary Health Care is not cheap but it is the most cost-effective. When politicians promise top priority for rural health, will they pledge the necessary funds to go with their promises? One encouraging development has been the inclusion of health within the area of interest of the World Bank. If good schemes for Primary Health Care delivery can be proposed, international finances surely can be found. Health is the most precious possession next to life itself and there can be no development without health.

The Primary Health Care movement is an endeavour worthy of international support and one that can bring decisive improvements at the level that touches the lives of great numbers of people.

The aged patient in a general practice

Moti H. Vaswani,

MBBS, MCGP (Singapore).

I. INTRODUCTION

Demographic studies have shown that there has been in recent years an increased number of aged persons in the population the world over. In 1970, the world population of people aged 60 years and over was estimated to be 291 million (or 8% of the total population). This figure is expected to reach 585 million in the year 2000, i.e., doubling in 30 years¹. These figures and their implications are even more formidable when we consider less developed regions separately, or the proportion of the total population aged 80 years and over.

In Singapore, the percentage of people over the age of 65 years is about 4½% (2% males and 2½% females), with a more than three-fold rise of actual numbers in this age group in the last 20 years. (Table I).

Table I.

Year	Total Population	Male >65 yrs.		Female >65 yrs.		Total >65 yrs.	
		Number	%	Number	%	Number	%
1957	1,445,929	12,346	0.85	18,715	1.29	31,061	2.15
1970	2,074,507	30,589	1.48	38,775	1.87	69,364	3.35
1979	2,362,700	48,600	2.06	60,300	2.55	108,900	4.61
(Estim.)							

II. OBSERVATIONS ON AGED PATIENTS IN A SINGAPORE GENERAL PRACTICE

In a study of aged patients seen in a family practice set in a rural area in Singapore, it was found that out of a total of 1200 patients seen during a two-week period, 70 patients were 65 or more years of age. Of these, 42 were female and 28 male, representing 3.5% and 2.33% respectively of the total number of patients. This compares with the percentage of these older persons in the total population in Singapore (females 2.5% and males 2%).

Over 65 age group $\left\{ \begin{array}{l} \text{in Singapore population} - F : M = 5 : 4 \\ \text{in patients seen} - F : M = 3 : 2 \end{array} \right.$

Paper presented at the 4th Combined Colleges Conference and S.E.A. Regional Meeting of W.O.N.C.A. in Manila, Philippines, from 17th - 20th September 1979. (Central theme: "The Family Physician in S.E. Asia Today")

A breakdown of these patients into 5-year age groups (Table II) shows that the majority of patients seen are in the 65-79 years group, mortality probably taking over morbidity after 80.

Table II

	65 - 69 years	70 - 74 years	75 - 79 years	80 - 84 years	85 years and over	Total
Female	17	10	10	3	2	42
Male	17	4	6	0	1	28
Total	34	14	16	3	3	70

Table III shows the types of disorders seen in these elderly patients. The presenting disorders most frequently encountered were hypertension, obstructive airway disease (bronchial asthma and bronchitis and their sequelae), upper respiratory tract infection (URTI), locomotor disorders, diabetes mellitus and skin disorders.

The figures in brackets indicate the number of patients whose complaints pertained to more than one disorder, so that the total number of patients

Table III

Disorder	Female	Male
Hypertension	11 (3)	7
Obstructive Airway Disease	9 (3)	5 (1)
U.R.T.I.	9	1
Locomotor disorders	6	2
Diabetes mellitus	6 (3)	3 (1)
Skin disease	4	5
Digestive disorders	2 (1)	2
Cerebro-Vascular disease	1	1
Mental Disease	0	1
Varicosities	1	1
Miscellaneous	4	3
	(U.T.I. Anaemia Hansen's Bite)	(Prostate Piles Tabes)

on this chart (82) is more than the actual number of patients seen (70).

Further study of these 70 patients showed that 17 had a history of previous encounter with one more of the other disorders in the list, 18 had had two of these disorders, and 8 had suffered from 3 more such illnesses. (Table IV)

Table IV

Previous encounter with:	Number of Patients		
	Female	Male	Total
1 other disorder	9	8	17
2 other disorders	12	6	18
3 other disorders	4	4	8

Also, records of past and presenting illnesses contributed to the finding that hypertension was very common in this age group, being recorded in 32 (almost 50%) of the 70 patients, with locomotor difficulties seen in 21 (30%) of them. (Table V).

Table V

Disorder	Female	Male	Total
Hypertension	19	13	32
Locomotor problems	15	6	21
Digestive disorders	12	4	16
Ostructive Airways Disease	11	5	16
Diabetes mellitus	7	3	10

III. HEALTH PROBLEMS IN THE ELDERLY

The Aged have received low priority for attention and consideration by the community, whose prestige values are based on productivity and tangible contribution to the population. However, these "debtors" of the Community are fully entitled to all the care, peace and happiness they can get in their remaining years, for they have well served their generation, and completed their role as "donors".

1. Implications of Age:

i) Retirement from work

Stieglitz² has defined the greatest tragedy of old age as the awareness of uselessness. At a fixed age, the world declares a citizen previously in good standing suddenly old and unemployable. The removal of meaningful content from the day has a deleterious effect on the physical, mental and social health of people at this age.

Only if old people have been prepared early in adult life or by pre-retirement courses for

hobbies, pastimes and other activities which are not physically taxing, can they live through this period fruitfully.

ii) Decreased Self-Esteem and Self-Confidence

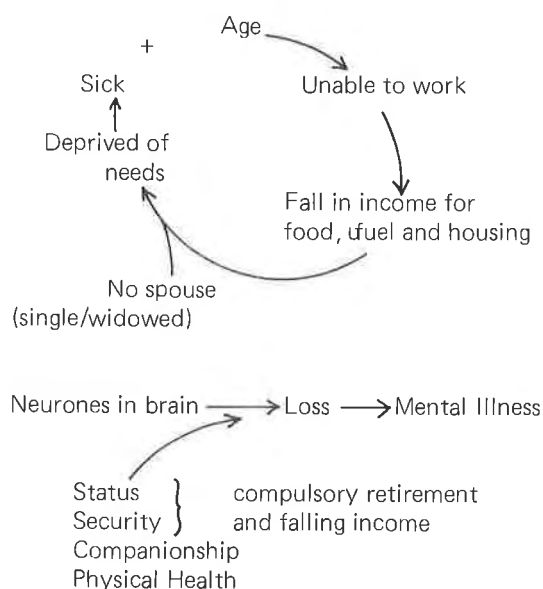
Retirement from work with its consequent reduction in income, works in combination with other factors like decreasing physical and mental capabilities, decreased energy, memory or hearing, and poor orientation and/or judgement, leading to a feeling of uselessness in the aged.

iii) Isolation and Withdrawal from Activities

Loss of family, status or peer group, poor financial situation and loneliness cause the elderly to withdraw from their usual activities and friends. This predisposes them to the development of psychiatric and mental illness, especially depression and dementia.

iv) Inadequate Diet

Unless the old person is looked after by his family, the state or some other organisation, he may find the cost of the protein foods, fruit and vegetables he needs out of his reach; the aged living alone may find cooking for one or two persons too troublesome. An unbalanced and inadequate diet makes them more vulnerable to ill-health.



v) **Use of Medical Services**

It has been found that the elderly either visit their doctor too often for minor complaints, or refuse to see him for various reasons like hurt to one's pride, fear of serious disease, apathy, or even the wish not to recover.

2. Illness in the Aged.

The most prevalent long-term diseases causing disability and incapacity in the elderly include cardio-vascular and cerebro-vascular diseases, malignancy, diseases of the locomotor system, mental illness, and defects in hearing and vision. The main features of illness in the aged are:

i) **Multiple pathology**

The occurrence of multiple disease processes in the same person is the main clinical characteristic of the older patient. The possible co-existence of physical, psychological, nutritional and social disturbance makes the diagnosis not a single, but usually a complex multi-system one.

ii) **Atypical or Non-Specific Presentation**

A general presentation with mental confusion, incontinence or falls seems to be common in the elderly. Any doctor who has treated old people will be able to recall the thyrotoxic old patient who presented with cardiac failure without any of the hyper-kinetic symptoms of sweating, tremors and weight-loss, or the old man who complained only of vague ill-health and turned out to have something serious like an acute duodenal ulcer.

iii) **Effects of Ageing Process**

The ageing process adds its toll to these diseases, modifying and complicating them. Besides making the aged person more vulnerable to illness and injury, it characterises illness in the aged by its chronicity, limited recovery and residual disability, with or without dependency.

However, no one is sick just because he is old. He is sick because of definite disease process or processes.

iv) **Drug Treatment**

Metabolism of drugs is different in the elderly — they may be more sensitive to the drug, or may have decreased tolerance to it. This is especially important to remember in the treatment of old people with digitalis.

In the medicinal treatment of the elderly patient, the doctor would do well to remember to stop all unnecessary or not-life-maintaining medications because the patient may not be able to take so many different pills together or may not be able to cope with complex dosage schedules.

3. Principles of Care of the Aged.

The approach to good and "total" care of the aged thus would need a complex medical, social, psychological and emotional approach if it is to succeed. The basic needs of health, emotional security and social involvement must be supplied, together with spiritual help if necessary, to help the aged help themselves and each other, so as to useful members of their families and society.

IV. THE GENERAL PRACTITIONER AND HIS AGED PATIENT.

The general practitioner, concerned as he is with maintaining the health of his patients throughout their entire lives, has a increasingly important role to play in the care of the aged. He must ensure that he does not only add more years to their lives, but also improves the quality of their lives and adds more life to those years.

1. Preventive Screening

Health services must endeavour to keep old people, as with all other age groups, healthy instead of treating them when they are sick. Self-reporting of illness in old people is not a sufficient means of detecting early disease, and cross sectional surveys of the aged living in various communities have shown the problem of undetected physical illness³, mental illness⁴, and social problems⁵. Thomas⁶ in U.K. screened the elderly at a health centre, and found that only 3.4% of those over 65 were completely fit, 15% had one disorder and 81.6% had more than one. However, opinion is not agreed regarding the clinical and cost benefit of such screening programmes. One criticism against such programmes is that they identify needs and problems for which there are few answers. Although this may apply to social problems more than organic illness, a study by Barber and Wallis⁷ has shown that the general health and welfare of the patient besides his physical health can also be improved.

Webster⁸ has advocated what appears to be a more rational approach — screening only for 'at-risk' patients over 65, and for all patients over 75. Anderson and Cowan⁹ showed by their experience in Rutherglen that once an older person has been found to be at risk, such a person must be

followed up forever. The groups who have been identified to be at risk are those with:

- Increasing age (especially 75 and over)
- Isolation and loneliness
 - aged people living alone
 - isolated old people (aged couples)
 - childless old people
 - aged people living in institutions
- Recent illness or injury
- Recent bereavement
- A seriously ill or handicapped spouse
- Established disease
 - locomotor difficulties
 - mental impairment, etc.
- Sub-standard living conditions — aged people having to live on the minimum support provided by family, state or social security, or even less
- Poverty

In the screening exercise, what must be stressed is the importance of asking about symptoms that the patient does not think worth mentioning, and a thorough, searching, physical examination, for there is evidence¹⁰ that old people often fail to report disabilities involving the urinary system, painful feet, depression, dementia and other mental disturbances, the symptoms of anaemia and diabetes, poor vision and deafness.

Screening for physical illness must be tied up with psycho-social evaluation if it is to have some meaning. For this, the general practitioner has to depend on social workers, community nurses and other health visitors.

2. Care of the Aged Sick

This implies the adequate treatment of physical (traumatic, inflammatory, degenerative or malignant) disease as well as psychological illness, the main aim being to rehabilitate the patient to go home and carry on his activities of daily living himself.

The prescription of eye-glasses or hearing aids is just as important as the treatment of serious illness in improving the quality of life for these senior citizens.

The general practitioner must advise his aged patients on a balanced and adequate diet, taking into consideration factors like financial, emotional and psychological problems. He must also educate his aged patients on proper hygiene and personal care, how to avoid accidents they are prone to, and advise sufficient exposure to sunlight.

The needs of the terminally sick and their families too would have to be identified, and services provided to fulfil those needs.

3. Rehabilitation

This is the especially important part of therapy, the aim being to return the old person, if possible, to his own home in as healthy and as mobile a state as possible.

Rehabilitation would consist of:

i) Re-activation

Here the aged patient who is passive, lethargic and physically and socially immobilised is encouraged to live again an active daily life in his own surroundings. Through corrective psycho-therapy, his self-esteem is restored by contact with a general practitioner who does not profess dislike or contempt for old people.

ii) Re-socialisation

This means that the aged patient, during or after his illness is encouraged to make contact with family, neighbours and friends, and as Townsend¹¹ says, although he may live in isolation, he does not continue to live in desolation.

iii) Re-integration

This involves the restoration of the old person to society. He must not only participate fully in normal life, but also depending on his capacity, use his talents for an occupation or for programs for children and youth in the community.

THE ROLE OF THE GENERAL PRACTITIONER IN THE "TOTAL" CARE OF THE AGED.

The complex medical and social needs of the aged can be handled only by adopting the holistic approach. The medical role of the G.P. in the care of the aged is clear, but he cannot fulfill this role without an appreciation of the social context in which these aged persons live.

Because of the complexity of diseases and disorders arising from medical, psycho-social and emotional causes, the G.P. cannot cope alone, and must rely on his colleagues from other disciplines, and other professions — occupational therapist, dietitian, priest, social worker, etc. — to help him with referrals and advice, so as to provide "total" care.

He must rouse the social conscience of the public and state towards its senior citizens; he must help alleviate those factors which impair the ability of relatives to cope with a sick old person in the house and which contribute to un-



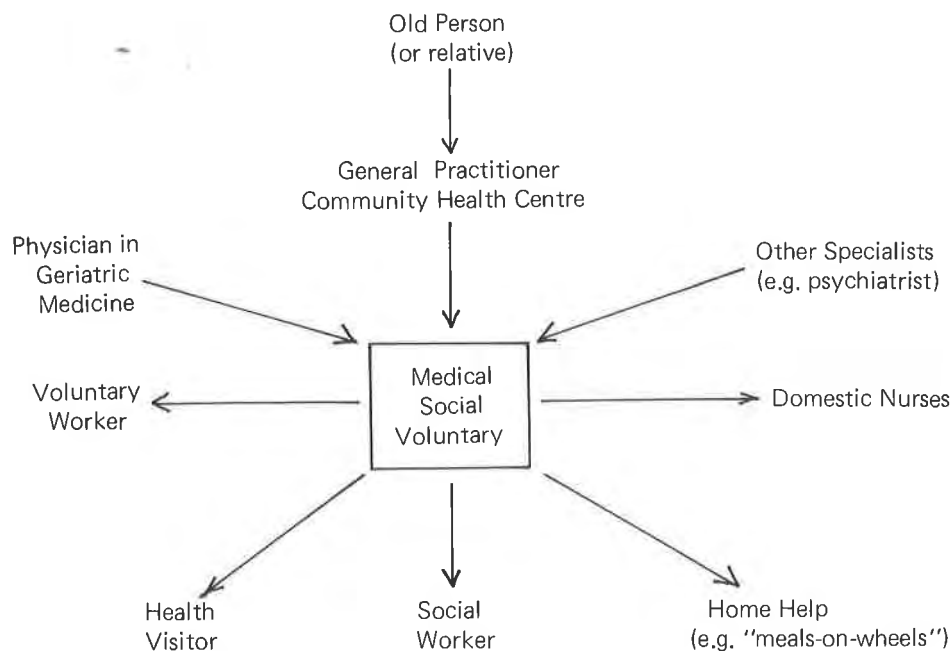
GERIATRIC MEDICINE — methodology of prevention

necessary hospitalisation; he must advocate improved living conditions; he must help initiate programmes of care, convince the appropriate sources — the State, or service organisations — to fund the necessary services, be personally involved, and provide leadership and co-ordination. At the same time, he must remain the person of primary contact for all his patients and for all their disabilities. In Singapore, the Singapore Action Group of Elders (SAGE) which runs homes

and organises activities for elderly persons, has a G.P. as its President.

A HEALTH CENTRE FOR THE AGED

Anderson and Cowan⁹ proposed in 1955 a model G.P. Health Centre for older people. The idea behind such a scheme was that the old person or his relatives would only have to visit or make enquiry at one place, to obtain the necessary help or advice.



At the health centre, the entire health team (which includes the physician supported by social workers, nursing colleagues and voluntary agencies) can meet, and the domiciliary, community and hospital services can be linked for the benefit of the older person. The district nursing service is organised from the health centre, and nurses with special interest in or training with the elderly assist the general practitioner. Social services (home help, "meals-on-wheels", etc.) would be organised from the centre through representatives either of the state social service department or of voluntary organisations.

The physician specialising in geriatric medicine would see patients referred by the G.P. and also give advice to those concerned with building houses for the elderly or re-housing older people, to social workers and to voluntary agencies.

The G.P. would not only treat the aged sick, but also carry on a screening service to detect early illness in the community with the help of his nurses. The team framework facilitates organised follow-up of the chronic sick as part of continuous care which characterises general practice or family medicine.

CONCLUSION

There is no question that the one person who can be of the greatest help to the elderly sick patient is his own G.P. However, in spite of changing trends, many doctors still consider the problems of their aged patients in a spirit of hopelessness. "Just old age" or "senility" seems to be a common diagnosis, and since the pathology is an act of God, nothing is prescribed, except perhaps

tranquillisers.

The general practitioner, in his pivotal role in the delivery of health care for the aged, must have the empathy, interest and necessary training (both at undergraduate and post-graduate levels) — to provide the attention, emotional support and medical diagnosis and treatment that the aged patients in our practices rightly deserve.

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The more perceptive readers will have noticed that the present issue of *Singapore Family Physician* has a number printed on its front page. What is the story behind this unique number?

The Singapore National Library is participating in an international project — the International Serials Data System — which has been set up to create and maintain computerised data banks containing essential information for the identification of serial publications.

As one of the serial publications originating in Singapore, the *Singapore Family Physician* has been assigned by the National Library an unique number ISSN 0377-5305. The letters ISSN stand for International Standard Serial Number. The *Singapore Family Physician* will be permanently associated with ISSN 0377-5305 which is used to

identify it internationally.

The International Serials Data System (ISDS) has its headquarters in Paris. Its regional centre for South East Asia is in Bangkok and the National Library is the national centre for Singapore. Bibliographical information about all serial publications in Singapore is sent first to Bangkok and then to the Paris Headquarters for input into the international data bank.

The aim of ISDS is to provide an international registry of all serial publications throughout the world. This implies that all countries have access to this registry and facilitates communication between libraries, publishers and users. It also helps promote international standards for bibliographic description and communication format.

Editor

Impotence in general practice

Chong Peck Koon, Gabriel,
MBBS, MCGP(S)

Impotence is a devastating blow to the male ego and masculinity. In family practice, sexual disorders are seldom encountered in this part of the world because of our inhibited nature. Self-medication with tonics especially sex tonics amongst Chinese males in our country is common. As a result, the reported incidence of impotence is much lower than expected. However, this sexual disorder is of importance in family practice and the incidence increases as leading questions are asked.

Unlike the menopause in females, the male climacteric is disputed. Just as the menstrual history is sought for in female patients, a family physician should also seek in male patients a sexual history including impotency. This is important because impotency may bring about marital disharmony as well as manifestations of psychosomatic illness not only in the patient but also his spouse.

Two percent of young men in America at age thirty-five and fifty percent at age seventy-five and beyond are impotent. We do often encounter temporary impotence in our young male patients. As most men are unwilling to discuss this problem, it is usually their spouses who mention this during their consultations of other problems such as symptoms of anxiety and depression.

Impotence is classically divided into three big headings, namely, organic, psychogenic and constitutional causes. Sometimes all three factors may co-exist and complicate the diagnosis. In the United Kingdom, impotence is classified under the less common mental disorders with an incidence of 0.8 per 1000 NHS (National Health Service) patients per year. The suspected and the confirmed being the same figure.

Definition

The Dorland's illustrative medical dictionary defined impotence as:— (in Latin, not potential) no power or lack of power; chiefly of copulative power or virility. It may be atonic, due to paralysis

of the motor nerves (nervi erigentes) without evidence of lesion of the central nervous system; paretic, due to lesion in the nervous system particularly in the spinal cord; psychotic, dependent on the marital couples; or symptomatic, due to some other disorder such as injury to the nerves in the perineal region by virtue of which the sensory portion of the erection reflex arc is blocked.

The Oxford Dictionary simply defined it as incapable of sexual intercourse. Alternatively, a better definition would be inability to obtain or sustain erection.

Causes of Impotence

Constitutional causes of impotence are related to persistence of low sexual drive and responsiveness. Sometimes there is a history of sexual interference either from self masturbation or homosexual contacts.

About 5% of all impotence according to the U.K. figures are due to organic causes which consist of the following:—

Metabolic diseases,
Central nervous diseases,
Cardiovascular disorders,
Any debilitating disease,
Drugs,
Endocrinological disorders:—

adrenal tumours
acromegaly
craniopharyngioma
infantilism
myxoedema
obesity
thyrotoxicosis
ingestion of oestrogenic substances
diabetes mellitus
chromophobe adenoma &
feminizing interstitial-cell tumour.

Paper presented at the 4th Combined Colleges Conference and S.E.A. Regional Meeting of W.O.N.C.A. in Manila, Philippines from 17th — 20th September 1979.

Drugs commonly used by family physicians are important causes of impotence and are sometimes forgotten in the history of patients complaining of impotence. These are narcotics, alcohol (Alcohol, says Macbeth's porter, promotes sexual desire but diminishes the performance.), alphas-methyl dopa, guanethedine, reserpine, nicotine, digitalis, phenothiazines, atropine, chlordiazepoxide, imipramine, monoamine-oxidase inhibitors etc.

Although the most likely causes of impotence are psychogenic, in organic causes, diabetes mellitus is the commonest cause of this complaint. These are conditions frequently encountered in the practice of family medicine.

The diagnostic points towards a psychogenic cause of impotence are: The acute nature of the onset; it is usually related to stress and anxiety or fatigue; it is intermittent; patients are able to have erections on masturbation and they have morning erections as well as erections from sexual fantasies.

Diabetic impotence is usually of insidious onset with a history of previous competency. Diabetes mellitus may or may not be previously diagnosed. It is progressive and more than half of the diabetics will develop impotence in five years. There will also be loss of sexual interest and reduced morning erections. These points are not without exceptions. The aetiology of diabetic impotence is obscure. Neuropathy, arteriosclerotic changes in penile vessels as well as hormonal upset have been speculated.

Anatomy & Physiology

To understand impotence and its management, let us go through briefly the anatomy and physiology of the male genitalis (Figure 1).

The anatomy of the penis. It comprises the radix (root) and the corpus (body). The former comprises three masses of erectile tissue i.e. the crura and the bulb. These are the posterior region of the corpora cavernosa and corpora spongiosum. The corpus is composed of three elongated masses of erectile tissue namely, the corpora cavernosa penis, the corpus spongiosum penis and the glans penis. Erection of the penis is a vascular phenomenon independent of muscular compression. Rapid flow from the helicine arteries fill the cavernous spaces and the distended corpus cavernosa acts as a device by compression of the veins which drain the erectile tissue.

The second, third and fourth sacral spinal nerves through the pudendal nerve and pelvic plexuses are the nerve-supply. Lamellated corpuscles are present on the glans and the bulb of penis. Stimulation of the glans and the frenulum of the penis is of great importance in the maintenance

of erection, orgasm and ejaculation of semen. The integrating centres are in the spinal cord and the descending tracts mediate the erection in response to erotic stimuli or psychic stimuli. The efferent fibres are in the pelvic splanchnic nerves termed the nervi erigentes. The sympathetic vasomotor impulses to the arterioles terminate the erection. Emission is also a sympathetic response involving the contraction of vasa deferentia and seminal vesicles via the hypogastric nerves stimuli.

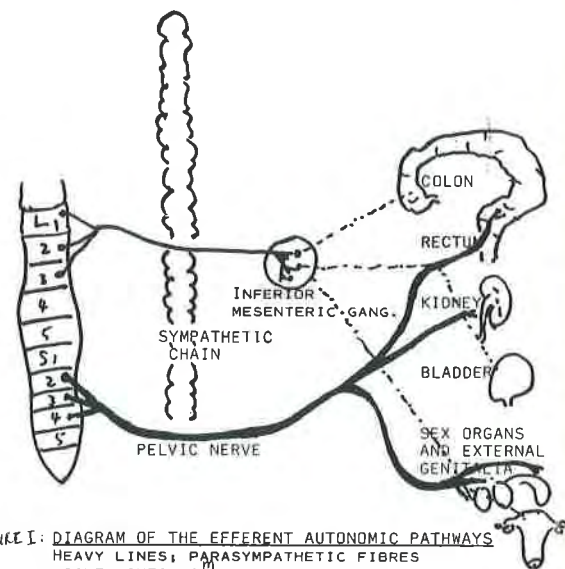


FIGURE 1: DIAGRAM OF THE EFFERENT AUTONOMIC PATHWAYS
HEAVY LINES: PARASYMPATHETIC FIBRES
LIGHT LINES: SYMPATHETIC FIBRES

Parasympathetic nerve diseases also prevent the development of tumescence of the corpora cavernosa e.g. cord tumour, tabes and multiple sclerosis.

A Study

A group totalling 220 patients within the age groups 35 years to 72 years was studied (see Figure 2). The peak for impotence is at the 35 to 45 age group and the age group of 66 years and beyond. These patients are selected at random with presenting symptoms of other complaints. Leading questions were asked regarding erections; whether there was complete atony or partial erection with temporary erection followed by softening. Less than 4 percent of male-patients confessed impotency when leading questions were asked. This figure is much higher than the actual one, as I have mentioned before. In the age-group of 46 to 60 years, the low percentage could be explained by the lesser number of times of coitus and in the younger age group there was greater frequency of intercourse resulting in temporary

impotence. From the age group 61 and over, the so-called male climacteric may be an explanation.

The bar-chart in figure 3 is drawn from a group of established psychogenic impotence of age 35 to 72 with a total of 27 patients. This group also includes other dysfunctions such as premature

ejaculation and lack of interest as these more often than not overlap the complaints of erectile problems. Partial failure of erection, total failure of erection and inability to maintain erection are the most frequent complaints of the twenty-two patients studied.

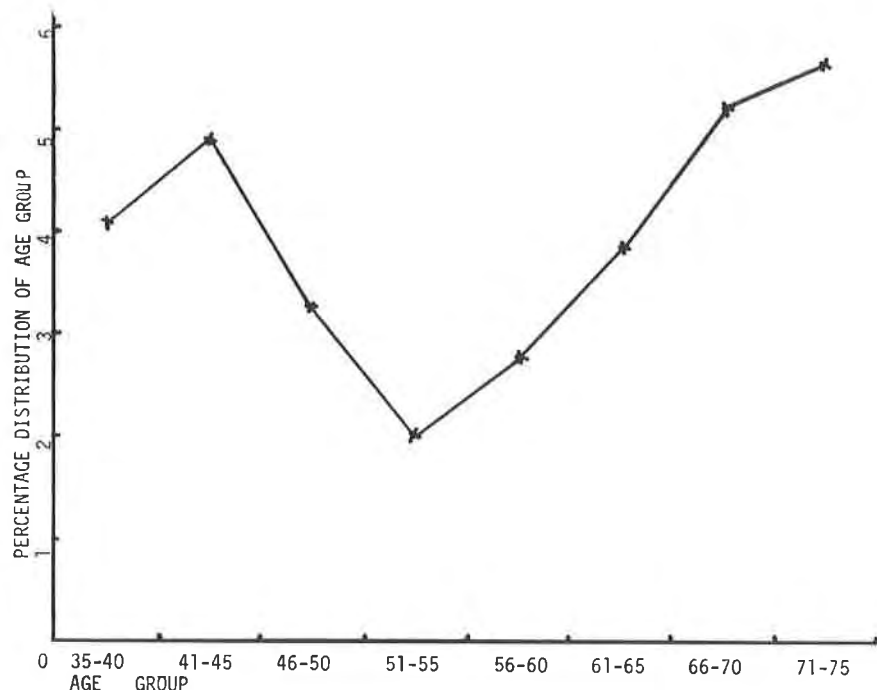


Figure 2. IMPOTENCE RELATED TO AGE GROUP IN STRATIFIED SAMPLE WITH TOTAL OF 220 MALE PATIENTS.

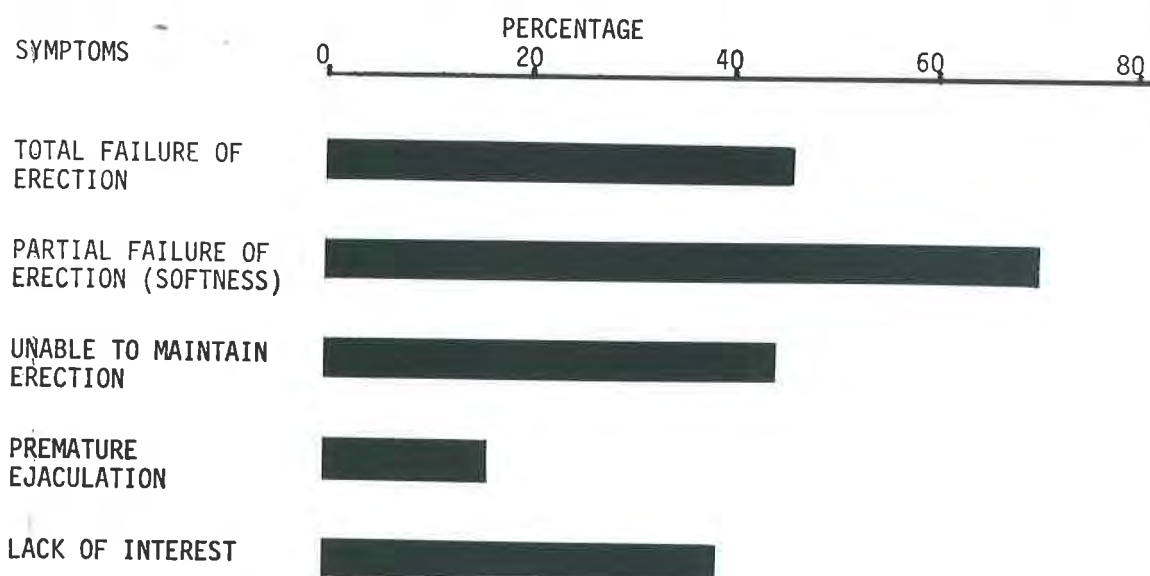


FIGURE 3. A BAR CHART SHOWING THE PERCENTAGE OF 27 PATIENTS WITH THE ABOVE SYMPTOMS IN FUNCTIONAL IMPOTENCE.

Of these patients with impotence only 6 patients i.e. 22% responded to treatment with daily tablets (for 3 months) of Vitamin B1 100mg (aneurine) combined with Vitamin B12 1000 mcg. (cyanocobalamine).

Perhaps physical relaxation has a beneficial effect on impotence. Aneurine and cyanocobalamine theoretically have direct nutritional effects on the neurones and nerve-supply to erectile tissues. These combinations serve as adjuvant to the psychotherapy and sex counselling.

The Role of The Family Physician

The role of a family physician in the diagnosis and management of psychogenic impotence is important. In the history taking, he must ask leading questions to screen the shy group of male patients who have problems of impotency but not presenting it as the chief complaint.

In any case of impotence, detailed sexual history is mandatory. Questions asked include the time of puberty, the age of awareness of sex, the age when masturbation started, premarital sexual experience, the type of impotence or the type of sexual dysfunction, relationship with his spouse and extramarital sex. A direct history from his spouse is also rewarding.

Since the majority of impotence are psychogenic, the family physician should provide the reassurance. Sometimes sexual education to the couple is better than individual advice. The partner is taught how to be patient and not loose temper or insult the male ego as this may make the situation worse. Most men are intimidated and ashamed to deal with erectile failure. Lack of confidence or fear of failure may be corrected by encouragement from the spouse. Mild sedatives may be required before the coital act when psychogenic depression is the underlying factor.

Sometimes counselling of the non-marital relationship is more important than dealing directly with impotence itself. Inhibition during childhood, parent-child relationship etc. may be part of the cause. For example, fear of having heart disease with frequent sex, fear of disturbance by adult children, privacy etc. are just a portion of it to be explored by the family physician.

Social factors as mentioned above can also give rise to inhibitions. In Singapore we have one-hall-one-room flats and all children, mother-in-law etc. are residing in one house. Spouses working in different shifts apart from fatigue may also require correction. One patient complained of his younger daughter coming into his bedroom in the middle of the night and try to sleep between him and his wife resulting in his fear and impotence.

Individually, masturbation techniques is taught so that certain inhibition is abolished. Masters and Johnson's technique of sensate focus can sometimes tackle some sexual dysfunction. Diversion of the attention of penile erection to the partner's response is particularly useful in some of my patients. A fast vaginal entry is never successful and the squeezing technique may have to be employed. Semen's technique of repeated masturbation to a point short of ejaculation is sometimes helpful.

A list of androgenic hormones available in Singapore is provided in Appendix I. They are of doubtful value in the treatment of impotence in my experience. Western workers have conflicting evidence.

Conclusion

The role of the family physician in this increasingly important disorder of sex in this part of the world is to provide reassurance, counselling and maintaining the marital and non-marital relationship of the patient.

He must also make a great attempt to screen out the shy and inhibited group of patients. He must also be aware of female patients with certain psychosomatic disorders that may be the result of her spouse's sexual dysfunction. In other words, sexual history is always included in any psychosomatic disorder of patients of either sex.

APPENDIX I

A. LIST OF ANDROGENIC HORMONES AVAILABLE IN OUR MARKET

1. Depo Testosterone inj; Upjohn; testosterone cyclopentyl-propionate 100mg/cc
2. Halotestin tablet; Upjohn; Fluoxymesterone 5mg.
3. Lipolit Forte Tablet; Sarget; Methyltestosterone 5mg, vit. E, EphedrineHCL, caffeine, Lecithin, glycerophosphate, ext. liriosma ovata, yohimbine
4. Neo-Testophos tablet; Seigried; Sod salt of a-hydroxy-benzyl phosphinic acid 100 mg, methyltestosterone vit. E, yohimbine HCL ext cola.
5. Pasuma Strong Tablet; E Merck; Methyltestosterone, a-tocopherolacetate, yohimbine, caffeine, strychnine glycerophosphate.
6. Potensan Forte pill; Medo-chemicals; Yohimbine, methyl testosterone, pemoline, strychnine

7. Provironum tablet; Schering Mesterolone. 10 or 25 mg.
8. Sunviron Tablet; Mesterolone 10 mg.
9. Testifortan inj. Byk-Gulden; testes ext; phenylpropionate papaverine, yohimbine, pulverized testes, glycophosphate, strychnine, yohimbine, a caffeine 17, a-methyltestosterone, D a-tocopherol succinate, pulverized and pituitary gland
10. Testoviron Depot; Schering; Testosterone propionate 25 mg testosterone oenanthate 110 mg.
11. Testo-Tropin; Leo; testosterone propionate 2.5 mg. chorionic gonadotrophin 1000 iu
12. Tonovan capsule; Schering AG; mesterolone 7.5 mg a-tocopherol acetate 11 mg. yohimbine 3mg., strychnine 0.1mg., Mg Nicotinate 10 mg.
13. Triolandren injection; Ciba; Testosterone propionate 20 mg Testosterone n-valerianate, testosterone undecylenate

B. LIST OF ANDROGENIC HORMONES SIMPLIFIED

Depo Testosterone inj
Halotestin tablet
Lipolit Forte Tablet
Neo-Testophos Tablet
Pasuma Strong Tablet
Potensan Forte Pill
Provironum tablet
Sunviron
Testifortan inj/tab
Testoviron-depot inj
Testotropin inj
Tonovan Cap.
Triolandren inj.

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News from the Council

- 1 The Censors Board has announced that the Eighth College Examination will be held over 2 week ends in October/November 1980. The dates will be announced later.

- 2 **Continuing Education**

A Course in Psychological Medicine will be held in March/April 1980.

Video Cassettes and Audio Tapes are available from our Library. The Committee would like to inform members that the audio tapes borrowed may be sent by post for the convenience of members.

The Home Study Programme of our College has been well received by members. So far the following programs have been sent out to members:

- i) Pulmonary Tuberculosis
- ii) Management of Patients with genital discharge following promiscuous sexual intercourse
- iii) Management of patients with genital ulcers following promiscuous sexual intercourse.

The co-ordinator would welcome more feedback from members to further improve the program.

- 3 Undergraduate posting to Family Physicians/General Practitioners for the academic session 1979/80 will be from 21 April 1980 to 28 June 1980. The students will be attached to the private clinics for one week only.
- 4 The Finance Committee will be writing to members to contribute generously towards the College Building Development and Research Fund. To date Council Members have pledged a total of \$28,000.00.

MEDICAL NEWS

Ginseng Abuse

Ginseng has been used by Oriental for thousands of years as a tonic and a stimulant. Now it is a popular remedy in the United States. Ginseng is derived from a variety of plants, and its active ingredients consist of a mixture of glycosides. It is usually taken orally, but some individuals have experimented with intranasal or injection routes.

Siegel reports that long-term heavy use of ginseng may produce a symptom complex which he refers to as the "ginseng abuse syndrome," or GAS. The symptom complex consists of hypertension, nervousness, insomnia, skin eruptions and diarrhea. Edema was observed in a few subjects. The average daily dose of ginseng in individuals with GAS was 3 Gm. of the root material. A number of GAS subjects experienced psychologic changes such as mood elevation, euphoria, agitation and restlessness. The hypertension observed in some of the subjects was considered to be due to the central nervous system excitatory actions of the glycoside components of ginseng.

Individuals exhibiting GAS should be withdrawn from ginseng and should be monitored for possible hypotensive crises during the withdrawal period. (*JAMA*, April 13, 1979, p. 1614.)

TIME JAN 28. 1980.

Smoke Signs

New alert for women

For years women had the consolation that cigarette smoking was somehow more hazardous to men. No longer. In a 400-page report to Congress last week, Surgeon General Julius Richmond said that women face the same dangers in smoking as men. Indeed, lung cancer deaths among women are rising so rapidly that by 1983 the smoking-related disease should overtake breast cancer as the leading cancer killer of U.S. women. The reason, says Richmond, is that so many women picked up the habit during and after World War II, a full 25 years after men did; and lung cancer often takes that long to develop.

The report also emphasized that pregnant women who smoke risk spontaneous abortion

and neonatal death, and that their babies weigh an average 200 gm (7 oz.) less than those of non-smoking mothers. And though smoking among both men and women overall has declined, young women between 17 and 24 are now outsmoking their male peers.

What Others Are Saying ... 'Seat Belt Syndrome'

Seat belt use may increase risk of a ruptured diaphragm, multiple costal fractures and pelvic or vertebral fractures in short individuals, according to a report by Bergqvist, Dahlgren and Hedelin of Sweden.

The "seat belt syndrome" affects those who are shorter than the average-sized man for whom seat belts are typically designed. The authors believe that the injuries occur because the diagonal seat belt strap is placed too high on the thoracic wall of the shorter-than-average person. On impact, the lower section of the belt may produce a pelvic or vertebral fracture, which causes a rapid rise in intra-abdominal pressure and expands the diaphragm upward. Simultaneously, the poor fitted diagonal strap of the seat belt produces costal fractures which create a counteracting tearing force in the diaphragm, thereby causing a rupture.

The authors support their hypothesis with the fact that approximately one-half of patients sustaining intra-abdominal injuries in automobile accidents are women, despite a much lower frequency of women involved in car accidents. ("Diaphragmatic Rupture May Be the Result of Seatbelt Injury," *Modern Medicine*, April 20-May 15, 1979, p. 68).

Propensity for Anorexia Nervosa Found in Ballet Dancers

(132nd Annual Meeting of the American Psychiatric Association) Findings from a study of eating attitudes among female ballet dancers support the theory that cultural pressures play a role in the pathogenesis of anorexia nervosa. On the basis that these individuals must focus increased attention on body size, coupled with results from a questionnaire which elicited eating attitudes among this population, professional dance students are identified as a

group at risk for the development of anorexia nervosa. When compared to test scores of 59 normal female university students and 33 patients with anorexia nervosa, assessment of symptoms of anorexia nervosa in 112 dance students, based on findings from the Eating Attitudes Test, revealed that 28 percent of the dance students had test scores in the range of anorexia nervosa patients. In addition, six cases of primary anorexia nervosa were diagnosed in the dance group. It is postulated that individuals with the psychologic characteristics of anorexia nervosa but with minimal weight loss — the "thin fat" syndrome — may selectively enter dance school, an environment that stresses body size and possibly fosters the development of dieting problems and anorexia nervosa. — DAVID MARSHALL GARNER, PH.D. and PAUL GARFINKEL, M.D.,

Death row Should doctors co-operate?

Capital punishment is most humane when carried out by 1. hanging, 2 firing squad, 3. electric chair, 4. gas chamber or 5. lethal injection?

Since 1977 four states in the United States have opted for the fifth choice, and others may soon be doing the same. The state legislators have practical as well as humanitarian motives; they believe that juries will be less reluctant to view the death penalty as "cruel and unusual punishment" if it is carried out by injection. But the lethal substance, probably a fast-acting barbiturate mixed with a paralyzing chemical agent, would have to be administered at least indirectly by a physician. And that, charged a Boston doctor and a lawyer, would constitute a cruel and unusual breach of medical ethics.

Writing in the New England Journal of Medicine, William J. Curran, 52, professor of legal medicine at Harvard Medical School, and Ward Casscells, 28, a resident at Boston's Beth Israel Hospital, maintain that death by injection, however carried out, violates the Hippocratic oath, by which all doctors vow never to harm their patients wilfully. In fact, the oath specifically forbids using or suggesting the use of poisons. The policy adopted by Oklahoma tries to avoid any conflict with medical ethics by requiring "trained medical employees" to insert a drug-carrying catheter and inject the lethal substance. But does that relieve doctors of their responsibility? Not really, say the authors. They point out that a doctor must still prescribe the drug, supervise the lethal injection and pronounce the prisoner dead.

Routine Circumcision

There is no sound argument for routine circumcision of the newborn male, comments Gellis. While the risk of penile cancer is somewhat greater in the uncircumcised male, there are more deaths each year from complications of circumcision than from cancer of the penis. Likewise, there are no solid data to prove that malignant neoplasms in the genital tracts of women married to circumcised men are less frequent.

It is unlikely that a discussion of the hazards of circumcision will deter parents who insist on the procedure because of religious beliefs. However, two recent reports should prompt the physician to become more positive in discouraging circumcision of the newborn.

In one study, Annunziato and Goldblum report three cases of the staphylococcal scalded skin syndrome complicating circumcision in the newborn. This condition is due to infection with *Staphylococcus aureus*, which releases an exotoxin causing separation of the epidermis from the basement membrane. This disease can be rapidly fatal if untreated. Any rash, especially pustulosis, should force the surgeon to delay the procedure. An outbreak of staphylococcal infection in the nursery is also a contraindication.

In a second report, Sussman and his associates note that Fournier's syndrome, a malignant gangrenous infection of the scrotum or penis and the perineum, is another complication which can occur.

Many complications of elective circumcision are reported. Haemorrhage is the most common, followed closely by local infection. Other more severe infections include partial necrosis of the penis, staphylococcal septicemia with osteomyelitis, pulmonary abscesses and neonatal sepsis. Rare complications include urethral fistula, circumcision of unrecognized hypospadias, laceration of the penile and scrotal skin, wound dehiscence, urinary retention from a too-tight dressing, injury to the glans, retention of a plastic device ring with edema of the penile shaft and surgical bi-valving of either the dorsal or ventral half of the glans while making the dorsal slit.

Gellis notes that the circumcised infant is currently at greater risk than ever before. He is likely to be in a large newborn nursery and therefore exposed to even greater numbers of organisms that have been altered by their own exposure to multiple antibiotics. These organisms can enter through the nose, mouth, conjunctiva and umbilicus. The raw wound following the circumcision is another entry site. (*American Journal of Diseases of Children*, December 1978, pp. 1168, 1187 and 1189.)

BOOK REVIEW

Practical Ophthalmic Microsurgery

Arthur Lim Siew Ming

85 pages. Price: not stated.

Publishers: PG Medical Books, Singapore, 1980
S Karger AG, Basel.

This is the latest book by ASM Lim, a companion volume to his previous books on Practical Ophthalmology and the Colour Atlas of Ophthalmology.

This book is made up of eight chapters with one chapter on Developments in Microscope Designs by Professor Saiichi Mishima of the University of Tokyo. This chapter discusses the desirable features of a modern operating microscope not forgetting the need to document photographically with either the still or movie camera and colour television link-up. There are 83 illustrations and 3 tables. The 70 colour illustrations showing a high standard of photography are perhaps the photographic documentation which the modern operating microscope is capable of producing.

In the other seven chapters the author sets out to convince his readers, "ophthalmic surgeons, surgeons from other disciplines, theatre sisters and others interested in microsurgical techniques", to make greater use of the operating microscope because of its numerous advantages. The fact that presently only 30% of ophthalmic surgeons in developed countries and 10% in developing countries do in fact use the operating microscope, does not seem to deter him from his "mission".

With the same "missionary" zeal he sets down with meticulous care and detail the necessary steps in reaching the desired objective — the mastery of the operating microscope.

Normal vision has many implications. It means a circumscribed field of vision, a certain depth of focus and a visual acuity of modest clarity and resolution. Our tactual experiences since birth are conditioned by these limitations of nor-

mal vision. The microscope in magnifying our acuity of vision places limitations on both the field and depth of microscopic vision. With magnified vision our tactual movements for microscopic work become clumsy and gross and cannot really serve it well. The normal visual-tactual linkages have to be reforged. It is of course a tribute to man's versatility and adaptability that he can overcome the initial clumsiness accompanying magnified vision. With sufficient practice new visual-tactual linkages are forged and the normal person can master the necessary finer movements of his hands which microscopic vision demands.

The watchmaker, the jeweller, the Chinese seal carver and those whose skill permit them to carve on even a grain of rice are examples of people who have mastered the techniques imposed by magnified vision. If one lesson can be learned from these expert craftsmen it is this. Training to use the hands effectively with magnified vision has to be learned early. Subsequently it is practice, practice and more practice.

The surgeon who operates with magnified vision soon realises the inadequacy of instruments and tools made for normal vision. In the case of microscopic suturing material, he has to take into consideration its fragility in relation to the tension that can be put on it. The techniques of microsuturing have to be learned and mastered by the only way possible — practice, practice and more practice.

With wisdom accrued practicality, the author discusses the common errors in the use of the operating microscope; its structure, choice and care; the microinstruments, microneedles and microsutures; the 10/0 monofilament nylon; the basic techniques of suturing under the operating microscope and learning ophthalmic microsurgery in the laboratory and workshops. Teaching assignments are listed in Appendix I of the book. A useful list of microsurgical equipment suppliers with their addresses is included in Appen-

dix II. The Index of the book is certainly no disappointment to me. It gives every indication of thoroughness and painstaking care and it certainly reflects well on the author.

This book is the testimony of one who has done it and found it advantageous. He now records and informs anyone who wants to do it the shortest and best way to achieve it. A trail-blazer who records his trail and maps out the difficult terrain and pitfalls deserves the accolade of congratulations.

One minor criticism of no consequence. One sentence on page 70 lacks clarity and should be rewritten in subsequent issues. This is the first sentence following the title "Microvascular surgery and ophthalmic microsurgery". The words "According to" are clearly redundant and should have been deleted at the proof-reading stage.

I find this book interesting not because I am likely to perform microsurgery after reading it. It certainly illustrates the fact that although technology may extend one of our senses, it also makes demands on one or more of the other senses in its service.

L. V. C.

A NEW APPROACH TO MEDICINE — John Fry.
MTP Press Ltd, England. 154 pp.

When I first wrote on Primary Health Care in a medical article fifteen years ago, the term PHC was one few doctors in Singapore had heard about. My interest in primary health care was generated by writers like John Fry, and John Hunt, eminent family physicians who blazed the trail of the family doctor as the primary care physician. Today the term primary health care is much bandied about but even now some of us are still unsure as to where primary health care begins and ends.

This new book by John Fry should be read by all those who want a clearer picture of what Pri-

mary Health Care is all about. What are its contents and implications? Who comes and why? These are interesting chapters that set out to delineate the work of the Primary Health Care physician. Few authors are as well qualified as John Fry to give his views on the subject. Besides being a busy general practitioner, he also served as Consultant to the World Health Organisation on a number of occasions, and is the Chairman of the Board of Censors of the Royal College of General Practitioners.

If you think the advanced industrial countries are the ones who are in the forefront of primary health care, you should think again. He writes, "The most exciting examples of primary care team-work come from developing countries." If you think the doctor is the pillar of the primary health team, you should also do a re-think. "No longer is the physician considered the most important member of the team," says John Fry.

A good book must stimulate the reader to think, and this Dr. Fry does so admirably. I have always found him full of new ideas. What is "negative health education"? Looks like one of the dreaded terms medical students in social medicine especially abhor. Find out by reading this book.

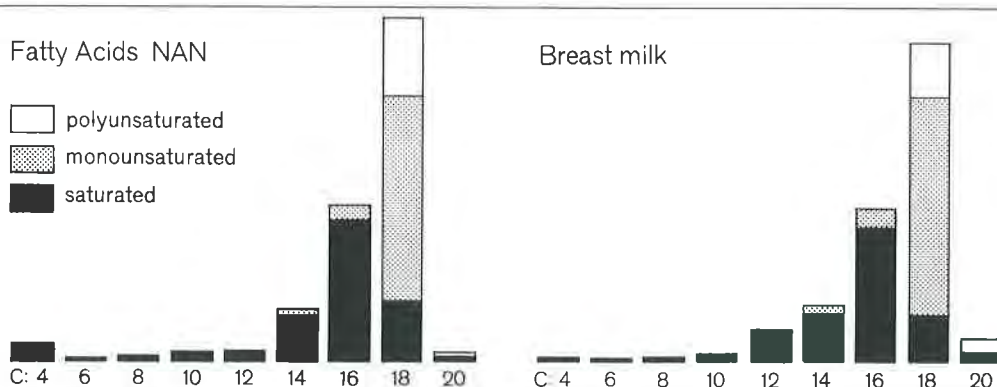
He introduces a new word which we would probably see more of in the future — the "specialoid". What is a specialoid? "In the USA with its pluralistic system, the family has free access to the whole range of specialoids (paediatrician, internist, psychiatrist, OBC, etc) and true specialists," observes Dr. Fry. When is a specialoid a specialist?

Being a true family physician he does not forget to emphasize the need for the caring doctor. Far too many doctors suffer from the ALG syndrome (Acting Like God) he contends. Only when a doctor is honest and humble does he really become a good doctor. And who can quarrel with that!

E. K. Koh.

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