

THE SINGAPORE FAMILY PHYSICIAN



**THE COLLEGE OF GENERAL PRACTITIONERS
SINGAPORE**

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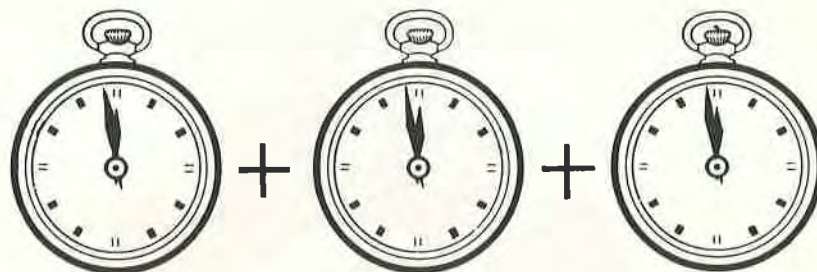
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Editorial:

PRIMARY MEDICAL CARE

The recent debate in Parliament on the raising of attendance fees at the A & E Units of our general hospitals focusses attention again on the need for good primary medical care in the Republic.

Proponents of the raise in the Ministry of Health justify it in saying that too many people still clog up the emergency units with minor ailments thus reducing the efficiency of the doctors working there. Those opposed to the raise counter this by saying that if ready access to the A & E Unit was denied to the sick then the burden of deciding whether the ailment was an emergency or not rested upon the patients themselves, people who perhaps were least qualified to make the judgement.

Leaving aside the argument whether higher cost of attendance at an A & E Unit is a justifiable or effective deterrent against patients coming in with minor complaints, the Ministry is right in insisting that the Emergency Unit is not the correct place to treat all types of medical ailments. The only place where this should be done is the Primary Medical Care centre but although our out-patient services function during the day we do not have primary care centres which function continually for 24 hours. Nor is it practical or economical to do so.

There are problems enough at present trying to staff the out-patient services, and if late night clinics were introduced, a mass exodus of medical officers from the O.P.S. might well result.

The A & E Unit is the portal of entry to secondary and tertiary medical care and if it is to fulfil its role efficiently there can be no other recourse but to use it as such.

What then of the patient who seeks primary care in the middle of the night? For a start no patient should really wait till the odd hours of the night to start frantically looking around for medical attention. Very few ailments strike like a bolt out of the blue in the middle of the night. Most ailments give early warning or prodromal symptoms. Too few people however heed these signs hence the panic to scamper for medical treatment when most people are already in bed.

From five in the afternoon to nine in the evenings primary medical care is provided by the many GPs who hold night clinics. Most of these clinics do not have a surcharge for seeing patients outside the normal hours of nine to five in the day and there should not be much hardship for those who wish to consult the doctor for their ailments outside the usual clinic hours.

The problem really arises when all the clinics are closed and although GPs do attend to their own patients when called, some may find it a financial hardship to have to call in a GP in the early hours of the morning. Still some form of primary care must be available, the patient must not be left with the burden of deciding whether he was a medical emergency or not. Hence all cases reporting to the A & E Unit from midnight to 7 am in the morning should not be charged \$10 per visit, the charges should be the usual charge of \$4. This would mean the poor would not be denied proper medical care in the early hours of the morning, and no seriously ill case would have to stay away because of faulty self-diagnosis by the patient. It is also extremely unlikely that any person would want to pop into the A & E Unit at 1 am in the morning merely to have a bottle of cough mixture.

Unless we can offer a round the clock primary medical care service the A & E Units will unfortunately have to bear a little of the burden. Comforting a frightened patient in the wee hours of the morning may not be as dramatic as attending to a surgical emergency, but it nonetheless provides relief to someone in distress. After all isn't this what medicine is all about.

E. K.

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

College Gift to Convention '77



Dr. V.L. Fernandez, President of the College presenting a plaque to the President of the Malaysian College of General Practitioners Tan Sri Dr. Mohamed Din at the combined Colleges Conference at Kuala Lumpur. (Picture courtesy of New Straits Times).

WONCA Executive



Seated – Right to left: Dr Donald I Rice, Past President, Canada; Dr David A Game, Hon. Secretary/Treasurer, Australia; Dr Stuart Carne (Chairman), President, U.K.; Dr E Kowaleski, President-Elect, U.S.A.; Mrs. Max Dunston, Secretarial Assistant, Australia.

Standing – Right to left: Dr D P Finnegan, Editor, Wonca News (Observer), Australia; Dr V L Fernandez, President, CGP(S) (Observer) Singapore; Dr G Goh Representing Tan Sri, Datuk Dr Mohd Din bin Ahmad – President, CGP (M) (Observer), Malaysia; Dr A Robles, Member of Executive Mexico; Dr R C Montes, Representing Dr E B Morales – President, Philippine Academy of Family Physicians (Observer), The Philippines; Dr Wong Heck Sing Member of Executive, Singapore.

REPORT ON THE 3RD COMBINED CONFERENCE OF ASIAN AND PACIFIC COLLEGES OF GENERAL PRACTICE.

HELD AT EQUATORIAL HOTEL, KUALA LUMPUR, 8-11 September 1977.

CONFERENCE THEME:

'CARING FOR THE COMMUNITY'

FIRST DAY: THEME: PRIMARY CARE OF THE COMMUNITY:

The opening ceremony was addressed by the Honourable Deputy Prime Minister Datuk Seri Mahathir bin Mohamad; and the first Plenary then followed.

The four panel speakers presented their papers and covered the essence of the whole Conferences theme. Dr Rajakumar stressed the importance of primary care and the true role of the General Practitioner in supplying this basic requirement to the Community. He also stressed that if the Primary care was well presented then the overall cost would be much less as the number of problems that could be dealt with at the GP level was immense; but unfortunately a lot of GP work failed in this regard, and numerous problems were allowed to get to the stage of requiring expensive other care.

He also pointed out that Primary care was a true speciality and GPs should not avoid the task at hand, becoming involved in peripheral issues.

Prof. Neil Carson then carefully outlined the Processes and content of General Practice, detailing the important aspects of first contact medicine and the GP's role. He showed how the processes could be divided into those specifically associated with GP and not seen in other medical care situations; specialities within General Practice, Disease prevalence and diseases

only requiring convenient medical services and the Non-medical and Medical skills of the GP.

Dr. Raj Karim then covered the problems of the delivery of adequate primary medical care to the rural areas of Malaysia, pointing out the problems of communities, local medicines, herbalists and the other obstacles that had to be overcome; as well as the perennial problem of money and trained personnel.

Dr. Fred Samuel then raised the interesting historical point, that GP's were the originators of the hospital, but with the division into specialities, the Specialists have pushed the GP out into the community and even denied the GP the right of continuing care to his own patients. However it was noted that there has been a large upsurge of GPs returning to the hospital, and where this has been denied, the GPs have started their own primary care hospitals. Examples of such hospitals were then shown.

The discussion then centred around the points raised by the speakers, but it was interesting to note that none of the opening lecturers even defined the communities or primary care, before launching into their topics.

The papers presented then covered more detail of the above main theme; with Dr. Dobson covering the interplay of the Doctor, the patients and the Community. He indicated the importance of

recognising the demands of the patient and the Doctor's expectations of the patient, and how these were important in the overall result of primary care; and especially the effect on the result of the care.

Dr. P. Robinson then covered the Experience gained in operating the New Zealand Forces Hospital at Sembawang in Singapore, and indicated that the hospital was a true General Practice hospital, but the cost of running it was high, but when compared to the overall supply of primary care, it was cost effective.

Dr. Param Palam briefly covered the important aspects that must be considered in the proper Health Delivery to people in developing countries.

SECOND DAY: THEME: HEALTH EDUCATION IN THE COMMUNITY:

This session was initiated by the lectures of Prof Paul Chen, and Dr. V.S. Rajan. Prof Chen showed how the interplay of local customs, native superstitions, massive advertising and pressurising by Multinational Companies and the community can have markedly adverse effects on the health of the community. He showed how the local use of herbs could actually make the illness worse and that the "super-food" image of highly refined food products were causing more problems than helping. This was done with highly illustrative slides and the description of the importance of human behavioural patterns and their interrelationship with the disease patterns.

Dr. Rajan then covered the important topic of preventative education against sexually transmitted diseases. He showed clearly that the present education patterns were ineffective, and pointed to far more active utilisation of media to convey the basic facts, that have not been communicated adequately with the present teaching procedures.

Three papers were then presented, the first questioning who should be educating whom and what were the more effective methods available.

The second paper covered the Importance of Education on Breast Feeding, and Dr. Ruby Majeed showed the effects of half hearted education and the Multinational "free" milk in hospitals; which had caused a large number of the problems that Prof. Chen had touched on earlier. Dr. Tan then detailed the GP's role in the sex education of the patient; and he clearly pointed out the lack of both training and knowledge caused a lot of the problems experienced by GPs; and that the lack of time was really a very poor excuse for the GP.

The session then divided into three sections for the workshops.

The first workshop covered the topic of Educating the Patient; and the first presentation detailed the problems of educating the people in a new Malaysian village. The success of the venture was largely due to the positive attitude of the doctors and associated health people living in the village. Health education in the general practice was then described, but it did not break any new ground, with the same problem of time and patient demand being the stumbling block.

The role of the GP and Travellers was discussed, but the overall comment was that the Travel Agents should be trained to properly inform the public of the likely health risks, as the public rarely asked the GP, who frequently was unaware of the problems.

The paper on Prickly Heat was one of the few which dealt with the basis of educating the patient. In presenting this paper, Dr. McKay demonstrated the need for the Doctor to first re-educate himself, to understand the patho-physiology of the disease; then to ignore all the false claims by the drug companies; and most importantly to educate the patient on the management, thus preventing unnecessary complications of incorrect treatment.

Health Education for the Community was then highlighted by Dr. Mak from Hong Kong; and he introduced some novel approaches which may prove effective. The discussion centred around the paper on Prickly Heat, with a Sri Lankan dermatolo-

gist admitting that he was not really sure why he treated Prickly Heat with powders but he was now more aware of the need to consider the true disease state before putting anything on the skin.

The Second workshop dealt with the problems of breast feeding in the Asian communities. The main points were the effects of the Multinational companies, the bad effects of the hospital on the mother with the new baby; the need for increased education of both hospital and community nurses to teach the benefits of breast feeding and thus reverse the trend of a reduction in the incidence of breast feeding.

The third workshop dealt with the problems of conjoint marital therapy, VD in Sex Education, Young people and VD and Sex Education and the GP. These presentations resulted in a lively discussion of who should be doing what and what were the real needs of the community with the greater realisation of the part played by the GP in the education and preventative aspects of Sex Education and VD reduction in the community.

THIRD DAY: THEME: CLINICAL PROBLEMS IN GENERAL PRACTICE:

Prof H.O. Wong opened this session with a quick refresher on the importance of looking and being aware; and that this was the GP's greatest asset in the delivery of primary care. The talk was well illustrated with many slides. The second speaker was Dr Abu Bakar Sulaiman who covered the causes and importance of Proteinuria. This was enlightening for the GPs and certainly refreshed the memories of many doctors.

The papers presented were on varying topics, and Dr Balasundaram managed to condense into 20 minutes a whole review of the diagnostic problems of a GP. A brief visit to a text book may have been a better title of his paper! Dr. Catterall then covered the topic of Initiating Treatment in Emergencies with grace and great educative benefit. He pointed out the need for Basic knowledge and proper rapid assessment of the injured at the time of an emergency.

He then proceeded to delineate the important and basic actions that GPs should follow in the various emergency situations.

The highlight of the morning came with Dr. Liew Fu San and his brief treatise on Acupuncture. He managed to convince most listeners that self limiting disease will get better in the same amount of time, whether treated with conventional methods or acupuncture. He did however put forward the most important point that if the patient has confidence in his doctor, the form of the treatment is only secondary, and if doctors remember this, then a lot of the drugs and medications prescribed could be done away with.

As on the previous days the session then divided into three groups for the Workshops.

The first workshop was on specific Clinical problems. Dr. Chancellor presented an example of the utilisation of the General Health Questionnaire in the detection of non-psychotic illness in General Practice. This clearly showed that the use of such a proforma can save the GP many hours of interview, and also gain more rapid results in the patients morbidity.

Dr. Liao, a Canadian Dermatologist showed what new "toys" the Dermatologists have for treating Psoriasis, Acne vulgaris, and skin cancers. She indicated that we can now rub antibiotic powders into the skin, (maybe in Canada but not in Asia/Pacific areas due to the medico-legal aspects), we can inject the acne with steroids or freeze them with liquid N₂ or apply potent oxidising agents; but she failed to convince any of the GPs present that there is any real patho-physiological basis to the success of the treatment and the advances she described are no prevention of the conditions, but merely palliation.

A comprehensive coverage of the Hyperuricaemic Syndromes was described by Dr. Seevaratnam, and he made it clear that this condition must be taken a lot more seriously than previously, because the elevated serum uric acid has been found to be associated with many other conditions; and early treatment of this may be

a step towards the prevention of the conditions.

Dr. Vaswani then described his own experience in the use of beta-blockers and indicated that they are definitely the current major advance in medicine; which is easily understood by GP and patient alike, and is surprisingly cost-effective.

Dr. Param Palam then demonstrated a superb small problem orientated record, which was cheap, fully detailed, small, and ideal for both GP and hospital use. This will undoubtedly become the GP history/case notes of the future.

Common problems of monetary lack, transient population, poor equipment and local herbs and customs and their effect on the Obstetric and Gynaecologic practice in Bangkok were then described. The final presentation was on the problems that can confront G.P.s in group practices. This was presented by Dr. McKay, and he showed that group GPs can cause as many problems in the management and diagnosis of patients, as actual pathologies. By the use of two cases it was shown that multiple pathologies do occur in younger people and a clear approach to patient management is essential.

The second workshop dealt with the topic of Emergency Medicine, and the management of childhood convulsions, and Anaphylaxis were discussed. The ensuing discussion then centred around the medico-legal problems of emergency care

in the light of the current American situation.

The third workshop was one of entertainment, as Dr Liew tried to convert more people to the use of acupuncture, but he left the cynics cynical, the believers possibly still believing and the onlookers entertained!

FOURTH DAY: CLOSING PLENARY

This was the summary of all the proceedings of the conference, including the Lectures, the Papers and the workshops.

THE OTHER ITEMS OF THE CONFERENCE:

The first night was an entertaining Informal Night which was enjoyed by all. The demonstrations of local dances and customs were most enjoyable. The informal approach for the Saturday night Banquet was most relaxing and the typical Chinese dinner was thoroughly enjoyed by all.

Throughout the conference, the luncheons with satay, murtabah and other local dishes were fit to serve a king, and all enjoyed having their wives and children present in the idyllic pool-side setting.

The visits to the University Hospital at Petaling Jaya and then to the Kuala Lumpur General Hospital gave the conference visitors a chance to see the conditions and operations of two large hospitals in South-east Asia.

M. K.

Address by Dr. V. L. Fernandez

*President Singapore College of
General Practitioners*

It is my pleasure and privilege on behalf of the Council of General Practitioners Singapore to convey to you greetings from Singapore. Today my pleasure is twofold – not only am I bringing greetings to the President and Members of the Colleges in Malaysia, Australia, New Zealand, Hong Kong and Philippines as well as the President and Executive Committee Members of WONCA who are here for their regional meeting, but I am also deeply honoured to convey greetings personally to the Hon Deputy Prime Minister of Malaysia, Datuk Seri Dr. Mahathir Mohd and his charming wife Datin Dr. Siti Hasmah with both of whom I had the providence and privilege of starting my medical career in the class of 1947 at the University of Malaya in Singapore. That a colleague of mine should occupy such an eminent and responsible position and be of service to his nation, is a source of great pride and joy to me.

Convention '77 brings together General Practitioners from Malaysia, Singapore, Hong Kong, the Philippines, Australia, New Zealand and further afield. Though our health problems and national policies on the delivery of Primary Health Care may differ from community to community we have one thing in common; we are all concerned and committed in caring for the Community. This Convention, covering the theme "Caring for the Community" would therefore provide us with a unique opportunity to share experiences, study the problems, stresses and strains of community and family life.

Since the dawn of human civilization, Man has been concerned not only with his survival but also with his well-being. Doctors and others concerned with the everyday problems of health and sickness approach their problems from varying points of view, depending on the way they have been trained and upon the particular type of work they are engaged in within the

framework of the health care delivery system of their respective countries. There are, however, two important and essentially different lines of approach; the first is that concerned with the problem of health and sickness in the individual, and the second, the problem of health and disease in the community as a whole. Although the two are invariably inter-related we shall be dealing principally with health and disease in the community as the main theme for this convention.

History records a growth of understanding of the nature of the health and of the value which society places upon it. Through the ages, caring for the community has manifested itself in varied terminology and in many forms. It will be superfluous at this juncture to go into details but it will suffice for me to say, that the underlying theme has always been caring for the community with varied emphasis – depending on the sophistication of society, its consciousness of health, availability of funds and respective national health policies.

There are many ways of taking a hard look at "caring for the community" and defining it, but a useful working definition can be congealed as follows:

"It is the science and the art of preventing disease, prolonging life and promoting physical health and efficiency through **organized community efforts**, for the sanitation of environment, the control of community infections, the education of the individual in principles of personal hygiene, the organisation of medical and nursing service for the early diagnosis and preventive treatment of disease, and the development of social machinery which will ensure to every individual in the community a standard of living adequate for the maintenance of health."

It has been said "that a family cannot exist in a developed society without a family doctor ... but nowadays it is easier

to find a good wife than a doctor who is ready to look after you personally for as long as you want, and who understands you fully and truly." The family doctor now and of the future should therefore play a larger role if he is to practise "comprehensive medicine". He must take into account the preventive and social aspects of illness when dealing with patients and play his part fully in community schemes for the control of diseases and the promotion of health. Customs and practices may vary in different countries and would affect the way in which health services are administered. Nevertheless, there is a great deal of basic knowledge and fundamental principles that are common to people everywhere. A comparison of the relative advantages and disadvantages of different systems can be of great assistance in evaluating what are the better ways of providing optimum methods of caring for the community.

Throughout this convention various speakers will highlight and hopefully help us to understand the various aspects and allied problems of caring for the community. Let us strive and hope that this convention will stimulate thoughts and discussion for the greater care of the individual community from which we hail.

In conclusion, may I leave you with an astute and trenchant observation by Lord Hunt of Fawley that "No matter how clever the Consultants or how excellent the Hospitals, it is the efficiency of the family doctors and the work they do in and near the homes of their patients and the community that they serve, which will determine the calibre of the medical services in any country."

As CONVENTION 77 draws to a close it is with nostalgia that we reflect on the proceedings of the last few days of our fellowship exchange of ideas and discussion. The theme caring for the community has gained a wider and meaning for us family physicians in the community.

To some, I hope a minority, it has been a holiday, but to the others I am sure it was an educational and intellectual adven-

ture that will make us better doctors, bringing us a step nearer towards our ultimate goal of making FM/GP the premier discipline in the health care delivery system.

A great deal has been learnt from the plenary sessions and workshops and if we want to be accepted and respected by our peers and the community, worthy of the appellation of a specialty, we will have to work very hard to gain acceptance and prove our intrinsic merits.

I do hope that on returning home to your respective spheres of activity, you will ponder, imbibe and disseminate the new idea that you have learnt. One also hopes that in applying these ideas to your practice you would evolve new systems and methods of caring which you will bring to CONVENTION 79 in Manila to share with your colleagues.

An interesting feature of this CONVENTION 77 was the large number of observers and potential new participants from Canada, India, Pakistan, Sri Lanka and Thailand, and I hope that in future conventions they would lend us their expertise and wisdom by active participation.

While regional conferences of this nature are necessary for broad-based grass root level participation of members, one should not forget that there is a place for a global organization like WONCA to co-ordinate, guide and lend leadership towards the concept of the family physician.

It now leaves me to thank our host College the C.G.P. (Malaysia) and G.O.C. in particular, for their untiring efforts that has made Convention 77 an outstanding success. We thank them most sincerely for their supreme effort and magnificent hospitality.

On behalf of the C.G.P. (Singapore) I would now like to present a plaque to the President, members of the C.G.P. (Malaysia) to commemorate CONVENTION 77. We hope that this plaque will find a place in your Conference Room to remind you of our participation and the bonds of friendship that exist between our Sister Colleges.

REPORT ON CONVENTION '77

OPENING PLENARY

SEPTEMBER 8-11, KUALA LUMPUR.

Report on the Opening Plenary Session Thursday September 8, 1977

Dr. Warren Ogborne

When I was asked to summarize this opening plenary I was daunted by the mass of information presented by the several speakers. As so often happens, opening plenary sessions are something of a catharsis, the speakers have something to "get off their chest", and Convention '77 was no exception.

We all know for example, that most of the health care dollar is spent on the least needy, which is to say that most of the health care dollar is spent where it will do the least good, namely, in the sophisticated care of the terminally ill in research units of university teaching hospitals.

We all know for example, that despite ever-increasing expenditure on National Health, such diseases as hypertension, diabetes, myocardial infarction, stroke, renal failure and many others are on the increase, and, to an alarming degree.

Dr. Rajakumar painted for us this gloomy picture with uncompromising clarity, but he did not leave it there. The new breed of general practitioners he described were people working with their patients and their families. This he described as "an idea whose time has come" — and in so doing, was partially quoting Voltaire who said that "nothing is so powerful as an idea whose time has come". It seemed to me that this was the theme that underlined the opening plenary.

That general practice is a definable discipline with its unique content and its unique process, was stressed by Professor Carson, who encapsulated his ideas with one daring and challenging sentence when he declared that "General Practice is a health service". What we do and how we do it makes our discipline unique. This is

powerfully illustrated in Australia where the Royal Flying Doctor Service from its base at Broken Hill covers an area larger than the entire United Kingdom, and can probably lay claim to being the biggest general practice in the world. As such, it is a complete health service.

But this is a rural health service quite different to that described by Dr. Raj Karim, and yet, there is an interesting common ground. Dr. Raj Karim spoke with conviction about her "community nurses" and their vital role in rural health care. Without such nurses in Australia, our Royal Flying Doctor Service could not function. These nurses made John Flynn's "mantle of safety" a reality. I believe they will undergird your own rural health services. Their time has come, and "nothing is so powerful as an idea whose time has come".

Another idea whose time has come was suggested by Dr. Fred Samuel, namely, that general practitioners must return to their role in the hospital if they are to fulfil their duty to their patients and realise their total professional role. The general practitioner may well determine the future of the hospital in its changing role.

But what of you and me? How do we fit into this daunting picture? What can we do? Many speakers made many suggestions, for example:

- * we must be accessible to our patients,
- * we must be seen to be G.P.s by choice and not default,
- * we must keep in touch with people,
- * we must cooperate with and not confront other health professions,

* we must critically assess what we do and ask ourselves — “are we cost effective?”

* we must involve ourselves in undergraduate teaching and in vocational training programmes for our younger

colleagues,

* we must vigorously pursue our own continuing education.

As Wong Heck Sing has said: “only thus will we earn our rightful place within the medical profession”.

REPORT ON THE SECOND PLENARY SESSION FRIDAY SEPTEMBER 9, 1977

Dr. Warren Ogborne

The second plenary of Convention '77 opened with Professor Paul Chen who enthralled us with his illustrated tour through various cultural “behavioural patterns” in the society in which he lives and works. He described for us, for example that various foods eaten for reasons of nutrition, prestige, ritual and ceremony, and their various impact on health within the community. He showed us the “hocus pocus” practised in this society and threw out the challenge that to many cultural groups this offers something that we of a sophisticated and scientific west fail to offer and that we should reexamine ourselves and see whether it is not possible to bring our style of medicine closer to the cultural needs of our patients.

Dr. Rajan in sharing his vast experience in sexually transmitted diseases did not flinch from challenging us to stand for moral values that have been expressed by all great civilizations since the dawn of human history. Dr. Rajan fearlessly asserted that “happiness and freedom cannot be realised without personal self restraint”. His indictment was that our profession had been blown about by the winds of change and our silence on many moral issues has been interpreted as consent to declining moral standards within our communities.

These winds of change and our seeming

acquiescence were powerfully illustrated by Dr. Ruby binti Abdul Majeed who spoke on the importance of breast feeding. Have we as doctors created serious health problems by our disinterest in whether or not our mothers breast feed?

Dr. Ruby enumerated many important reasons why we as G.P.s must accept an educator role to encourage mothers to breast feed. Could I add to the list she provided the now proven role of breast feeding in the prevention of atopy — and that, no matter whether the baby receives breast milk from its own mothers or that of another.

The role of the general practitioner is vital in this context because he has the greatest interface with the community over a longer period and under more intimate and personal problems than any one else in our society. In Australia, for example there are 65 million doctor/patient contacts every year and as Dr. David Watson pointed out, we are there as general practitioners, by virtue of this interface, at the “teachable moment”. This moment may present itself but once and it is our responsibility to seize that moment lest we lose it forever. The question is are we equipped to act in that “teachable moment”, and are we willing to do so? — The judgement rests with our patients!

PREVENTIVE HEALTH EDUCATION IN SEXUALLY TRANSMITTED DISEASES *

DR. V.S. RAJAN

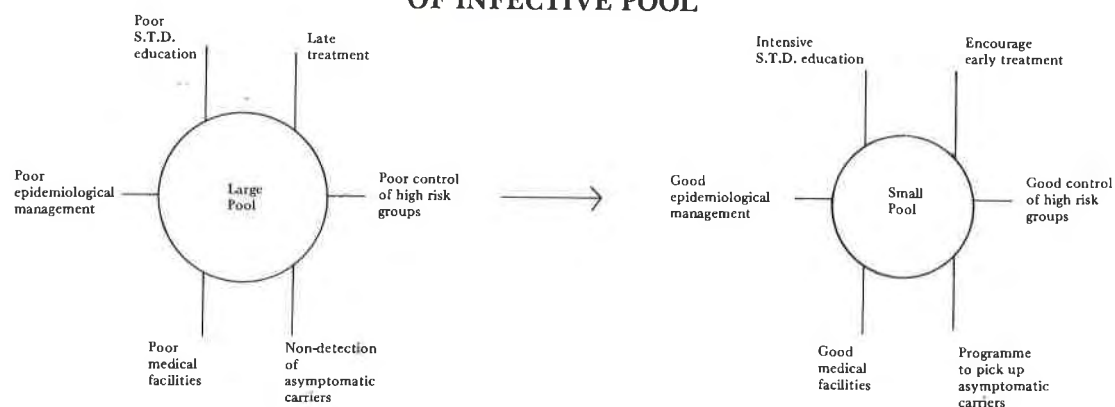
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Many factors determine the size of sexually transmitted diseases problem in a community (Figure 1). Amongst them, sexually transmitted diseases education and late treatment are two significant factors. The aim of any control programme should be to reduce the size of the infective pool within the community. Introduction, intensification or modification of sexually transmitted diseases education programmes is one modality that requires closer scrutiny and examination by doctors, administrators and leaders of public opinion.

they have been influenced considerably by the mood and attitudes of the public.

In the earlier centuries public opinion and no doubt, that of the medical profession to the question of promiscuity and sexually transmitted diseases was one of condemnation and castigation. Attitudes were authoritarian and judgemental. It was argued that these attitudes stigmatized and drove away patients from doctors to the mercy of quacks and charlatans. As an overcompensation, I guess, attitudes began to change, for the Royal Commission on

FIGURE 1
FACTORS CONTRIBUTING TO SIZE
OF INFECTIVE POOL



If the aim of education is to transmit knowledge and influence mentality and morality, then we should examine the fruits of our labour thus far in the area of sexually transmitted diseases education. Have we succeeded, and if not, why? I believe the content of sexually transmitted diseases education programmes have fallen short of attaining their objectives, because

Venereal Diseases in 1916 found it necessary to make a call for instruction in moral conduct in relation to sex matters. Nevertheless these trends were irreversible, and the permissive society of today with all its promise of universal love and bliss has arrived. We know today, at least in the context of sexually transmitted diseases, this promise is an empty one. From my

* Talk delivered at the Third Joint Colleges Conference held in Kuala Lumpur from 8-11 September 1977.

experience and reading on the subject, I am convinced the profession has swayed with this wave of public opinion. Most educational talks on sexually transmitted diseases have been designed to pass on didactic dissemination of facts about the consequences of sexually transmitted diseases and the medical services available. None of the programmes has reminded society that their attitudes on promiscuity is the root of the problem. The words, virtue and morality, have come to be dirty words to the public and we, by our chosen silence have given it sanction. I endorse the opinion of Dr Ambrose King when he said "I believe it is wrong to teach the young that there is no harm in indulging in sexual activity providing that they avoid pregnancy and venereal disease. I believe it is right to appeal to their idealism, to try to convince them that self-restraint is essential in this life, and the road to happiness and freedom lies in the ideals of love, marriage and the family." Let me hasten to say that direct attempts to lessen promiscuity will not commend universal acceptance, but let it be an expression of a point of view for discussion and debate upon which enlightened public opinion may grow. Today we call venereal disease clinics 'special clinics' and by inference venereal disease is a special

disease. I have often wondered what connotation this may have in the minds of our youths. The ancient Hindu considered smallpox a curse of God, and our youths may consider sexually transmitted diseases a special blessing of the present day permissive society!

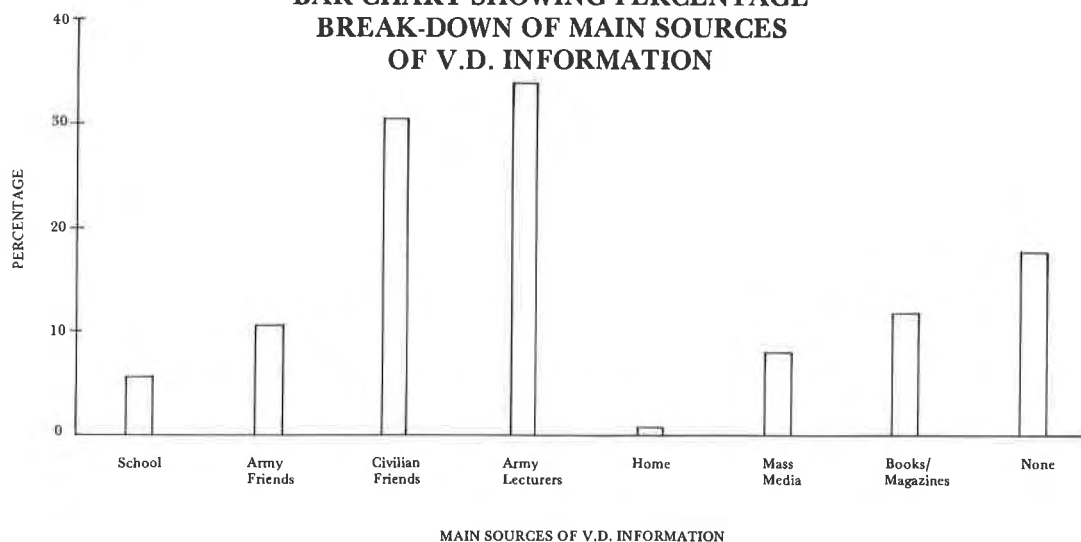
Before I am misunderstood let me add that I am not advocating the profession to turn the clock back and resort to authoritarian methods and pass moral judgement on their patients. A patient with syphilis or gonorrhoea should be treated with the same sympathy, kindness and understanding as a patient with carcinoma of the bronchus from smoking. The point I am making is the question of morality should arise before people become patients, and never thereafter.

The Need of Sexually Transmitted Diseases Education

Studies conducted in the West have shown there is considerable ignorance on sex related matters amongst the young (Schofield 1965, Morton 1967, Holmes 1968). In Indonesia and Singapore similar patterns exist (Soendjojo 1977, Rajan).

In England, parents played no significant role in sex education (Bird 1965). In Singapore, the situation is no different (Figure 2).

FIGURE 2
BAR CHART SHOWING PERCENTAGE
BREAK-DOWN OF MAIN SOURCES
OF V.D. INFORMATION



The results of a survey of young men aged 18-21 doing national service in Singapore revealed that the majority of them had unsatisfactory sexually transmitted diseases knowledge, and parents were totally inactive in this area. Thus the need for sexually transmitted diseases education is clear.

Differences of opinion prevail as to when and to whom should sexually transmitted diseases education programmes be maximally exposed to derive best benefits. These differences arise because opinions expressed are based on different population samples. I believe, before a decision is made, the local pattern of sexual behaviour should be studied, the age groups most susceptible and the existence of high risk groups, if any, in the population sample identified.

Based on our pattern in Singapore we recommend 15 to 21 years as the main target groups. This embraces secondary school children and boys doing national service. Unfortunately excluded in this set are girls who left school after primary education. Notwithstanding our recommendations, no formal teaching of sex and sexually transmitted diseases education is undertaken in Singapore secondary schools, though it is included in the health education curriculum for teachers in their training. Thus it is not surprising to learn, in a recent study, just completed in our department only 5% of the youths received any sexually transmitted diseases education in their schools and a further 43% picked up whatever they knew from friends (Figure 2) (Rajan et al). Premature exposure to sexually transmitted diseases education in children will not achieve the desired results due to lack of consciousness of the problem. Holmes (1968) however believes that for any education on sexually transmitted diseases to be useful it should be given before the age of 15.

Content of Sexually Transmitted Diseases Education Programmes

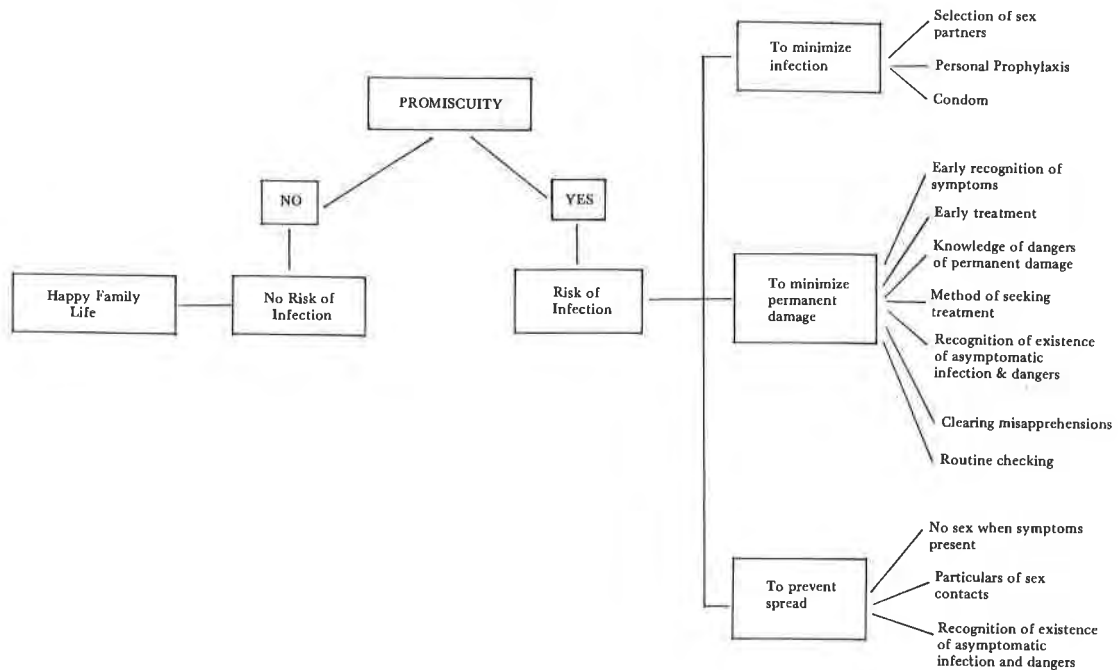
No other aspect of sexually transmitted diseases education has been more strongly

debated than its contents. The World Health Organization in a meeting in November 1974 recommended: "Two basic goals of health education in sexually transmitted diseases control can be distinguished. The first consists in the preparation of the young toward a positive appreciation of their sexuality and correct information about its health related aspects. This involves a long-term approach and is the most realistic possibility for influencing attitudes and behaviour with respect to multiple sexual contacts or to casuality in selecting sexual partners. The second goal is based on the elimination of barriers and the improvement of positive factors which will lead to the adoption of a number of basic actions among people at risk, such as the use of individual preventive measures, participation in community preventive measures, participation in community prevention, seeking of early diagnosis and treatment, and the cooperation of patients with treatment, including contact tracing."

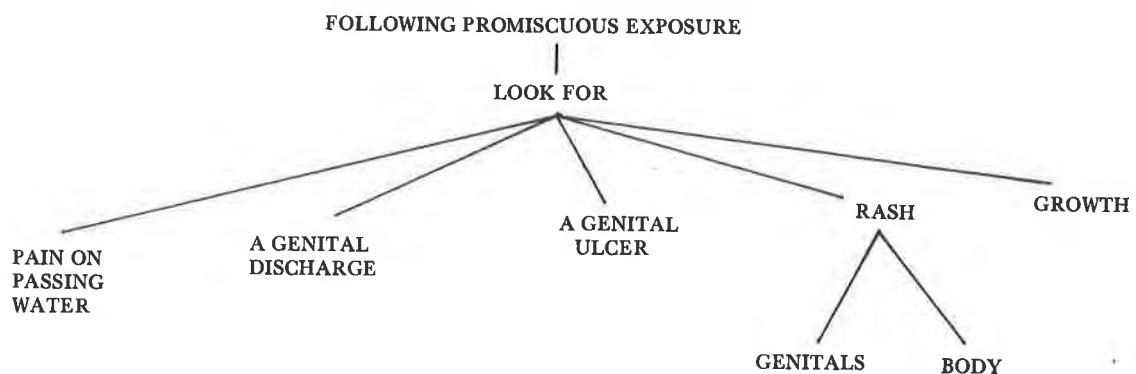
Figure 3 gives the essence of a sexually transmitted diseases educational programme. Greater stress should be focussed on the value of condoms in preventing spread of infection, recognition of symptoms of sexually transmitted diseases, the existence of asymptomatic carriers of infection in both males and females; more likely chance of asymptomatic carriers developing permanent danger and finally the importance of keeping a tag on sex contacts and providing necessary information for epidemiological control. I do not believe that any stress should be laid on the microbiological aspects of the causative organisms or details of treatment methods. Figure 4 enumerates the early symptomatology of sexually transmitted diseases that the public should be aware of.

We should not be carried away with the idea that a good all-comprehensive health education programme will eliminate most of the ills of sexually transmitted diseases. Sweden introduced compulsory sex and venereal disease education in their schools since 1956 but the gonorrhoea rates

**FIGURE 3
ESSENCE OF SEXUALLY
TRANSMITTED DISEASE EDUCATION
PROGRAMME**



**FIGURE 4
SYMPTOMATOLOGY OF SEXUALLY TRANSMITTED DISEASES**



continued to go up. However when they specifically singled out and campaigned for the use of condoms, the figures began to drop (Starck-Romanns 1973). It should be borne in mind that education is of no value if the home background is unstable and unhappy. The example of parents is of

paramount importance. To quote Parsons (1951): "Health behaviour is influenced by social norms and value-orientation patterns laid-down in childhood and not on a large scale subject to drastic alterations during life by social pressures, sanctions, or by knowledge of an intellectual type." Thus

it is just as important that grown-ups and parents be educated by value orientated programmes.

Singapore National Health Campaign

In 1976, the Ministry of Health, Singapore launched a National Health Campaign with the theme "Combat Infectious Diseases". Included in the six diseases was venereal disease and the main target groups for venereal disease were youths in and out of school. To evaluate response, a survey to assess knowledge on venereal disease before and after the campaign was undertaken. Secondary school children, national servicemen and police trainees made up the

study groups. Tables 1 and 2 clearly show significant improvement of mean scores of knowledge for both secondary school children and uniform groups. The survey clearly showed improvement in knowledge but since knowledge in itself is no indicator of better motivation and healthier attitudes, other parameters have to be employed to check the full impact of the campaign (Loh). Presently we are monitoring the attendances, requests for tests in both the private and public sectors to assess its impact. In the campaign every effort was made to popularise the condom. Table 3 shows a sharp increase in the numbers of condom acceptors after launching the campaign in August 1976.

TABLE 1
SECONDARY III STUDENTS

LANGUAGE	RESPONDENT/ SCHOOL	TOPIC	TIME OF SURVEY	NUMBER OF RESPONDENTS	MEAN SCORE	STANDARD DEVIATION	T VALUE	0.05 LEVEL OF SIGNIFI- CANCE	0.01 LEVEL OF SIGNIFI- CANCE
English	All areas	Venereal Disease	Pre-Campaign Post-Campaign	218 214	4.27 5.25	1.55 1.56	6.5342	YES	YES
Chinese	All areas	Venereal Disease	Pre-Campaign Post-Campaign	175 207	4.47 5.39	1.28 1.40	6.6368	YES	YES
Both Streams	All areas	Venereal Disease	Pre-Campaign Post-Campaign	393 421	4.36 5.32	1.44 1.48	9.3576	YES	YES

TABLE 2
UNIFORM GROUPS (BOTH STREAMS)

LANGUAGE	RESPONDENT	TOPIC	TIME OF SURVEY	NUMBER OF RESPONDENTS	MEAN SCORE	STANDARD DEVIATION	T VALUE	0.05 LEVEL OF SIGNIFI- CANCE	0.01 LEVEL OF SIGNIFI- CANCE
English	All Uniform Groups	Venereal Disease	Pre-Campaign Post-Campaign	220 222	5.61 6.30	2.00 1.79	3.8137	YES	YES
Chinese	All Uniform Groups	Venereal Disease	Pre-Campaign Post-Campaign	231 214	5.39 6.17	1.91 1.76	2.2453	YES	YES
English and Chinese	All Uniform Groups	Venereal Disease	Pre-Campaign Post-Campaign	451 436	5.50 6.24	1.96 1.78	5.8737	YES	YES

TABLE 3
TABLE SHOWING CONDOM ACCEPTORS
BEFORE AND AFTER THE CAMPAIGN

PERIOD		CONDOM
1972		7,343
1973		7,884
1974		7,245
1975		7,023
1976		8,477
1976	January	617
	February	642
	March	689
	April	632
	May	639
	June	691
	July	644
	August	669
	September	703
	October	824
	November	896
	December	831
1977	January	832
	February	620
	March	698
	April	703
	May	712
	June	633

The Role of General Practitioners in Sexually Transmitted Diseases Education Programmes

General practitioners can play a major role in this area of activity. They should be encouraged to participate in public forums and talks on the subject and indeed in Singapore many are. Public response to what a doctor says will be more favourable and positive, and hence doctor participation will enhance the force of its impact on them.

People with sexually transmitted diseases seek counsel from their general practitioners. He is thus in a position to redress misconceptions by offering correct advice. The potential patient seeking advice on prophylaxis should be given the appropriate advice on promiscuity and precautions as enumerated earlier. If a general practitioner succumbs to pressure and

administers a prophylactic injection, I believe he has done great damage to the whole sexually transmitted diseases control programme. A prophylactic injection before exposure is not only bad medicine but a positive encouragement to promiscuity. Also the opportunity to educate his patient is lost. When the patient presents with disease, he should then receive all the sympathy he deserves, and strongly urged to bring his primary and secondary sex contacts whether they have symptoms or not.

May I end up saying you have a major role to play not only in public education but the entire sexually transmitted diseases control programme. I believe the G.P. can either make or break national control programmes and the most important step would have been taken when a close liaison is established and fostered between the body of general practitioners and the institutions.

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PSYCHOLOGICAL INTERVENTION IN PATIENT WITH CANCER

By Chong Tong Mun,
M.B.B.S. (Malaya), M.D. (Singapore).

*"It is the Mind
that maketh good or ill,
that maketh wretch or happy,
rich or poor"*

Spenser, Faerie Queene

Ways In Which Patient With Cancer Can Be Helped Through Psychological Intervention

The use of psychological measures in the treatment of human illness, whether organic or psychological or a combination of both, is as old as human history. In fact, Erickson (1959), stated, "The psychological aspect of medicine constitutes the art of medicine and transforms the physician from a skillful mechanic or technician into a needed human source of faith, hope, assistance, and, most importantly, of motivation for the patient toward physical and mental health and well-being".

Psychological intervention in the patient with cancer can contribute much to the patient's comfort, not only in the terminal stages of the disease but also during any time starting at the point when the patient is informed of the malignancy. The use of hypnosis in the management of the cancer patient is the most effective psychological intervention that can be used. Psychotherapy under hypnosis can often be used with much better therapeutic effectiveness because of:— (a) the heightened intensity of the interpersonal relationship between the patient and the physician, (b) the greater readiness on the part of the patient to utilise the therapeutic offerings, and (c) the characteristics of the hypnotic experience which may enhance the patient's

feelings of control and accomplishment, Wright (1960). Also, the reason why the hypnotic state is so valuable therapeutically is that whereas in the waking state the individual is unable to control the functioning of his autonomic nervous system, in the state of hypnosis this becomes possible, Paterson (1963).

The management of the cancer patient is one of the most challenging medical problems of our time. The doctor's ability to carry the patient through his travail taxes not only his therapeutic resourcefulness but also his general ability to deal with human suffering.

The cancer patient often becomes very depressed, fearful and unable to sleep as soon as he is informed of the diagnosis. Hypnosis is useful in assisting the cancer patient in accepting the diagnosis. Often through the use of hypnosis he can be changed from a state of complete despair to one of hopeful toleration. His surgery can be much facilitated; he will be able to sleep well, and will require no night's sedation before surgery, the amount of chemoanaesthesia can be much reduced, post-operative discomfort is minimised and the patient enjoys relative post-operative well-being and comfort, and his need for narcotics very much reduced, Chong (1964). When chemotherapy or radiotherapy is required, hypnosis can greatly minimise the adverse side-effects associated

with these therapies. He can tolerate better the radium needles inserted in the malignant area. Hypnosis can help to control the nausea and vomiting and to alleviate most of the discomfort associated with these therapies, Chong (1968). As the disease advances — in terminal cases, pain states are the most difficult problems to manage in the cancer patients. The severe protracted pain in advanced cancer is capable of sapping the strength and the will-to-live of the patient. Sedatives, analgesics and narcotics which are often employed may deprive the patient of the privilege of knowing that he is alive and of enjoying what pleasures yet remain; also they deprive his relatives of adequate contacts with the patient. Hypnosis can often relieve these pain states so that other heroic measures of neuro-surgical intervention are rarely necessary.

Emotions and Stress in Relation to Malignancy

There are numerous medical literature on the relationship between emotions and stress to malignancy, and all these articles point to a strong relationship between the two and none concludes that there is no relationship.

The first employment of statistical tools to determine the relationship between psychological attitudes and cancer was by Snow in 1893. From the study of 250 patients he found that loss of a near relative, hard work, and deprivation were among the major psychological factors preceding the development of malignant tumours.

Investigation into psychological influences on cancer was revived in the first quarter of the twentieth century. It was then postulated that the existence of hormonal processes was possibly an important factor in cancer development. A further thought was that cancer was the result of social and emotional stress acting through changes in serum salts and blood chemistry.

Psychoanalysis has opened the door to a better understanding of the psychological influences involved in cancer growth. In the second quarter of the twentieth century, studies involving the relationship between the psyche and the origin and development of the neoplasm began to emerge. It was hypothesized that loss of an important emotional relationship had occurred prior to the development of the tumour. Emotional energy was turned inward and expressed itself through a primitive outlet bringing the cancer into existence as a result of intense stress.

The relationship between stress and host resistance particularly in animal experimentation is clearly defined in medical literature. The evidence is conclusive that prolonged or intense stress predisposed the animal to the development of malignancy and significantly influenced the course of the disease. Riley (1975) showed that by varying stress he could alter the incidence of breast cancer in mice from 92% under stressful conditions to 7% in a protected environment. He described how corticosteroids stimulate mouse tumour viruses and how the production of corticosteroids increased during chronic stress. He also discussed how the impaired surveillance mechanism of the immune system was affected by stress and how the decrease in this mechanism allowed the more rapid growth of malignancy. LaBarba (1970) reviewing the animal experimentation concluded that environmental factors influenced tumour development and tumour growth rates in laboratory animals. The mechanisms responsible were hormonal imbalances, immune incompetence and altered connective tissue reactions. These factors were influenced by the central nervous system mediated through hypothalamic regulation.

Galen had stated that "melancholy (depressed) women suffer from cancer more frequently than sanguine (happy) women". Blumberg (1954) and Klopfer (1957) were able to correlate certain personality variables to rapid or slow tumour growth, and thus substantiates

the notion that attitudes, emotions and personality characteristics were related to treatment response.

The president of the American Cancer Society in 1959, Dr. Eugene P. Pendergrass, in his presidential address, remarked, "Anyone who has had an extensive experience in the treatment of cancer is aware that there are great differences among patients. . . I personally have observed cancer patients who have undergone successful treatment and were living and well for years. Then an emotional stress such as the death of a son, the infidelity of a daughter-in-law, or the burden of long unemployment seem to have been precipitating factors in the reactivation of their disease which resulted in death. . . There is solid evidence that the course of disease in general is affected by emotional distress. . . Thus, we as doctors may begin to emphasize treatment of the patient as a whole as well as the disease from which the patient is suffering. We may learn how to influence general body systems and through them modify the neoplasm which resides within the body. As we go forward. . . searching for new means of controlling growth both within the cell and through systemic influences it is my sincere hope that we can widen the quest to include the distinct possibility that within one's mind is a power capable of exerting forces which can either enhance or inhibit the progress of this disease".

LeShan (1959) in a critical review in the *Journal of the National Cancer Institute* showed that psychological states were important factors in the development of malignant disease. In his review he pointed out that "The idea that a loss or conflict which is perceived by feelings of hopelessness and helplessness predates the development of cancer by a few months" had been expressed by numerous medical writers over one hundred years ago. In 1966 in another paper in the *Annals of the New York Academy of Sciences* on "An Emotional Life-history Pattern Associated with Neoplastic Disease" he presented a summary of a 12-year

research project carried out on 450 adult cancer patients and concluded that there were psychological factors that appeared statistically more often in cancer patients than in controls and which appeared to antedate the first noted symptom of the neoplasm.

Prehn (1969) came to the same conclusions that host resistance was a significant factor in tumour development mediated through immunological reactions and hormonal balance. He agreed that stress reactions mediated through the hypothalamus provide the mechanisms for causing the hormonal and immunological deficiencies that allowed malignancy to become fulminant.

Schmale and Iker (1971) in a carefully designed study on 68 women were able to verify the concept of the helplessness factor as the basis to predict with a significant degree of accuracy whether a benign or malignant condition would be diagnosed at biopsy in the group of patients studied. They reported their findings in their paper on "Hopelessness as a predictor of cervical cancer".

Solomon (1972) reviewed the inter-relationships of emotions, stress and immunity, and concluded that the significant factors in host resistance relating to malignancy were the immune system and hormonal balance. He showed how lesions in the dorsal hypothalamus resulted in suppression of the immune system with decreased antibody production and prolonged retention of antigen. Electrical stimulation to the same area lead to enhanced antibody response.

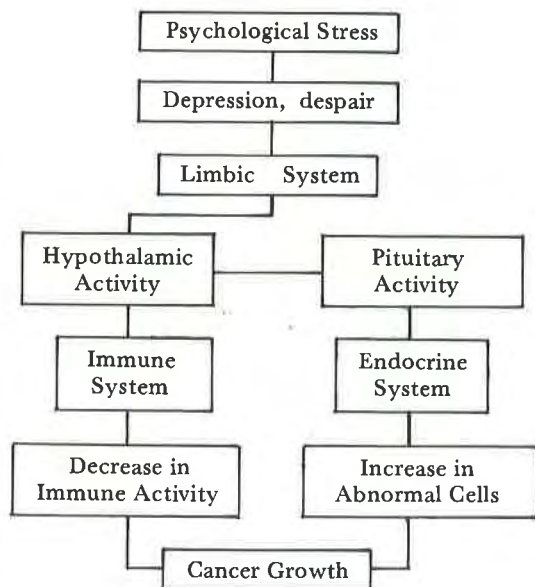
Brown, et. al. (1974) in a review in the *Journal of the Canadian Psychiatric Association* on "Psychiatry and Oncology", dealt with the relationship between cancer and mental states and suggested some common causal factors. They postulated that there was a common relationship between depression, depressive illnesses, and carcinoma, and suggested that the depressive illness had an effect on the immune system mediated through the central nervous system, predisposing to

the development of malignancy. They described how psychological stress through the general adaptation syndrome led to over-production of cortisone and the depression of the immune mechanism resulting in an increased vulnerability to cancer.

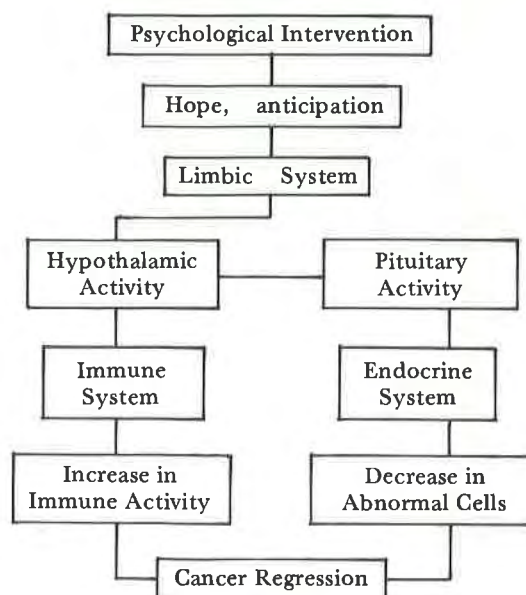
Carl and Stephanie Simonton (1975) reported a study of 152 patients presenting for radiation therapy. They found that the patient's responses to treatment were correlated with their attitudes and that responsiveness to treatment was directly related to attitude, regardless of type or extent of the disease. They described a theoretical model in a rather simplistic way the psyche/soma interplay in the development and reversal of cancer.

training, and self-hypnosis. They run a Cancer Counselling and Research Center in Texas. Patients are given two cassettes, one on "Relaxation and Mental Imagery as Applied to Cancer Therapy, and the other on "The Role of the Mind in Cancer Therapy; and two books, one on "Stress, Psychological Factors and Cancer", and the other on "The Will to Live". These materials offer an explanation of the program and enable the patient to begin using the relaxation and mental imagery process. The patient is instructed to visualise his cancer with his treatment and his body's own immune mechanisms (white blood cells) acting on the disease. The process is repeated three times a day. The secondary gains of illness are discussed

Psychophysiological Model of Cancer Growth (Simonton, 1976)



Psychophysiological Model of Cancer Regression (Simonton, 1976)



They stressed that the psychological approach, in making an organised attempt to stimulate the patient's "will to live" should not be ignored in the management of serious illnesses. They develop a method of psychological intervention in dealing with the psychological component of cancer by a process of relaxation and visual imagery which has components similar to biofeedback, meditation, autogenous

at group sessions. They utilise the patient's reports of his imagery procedure in determining his attitude toward the disease, how powerful he visualises the cancer, how active and effective the treatment and the immune system. Attempts are made to assist the patient in modifying these images to change attitudes about his disease, his treatment and his body's ability to fight the disease. By this method

of psychological intervention they are able to change significantly both the quality and quantity of the patient's survival time. Their results achieved are remarkable.

Illustrative Case Histories

1. A 50-year old married housewife had been under regular cancer check-up by a gynaecologist for about a year when her Pap Smear showed gross abnormality and the cytologist advised a cone biopsy. This was done and the result showed carcinoma-in-situ. Her gynaecologist advised a total hysterectomy and gave her a date for operation. She was dazed and was considerably upset by the diagnosis. The author is her family physician whom she often consults. She anxiously waited about two weeks for his return from conference abroad to seek his advice. When seen she was very depressed and kept on asking what wrong she had done to get cancer. The operation was scheduled in a week's time. Hypnotherapy was given to help her to accept the diagnosis and to prepare her for the operation. Rapport was excellent and she responded quite well. She requested the author to be present in the theatre during the operation. This was agreed. Unfortunately the operation had to be postponed for another six weeks because the gynaecologist went on vacation. The delay again caused her considerable anxiety, and further hypnotherapy had to be given to re-establish her confidence and co-operation. She had an easy, comfortable and successful operation to the surprise of her anaesthetists and gynaecologist because she was a neurotic, hyper-sensitive and hyper-reactive type of woman and they would expect a lot of trouble from her. The operation was done about a year ago and she is doing well.

2. A 44-year old married woman underwent a radical mastectomy for cancer of the breast. After the operation she complained of insomnia, epigastric discomfort, irritating cough and was very depressed. Hypnotherapy relieved her of all these symptoms. She was then condi-

tioned for the deep X-ray therapy which she was going to have the following week and which she was doubtful, fearful and reluctant to undergo. Hypnotherapy removed her doubt and fear, and suggestions were given that she would tolerate the deep X-ray well and would have no blister or discomfort. Relaxation and visual imagery techniques were used. She went through very successfully the 20 times deep X-ray therapy with no discomfort or burn. During the conditioning sessions the will to live was strongly instilled into her. The operation was done in 1967 and she is still alive and well.

3. A 37-year old man was very much distressed when he was diagnosed having carcinoma of his stomach and required surgery. He was very depressed, fearful and unable to sleep. Two hypnotic sessions turned him from a state of complete despair to one of confident hope. His surgery was also facilitated. He required no night's sedation before surgery, the amount of thiopentone used was much reduced, he needed only one single injection of omnopon after the operation, and his post-operative convalescence was remarkable. The operation was done in 1964. The pathology report showed poorly differentiated adeno-carcinoma of stomach, showing considerable areas of carcinomatous simplex appearance. There was right regional node involvement. He is still alive and very happy and fit.

4. A staff-midwife told her doctor employer that her father, age 55, had painless hematuria and had consulted a general practitioner two times. He was immediately sent for IVP which reported a hypernephroma of his left kidney. He was persuaded to go for an operation to "cure him" of his condition. He accepted the advice and was soon operated on. Immediately after the operation he was told that he had been "successfully operated". He had an uneventful post-operative convalescence and underwent a course of deep X-ray therapy. The pathology report showed "clear cell" renal carcinoma, with chronic pyelonephritis in the adjacent

renal tissue. There was embolus in the renal vein. The operation was done in 1971. He is alive and very well.

Discussion

In the management of serious illness it is important to deal with the psychological component of the illness and to stimulate "the will to live" in the patient. Psychological implications not only hinder but also delay recovery in any illness. Actually, recovery from any illness depends on the patient's ability to restore his own homeostasis. Doubts, fear, apprehension, anxiety and depression act adversely against the patient's defences and his ability to restore his own homeostasis. Sir William Osler declared: "What happens to a patient with tuberculosis depends more on what he has in his head than what he has in his chest". This is true with all illnesses for every illness has a psychological overlay. Even Plato in his days lamented, "For this is the great error of our day . . . that physicians separate the soul from the body". The fact that the mind rules over the body, no matter how much it was neglected by biology and medicine, is the most fundamental fact which we observe continuously throughout our lives. All our emotions are expressed through physiologic processes: joy by laughing, sorrow by weeping; shame by blushing; despair by sighing; fear by palpitation; anger by increased heart beat, elevation of blood pressure, and a change in the carbohydrate and cholesterol metabolism; and so on.

The stomach cancer patient was given only six months to live by his surgeon. Most patients with hypernephroma seldom live more than three years. If not for psychological intervention the carcinoma-in-situ patient would not have an easy, comfortable and successful operation; and the breast cancer patient would not have done so well. Probably through psychological intervention their belief systems are altered; and they do not want to die yet. Understanding illness and curing sick people

involve something more than a knowledge of pathology.

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Genetic Counselling in General Practice

by Freda M. Paul,

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It is the family doctor that patients or parents first turn to when confronted with some disease or a defect or a problem. The general practitioner is increasingly asked about genetic risks by mothers with some disease or defect, young parents with some abnormal child, persons about to marry their cousins or parents about to adopt children. Ideally, genetic evaluation and counselling should be done by a trained medical geneticist. Since these facilities are available in only a few large medical centres, it becomes necessary for the family physician to handle the problems himself. In a counselling situation, it is necessary for the physician to consider the following questions:—

1. What is the nature of the condition?
2. How much genetic information is available and how precise is it?
3. What induced the family to seek advice?
4. What is the preconceived knowledge about the condition in question?
5. What should be the mode of presentation of the data to the family?
6. Was the information understood and is it likely to have an impact upon them?

Dominant Inheritance:

In a simple dominant inheritance, the following are the main characteristics:—

- a. Every affected person has an affected parent.
- b. Affected persons, have on the average, affected and normal offspring in equal proportion.
- c. The abnormal gene is often transmitted through several subsequent generations.
- d. The normal children of affected persons when they in turn marry normals, have

only normal offspring.

In a good majority of cases of dominant inheritance, the homozygote state cannot be distinguished from the heterozygote state.

In autosomal dominant disorder, the recurrence risk after an affected child has been born is 50%. Since not all carriers of a given dominant gene manifest the disease, the actual disease risk will often be less than 50%. Generally, an affected person who comes for counselling may often be mildly affected. Since dominant diseases have a wide spectrum of clinical variability, their affected children have a good chance of being more severely affected. Some examples of the disease transmitted by an autosomal dominant mode of inheritance are Marfan's syndrome, aniridia, partial albinism, and achondroplasia. Marfan's syndrome is characterised by tall thin patients with poor musculature, long extremities, tapering fingers, subluxation of the lens, loose-jointedness and cardiovascular anomalies, (the most important being dissecting aneurysm of the aortic arch). Marfan's syndrome is inherited as an autosomal dominant trait, but there is marked variability in the severity of the clinical picture. Of the three main features, ocular skeletal and aortic, one may be present with little or no apparent involvement of the other two. In aniridia, no iris is visible on ordinary examination. The condition is bilateral and is a hereditary defect of the dominant type. There is a close link between coloboma of the iris and aniridia. The cause is failure of ectodermal development when the ectoderm goes for-

ward to form the rim of the optic cup. Clinically, the child suffers from extreme photophobia, defective vision and nystagmus. In achondroplasia, the possibility of a gene expression is an explanation of a sporadic case with dominant disease.

Recessive Inheritance:

Contrary to the dominant gene which affects the phenotype in heterozygotes, other abnormal genes apparently produce no effect in heterozygotes, their normal allelomorphic gene being able to secure a normal phenotype. Such genes are called recessive and they affect the phenotype only when present in the homozygote state. The main criteria of recessive inheritance are as follows:—

1. The great majority of affected persons are the offspring of parents with a normal phenotype.
2. In a large number of siblings, it is possible to discover that the proportion of normals to affected is 3 to 1.
3. If the abnormality is rare, an undue proportion of related marriages is found among the parents of affected persons. The rarer the defect, the higher the proportion of consanguineous marriages.
4. Affected persons who marry normals have normal offspring in the great majority of cases.
5. Affected persons who marry other affected persons have affected offspring only, provided both are homozygous for the same gene.

Some of the diseases transmitted by an autosomal mode of inheritance are Hurler-Hunter's syndrome, Laurence-Moon-Biedl syndrome, congenital ichthyosis, congenital microspherocytosis, phenylketonuria, galactosaemia, congenital adrenal hyperplasia.

Gargoylism is a condition in children where cartilage formation is affected, accounting for dwarfism, kyphosis, ugly facial characteristics and ulnar claw hands. In addition, an abnormal substance is stored in vital organs like the heart, the brain and the liver, producing hepatosplenomegaly, skeletal deformities, mental deficiency and cardiac enlargement. In the auto-

somal mode of inheritance, both males and females are affected, all the affected children are dwarfed and have corneal opacities. In the sex-linked variety only males are affected, and corneal clouding and deafness are absent. When a recessively determined condition is a major public health problem, affecting 1% of all births (as in the case of congenital microspherocytosis which occurs in certain parts of Italy), then there is a good case for a determined attempt by general practitioners and public health authorities to detect all heterozygotes in the child population. Once identified, such heterozygotes may be warned of the 1 in 4 risk to their children, if they marry each other. Such "marriage prophylaxis" is already put into effect in parts of Italy where there is a high incidence of anaemia.

Disease transmitted by a sex-linked mode of inheritance:

If the condition is sex-linked, affected males are hemizygous for a mutant gene; they carry it on their single x chromosome. Sex-linked conditions include classical haemophilia, Christmas disease, the severe form of Duchenne muscular dystrophy and glucose-six-phosphate dehydrogenase deficiency. The main principle in genetic counselling with such conditions is that if the mother of a patient has another male relation affected (including another son) she is certainly a heterozygote carrier and there is a 1 in 2 risk of her further sons being affected and of her daughters again being carriers. But if the patient is a sporadic case, then there is the possibility that he is affected as a result of fresh mutation. The mother is not a carrier and is not likely to have further affected children.

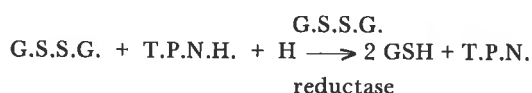
Haemophilia:

This is a well-known sex-linked condition, where it is possible to detect carriers of a gene for bleeding disorders without manifesting any clinical symptoms. In Sweden Nillson (1964) has shown that affected members of a given family have haemophilia of the same type and severity. She has shown that the mean A.H.G. level

for carriers of antihaemophilic globulin of fertile age was 38%. Carriers of haemophilia are advised not to have children.

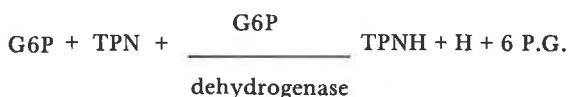
Glucose-six-phosphate-dehydrogenase deficiency:

Glucose - six - phosphate - dehydrogenase deficiency of the red cells is a common sex-linked genetic trait affecting approximately 100 million individuals all over the world. G6PD is an enzyme that plays an important part in the pentose-phosphate shunt mechanism.



The enzyme GSSG reductase is dependent on TPNH which is supplied from two sources:—

(a) Dehydrogenation of glucose-six-phosphate \searrow



(b) Oxidation of 6-phosphogluconic acid to pentose phosphate.



The deficiency in glucose-6-phosphate will result in diminished amounts of available TPNH for glutathione reduction and hence a lower level of reduced glutathione, which falls to 40% of normal G6PD activity in normal as well as mutant red cells, and this decreases with the age of red cells. All biochemical changes appear to affect in greater severity the older segment of a red cell population.

Genetics of G6PD deficiency:

G6PD deficiency is genetically determined and it is sex-linked. The gene for G6PD deficiency is located on the X chromosome. If X represents the chromosome with the normal gene, and X' the chromosome that causes the gene for G6PD deficiency, then XY is a normal male,

X'Y a hemizygous male, XX a normal female, X'X an intermediate heterozygous female, X'X' a deficient homozygous female.

(1) Intermediate mother with normal father

	X'X	XY	Parents
X'X	X'Y	XX	XY
			Offspring

Half of the sons are normal and half of the sons are deficient.

Half of the daughters are intermediate and half of them are normal.

(2) Normal mother with normal father. All children will be normal.

(3) Deficient mother with normal father.

(4) Deficient mother with deficient father.

	X'X'	X'Y	Parents
X'X'	X'Y	X'X'	X'Y
			Offspring

All sons and all daughters are deficient.

(5) Normal mother and deficient father.

	XX	X'Y	Parents
X'X	XY	X'X	XY
			Offspring

All sons are normal. All daughters are intermediate.

(6) Intermediate mother and deficient father.

	X'X	X'Y	Parents
X'X'	X'X	X'Y	XY
			Offspring

Half of the sons are deficient and half are normal.

Half of the daughters are deficient and half are intermediate.

Investigations all over the world show that there are two states possible — either deficient or normal, while among the females, they are either deficient, intermediate or normal. However, in some of the female heterozygote carriers where you expect the levels to be intermediate, the

levels of G6PD are normal, i.e. in some cases they are deficient with normal parents. To explain this, Mary Lyon's hypothesis fits. According to Mary Lyon, the heteropynotic X chromosome which contributes to the formation of the Barr body becomes genetically inactive. This heteropynotic X chromosome could be paternal or maternal in origin in different cells of the same animal. Applying this hypothesis, one can state that the normal X chromosome on the abnormal X' chromosome could be heteropynotic early in embryonic life and becomes genetically inactive, and it is a matter of chance which of her cells has X or X' inactivated genetically. Therefore, X'X or X'X can have intermediate or normal values.

Importance of G6PD deficiency states in Genetics:

In this country, it has been shown by Wong that 47% of our cases of neonatal jaundice are associated with glucose-six-phosphate dehydrogenase deficiency (Wong 1965). In 1963, neonatal jaundice was our biggest killer in children under the age of one week. If the baby is found to be G6PD deficient, the baby is kept at Kangar Kerbau Maternity Hospital nursery and observed very carefully. Any development of jaundice with a serum bilirubin level of 20mgm% or above, requires a timely exchange transfusion to prevent kernicterus and death. In this way, our neonatal mortality due to kernicterus is kept down to a minimum. In our department, the families of babies with glucose-six-phosphate deficiency are then screened to discover if there are others with enzyme deficient state. All mothers who have delivered one affected jaundiced child are given letters to the obstetrician for further pregnancies, so that the next baby who develops jaundice, will be brought early for treatment. In the older child, and adult, there are many drugs which, if prescribed or given to adults with this enzyme deficiency, will give rise to acute haemolytic anaemia. It is important for general practitioners to be familiar with these drugs

which are likely to cause haemolysis, e.g. sulphonamides, phenacetin, P.A.S. and anti-malarial drugs.

Chromosomal Abnormalities:

The importance of chromosomal studies lies in the fact that in certain diseases, it is possible to advise parents on the risk of future children being involved, eg. in translocation mongolism. A translocation mongol is a mongol with 46 chromosomes, each occurs in young mothers where there are 2 chromosomes in the 21 group, but only one in the 15 group, but an extra chromosome is also present making a total of 46 chromosomes. This chromosome represents a union of a 15 chromosome with a 21 chromosome, i.e. a 15/21 chromosome. The parents look normal, but they carry the 15/21 translocation through several generations, and it is the transmission of this abnormal 15/21 translocation that results in mongols being born to mothers of the younger age group. If a 15/21 translocation carrier marries a normal person, then the following are the possibilities:—

15 21	15 0	15/21 0	15/21 21	Gametes of a carrier person
			15 21	Gametes of a normal person
15 15 21 21	15 15 0 21	15 15/21 21 0	15 15/21 21 21	

The risk of a mother who is a translocation carrier producing an affected mongol would be 1:4.

Other Inheritable Diseases:—

The risk associated with inheritance of more complex change is usually not high and the medical geneticist can often give empirical risk figures which are used in genetic counselling and which can help the general practitioners. We will now consider some of the risk figures as laid down

by Blyth & Carter (1969) in commonly encountered conditions.

It must be remembered that these are empirical risk figures and are based on purely family studies of several hundreds of patients and in this particular series the studies were done in Britain (Blyth & Carter, 1969). Even within Britain, the figures are modified by family history and they are substantially increased when there are two affected children, and in certain areas, the empirical risk figures for conditions like spina bifida cystica is probably higher in areas like South Wales or Glasgow than in South East England.

**Risk figures for some inherited diseases
(Blyth & Carter, 1969):**

Condition	Genetic Risk
a. Cleft lip with or without cleft palate	Part genetic. Both parents normal; risk to sibs or children is 4%. If one parent and one child is affected, 12% risk to subsequent sibs.
b. Pyloric Stenosis	Risk to relatives. Son of proband is 1 in 20. Brother of male proband is 1 in 25. Daughter of male proband is 1 in 40. Sister of male proband is 1 in 40. Son of female proband is 1 in 5. Brother of female proband is 1 in 10.
c. Thalassaemia major	Recessive. The heterozygote for the gene may show thalassaemia minor.
d. Congenital heart disease	Partly genetic, probably polygenic in most instances. Overall risk to sibs is 3 to 40%, but only 1 to 2% in Patent Ductus Arteriosus.
e. Diabetes mellitus of early onset	Partly genetic. Risk to later sibs of index patient about 1 in 20 (W.H.O., 1965). Diabetics should be counselled not to marry another diabetic, they should not have children.
f. Severe microcephaly	Autosomal recessive (25%)

g. Severe non-specific types of mental deficiency	Overall risk of recurrence in sibs is 25%. If 2 members involved, risk will be higher.
h. Perceptive dwarfism	Dominant recessive and sex-linked. Recessive forms are the commonest.
1. Congenital Dwarfism without associated defects	Dominant recessive and sex-linked. Recessive forms are the commonest.
2. (i) In association with other defects, e.g. partial albinism	Usually dominant.
(ii) Conductive deafness	Usually dominant.
(a) Otosclerosis	
(b) With Treacher-Collins syndrome	Dominant.
(c) With cryptophthalmus	Recessive.
i. Polycystic disease	Autosomal recessive.
j. Renal glycosuria	Often dominant.
k. Cystinosis	Recessive.
l. Cystinuria	Recessive.

Conclusion:

As stated by Hauge (1964), it will be seen that genetic counselling is an important tool in preventive paediatrics aiming primarily at the prevention of inherited abnormalities and disorders. It is important for the practitioner therefore, to take a clinical history, rather than the hospital doctor. Two individuals may present with what seems to be identical types of defect or a special pattern in the family may dissolve different mechanisms at work leading to different genetic risks in 2 cases. For special investigations the case should be referred to the hospital. Ideally, there should be genetic counselling clinics where the family doctor who refers the case, the medical geneticist, the statistician and the social worker, all work together. It may take 3 to 4 or 5 visits before the family understands genetic risks. It should be remembered that genetic counselling has no element of compulsion, and it is up to the families to accept risk figures put for-

ward to them. With new developments in human genetics, this will bring the general practitioner back into the forefront in preventive paediatrics, and hence it is necessary to understand the basic elements of human genetics. It will follow, therefore, that genetic counselling of families will improve not only the qualities of a family, but also that of the whole population, and this is one of the first steps of eugenics.

Summary:—

A competent general practitioner can be a reasonable genetic counsellor if he proceeds as follows:—

1. He must be familiar with basic principles of genetics.
2. He should be able to make an accurate diagnosis and take a good family history.
3. He must treat the condition as a family

problem.

4. Not only must he give an accurate recurrent risk rate but he must be certain that its significance is grasped.
5. He must keep in mind his limitations and refer cases that are not simple to a counselling centre.

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President's Message

This is the first edition of Volume Four of the Singapore Family Physician. The late appearance of the journal has been beyond our control and the delay difficult to beat. As you might be aware, there has been a change in the Editorship. Dr. Gordon Horne has been the Honorary Editor of our journal for the past five years and has been responsible for the production of two volumes of the G.P. and three volumes of the Singapore Family Physician.

He and his editorial board members have struggled against great odds to keep the journal viable. This he has done remarkably well and I am sure readers will join me in thanking him most sincerely for a job well done.

Our new editor, Dr. Koh Eng Kheng is known to most members and is not new in the literary field. He is not lacking in experience, having been until recently, the Editor of the Singapore Medical Newsletter. He has promised to keep members in touch with recent events and in return has called for more support from the membership of the College. He is looking forward to receiving more articles from General Practitioners.

* * * * *

Another year has gone by and it is now seven years since the College was founded. Progress which has been made is the direct result of a great deal of effort and time by a few who are dedicated to the ideals for which the College stands. During the past academic year, as in previous years, we continued our education programme successfully. The in-depth course in Obstetrics and Gynaecology, the weekend Seminars and Lectures, the teach-in sessions at the Maxwell Road and Still Road Out-Patient Departments have all proved popular and well-attended by our members. However programmes for the continuing education of the practising



*DRS. KOH ENG KHENG & GORDON HORNE
Present and Past Honorary Editors of the Singapore Family Physician at a Council meeting.*

doctor must be further developed — programmes that are practical, fulfil individual needs and provide a stimulus which will encourage participants to continue. We must develop the concept of assessment — preferably self assessment — of work performed and knowledge gained, with the object of upgrading the standards of patient care.

The College is no more than its members. To achieve its aims and objectives it needs the active involvement — and participation of all its members. If we believe that general practice is a special and definable discipline, then we must assist in the recognition and attainment of this through active membership. We should make our membership more significant by contributing to the preservation, improvement and promotion of the speciality of general practice/family medicine as a new and vital medical discipline.

BOOK REVIEW

Planning or Prevention

Peter Diggory & John McEwan (pp123;
£1.95) Marion Boyars Publishers Ltd,
No.18 Brewer Street, London W1R4AS,
1976.

Interesting facts in conjunction with equally provoking opinions on controversial topics related to Family Planning makes this book very readable both to the layman and doctor alike. The two-fold aim of the authors is to show that Family Planning is not synonymous with population control and to make out a case against clinicians becoming involved with population control.

In Singapore, birth control methods are not only available to the populace, but incentives for limiting one's family and disincentives for having more than two children are very much enforced by the Government in the belief that reproductive stability will only then be achieved. This implicit belief underlying Family Planning policies in many countries is criticised by Diggory and McEwan, who believe that where the population already has access to the technology of birth control, reproductive stability will be achieved and that attempts to "impose solutions from above are unnecessary and counter-productive." They argue most convincingly that motivation, particularly *economic motivation* is one of the most crucial factors affecting Population Control. The mere availability of contraceptives is not important. This implies that if Singapore or other countries have been successful in their family planning programme, it has been due largely to the improving standard of living, which has resulted in the necessary economic motivation for successful Family Planning, rather than any other persuasive and/or coercive measures.

However, it is acknowledged that in developing countries there is little motivation to limit the size of one's family as the standard of living is low, the promise of future security is bleak, and another child makes relatively little difference, and may in fact provide some insurance for the parents in old age. With little motivation from individuals themselves and faced with the resultant ever-increasing population, politicians in these countries find it near impossible to improve social conditions. A few suggestions to improve this paradoxical situation are advanced by the authors.

I That Western nations concentrate their economic and technical aid on increasing the living standards of developing countries, rather than reducing fertility. They point out that some developing countries are suspicious of any birth control ideas emanating from the West.

II That Western nations themselves achieve genuine birth control with unwanted babies reduced to the minimum, before their credibility is accepted by developing nations. Also, unwanted babies will consume much of the Western nations' limit of resources and therefore it is in their interests to conserve their resources and utilize them for maximal economic growth.

III Through sex education, making acceptable the idea that sex is for enjoyment and the deepening of natural relationships. This will help get rid of the sexual hang-ups and the psychological inhibitions that prevent many from using adequate contraception.

Whilst these suggestions are sound, we

feel that in developing countries where the reality of the situation is that economic aid from other countries to improve the standard of living is not yet forthcoming significantly, it might be necessary to impose incentives and disincentives to aid the Family Planning programme. And even if such aid were available, a considerable time would have to lapse before the appropriate *Economic motivation* response would be realised. It is *time* that developing nations cannot afford and perhaps measures like those existent in Singapore to assist the Family Planning programme are more necessary than the writers realise.

Diggory and McEwans also pin-point the attitude of British doctors to birth control as one of the significant reasons for Family Planning not achieving as much success. From the very early days of the introduction of contraceptives, British doctors have been suspicious and critical of them. Their attitude probably stems from a disapproval of the enjoyment of sex and the fact that contraception makes illicit sex more readily possible. There are some consultants who try to show rare, pathological conditions which theoretically could occur in patients on the pill, but which in fact do not, and, succeed only in alarming General Practitioners. Serious complications of the pill are rare and the authors believe it is safer than aspirin or any of the other pain killers available over the counter in drug stores. Moreover, the stringent test trials required by drug safety organisations in U.S. and Britain has meant enormous expense to drug companies who consequently are reluctant to develop new drugs in contraception.

Whilst the Pill has to date shown little serious side-effects, we think that only time and further research, particularly biochemical and hormonal studies can conclusively prove that there are no long-term effects. This fact is probably at the root of doctor's acceptance of, but lack of enthusiasm for the Pill. As for drug companies, who generally are not scraping the barrel in terms of monetary profits, we see no reason why exacting tests should deter

them from testing new drugs in contraception. It is the right of the public to expect only well-tested drugs to be made available to them.

Doctors are also criticised by the writers for their reluctance to prescribe contraceptives to young people, particularly since they are aware that pregnancy in young people is more dangerous for the mother and baby than in an older woman. In fact some doctors in screening clinics adopt a 'tut-tutting' (patronising attitude) over marginally abnormal laboratory tests in an apparently healthy person. The authors suggest that this sort of attitude is because doctors feel their familiar role and identity in the usual doctor-patient relationship is missing and they are instead mere dispensers.

Thus, Diggory and McEwan suggest that doctors may not be the best persons to give advice on contraception. In fact patients are often embarrassed about the circumstances in which the advice is sought and given, and the medical examinations carried. Single women are afraid of being snubbed or embarrassed by General Practitioners and even in the Family Planning centres. They raise the possibility of the pill being made available over the counter or through a midwife, nurse or health visitor.

They also feel that if medically supervised contraception is to be universal, it must be integrated with other health services, and not just left to Family Planning clinics. General Practitioners and Gynaecologists should bear the main brunt of the work.

Doctors whilst being involved in making available contraceptive methods and advising patients are warned of the danger of becoming involved in promoting fertility control for reasons of 'social engineering' as there is the inevitable implication that local medical policy might be revised if the population changed or if the political assessment altered. We think that this warning is most timely as the political and social pressure is high on doctors in developing countries to help engineer popula-

tion dynamics. It is essential for the medical profession to remain above politics and leave any incentives or disincentives for population manipulation to the politicians.

Abortion is a significant factor in the control of human fertility, and unless legal abortion is freely available, it will lead to criminal abortion. The authors point out that it is insufficient for the abortion law to be liberal, but to be successful as a method of Population Control, the medical leadership must favour abortion on demand. In practice, abortion is widely used, but as a method of family limitation, it has not gained acceptance. In some countries this is due to religious reasons, but in other countries in the Far East, it is the cultural attitude rather than religious reasons that affect the acceptability of abortion as a method of family limitation.

The writers also suggest that in the field of spontaneous abortions where an important cause of abortions is due to foetal abnormality, it is important for researchers to try and find the cause of these abortions, before following an elaborate treatment to try and prevent these abortions as they may in fact be saving only deformed babies. It is more important to concentrate research on the detection of foetal abnormality than in producing an anti-abortion drug.

The Intra-Uterine Device has an advantage over the pill in that it does not depend upon strong *continuing motivation*. It would be of great advantage if it could be inserted immediately after birth without it being expelled out. So, the writers feel, that there is a need to design devices capable of being retained even when inserted immediately after child birth.

Whilst the two most effective methods of contraception are the Pill and the IUD, there is still a reluctance to accept contraception by some people. They are afraid to 'interfere with nature' and feel that doing so will result in adverse reactions. This attitude is closely associated with their feelings of guilt at being able to enjoy sex without the fear of pregnancy. They fail

to appreciate how small in actuality are the risks of effective contraception. Others, fear that effective contraception will lead to promiscuity. Promiscuity is usually taken to mean having sex with several partners without much emotional involvement. Diggory and McEwan strongly attack this view-point, arguing that if it was the fear of illegitimate pregnancy that prevented illicit intercourse, and not morality, then contraception was not relevant to morality. Also, in actual practice some people have multiple partners and some do not! A recent study of pregnant girls under 17 in the King's Health District of South London showed that those who were pregnant did have emotionally deep attachments and that their behaviour could not be described as promiscuous. The restrictive attitude of older persons and those in authoritarian positions have an influence on peoples' acceptance of contraception. The writers suggest that the "professionals" have subjugated their own sexuality to achieve the status they have worked for and now unconsciously envy those who enjoy sexual freedom. This psychological hypothesis cannot be proved but it may explain doctors' dislike of the promiscuous! It has also been shown that the influence of social, educational and religious background of health visitors also affects the views of doctors, health visitors and midwives who give advice on contraception. Diggory and McEwan also feel that the ambivalence of social policy towards contraception in the U.K. affects the success of the Family Planning movement. Condom-vending machines are not available in public places and are found in places like the pub, barbers or chemists which are closed at night, at a time when a young man would probably want to purchase one. The writers realise also that the problem with the more effective contraceptive methods lies in failure of continuity. The reasons for this are varied, but not very specific and the writers suggest that there is a need to study why the current methods are being insufficiently utilized.

In this book the authors have discussed quite comprehensively why contraception by itself will not lead to birth prevention in the long run. It needs motivation, particularly *economic motivation*. But as Economic motivation is often lacking in developing nations with a rapidly increasing population, it is perhaps the only pragmatic measure made available to the governments to supplement economic motivation with coercive and persuasive measures. The writers outline of the short-comings of the existing contraceptive methods and ways to overcome them are generally realistic and helpful. But, one cannot help feeling that their emphasis and attack on the

doctors' attitude to contraception as being one of the main reasons for the insufficient acceptance of contraception as being totally unfair. As medical men, doctors, rightly or wrongly, feel the onus and responsibility to their patients in the administration of any drug(s). Perhaps, cautiousness geared over a period of long and arduous scientific training and a sense of conscience, is responsible for doctors' reservation to contraception rather than any sexual hang-up!

Fred and Vimala Samuel.

MEDICAL NEWS

VENEREAL DISEASE

Under the Infectious Diseases Act 1976, Sexually Transmitted Diseases are now notifiable. The regulations stipulate that all doctors notify to the Medical Superintendent of Middle Road Hospital. The notification is non-nominal and only the diagnosis, age, sex and clinic reference number of the patient are required. Thus the identity and personal particulars of the patient remain anonymous.

However, according to the Epidemiological News Bulletin Feb. 1978 Vol. IV No. 2, a "study of the returns from general practitioners and laboratories indicate under reporting from doctors."

SMALLPOX

(The following are abstracts from the Epidemiological News Bulletin February 1978 Vol. IV No. 2)

Smallpox Surveillance

As on 10 Jan. 1978, WHO has recorded zero smallpox incidence world wide for the last 11 weeks, since a patient was reported from Somalia with onset of rash on 26 Oct. 1977. For over two years, smallpox cases have been detected only in two other countries bordering Somalia: Kenya, where five cases were reported in February 1977 following an importation from Somalia; and Ethiopia where the last known case was discovered in August 1976.

Smallpox in Singapore

The last case of smallpox in Singapore was reported in 1959. A total of 10 cases was reported in the 1959 epidemic which lasted for two months and localised in its distribution. The case fatality rate was 20%. 1,125,411 doses of smallpox vaccines were administered covering nearly 72% of the Population. The generally satisfac-

tory level of herd immunity, boosted up by the mass vaccination campaign was primarily responsible for the small and localised nature of the outbreak.

Smallpox Vaccination Certification

The twenty-ninth World Health Assembly (1976) recommend that Government restrict their requests for smallpox vaccination certificates to travellers who, within the past 14 days, had visited a smallpox infected country. At the end of 1977, 81 countries and areas still required a smallpox vaccination certificate from all arrivals. In 72 countries for which information is available, a primary smallpox vaccination is still required under existing legislation whereas vaccination is no longer required in Austria, Belgium, Canada, Denmark, Finland, The German Federal Republic, Japan, the Netherlands, New Zealand, Norway, Sweden, the United Kingdom, and the United States of America.

To facilitate international travel, with effect from 14 January 1978, Singapore requires smallpox vaccination certificates only from travellers from Smallpox infected countries (Ethiopia and Somalia) or who within the preceeding 14 days have visited any smallpox infected countries as reflected in the WHO Weekly Epidemiological Record.

However, the present national smallpox immunisation programme for infants and school children would continue for the time being.

CHOLESTEROL AND YOU

In his book "Give your heart a chance", Dr Winston Oh wrote: "The recommended daily cholesterol intake is 300mg or less. This is the equivalent of 21 oz of fish, or 3 whole chickens, or 16½ oz of lean pork, or 9 oz of medium fat beef, or 7 oz of

shrimp, or 3½ oz of liver, or 3½ oz of butter, or 1½ eggs, or 6 oysters!"

A dish such as oyster omelette ('O-loah' or 'O-chian') highly popular among the Chinese, is very rich in cholesterol. It is recommended therefore that one should not indulge in such a dish.

CALORIES AND YOU

Dr. Oh stated "that weight gain results from eating excess calories. The average,

moderately active Asian requires between 2000 to 2500 calories a day. The amount varies according to the body frame size, age, and the degree of occupational physical activity."

"A person who eats 100 calories more than he needs a day (the equivalent of two slices of bread or a bowl of rice), will gain ½ kilogram (1 lb) in 35 days and therefore 4½ kilograms (10 lbs) in a year. Within 5 years he will be grossly overweight!"

PROCEEDINGS OF THE THIRD COMBINED COLLEGES CONFERENCE

PROCEEDINGS of Third Combined Conference of Colleges of Australia, Hong Kong, Malaysia, New Zealand, the Philippines and Singapore held in Kuala Lumpur from 8th to 11th September 1977 has been published. Copies are priced at Malaysia \$ 10.00 each postpaid. Correspondence should be addressed to College of General Practitioners Malaysia, Room 1, 5th Floor, MMA House, 124, Jalan Pahang, Kuala Lumpur, Malaysia 02-14.

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Optimal tolerability	superior to antirheumatic agents hitherto available
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Further information is available on request from **Geigy**

A gleam of light for the hypertensive

Despite treatment many of your hypertensive patients may have a gloomy prognosis, because reducing blood pressure does not prevent myocardial infarction. More patients die from infarction than from any other consequence of hypertension, *whether or not blood pressure is controlled*.^{1,2}

If your patients are treated with 'Inderal,' however, their prospects may be brighter. Although other antihypertensive drugs have failed to reduce the probability of myocardial infarction,²³ 'Inderal' has now been shown to reduce it *fourfold*.³⁴ Only 'Inderal' has been associated with a protective effect against infarction in hypertensive patients who have no signs of heart disease.

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1. Kannel, W.B. and Dawber, T.R. (1974). *British Journal of Hospital Medicine*, 11, (4), 508-523.
2. Breckenridge, A., Dollery, C.T. and Parry, E.H.O. (1970). *Quarterly Journal of Medicine*, 39, 411-429.
3. Stewart, J. McD.G. (1976). Fourth Meeting of the International Society for Hypertension, Sydney.
4. Lambert, D.M.D. (1974). *British Medical Journal*, 3, 685.



'Inderal' is a trademark for propranolol hydrochloride.

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Why 'Orudis'* first in rheumatic disease?

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Propionic acid derivatives like 'Orudis' (ketoprofen) have far fewer side-effects than traditional first-line antirheumatics – and with comparable analgesic/anti-inflammatory activity can make progression to other treatment unnecessary.¹

3. Because 'Orudis' exemplifies their greater safety - and good effect

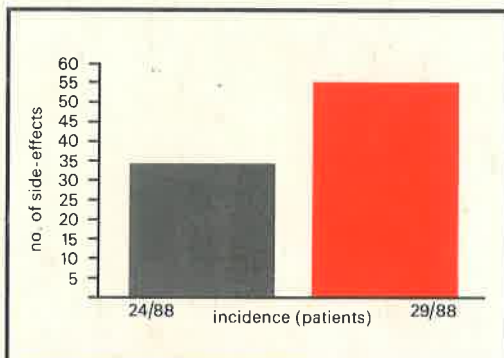
"... well tolerated with a minimum of side-effects ..."

Short-term, side-effects with 'Orudis' are mild and much fewer than with traditional potent first-line drugs. Long-term, its record of safety is far better, with no reported toxic effects on major organ systems.³

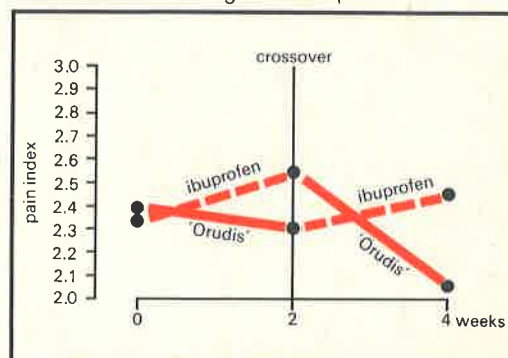
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1. *Practitioner*, 217, 546, 1976
2. *Curr. Med. Res. Opin.*, 3, 423, 1975
3. *Rheumatol. Rehabil.*, 15, Suppl. 85, 1976
4. *Br. Med. J.*, iv, 398, 1972
5. *Ibid.*, iv, 82, 1973
6. *J. Int. Med. Res.*, 4, 427, 1976
7. *Clin. Trials J.*, 13, (1), 19, 1976
8. *S. Afr. Med. J.*, 48, 1526, 1974
9. *Scand. J. Rheumatol.*, 5, Suppl. 14, 99, 1976
10. *Ann. Rheum. Dis.*, 32, 62, 1973

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