

The Singapore Family Physician



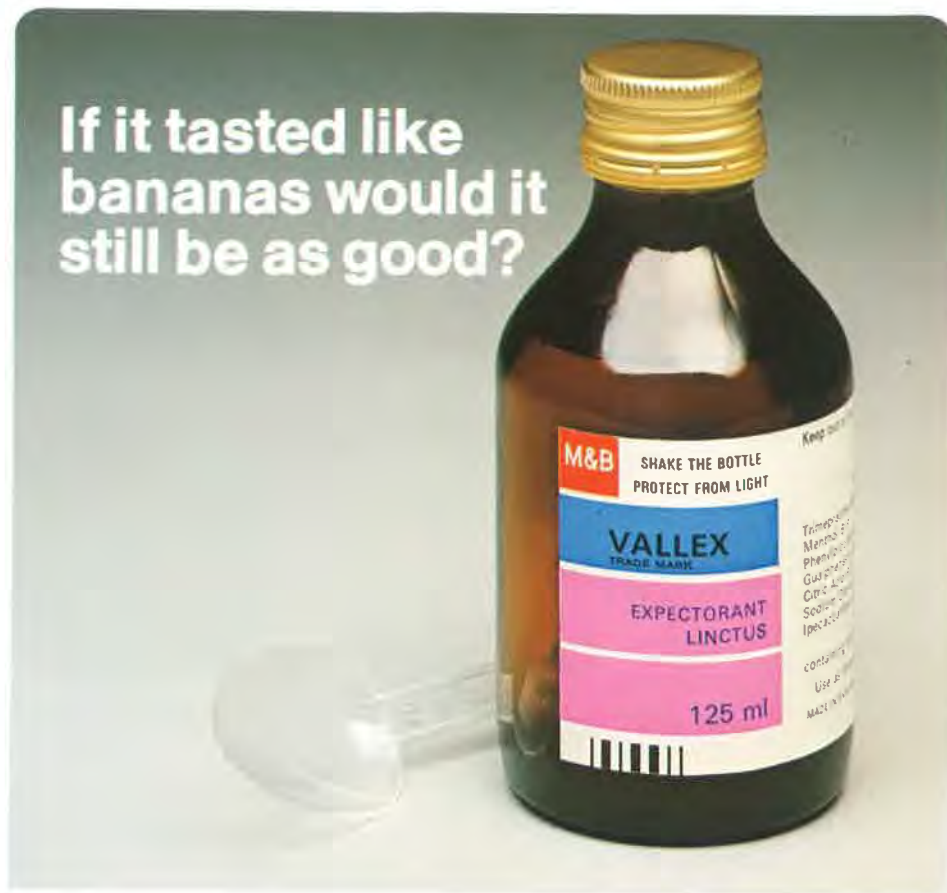
**The
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Vol. V

No. 1

Jan./March 1979

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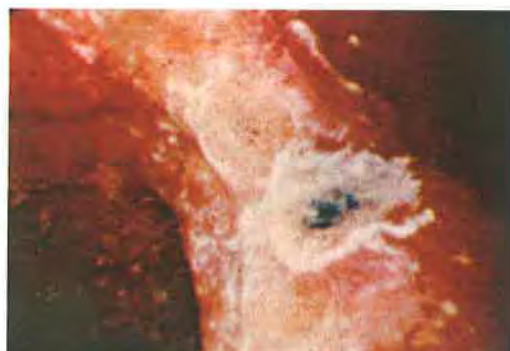
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CONTENTS

	Page
Editorial — The Pharmaceutical Trade	3
Pentazocine Hydrochloride (Talwin) The Truth The Whole Truth and Nothing But The Truth Dr. M. C. E. Gwee and/Prof. T. S. Yeoh	5
President's Address to Singapore Association of Pharmaceutical Industries	8
Common Examinations in Diagnostic Radiology — Principles. Dr Chin Wah Seng	10
Family Counselling in the East Dr. E. K. Koh	15
Physicians and family doctors: a new relationship Dr. J. P. Horder	18
International Assembly of Family Physicians — 1980 W.O.N.C.A.	25
News from the Council.	27
Medical News	28
Use metric in medicine	31
Book Review	32
Shame is the best contraceptive	33

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Editorial

The Pharmaceutical Trade

The pharmaceutical trade has always had good relations with the medical profession in Singapore. In fact it is not untrue to say that a certain amount of symbiosis exists in this relationship. The pharmaceutical trade is of course heavily dependent on doctors' use of their drugs, and in turn doctors would find it difficult to effect cures but for the drugs provided by the industry.

Unlike in many other countries where even scheduled drugs can often be purchased over (not under) the counter, in Singapore strict governmental control has restricted the free purchase of such drugs by the public. Although some members of the public may be inclined to view this as a form of professional exploitation and monopoly, the real truth is that such measures are enforced for their own welfare and safety.

The pharmaceutical trade has been very co-operative with our medical bodies. Those of us who have had to organise conventions, seminars or publish medical literature will attest to the generosity and help given by some of our established pharmaceutical firms.

With such harmonious relationships between our doctors and the drug houses, is it possible to find any fly in the ointment? Like all things else no relationship is ever perfect and there are in fact a couple of flies in the ointment. Generalised criticism of the trade as a whole would be unfair but nonetheless there have been instances where the trading ethics of some firms could have been better.

The pharmaceutical trade like the medical profession must have certain ethical standards. It is unwise and unethical for them to presume that being tradesmen they exist only to make money where money is to be made. There must be concern for the welfare of the patient and the good of society as a whole. Yet unfortunately a few drug firms exist in Singapore whose main motive is to make money from doctors and their patients. There is nothing intrinsically evil in making money, all economic progress is based on an ability to show profit, **but** there must be some thought at least on how profits are made or losses avoided.

There are some pharmaceutical firms who after selling the doctor their product, see little point in backing sales with service. Recently some firms marketing vaccines for immunising young children discontinued marketing their product for some length of time because of the "difficulty of obtaining supplies." This left some of the children who were half-way through their immunisation schedules high and dry because of non supply of the vaccines. Surely it is not all that difficult for these firms to arrange to air-lift some vaccine from alternative sources so that the immunisation schedules of these children should not be interrupted.

Then there is the question of carrying sufficient stocks to meet any contingency. In a recent 'flu outbreak one big pharmaceutical firm was unable to supply any paracetamol to its regular buyers. What was unfortunate was that it made no attempt to get stocks in from countries around which were at that time not undergoing a 'flu epidemic.

There is of course the case of the drug firms who decide to drop non or low-profit items from their list and concentrate on newer and high-profit drugs. Some drugs are no longer manufactured by these firms not because of adverse side effects but because demands do not justify cost of production presumably. For those patients who have within the years come to depend upon the products to relieve their asthma, anxiety, or other illness, it is difficult for them to accept change to another drug.

More outrageous are the revelations by Charles Medwar in a study released by Social Audit, an independent British research organisation. He makes four charges against the big multinational drug firms. The first is that these firms operate on a system of double standards when selling to third world countries. "When selling in Asia, drug companies suggest that their drugs should be used for treatments which are considered dangerous in the rich nations."

The speed in which some big firms was able to re-enter the local market with "modified" products when amidopyrine containing drugs were banned recently makes one wonder whether in fact these "modified" non-amidopyrine products

were not already available in the markets of the rich industrialised nations.

The second charge by Medwar is that they often recommend excessive dosages. "A British drug company, marketing tablets to relieve migraine recommend a dosage of 12 tablets in Asia and Africa — more than double the suggested dose for the same drug in the U.S.A."

The third charge is that they use unscrupulous sales tactics. We have in this issue an interesting article on exaggerated claims by a drug written by two writers from the pharmacology department of the University of Singapore. The views expressed however are the authors' own views.

The recent Act regulating medical advertisements in this country is timely but it is shocking to know that in the United Kingdom up and until 1914 there was no law to prevent anyone from making **any** claim for any medicinal product he wishes to sell. It was only after the instigation of the British Medical Association that the British government decided to take a closer look at all the quack medicaments that were being offered for sale to an unprotected public. The wheels of law move slowly and it was not until 1939 that advertisements claiming to cure cancer were disallowed. Stricter control of medical advertisements did not come about until as late as 1950.

Doctors who rely only on hand-outs from drug firms for their medical edification would be well advised to look to less partial sources like reputable medical journals.

The fourth charge is that multinational drug firms exploit poor countries by over-charging. To be fair to these companies their products sell at higher prices often because they have to spend more on research, quality control and marketing. On the other extreme it is common practice here for some small operators to hawk around the mar-

ket with drugs at basement bargain prices. Some of these firms may be bonafide but during the time of the Vietnam war it was not unknown for a few small firms in the region to re-package U.S. war surplus drugs with an extended date of expiry of efficacy.

Quite obviously it is time both the pharmaceutical trade and the medical profession got together to have a joint committee to see that there are no malpractices in the sale of drugs to the profession. The Government already has a body which decides what drugs should not be marketed but a non-Governmental joint body could serve the medical profession and the community in many other ways.

The President of the College in a speech to the Singapore Association of Pharmaceutical Industries stressed the need for a standard profile for drugs marketed for ready reference by the doctor. He also proposed the introduction of information by computer of adverse drug reactions.

Such a committee too can request the Ministry of Health to review decisions to ban or limit use of drugs. A case in mind is the banning of oral hormonal compounds for amenorrhoea. Whereas the ban is justified if the drug is used as a pregnancy test, there is however a strong case to permit its use in amenorrhoea not related to pregnancy. The anxiety of these women often present mental health problems.

It is good that there should be some soul-searching within both the medical profession and the pharmaceutical trade from time to time. It is better that such soul-searching should result in concrete and tangible evidence of service both to the doctor and the patient under his charge.

E. K.

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

Pentazocine Hydrochloride ('Talwin'): The Truth The Whole Truth And Nothing But The Truth

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A full page advertisement on pentazocine appeared in the current issue of the Drug Index for Malaysia and Singapore (D.I.M.S., Volume 6 Number 2, page 107, 1977).

Some of the claims made for pentazocine are:

- (1) It is "not a narcotic"
- (2) It "controls pain without addiction"
- (3) It is "generally well tolerated even by elderly or very ill patients"
- (4) It is recommended "for acute or chronic pain . . . regardless of the cause".

Are these claims justified?

1. Is pentazocine a narcotic?

The term narcosis has a Greek origin meaning "a benumbing effect" associated with a state of stupor. In this respect pentazocine can be considered a narcotic drug since its pharmacological actions on the central nervous system are "generally similar to that of the opioids, including analgesia, sedation and respiratory depression" (Goodman & Gilman, 1975). Therefore, from the pharmacological viewpoint, pentazocine should be considered as a narcotic drug like morphine and pethidine are.

However, under international drug legislation the term 'narcotic' is used to classify those drugs with a great potential for abuse. Under this legal definition pentazocine is considered a non-narcotic, since its potential for abuse is less than that of morphine or heroin.

2. Does pentazocine control pain "without addiction"?

When it was first introduced pentazocine was heralded as a potent, non-addictive analgesic. However, clinical experience with the drug has now

established that pentazocine can cause serious problems of drug addiction, especially with long-term use of parenteral preparations (Kane and Pokorny, 1975; Medical Letter, 1976; Martindale, 1977; Waldman and Horsfall, 1977). Moreover, there are also reports of pentazocine-induced withdrawal syndrome in newborn infants of mothers who took the drug for several weeks in late pregnancy (Preis et al, 1977).

The Association of the British Pharmaceutical Industry (ABPI) compiles a Data Sheet Compendium for distribution to health professionals in the U.K. The information on the drugs listed is prepared by the manufacturers in accordance with the requirements laid down by "The Medicines (Data Sheet) Regulations 1972" in the U.K. In the 1975 edition the manufacturer draws attention to the dependence liability of pentazocine. Admittedly, pentazocine is less liable to cause dependence compared to morphine; but to make a positive claim that pentazocine "controls pain without addiction" is simply stretching the point too far.

3. Is pentazocine "generally well tolerated even by elderly or very ill patients"?

In equally effective doses pentazocine causes at least as many adverse effects as morphine or pethidine. Most prominent are its effects on the central nervous system; pentazocine appears to produce a higher incidence of severe emotional and mental disturbances, including hallucinations, disorientation, bizarre feelings and even frank psychosis (Kane and Pokorny, 1975; Medical Letter, 1976). In one study these disturbances occurred in 7 to 10 per cent of patients taking therapeutic doses of the drug (Wood et al, 1974).

Sedation and/or severe vertigo occurs frequently with pentazocine. Nausea and vomiting,

constipation, biliary tract spasm or urinary retention occur to about the same extent as with morphine or pethidine. Pentazocine can also cause respiratory depression, a fact to be considered when giving the drug to individuals with obstructive respiratory conditions.

Like the other narcotic analgesics, pentazocine can precipitate hepatic coma in patients with liver disease. Complications at the site of injection are common after prolonged use; these include minor local reactions to widespread ulceration and fibrous myopathy (Winfield and Greer, 1973; Oh et al, 1975; Martindale, 1977).

4. Should pentazocine be used for treating any kind of pain?

The advertisement recommends pentazocine "for acute and chronic pain regardless of the cause". This is a very strong statement and potentially dangerous recommendation to make. The use of pentazocine in myocardial ischaemic pain is controversial. Pentazocine significantly raises pulmonary artery pressure and myocardial oxygen demand; these effects are potentially dangerous to patients with myocardial infarction (Jewitt et al, 1970; Alderman et al, 1972; Lee, 1976; Medical Letter, 1976).

In the ABPI Data Sheet Compendium (1975) the manufacturer also cautions against its use in raised intracranial pressure, head injuries or pathological brain conditions, where clouding of the sensorium is undesirable. Finally, of course, all doctors know that all narcotic analgesics are contraindicated in the "acute abdomen".

Drug advertising in Singapore: *quo vadis?*

The advertisement for pentazocine serves to illustrate how some advertisements can be sometimes misleading and raises a few important issues.

1. Should misleading advertising to the medical profession be permitted?

Medical advertisements often show a drug company's assessment of the medical profession's capability to view advertisements critically. While some advertisements are false or misleading in character, others employ techniques more in keeping with the marketing of cosmetics and female apparel. In countries where advertisements to the medical profession are controlled, such advertisements are fast disappearing. Quite apparently drug manufacturers are employing double standards in their advertising policies: one for the 'home' situation where advertising is regulated by law and the other for countries where such laws are presently not

adopted yet.

In the absence of legal constraints, it is difficult to expect drug manufacturers (big or small) to tell "the truth, the whole truth and nothing but the truth" about the products they sell. In the scramble for sales, advertising ethics may sometimes be cast aside and replaced by misleading advertisements without any regard for the serious consequences that might arise from such practices.

2. Pharmacovigilance: a role for editors?

In order to use medicines safely and effectively, particularly with reference to more recently introduced agents, doctors need to have unbiased and relevant prescribing information made available to them. Apart from professional publications, advertisements form an important source of such information to doctors. In the absence of legal controls, editors of journals can, therefore, play an important role in ensuring that drug advertisements appearing in their journals provide a fair and true account of the pharmacological properties of the drugs concerned. Such vigilance exercised by journal editors will surely promote the safe and effective use of medicines and enhance the image of their publication. Of course a fair balance between economics and pharmacovigilance in drug advertising may be difficult to achieve.

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President's Address to Singapore Association of Pharmaceutical Industries 9 March 1979

Mr President, Distinguished Guests,

When I began to consider what I should say to-day I decided to make a few observations about the pharmaceutical industry in Singapore, and how it should seek to have an effective working relationship with the medical profession, each appreciating the essential role of the other, understanding that each makes different contribution but with the same shared aims and goals.

The Pharmaceutical Industry has had a remarkable record in introducing some important new drugs in recent years. Dunlop (1969) suggested that "Modern drugs are much potent weapons that the responsibility for their safe production and use can no longer be left entirely to the manufacturer and prescriber." The increasing potency and expense of modern drugs threatens to erode the established principle of clinical autonomy to prescribers. And this brings us to the question whether the drugs that we prescribe generally are necessary, effective, safe and economic, or is there room for improvement. Is the drug to be prescribed:

- 1) necessary — is it likely that the patient's problem(s) will be best solved by a medicine?
- 2) effective — does the drug really work?
- 3) safe — will the drug do more good than harm?
- 4) economic — is there a cheaper way of solving the patient's problem(s) as effectively?

In Singapore, the uniqueness of prescribing at the primary-care level as opposed to the hospital setting must be recognized. Although there is evidence for the existence of a significant amount of frequent and expensive prescribing, there is evidence of prescribing of inexpensive generics of doubtful efficacy as well as lack of therapeutic

knowledge, particularly in the area of drug interaction, hardly any research has been done in this field locally. Attention should also be paid to continuing education in therapeutics for doctors at the primary care level. Your Association should finance the research and the development of better system of continuous review of prescribing patterns, as a basis for such continuing education. The College of General Practitioners Singapore would wholeheartedly give you its support for such research and continuing education programme.

The knowledge related to the practice of therapeutics is changing so rapidly and so constantly that the practising physician can hardly keep up. The problem of keeping abreast is greatest for the general practitioner who must, by circumstance, deal with the broad spectrum of therapeutic change. There is therefore a great need for a drug information service within our medical community — a service that should be easily accessible and provide an ongoing education component.

I have two suggestions to make which perhaps your Association could make available to the profession. The first is that a profile be developed for all new compounds that are registered for marketing. This profile should be sent to all doctors at the time of release and should arrive no later than the first mailing from the pharmaceutical industry. An ideal format would be that of a filing card of standard size with one side of the card carrying information about the potential drug interactions and toxicity. This would prove very popular, be easily stored on a desk and be readily used. The second is a proposal for a rapid, readily accessible computerised system on adverse drug information. The challenges facing doctors when prescribing are numerous. Immediate access to all known contraindications, side-effects and interactions about a drug, or combination of drugs would be advantageous to all doctors. A computer service is advo-

cated on the grounds of the rapidity of information retrieval, possible access to all prescribing doctors, and because of the sheer complexity of the subject. The cost of such a service is not great after the initial computer programme is developed or purchased and altered according to the Singapore conditions and listed drugs.

Seen on a national basis with one computer programme and various on-line terminals and instant accessibility around the doctor to every doctor, pharmacist or hospital, the benefits would obviously outweigh the costs. Finally, I would like to thank the members of your Association for the advertising support that they have given to our medical journals — in particular to our College Journal, "The Singapore Family Physician". The income from advertisements for drugs is extremely

important to most scientific medical journals. Without such advertising support, journals of our kind could not be published at all or would have to appear very much reduced in size or frequency of publication. However, medical journals remain one of the most important methods of spreading new knowledge and ideas. It is therefore logical that the pharmaceutical industry advertise in medical journals as a means of informing the medical profession about the nature of its new products and reminding them of the existence of established preparations.

Dr. Victor L Fernandez
President
The College of General Practitioners
Singapore

Common Examinations in Diagnostic Radiology - Principles

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PART ONE

INTRODUCTION - PREFACE

This series of articles is not intended to teach general practitioners to interpret radiographs diagnostically. This is best left to the specialist concerned. But ideally,

- (1) he must be able to ask for the appropriate initial radiological examination to confirm his diagnosis or to exclude an important worrisome abnormality. The initial examination must also be correctly asked for as it may be the beginning of a long series of investigations.
- (2) he should be able to explain an intended radiological examination to his patient satisfactorily; what is required of him and the benefits and risks involved.
- (3) he should be able to appreciate the report of the radiologist, in particular the limitations of the radiographs and reasons for supplementary views and examinations. With this appreciation, the GP who knows more of the patient can assist the diagnostic radiologist to narrow the differential diagnosis, select the next best investigation, and arrive at a confident diagnosis swiftly.
- (4) he should, without much difficulty, be able to follow "radiological language" in his meetings with radiologists, clinicians and in his literature reading.

Hence, the articles will emphasize fundamental points in radiology which are often ignored in routine teaching but are essential in the understanding of the why and how of radiographs and radiological examinations. It is of course not possible to put down in writing in this Journal everything the author wishes. The articles will be concise and cover the common radiological examinations performed in the government hospitals. A degree of boredom is not unexpected from reading such dry semi-technical information.

A) THE CHEST RADIOGRAPH

The standard chest radiograph is taken in the erect inspiratory **posterior-anterior projection** (in the direction of the X-rays) as this enables the patient to rotate the scapulae forwards resulting in full unobscured visualisation of his lungs. As the heart is located anteriorly in the chest, this **PA** projection will result in minimal magnification of the heart shadow giving a truer estimation of the heart size.

As expected, there will be significant disadvantages in an **AP view** of the chest when ill patients are radiographed in the ward. The lung fields will not be fully exposed, the diaphragms tend to be high and heart size too magnified to be acceptable. In addition, the lungs tend to be blurred as the ward portable machine is not powerful enough to "capture" a static picture of the lungs, particularly when the patient is tachypneic. Hence, "portable" films should be avoided whenever possible.

A "**penetrated**" **PA** chest film is sometimes required following a standard PA film where an abnormality is suspected in the mediastinum and hila. The "penetrated" film employs a higher kilovoltage of X-rays enabling structures in the mediastinum to be more discernable, thereby providing more diagnostic clues of an abnormality located in the mediastinum.

A **lateral view** of the chest is usually not necessary although it is standard practice in some countries to have a pair of PA and lateral views routinely. Most importantly, the lateral view confirms a lesion to be intrapulmonary in location. A skin lump seen as a coin lesion on the PA view without confirmation with a lateral view will lead to unnecessary investigations and an embarrassing conclusion. A lateral view may be required to obtain further information to confirm the diagnosis suspected on the PA film. Ordinary chest infections do not require a lateral view and similarly, progress films of an uncomplicated known lesion.

But the lateral view is mandatory in assessing a mediastinal abnormality. Apart from eliciting specific radiological signs, the lateral view localizes the lesion to the anterior, middle and posterior mediastinum. This information alone narrows the differential diagnosis considerably. An anterior mediastinal mass if separated from the ascending aorta will likely be a thymoma, teratoma or thyroid gland. Commonly, a middle mediastinal mass is an enlarged lymph node or bronchogenic cyst; and a posterior mediastinal mass, a neurogenic tumour. A common error is to diagnose an ominous hilar mass on the PA view when it is actually a benign lesion in the anterior or posterior mediastinum which became superimposed on the hilum in the PA view. An aortic aneurysm or a tortuous atherosclerotic aorta is another common example of a differentiation which can be made confidently on a pair of PA and lateral views. To obtain maximum detail, order a right lateral view if the lesion is on the right chest and vice-versa. A lateral view is not to be requested in examining the ribs.

Oblique views of the chest are seldom required. They are still used by some for assessing cardiac abnormalities. For lung lesions, they are of little use. Their main function is to demonstrate rib fractures and other bony lesions. It is important to indicate the location of the suspected rib lesion i.e., upper or lower ribs, anterior or posterior segments; because the radiographic technique is different for each location.

An **apical view** is another supplementary view to obtain clear visualisation of the lung apices. This region of the lung tends to be obscured by the clavicle, upper ribs, and neck structures especially hair. A clear view of the apices will confirm the presence of a Pancoast tumour or pulmonary tuberculosis and is helpful in differentiating active tuberculosis from post-tuberculous fibrosis.

A **barium oesophagram** in a pair of penetrated PA and lateral chest films is very useful in the assessment of a posterior mediastinal mass, aortic abnormalities and to determine minor enlargement of the left atrium in equivocal mitral valve disease. The course of the oesophagus is quite constant and any deviation will provide valuable clues about the lesion responsible.

In addition to what has been said, there are further specialised supplementary views tailored to the particular problem or lesion which the diagnostic radiologist may request. However, these are very uncommon. Mention must be made of the MMR chest films. These examinations are certainly useful and reliable in routine mass screening. But any abnormality seen or suspected must be confirmed by the standard chest films. As the radia-

tion dose of the MMR examination is about ten times that of the standard one, pregnant women should avoid it.

The final point in this article is a strong exhortation to practitioners to keep all chest films of their patients. Many prognostic and diagnostic problems will not arise if there is an old film for comparison.

B) THE KUB — ABDOMEN RADIOGRAPH

The largest size film in diagnostic use is 17 x 14 inches. This size may not be large enough to cover the whole adult abdomen from the superior margin of the diaphragm to the pubic symphysis. Hence, the requesting doctor has to decide whether to order a KUB or an abdomen film.

The **KUB** film as the alphabets suggest (kidney, ureters, bladder) should be ordered when the urinary tract is the suspected site of disease. As the whole pelvis is included in the film, this should also be the examination for pelvic pathology. In searching for urinary tract disease, it is essential to have as little fecal shadows as possible. Fecal shadows obscure renal contours and opaque urinary calculi. Dense fecal opacities can be confused with urinary calculi. It is therefore recommended whenever feasible to prescribe a laxative to patients first before the KUB examination. The abdomen has an uneven shape and due to a technical difficulty, the kidney outlines may not be demonstrated satisfactorily. This can be overcome by an additional localised view of the kidney region. The referring doctor should therefore stress the need to see the kidneys if this information is particularly important.

The **abdomen** film includes the area from the superior margin of the diaphragm to as far below as the film can cover. Very often the lower half of the pelvis will be excluded from the film. Hence this film is for seeing abdominal organs above the pelvis. If the examination is to detect gallstones, the problem of excessive fecal matter stands and a laxative should be prescribed similarly. The palpation of liver and spleen could be difficult in some patients and an abdomen film is reliable in determining the size of these two organs. The abdomen film is of immense value in the investigation of an abdominal mass. It can first confirm the presence of a mass and then localise it to the organ or retroperitoneal space. The outlines of the liver, spleen, kidneys, psoas muscle, and the air in the stomach, small bowel and colon, all help in this respect. The information from this abdomen film can then determine the next best investigation.

The **erect abdomen** film is supplementary and complementary to a supine abdomen film. It is

very rarely justified to order only an erect film. A common error is to ask for an erect film in a suspected peptic ulcer perforation to see free air under the diaphragm. But in fact, air under the diaphragms is better seen in an erect chest film. The erect film is largely used to assess bowel air in suspected intestinal obstruction and gas-forming abscesses. To be reliable, the erect film must be examined with a corresponding supine film.

The **oblique abdomen** film is infrequently used. It is almost only used when a calculus is seen in the right or left upper quadrant on the AP abdomen film. The oblique view (posterior oblique) will then confirm if the calculus is intra-renal i.e., renal stone. This is particularly useful in the right upper quadrant where a gallstone will be seen to be anterior in location in the oblique view, differentiating it from a right renal stone.

The **lateral abdomen** film is rarely used. A relatively large amount of radiation has to be used and the film images tend to be unsharp. It is a common error to use it to differentiate gallstones from renal stones but very often, the stones are not dense enough to be demonstrated on the lateral view. The oblique view will serve this purpose. Very dense opacities in the abdomen can of course be located on the lateral view. The only condition where a plain lateral abdomen film is really useful is in diagnosing an abdominal aneurysm when the calcified anterior and posterior wall of the aorta can be seen unobscured by the lumbar spine.

The **left lateral decubitus abdomen** film should be remembered when the patient is too ill to stand. Here, the patient lies on his/her left side and the X-ray beam is horizontal to the table. Air-fluid levels can be seen as in the erect film and free intraperitoneal air from a perforated viscus will be clearly seen between the lateral abdominal wall and the lateral edge of the right lobe of the liver.

It must be remembered that "portable" abdomen films should be avoided as the diagnostic quality of the film is much reduced because of technical limitations. This disadvantage is more serious than in a "portable" chest film.

C) THE BARIUM MEAL

The barium meal examination of today has become a highly reliable and accurate method of detecting lesions in the stomach and duodenum. The old method of using a large volume of barium (single contrast method) has been replaced by a double contrast technique using a smaller volume of barium and a large volume of air. Japanese workers have been mainly responsible for bringing this technique into general acceptance. Small and early lesions are now more easily detected and

differentiation of benignity from malignancy is much improved by the double contrast method. This method also involves the use of a short acting anticholinergic drug to relax the stomach during the examination.

A completely empty stomach is essential and this must be stressed to the patient. Perfect barium coating of the mucosa is the key to the demonstration of lesions and any solid or liquid gastric residue will impair this effect and reduce the diagnostic accuracy. Solid residue will in addition introduce artefacts causing confusion and false positives. A patient with pyloric stenosis must therefore be on drip and suck until the stomach is empty before the nature of the obstructing lesion can be determined. Patients on daily essential medication should withhold their drugs until after the barium examination. Referring doctors must provide this information so that these patients will receive priority.

The patient should be informed that he will have to swallow effervescent powder and tasteless barium for the examination. In addition, except for paediatric and very elderly patients, an intramuscular injection of a short acting anticholinergic (i.e. Coliopan, Buscopan) will be given to paralyse the stomach. Therefore the referring doctor must inform of any contra-indications to the use of an anticholinergic on his patient e.g. heart disease, glaucoma, prostatic hypertrophy. It should be noted that the barium may cause slight constipation.

4 to 5 large films of the stomach will be routinely taken. Some radiologists use small films, i.e. 70 or 100mm size, in addition to large films. The underlying principle in the examination is to show every part of the stomach and to see each part at least twice on single and double contrast appearance. A lesion found must be shown to be constant, hence genuine and not an artefact, and supplementary views may be taken to elicit details of the nature of the lesion. Important information may also be obtained during fluoroscopy (screening) and it is wise to speak to the radiologist who performed the examination when the diagnosis is critical to the patient.

Examination of the duodenum is always part and parcel of the barium meal. The duodenal cap or bulb, being the characteristic area for peptic ulceration is always examined in detail using spot films. It can be badly deformed and contracted by fibrosis from chronic peptic ulceration, making it impossible to identify the presence of active ulcers. This will require correlation with symptomatology and signs i.e., melaena. The rest of the duodenum is also examined for post-bulbar ulcers,

pancreatic and Ampulla of Vater tumours, etc.

The esophagus is always examined under fluoroscopy during the barium meal examination. Often, films of the esophagus are not taken routinely, unless an abnormality is seen. But if an esophageal lesion is suspected, then a barium swallow should be formally requested. The patient need not be prepared if the suspected lesion is high. But for low esophageal lesions, the stomach must be empty. The stomach, duodenum and small bowel are also examined when esophageal or gastro-esophageal malignancy is present and surgical treatment is expected. The referring doctor must specifically mention hiatus hernia or gastro-esophageal reflux if these conditions are suspected. The radiologist may have to perform special manoeuvres to exclude them. There are uncommon delicate situations where the esophagus has to be carefully studied, i.e., esophageal fistula, perforations, etc. Discussions with the radiologist is advised as the examination may require special technique and different contrast media.

If the small bowel is the suspected site of disease, this must be clearly stated. The anticholinergic IM injection will not be given to allow normal movement of barium through the small bowel. Supine films of the jejunum, ileum and ileo-caecal region will be taken. The patient should be forewarned that the entire examination may take a few hours. An erect film will be included where jejunal diverticulosis as a cause of malabsorption is suspected. In practice, it is almost impossible to demonstrate a Meckel's diverticulum and a barium small bowel study should not be ordered for this purpose. In some centres, instead of an anticholinergic drug, glucagon is used. Glucagon appears to be ideal for examining the stomach and small bowel at the same sitting for it will relax the stomach for a double contrast examination but does not alter small bowel transit time. Although the colon will be shown on the barium follow through, this must not be employed as a cheap way to examine for colonic lesions. Apart from gross obstruction, diagnosis is fraught with errors due to the barium breaking up in clumps along the length of the colon. The colon must be examined by a proper barium enema study. In the investigation of malabsorption, a routine barium follow through may provide clues but is too non-specific for diagnosis. To establish malabsorption from disaccharidase deficiency, a two stage barium study is required; one with plain barium to be repeated with the addition of a quantity of a disaccharide. The radiological findings are characteristic.

In a situation where it is not certain whether

the lesion is in the colon or in the stomach/small bowel, the barium enema should be done first as barium will be evacuated quickly allowing the barium meal to be undertaken very soon after. The barium enema should also take precedence over the barium meal in a patient with bowel obstruction where the level of obstruction is indeterminate. The reason for this is entirely different. It is a very common error to assume that a barium meal will aggravate a small bowel obstruction. This is just not so. The fluid stasis in a small bowel obstruction will keep the barium in suspension and will not convert a partial obstruction into a complete one. A barium meal is indicated when you want to confirm and determine the level of the small bowel obstruction. But where the obstruction may be in the colon, then a barium enema must be done first. In colonic obstruction, the barium in the colon can become compact due to water absorption by the colon, thereby aggravating the obstruction.

When the terminal ileum and the ileo-caecal region has to be examined, i.e., Crohn's disease and ileo-caecal tuberculosis, a barium enema, not a barium follow through, should be performed first. Very often the ileo-caecal valve is incompetent allowing reflux of barium into the terminal ileum. The terminal ileum will be clearly seen without interference from opacified loops of ileum and jejunum. A barium follow through is next if the barium enema is unsuccessful or equivocal and to exclude skip lesions of Crohn's disease or tuberculous strictures.

A small bowel enema examination is rarely done. But this will give additional clues about any small bowel lesion. It usually comes after a routine barium follow through has established the presence of an abnormality of uncertain nature. The examination is rather time consuming and requires insertion of a tube into the duodenum to introduce air and barium intermittently. Prior consultation with the radiologist is advised.

D) THE BARIUM ENEMA

The barium enema is viewed upon by many patients with marked apprehension with further aggravation on hearing the experiences of other who have undergone this examination. It is of course true that the examination is rather undignified to the patient and there is a measure of discomfort depending on the tortuosity of the individual's colon and the nature of the disease process. But the present method practised in the Singapore government hospitals is quicker and less uncomfortable compared to previous methods. The patient should be duly assured of this and

expect the minimum of discomfort and indignity.

The routine method employed in the government institutions is largely a double contrast method. Paediatric and very elderly patients will receive a simple examination modified to suit the diagnostic problem. For the routine barium enema, there will be two days of bowel preparation consisting of low residue diet, Dulcolax and magnesium sulphate laxatives and finally a Dulcolax suppository. It is important the colon is clear of faeces for the examination as fecal matter introduces diagnostic errors. For the detection of polyps, a clean colon is mandatory. If the patient's problem is that of severe diarrhoea, the bowel preparation can be reduced accordingly. Conversely, a patient known to be habitually constipated should receive additional measures to clear his colon. It is a waste if the patient is to return for a repeat examination because of inadequate preparation of his colon.

On the day of the examination, the patient can have a light breakfast. There will be no uncomfortable colonic wash-outs as the colon should be clean by then. An intramuscular injection of an anticholinergic drug (Coliopan) is given and the examination begins right away. Barium is introduced into the left colon only and then followed by air insufflation to distend the colon adequately and coat the whole of the colonic mucosa with barium. Because of the anticholinergic, there will be little discomfort on distension of the colon. Films will be taken of every part of the colon, arbitrarily divided (for filming) into the rectum, rectosigmoid, splenic flexure, hepatic flexure and caecum. Usually, the anatomy is such that oblique views are best for full visualisation of these regions. Reflux into the terminal ileum will always be attempted to complete the demonstration of the ileo-caecal area. This becomes very important diagnostically in inflammatory disease. Usually a final large film will also be taken for an over-all view of the colon. The whole examination is completed in one sitting which seldom exceeds 20 minutes in an uncomplicated case.

There is really no contra-indication to a barium enema except in toxic megacolon of ulcerative colitis. Minor ECG changes have been recorded during a barium enema but they are insignificant. Any known contraindications to the use of an

anticholinergic drug should be revealed by the referring doctor. It is preferable to delay the barium enema by a week following sigmoidoscopy to avoid aggravation of any trauma from sigmoidoscopy and biopsy. It should also be remembered that ano-rectal lesions are better detected by direct examination than a barium enema.

Special mention must be made of the barium enema in some paediatric conditions. There is of course no bowel preparation except for the older children. In an infant or small child, it can be difficult (on plain films) to diagnose bowel obstruction and determine the level of the obstruction. Under this circumstance, a barium enema should be ordered right away before laparotomy. A normal barium enema narrows the differential diagnosis significantly for the surgeon. A barium follow through is then usually not necessary unless the diagnosis of a mechanical obstruction is in doubt. A particular point to obtain from the barium enema is malposition of the right colon. A high caecum is a strong indicator of congenital malrotation with mid-gut volvulus as the cause of a high small bowel obstruction. This demands immediate surgical relief. In intussusception, the barium enema is diagnostic and can be therapeutic. If the intussusception is suspected early and the child's general condition is satisfactory, the barium enema after confirming the diagnosis, can be used to reduce the intussusception and spare the child a laparotomy. Another condition where the diagnostic enema can also be therapeutic is in the meconium plug syndrome. The barium enema is substituted by a gastrografin enema. The gastrografin will induce a diarrhoea with disintegration of the obstructing meconium plug. In Hirschsprung's disease, the bowel preparation is omitted. It is impossible to clean the colon and the presence of faeces does not impair the diagnostic accuracy. In fact, vigorous wash-outs can lead to water intoxication.

The usefulness of a barium enema is not restricted to conditions of the colon only. Small bowel abnormalities can be inferred from a barium enema study. Lesions in the terminal ileum and ileo-caecal junction are usually best shown on the barium enema and there are some who advocate using the barium enema to diagnose appendicitis.

Family Counselling in the East

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Montreux, 1978.

Family life in modern societies in the East does not differ much from that in the West. The same basic problems of trying to keep the family as a social unit are there. The generation gap is not a prerogative only of Western families, nor is insecurity amongst the aged and infirm seen only in the West. We have these problems too in the East.

The differences seen lie chiefly in the varying emphasis each society places on different aspects of family life. In the East two features are dominant. One is the closely-knit aspect of family ties and the other is the importance of culture in the behavioural norms of the people.

This has made it necessary for family counselling to adopt postures slightly different from methods used by counsellors in Western societies. Whereas in the West some may lay stress on group psychotherapy, social casework or even genetic counselling; in the East however, family counselling by the family doctor remains very much what the term implies — counselling or advice for the family.

Viewed in this light counselling can be considered to fall into two categories, a) solicited counsel, and b) unsolicited counsel.

Western society is characterised by being more open and frank than Eastern society. Much of family counselling perhaps falls into the category where counsel is solicited from the family doctor. The doctor is treated as a resource person from whom professional advice and information to assist the solving of problems is obtained. Whereas it is important that he should fulfil the role as the provider of medical information, it is important also for the family doctor to avoid the role of being a mere pedagogue.

In the East there is always the traditional reserve amongst the people and consequently less frank exchange of ideas and opinions. The traditional observation of "face" and other niceties in social communication also frequently prevents a person from really saying what he would like to

say. Hence amongst Indian females a doctor frequently finds that the traditional "purdah" not only covers the face but frequently cloaks their thoughts as well. Although Singapore is a highly urbanised Eastern city and the old is fast giving way to the new, we still find in our society both forms of social behaviour.

Tradition dies hard in the East and the family doctor frequently finds that not every one of his patients will come readily forward to seek his counsel when beset with a problem in the family. Such being the situation he often finds it necessary to give counsel to the patient or his family regardless of whether such counsel has been sought from him or not. This is because as the family doctor he feels a sense of responsibility for the welfare not only of his patient but the patient's family as well. The family doctor must regard the patient and his family as an integral unit.

Unsolicited Counsel

The giving of unsolicited counsel is not without pitfalls and the family doctor must be careful to always size the situation and be sensitive to the reaction of his patient and the family.

There are a few pointers which can assist him to do this without appearing to be clumsy on sensitive issues.

1) Knowledge of family dynamics

The family doctor should be guided by the pattern of social interaction within the family and be aware that when one member falls ill, the rest suffer also.

Like in the case of the pin-ball machine he should be able to trace the path or anticipate the trajectory of the ball as it lights up the pins when they are struck.

No ball in a pin-ball machine remains static when struck and likewise no one person who is ill within the family confines his ailment and misery

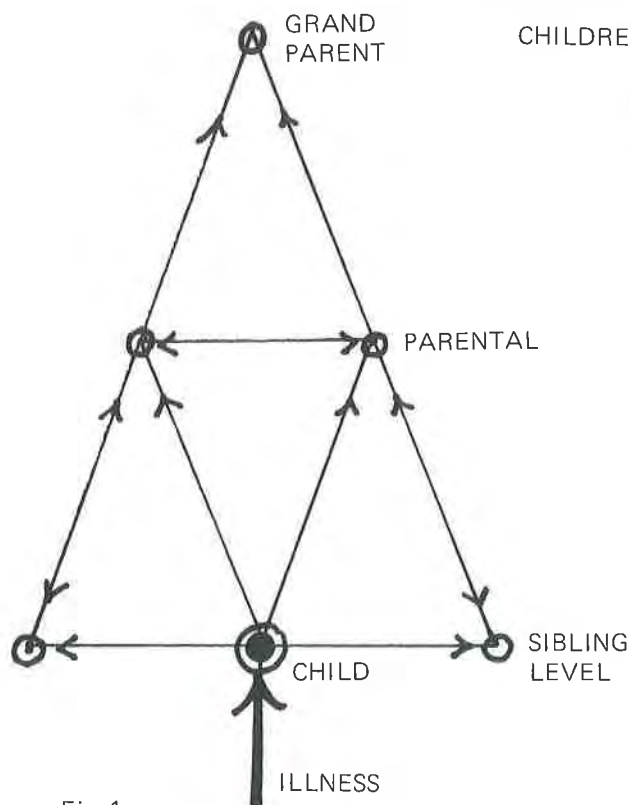


Fig. 1

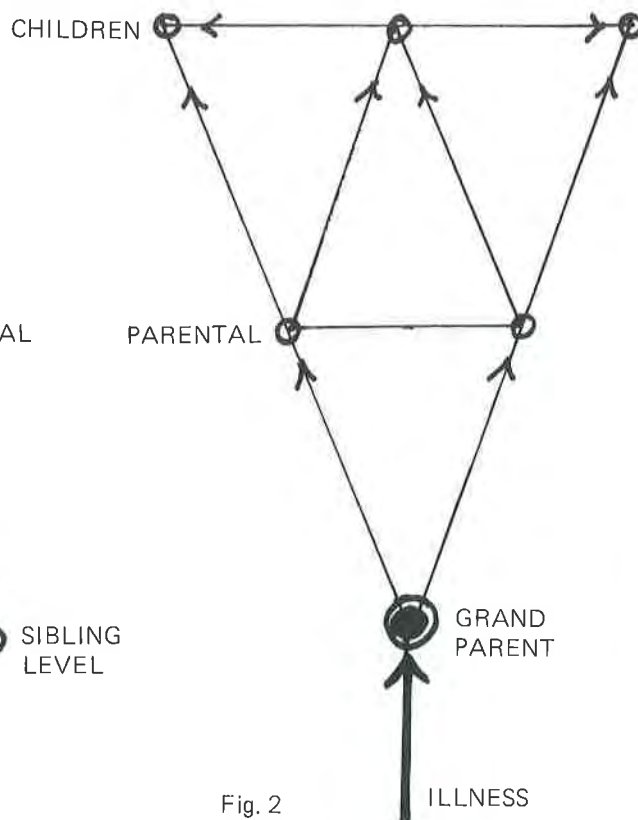


Fig. 2

PINBALL TRAJECTORY PATTERNS IN FAMILY DYNAMICS.

to himself. He may not wish to inflict his ailment on the other members of the family but in a greater or less degree there is always some reaction from the rest of the family.

Some of the reaction may be helpful and assist him in getting well. There are times when the reaction is not only unhelpful but aggravates his illness and slows down his recovery.

When illness affects a child in the family for example (cf. Fig. 1), pressures on the parents can often rebound on to the other siblings.

On the other hand when illness affects a grandparent (cf. Fig. 2) by the time the impact is felt at the level of the grand children much of the impact has been lost due to wider spread of the impact force.

2) Learn to understand paralanguage.

Firstly the family doctor should be able to converse fluently with his patient and so understand his complaints. Verbal language however does not tell everything. He must learn to read the paralanguage, the tone, the nuances, the emphasis or

otherwise which the patient places on the spoken word.

Communication is not wholly through the spoken word. There are many forms of non-verbal communication and the doctor who wishes to have empathy with his patient in order to counsel more effectively has to learn to read body language or kinesics.

3) Learn to communicate effectively

Communication is a two-way street, besides learning to understand the patient better the family doctor must also try to be understood himself. Often the thoughts of the patient and doctor are not on the same wavelength, hence it is important that the doctor's message must be put across in a way the patient understands. Too often doctors use medical jargon in talking to their patients quite forgetting that the layman's interpretation of medical terms may be completely different from that of the doctor's.

In the East to communicate effectively with a patient it is best to be familiar not only with his

home environment but with his cultural background as well.

4) Achieving empathy with patient.

Empathy is a much overworked word when it comes to doctor/patient relationships. Yet for counselling to be successful it is important that empathy be achieved so that the patient has full confidence in his family doctor.

Here it is important to level up patient's expectation and doctor's assessment of the ailment. If for instance a doctor's assessment of the patient's illness is low on the scale, while the patient himself gives his illness a high rating, empathy would be difficult to achieve.

Instead of the doctor and the patient seeing eye to eye on management, an eyeball to eyeball confrontation between the two is more likely to result.

It is not always the patient that has to come round to the doctor's point of view. Sometimes it may be necessary to look at things from his point of view. Failure to realise this will result in loss of empathy with the patient, and further counselling would be futile because it will only fall on deaf ears.

5) Don't be too keen to demolish established cultural patterns.

In the East rapid social and economic advances in certain countries like Singapore have created the problem of adjustment to such changes. As Alvin Tofler puts it, it is not the change itself that is the problem but the rate of change that many of the older generation find it difficult to accept.

The Western-trained doctor who tries to demolish established cultural patterns often finds that his iconoclastic methods only results in a bewildered and confused patient. Some who are hostile to change may totally reject any advice or help that the family proffers.

6) Take an active role in counselling, be involved.

Michael Balint introduced a new concept in patient care when he said that the doctor should regard himself as medicine which he prescribes to the patient.

In similar vein, the family doctor should not take a passive role but should actually involve himself in the task of problem solving.

This idea may not sit well with those counsellors who believe in non-directional counselling.

In the East however many patients look to the family doctor not only for advice but guidance as well. They expect some form of commitment from the doctor.

We have a proverb which goes, "one good act is worth a thousand words of advice." The family doctor by arranging for example for financial help or care of the family in distress goes a long way in establishing understanding with the family.

7) Help of paraprofessionals.

Paraprofessionals like the clinic nurse, teachers, elders in society can help the doctor in reinforcing the message.

What are the pitfalls of unsolicited counsel?

Counsel is only helpful when the family agrees to heed it. Few people will accept counsel from someone they do not know well. Hence for family counselling to succeed the doctor must be someone they have known for some time, this is usually the family doctor, not the specialist. The family must also have faith in his judgement and be convinced of his sincerity to help.

Most of what has been said of family counselling in the East can be profitably applied to counselling in the West. At best counselling is often a long and tedious process. At its worst it can be soul destroying for the GP as well.

Lastly on a lighter vein we have to view counselling from the patient's point of view. A dissatisfied patient once told his doctor bluntly, "Look, when I want help I seek my doctor. If I want advice I can always go to my mother-in-law."

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Physicians and family doctors: a new relationship

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Many general practitioners now think and feel that the future relationship between specialists and generalists will be one between two kinds of doctor who have different and complementary functions but on the same level. This contrasts with the past when they considered the relationship was in some respects as superior to inferior, with functions that were often the same. One-to-one relationships are not in question; specialists and generalists are often personal friends and, when they meet in consultation, the relationship is excellent. The point is the way in which one group considers the other. In this context general practitioners are defined as the generalists and specialists are those who hold career posts in hospital, particularly those working in medical specialties, many of whom act as consultants, and a few of whom are truly general physicians.

Although the relationship of specialists and generalists is changing, many of their old attitudes still motivate both groups today. These can be recalled by examining the relationship of 25 years ago.

How general practitioners saw specialists

General practice was going through a major crisis in 1950, which at the time seemed to have been caused by the start of the NHS, but which actually had much deeper causes, since the same difficulties had been experienced in many other countries with different systems of care. But it was the Health Service that was blamed and bitterly resented by a proportion of general practitioners. They feared that they would be overwhelmed by the free access which patients now had to their services, and felt that they had lost any financial advantage from better work. In many instances they had lost the hospital work which they did alongside their practice; they saw their specialist colleagues being better paid and given better resources. Patients asked to see a specialist because specialists were viewed both as

better doctors and as people who had the use of technology denied to the general practitioner.

Recruitment to general practice began to fall. The first career choice of the great majority of students was for a specialty. Lord Moran (1960) spoke of general practitioners falling off the specialist ladder, implying that they were losers in the race to climb it. This was indeed true for many people who became general practitioners. It made a beginning for them in which jealousy of their more successful colleagues was combined with a degree of contempt for the inferior circumstances of the job they had been forced to take and for which they had not received any special training. Even worse, the job did not appear to merit special training.

How specialists saw general practice

Specialists thought of the problems which patients present to general practitioners as mostly minor ones, of which a high proportion were psychological or social. A general practitioner was therefore nearly the same as a social worker, except that he had some medical knowledge, much of which was wasted. His main diagnostic task was to sort out what was minor from what was major and to refer the latter to specialists. General practice was mostly common sense. The practitioner was a very busy man and so, much as he would have liked to, he seldom had time to listen to patients, examine them, do tests, or talk to them. He could not afford to be as precise or scientific as the specialist. All this being so, the less intelligent doctors should go into general practice, which was most suitable for people good at games. There was no need for them to have a special training, because common sense cannot be taught. If a general practitioner found himself discontented with this role, he could hear about hospital medicine on a ward round at the local hospital, or do a bit of it as a clinical assistant, or, in rare circumstances, aspire to be a specialist by passing a

specialist examination.

In view of all this, certain assumptions followed naturally:

1. Patients would really prefer to be treated at a hospital.
2. It did not matter much if general practice or primary care was of a low standard because there was the safety net of hospital outpatients or secondary care. No great harm was done by transferring a patient from the first level to the second.
3. It was not important for the hospital to be concerned with the standards of primary care in its neighbourhood. It was even less important for a regional teaching hospital to be so concerned.

All these were predominant views 25 years ago. I held them myself when I worked in hospital. I defy any reader to deny that he has ever held any of them. They formed the kernel of the old relationship, but today they form a source of resentment to general practitioners and a destructive influence on the system of medical care that is developing in this country; also, they are out of touch with reality. This is most obvious if one looks at clinical work in general practice.

Clinical work in general practice

I shall start by introducing one of my patients, a widow, now 69, a well-preserved talkative lady who makes her presence immediately felt in my waiting-room. She arrives in a hired car, which waits for her. She has the following proven disorders: diabetes mellitus, myxoedema, gout, osteoarthritis, auricular fibrillation; a liability to pulmonary emboli, for which she has been on anti-coagulants for nine years since a carcinoma of the body of the uterus was successfully removed; diverticulitis, which two years ago led to a near fatal intestinal obstruction after a four-month illness treated at home; and benign hypertension: a total of nine diseases, for six of which treatment has been maintained. I take deeper breath when I see her name on the list or her eyes glued on me from the waiting-room. As I am always late, I think of the hired car, but I have not mentioned what is for me the most important problem: she is lonely. She lost her husband in the war; he was in command of a ship. Over the 25 years I have looked after her, I have seen her lose, in turn, her father, her only brother, her boyfriend, and her two favourite pets. She is left with a dependent boyfriend who drinks too much. In other words, she is bereaved and often depressed. However, perhaps the most difficult problem for me is how to cope with her in the surgery, where she normally has a 15-minute appointment. It is not just

the business of thinking simultaneously of her nine diseases, but the fact that she will come to problem two before I have had time to sort out problem one, so that she makes me angry. At the same time, she wants to consult me about her boyfriend's drinking and ask about my wife and children. After 25 years, I have not yet mastered the art of coaxing her out of the room. This case is not exceptional, it is merely an extreme example.

The last five patients seen consecutively on a recent evening were:

1. An old lady with a badly sprained ankle, doing badly, a deep vein thrombosis, visited at home with an orthopaedic surgeon. She uses any malady as a weapon to control her middle-aged children.
2. A single girl of 30 who has been depressed for eight years and has been resistant to all forms of treatment by anyone. She does not work; she is getting weekly support from both our social worker and me.
3. A senior social worker who finds that hard work allays her tendency to depression, which is partly constitutional and partly marital.
4. A Polish man of 60, with coronary disease, gall stones, diabetes, and an undiagnosable left-sided abdominal pain. Seen twice weekly at least for the last seven years. His speech is almost unintelligible.
5. An Irish lady with seven children who is never well. She suffers from postvagotomy diarrhoea after years of pain. Terrible low back pains.

With the exception of the social worker, who came to the neighbourhood recently, I have looked after each of these people for between seven and 20 years. Most of my practice consists of people like them with problems which are part physical, part psychological, and part social. Their problems are neither minor nor trivial, nor transient nor obvious. I cannot just pass them off to a specialist and be rid of them; their problems are too complex and too chronic. Most of them have been shared with a specialist at some time, but the specialist has proved more capable than I of finding solutions in only one out of three. They would not prefer to be treated at hospital, but they are sensible people and are grateful to know that the hospital and the specialist are there when I cannot cope.

They prefer to be treated in general practice because it is nearer and easier to reach at the crucial moment; they can talk to a familiar person and switch from one problem to another without changing doctor; it is easier to understand what the doctor says, and altogether less complicated and less alarming.

They tax me to the full. They require high-

speed pattern recognition in diagnosis. They all require time, whether it be for collecting information, examining, listening, or responding. With one exception they all impose an emotional strain. I can deal with the Polish man in five minutes, but not with any of the others.

General practitioners, of course, unconsciously select their patients over the course of their life in practice. I cannot be sure that 100 patients I see resemble 100 seen by a doctor in another practice. I cannot even be sure that another doctor will always see the same problem in the same patient. Nevertheless, I do not think that the gap between the cases I have outlined and the traditional picture — a minute's consultation, a chat, a certificate, and a bottle — is a mere artefact of my own.

Psychosocial problems are of course common and important in general practice. There is a long tradition in the whole of our profession that they are less important than physical ones. This is an error comparable to pre-Harveian ideas about the circulation of the blood or the practice of bleeding and purging. One has only to ask patients who have experienced both a serious physical and a serious mental illness; nine out of ten will have found mental pain harder to bear than physical, longer lasting, and harder to relieve.

The prevalence of psychosocial problems in general and hospital practice will depend, above all, on the doctor's willingness and capacity to recognize them. There is a most interesting paper by Querido (1963) about the extent to which they are missed in hospital practice and the extent to which they influence the ultimate outcome even of surgical operations. I believe that they are still being missed in both types of practice.

It is certainly crucial that they should be detected at first contact if the patient is not to be led up the wrong track. It is still potentially dangerous for a patient whose depressive illness presents with abdominal pain and constipation to be referred to medical outpatients, especially if he runs into an inexperienced doctor or the sort who says, "I practise sound clinical medicine; we hear too much of this psychosocial stuff". The risks range from future hypochondriasis to the occasional unnecessary laparotomy. This is one example of the disadvantages that do exist in transferring patients from primary to secondary care.

The general practitioner's role

The following job description (Leeuwenhorst Working Party, 1977) produced in 1974 by a working party from 12 European countries, owes most to this country and is accepted by the Royal

College of General Practitioners as a policy document. It helps to summarize the clinical work of general practice.

"The general practitioner is a licenced medical graduate who gives personal, primary and continuing care to individuals, families, and a practice population, irrespective of age, sex and illness. It is the synthesis of these functions which is unique. He will attend his patients in his consulting room and in their homes and sometimes in a clinic or a hospital. His aim is to make early diagnoses. He will include and integrate physical, psychological, and social factors in his considerations about health and illness. This will be expressed in the care of his patients. He will make an initial decision about every problem which is presented to him as a doctor. He will undertake the continuing management of his patients with chronic, recurrent or terminal illnesses. Prolonged contact means that he can use repeated opportunities to gather information at a pace appropriate to each patient and build up a relationship of trust which he can use professionally. He will practise in co-operation with other colleagues, medical and non-medical. He will know how and when to intervene through treatment, prevention and education to promote the health of his patients and their families. He will recognize that he also has a professional responsibility to the community."

The technical task is therefore early diagnosis, prevention where possible, and then a great variety of responses. The essential qualities are accessibility and continuity. Sir Theodore Fox (1962) was right when he rated continuity as the most important prerequisite for personal care. To say that continuity is also one of the few things that distinguishes the general practitioner from all other doctors is not to deny all possibility of personal care to specialists, but it does confirm the obvious fact that it is more difficult for the specialist to be personal, just as it is more difficult for the general practitioner to be technical.

The unique quality of the general practitioner in clinical work is the breadth of his approach. He cannot say: "This is not my business". He has to accept the problem, even if he may seek someone else's help in trying to solve it. In the 1950s this quality was regarded as impossible and even undesirable. Even today, it must be very difficult for anyone who specializes to believe that the generalist has a valid role which can be done well. The specialist finds it hard enough to keep up with his own literature and new techniques. How can anyone whose field overlaps with that of most specialists do a good job and remain up to date? The case

for the generalist depends on the facts that common diseases occur commonly and allow him a core of skill; that there has been a shift in morbidity away from acute diseases to recurrent and chronic ones seldom requiring hospital admission; that many patients have multiple problems which cut across the bounds of different specialties, especially those between medicine and psychiatry; that the generalist is willing to recognize the borders of his own competence — he can only exist today because the specialist is also there. Above all, the case rests on the obvious fact that people are whole units who go wrong as a whole and do not take kindly to being divided into organ systems. As one patient of mine put it, "It's not any of my parts that have gone wrong, doctor, but what holds me together". In addition, as Lord Snow (1967) has emphasized, the general practitioner has a pastoral function as one of the new fixtures in a fragmenting and changing society. It is a fact of observation that in countries where the general practitioner does not exist someone else has to mimic his role.

The new relationship

A new relationship is emerging between two sorts of doctors with different and complementary functions, but on the same level. This is a stage in a long historical process. Stevens (1966), when writing of the referral system which gradually grew up from the end of the last century, put it concisely: "The physician and surgeon retained the hospital, but the general practitioner retained the patient". Her statement is useful, even if it oversimplifies, because it shows succinctly the base of power from which both groups operate.

This suggests separate worlds. Recently there has been truth in this. General practitioners have been rebuilding their world and rediscovering its fascination. Some doctors find people more interesting in their natural setting. Common diseases can be as interesting as rare ones.

Recreating personal medicine outside hospital means creating new centres of excellence, where high quality care is given in the way people need and want, where the young are taught, and where research is done. General practitioners are no longer prepared to concede that, to attain excellence, they must work part-time in hospital or become specialists or hospital doctors. The idea that most of them really want to become hospital-based general physicians is not acceptable.

To realize this new relationship, there are three essential conditions that must be fulfilled:

1. Specialists and general practitioners must have clearly defined and distinct functions.

2. Each group must earn the respect of the other for the quality of the work that is done by it.
3. Members of the two groups must meet.

1. Distinct functions

The work of an obstetrician, a chest surgeon, or a radiologist is very obviously different from that of a general practitioner; the specialist and the generalist clearly complement each other in their roles. The generalist will consult the specialist on limited issues, the specialist will rely on the generalist to watch the rest of the patient's problems.

The situation becomes much less clear if the work of the general physician in hospital is compared with that of the general practitioner. There are few truly general physicians left. It would be more realistic to talk of the general physician with a special interest, since this is much more common. Between this doctor and the general practitioner there is much greater overlap. Lord Rosenheim used to say that he was really a general practitioner working in hospital. In some of his work, for colleagues and their families, that was indeed true, but in the rest of his work there were subtle differences which made me disagree. First, he was seeing a different range of problem from those I saw, as Professor Keith Hodgkin (1973) has demonstrated. Secondly, most of his patients were referred for problems that had already been sorted out by another doctor. Thirdly, he always had two patients, the usual one plus a general practitioner or, in hospital, his houseman, so that, like other consultants, he was in a triangular situation; this gave him a different and more complicated audience.

Nevertheless, in taking Lord Rosenheim as an example, I make things particularly difficult for my own argument, because he possessed the basic doctorly qualities in the highest possible measure.

2. Mutual respect for quality

This is the second condition on which a new relationship depends.

Stein and Susser (1964), in a paper on failures of medical care, suggest that the characteristic failures of hospital practice are in personal care, of general practice in technical competence. As a generalization, this fits my experience.

Hospital failures arise from the attitude which tries to turn patients into facts, theories, and nothing more; from excessive investigation and treatment; from the inevitable results of shared responsibility in a large team in which nobody is ideally qualified to look after the patient's thoughts and feelings, and responsibility easily slips between two members.

General-practice failures have mainly been in clinical method, through inadequate history-taking and absence of examination and investigation; but there are also failures in caring. We hear too often that the doctor is too busy to listen or talk or explain. We begin now to see failures in accessibility and continuity: appointment systems can be barriers, replacing the fee that kept poor people away 50 years ago; arrangements for night and weekend relief diminish continuity; group practice contains strong pressures that lead the patient into the wrong doctor's consulting room. We might all remember Bernard Shaw's comment that all professions are a conspiracy against the laity.

There is little objective evidence about quality in primary care or in general practice. One of the few straws to catch hold of is in the work of Peterson and his colleagues (1956) who showed a relationship between quality in the consultation as they defined it and the number of internships done, notably those in general medicine. It is not surprising that the Royal College of General Practitioners has put its major effort into education, although it has many other activities of comparable importance.

The development of three years of vocational training, now accepted by Parliament in the NHS (Vocational Training) Act 1976 as an obligation for all future general practitioners, has been a major effort in the last 25 years. It was Lord Cohen and a committee of the British Medical Association (1950) who first proposed this, but the Royal College of General Practitioners has been the main force in promoting this change since 1964, with the help of other bodies (College of General Practitioners, 1965).

We now have enough training practices and practically enough hospital posts, provided that specialists do not retain their senior house officers for more than six months. The content of training falls into these areas of knowledge: health and diseases; human development; human behaviour; medicine and society; and practice organization (RCGP, 1974).

A recent study by Byrne and Freeman (1976) proves that training schemes do produce the hoped for change in direction, particularly in attitudes, but also in knowledge and skills.

It has been immensely encouraging to see the quality of the young men and women who have been entering general practice recently, after three years' training taken at financial disadvantage. This has justified the initial act of faith that increasing the challenge at entry would be more likely to encourage than discourage young doctors. It is through this training that we can hope for the

most fundamental change towards higher quality in general practice in the future.

The Royal College of General Practitioners' examination is not meant to resemble the Royal Colleges of Physicians' famous endurance test. It took half the life of the College of General Practitioners to decide to have an examination at all. Now it is virtually the only way to become a member. It is voluntary and will not become obligatory like the three years' training. Starting in 1968 with 30 candidates, it had 430 in one half-yearly sitting in 1976; some had to be turned away. It tests a minimal level of competence. The Royal College of General Practitioners was a light shining in darkness when it started in the 1950s and today it is the most important single influence for raising quality in general practice.

A new relationship with specialists depends on mutual respect. On the general practitioners' side there is still a great deal to do. Only one third of general practitioners are fellows, members, or associates of our College. There is still a tiny minority of general practitioners who do not have a couch or wash-basin, and keep their case-notes under the stairs in a covering of dust. They represent the medical slum of general practice and, along with the other failures listed, they raise the question: "What actions are going to be taken by whom to determine minimal standards and to maintain them?" The quality of general practice is much more widely variable than that of hospital practice, but the aim of high quality, low technology medicine is valid and is seriously pursued. One measure of success is the recent change in choice of career made by young doctors about the time of qualification.

3. Meeting

If a new relationship depends on distinct functions and mutual respect for good work, it also depends on meeting each other. Bad relationships thrive on isolation.

It is crucial that general practitioners meet the hospital world and the specialists who work in it. Without this, general practitioners are cut off from vital sources of new knowledge and the specialist from the world of the well, to use Sir Geoffrey Vickers's term (1958). The contexts in which the two can meet can be the specialists' ground, the general practitioners' ground, or neutral ground.

General practitioners should have direct access to laboratories and x-ray departments, including contrast media. There can be no justification for denying these to doctors who were trained to use them nor for giving them second place when resources are short. In referral, the general practi-

tioner should write good letters about the patient's background, about what he has been told and about the precise question asked of the specialist. The specialist should send a report to the general practitioner even before the patient is discharged, not forgetting what he has been told.

However, in neither of these instances do general practitioners and specialists actually meet. In a study in south-east England, Long and Atkins (1974) found that in a four-week period half the general practitioners studied had had neither formal nor informal meetings with any specialist.

To what extent in fact do general practitioners work in hospital? We must distinguish clinical responsibility from education. How many general practitioners are able to look after their own patients in hospital beds? Published figures vary from 20 per cent to 39 per cent, and the actual variations must be even greater, especially between big cities and rural districts (Warren, 1962; Wessex Regional Hospital Board, 1964; DHSS, 1971; RCGP, 1971). Israel and Draper (1971) showed that the only increase in general-practitioner beds between 1955 and 1970 has been for obstetrics. The literature suggests a much more important and promising role in community hospitals than in district general hospitals at present. In the latter, bed occupancy in general-practitioner beds has been 70 per cent at the highest, more often considerably lower.

How many general practitioners hold clinical assistantships? Published figures vary between 13 per cent and 23 per cent. How much do general practitioners *want* to work in hospital? Published papers give an average of 75 per cent for hospital beds and a slightly lower figure for clinical assistantships, but my own impression is that when it comes to making firm proposals and plans, the figure drops; in the cities it drops so much that plans have sometimes been abandoned. It may now be unwise to assume that general practitioners will rush in where foreign doctors have ceased to tread.

There is no doubt that many inpatients in any hospital could be looked after by their general practitioners; they are there because they cannot be nursed at home. Loudon's figure of one third (1970) is often quoted. But from the point of view of general practice, it has never been proved that doing hospital work improves quality and it can be argued that the time so spent is time lost for the main task and used uneconomically. This argument, to my mind, does not apply to rural areas and small towns with community hospitals, but it may apply in big cities. In the meantime, a paper by Polliack and Shavitt (1976), from Israel,

points in the opposite direction. They showed how they halved their national rate for hospital admissions from their practice by the use of their general practitioner/nurse/social worker team.

Is there not a more fundamental task for the general practitioner in a hospital — simply to visit any patient that is admitted? It has been suggested to me that one of the weakest areas in our service at present is in continuity and personal care during and after hospital episodes. To quote Lady Wootton (1969): "To the seriously ill patient entering hospital, one of the most devastating experiences is the loss of contact with the general practitioner, who alone has watched over every phase of his previous illness and been the recipient of his confidence". Cartwright (1964) found that only seven per cent of patients in hospitals beds all over the UK were being visited by their general practitioners (apart from the six per cent directly looked after by them). I believe that general practitioners have given this too low a priority in the working day and that the hospital episode is for most patients a crisis from which the general practitioner should not be absent.

What about the specialist on the general practitioners' ground? The community hospital is now an important and promising context for meeting, about which I have too little personal experience to comment. True consultation has always been ideal in the domiciliary visit. The number of such visits has increased, but they are too often done separately. A number of group practices, including mine, now have the experience of specialists coming regularly to work in their premises. Our experience in a large health centre suggests that, when the clinical and educational values are combined, this is a good use of specialist time, but careful organization is needed for success.

Conclusion

My argument has been that specialists and generalists in medicine have functions that are becoming increasingly distinct, and that the two roles are complementary. In principle, specialists know more about a smaller segment of medicine, generalists know less about a larger segment.

The success of our future relationship depends not only on having distinct functions but also on the mutual respect which comes from recognizing that both doctors are striving for the highest quality they can achieve within inevitable constraints, and also on meeting fact to face as often as possible.

In stressing some of the ways in which general practitioners have been striving to develop their world, I have risked the impression of advocating separatism. I accept this charge only in so far as we

have had to look inwards to put our own house in order.

We are only too well aware that we could not possibly cope without the specialist in the hospital. We need to be informed, to be advised, and to share responsibility for patients with problems that we cannot understand or solve; in fact we need consultants. In a comparable way, consultants depend on general practitioners to protect their beds, their outpatient clinics, and their casualty departments from being overwhelmed, and for seeing that they are presented with patients to whom their special knowledge and skills can most valuably be applied. Because they do not see the rest, it may be more difficult for them to appreciate what they owe to general practitioners than for general practitioners to realize what they owe to consultants. In future, preventive work by general practitioners may have a profound effect on consultants; consider only what will happen if all the hypertensives in the community are identified and treated by general practitioners.

Consultants and general practitioners are together facing a bottomless pit of human need and both lack enough resources. This situation is unlikely to change in our lifetime, but we are fortunate in the referral system which is so firmly entrenched in this country. It removes many causes for rivalry between specialists and generalists that are only too obvious in other countries.

We all belong to the great world of medicine. The distinction between 'hospital' and 'community' is essentially false; the hospital is and must be part of that community. In the last analysis, patients look to all of us for the same two things, technical competence and personal care. I believe that, at present, we have more cause to be concerned about the supply of personal care than technical competence, whether in hospital or general practice. It is in this respect that we should all be looking at ourselves most critically.

Individual behaviour is not the same as group behaviour and I believe that the relationship which has developed between the officers of the Royal College of Physicians and the Royal College of General Practitioners exemplifies the answer to most of the problems which can arise between the specialist and the generalist parts of our one profession. When two people get to know each other face to face, group attitudes recede. We all know that when consultants and general practitioners see a patient together, history and politics count for nothing. Each gains from the other, and the patient gains most of all. Essentially, it is as simple as that.

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International Assembly of Family Physicians to meet in New Orleans, USA, October 4-9, 1980

More than 7,000 physicians from 30 countries will meet in New Orleans, Louisiana, USA, October 4-9, 1980, for six days of unprecedented opportunities in continuing medical education and social activities.

The 9th World Conference of WONCA (World Organization of Colleges, Academies and Academic Associations of General Practitioners/Family Physicians) will be held jointly with the annual Scientific Assembly of the American Academy of Family Physicians. The Academy is serving as the host to the WONCA delegates. Selected portions of the clinical program will feature joint lecture presentations, with instantaneous translation service in English, French, Spanish and German. In addition, both WONCA and AAFP will offer scores of individually planned continuing medical education features from which the physicians may choose.

Following a day in lectures, demonstrations, classes and seminars, participating physicians are invited to relax at joint activities which will include a spectacular Mardi Gras party in the Louisiana Superdome, a massive enclosed ten-storey sports stadium. Other events include a special welcoming reception at the Marriott Hotel for WONCA delegates, the impressive convocation of AAFP Fellows and inauguration ceremonies, and a festive reception and dance honoring the presidents of both organizations.

Special daytime tours, luncheons and other entertainment events are planned for the enjoyment of physicians' families. All non-scientific events will be keyed to the cosmopolitan tradition and charisma of New Orleans, including the famous Mardi Gras and Jazz music.

Scheduling and arrangements are under the direction of the Academy's professional convention management staff, which has produced annual assemblies for more than 30 years. Each year, 4,000 and 5,000 American family physicians

attend the AAFP Scientific Assembly. All events are keyed to the tastes and expectations of physicians. Experienced bilingual personnel will expedite registration processes, and staff a conveniently located information center. Charges for Assembly-related events will be kept as moderate as possible, and housing reservations will be available in a range of prices.

Headquarters hotels — the Marriott for WONCA and the Hilton for AAFP — are within walking distance of the Rivergate Convention Center, site of the joint lecture program, AAFP scientific events, and exhibits. Free shuttle bus service will be available to the other hotels housing registrants.

THE SCIENTIFIC PROGRAM

Joint AAFP-WONCA Programming: A lecture program opens Monday, October 6, with a ceremony featuring greetings by the AAFP and WONCA presidents. A slate of distinguished lecturers is being chosen by a joint planning committee. Presentations will include subjects of global concern such as substance abuse, immunization, hypertension, sexual behavior, hyperlipidemia, nutrition, aging, and population control. Simultaneous translations will be available in Spanish, French, English and German.

AAFP Programming: Small-group clinical seminars, continuing education courses for groups up to 200, clinical demonstrations, dialogue discussion groups and exhibits offer a multitude of learning experiences. More than 100 presentations will cover the range of clinical aspects of family practice. These modalities will be open to all registrants, but presented only in the English language. They run daily from 8:00 a.m. to 5:00 p.m. October 6 through 8, and 8:00 a.m. to 12:00 noon October 9. There are modest charges for the seminars and continuing education courses; the other clinical features are free to registrants.

Also on hand will be "Harvey," the world's first

manikin computerized to simulate a wide assortment of cardiac problems. Some 250 physicians will be able to listen simultaneously over stethophones, and participate in the diagnosis and treatment of "Harvey's" various symptoms.

WONCA Programming: The program begins Monday morning, October 6 with "An Overview of Family Medicine Around the World," addressed by one speaker from each of the WONCA regions: Americas, Western Europe, Eastern Europe, Australasia, Africa and the Middle East. This session will be followed by a keynote address and a presentation on the doctor's family.

WONCA plenary sessions will be held on the mornings of October 7, 8 and 9. Each day's session will address a broad subject area on which there will be three 20-minute talks followed by opportunity for questions and discussion. Three main subjects are Core Content of Family Medicine, Preventive Medicine, and Continuing Medical Education. Workshops presented in French, Spanish and English will follow these plenary sessions. In the afternoons, open meetings of WONCA committees will be held for presentation of specific educational programs.

Free-standing papers will be presented on the afternoons of October 7 and 8. Lecturers whose papers have been selected by a screening committee will give 15-minute abstracts of their papers.

BUSINESS MEETINGS

The AAFP Congress of Delegates will convene Saturday morning, October 4, and adjourn Monday noon, October 6. All sessions are at the Hilton Hotel.

The WONCA General Assembly will meet Wednesday, October 8 at the Marriott Hotel.

SOCIAL ACTIVITIES

Monday night, October 6, the huge Louisiana Superdome will be the scene of a Mardi Gras extravaganza staged exclusively for the physicians and their guests. Parades, performers, famous musicians and food specialties will abound. Included

are Pete Fountain, the Dukes of Dixieland, the Southern University Marching Band, strolling entertainers, and actual floats from the world-famous Mardi Gras parade.

Tuesday night, convocation of AAFP Fellows and the inauguration of Academy officers at the Rivergate is open to all registrants.

Wednesday night, all registrants are invited to the AAFP and WONCA Presidents' Reception at the Hilton. The festive affair will feature Bob Crosby's music for listening and dancing, and a complimentary buffet.

FAMILY ENTERTAINMENT

A special program of tours, luncheons and entertaining experiences will be offered to the physicians' spouses and children. These activities are optional and not covered by the general registration fee.

NEW ORLEANS — AN EXPERIENCE

New Orleans is an exotic blend of cultures and customs — of proud tradition and elegant serenity coexisting with progressive bustle and joie de vivre. Once the capital of the French Louisiana, then governed by the Spanish, the Mississippi River port became an American city in 1803. She has not abandoned her European heritage or Old South flavor.

Some of the world's finest musicians perform in local concerts, clubs and parades. Jazz was born there. World-famous restaurants offer exquisite cuisine, and meals are said to become events. The attached brochure gives details about sightseeing, cultural attractions, sports, shopping, restaurants and night life.

REGISTRATION

Registration for physicians is \$50. More detailed information will be available in late summer, 1979. If you have questions about the general program, write to the Director of Planning, 1980 WONCA/AAFP Meeting, 1740 West 92nd Street, Kansas City, Missouri, USA, 64114.

News from the Council

The Board of Censors has made the following announcements:

1 ELECTION OF FELLOWS AND HONORARY FELLOWS — Nominations to the Fellowship/Honorary Fellowship of the College may now be submitted to the Fellowship Committee. In submitting the nominations the following criteria should be considered:

a) Fellows

1. Must be a member of the College
2. Outstanding contribution to the College
3. Outstanding contribution to the Medical Profession

b) Honorary Fellows

1. Qualifications
2. Professional standing
3. Appointments held
4. Contribution to the College
5. Contribution to the Medical Profession
6. Honoris Causa

Nominations should be duly proposed and seconded either by Ordinary Members, Diplomate Members or Fellows of the College and should be accompanied by the nominee's curriculum vitae together with reasons in support of the nomination.

Closing date for receiving nominations is 31 March 1979.

2 SEVENTH COLLEGE EXAMINATION FOR DIPLOMATE MEMBERSHIP — The seventh College examination will be held during October 1979. Members desiring to take the examination must meet with the following requirements:

- a) hold a registrable qualification for not less than 5 years

- b) be engaged in general practice for not less than three years

- c) be a member of the College for at least two years (effective from 1 April 1979). Further information regarding details of the examination and application forms may be obtained from the Administrative Secretary of the College.

Closing date for submitting applications is 30 June 1979.

The Continuing Education Committee: In January 1979, a Seminar was held in conjunction with the Singapore Family Planning Association and the Professorial Unit of the Department of Obstetrics & Gynaecology on various gynaecological problems associated with contraception. The response was overwhelming with 45 registrants.

For the year 1979, the Committee proposes to hold module/in-depth courses in at least three of the five major subdisciplines of general practice, i.e. adult medicine, paediatrics, psychological medicine, surgery and obstetrics & gynaecology. Apart from this, symposia and clinical teaching associated with institutional practice will be held from time to time on Sundays.

FOURTH COMBINED COLLEGES CONFERENCE

The Fourth Combined Colleges Conference and S E Asia Regional Meeting of WONCA will be held in Manila from 19-22 September 1979. The central theme will be: "The Family Physician in South East Asia To-day". Members are urged to attend this Conference, and to participate fully by presenting papers during the workshop and Free Papers Sessions.

MEDICAL NEWS

GENERAL PRACTICE/FAMILY MEDICINE A SPECIALTY IN NEW ZEALAND.

The Medical Council of New Zealand has given its approval to the recognition of the M.N.Z.C.G.P. as a registrable higher qualification.

In November 1978 by a unanimous decision the discipline of General Practice/Family Medicine was also approved for inclusion in the first column of the First Schedule of the Medical Practitioners (Registration of Specialists) Regulations 1971.

The First Schedule of the Regulations is in four columns:

- Column 1 — Principal specialty
- Column 2 — Sub-specialty (e.g. cardiology)
- Column 3 — Body granting the qualification
- Column 4 — The Qualification.

The New Zealand College of General Practitioners has also been asked to consider what other qualifications of other similar bodies, (eg. R.A.C.G.P. and R.C.G.P.) should also be recognised in these columns.

SINGAPORE'S CRUDE DEATH RATE — WORLD'S LOWEST!

The World Bank very recently came out, for the first time, with an informative and interesting report called World Development Report, 1978, which gives a large number of statistical tables on countries that are members of the United Nations or the World Bank. There are altogether 153 countries, but the report only gives various statistics on 125 countries, that is, those that have more than one million people each. The list includes Singapore, since its population is 2.3 million.

In terms of land size, of the 125 countries, Singapore with a land size of 616.3 square kilometres, is by far the smallest.

.... for crude death rates, the report shows Singapore as having a crude death rate of five per thousand people — this is the lowest rate in the world. Only Taiwan, Hongkong and Kuwait register this rate. All other countries have higher rates.

The United States has nine; Australia eight; New Zealand eight; Switzerland ten.

As for infant mortality rates, Singapore with 14 per 1,000 births, is one of the lowest in the world too. Even West Germany has 20. Australia is shown to have 17 and Israel 22 with India 122 and Afghanistan 269.

However, surprisingly many countries beat Singapore in terms of doctors to population ratio. Singapore's ratio is 1:1400 compared with Argentina's 450, Yugoslavia's 850, Portugal's 850 and Greece's 500. These countries, it should be noted, all have a per capita income below that of Singapore.

(from The Mirror, October 16, 1978)

CRITERIA FOR DIAGNOSIS OF DHF (Dengue haemorrhagic fever)

CLINICAL

- a. Fever — acute onset, high, continuous and lasting 2-7 days.
- b. Haemorrhagic manifestations including at least a positive tourniquet test and any of the following:
 - petechiae, purpura, ecchymosis
 - epistaxis, gum bleeding
 - haematemesis and/or melaena.
- c. Enlargement of liver.
- d. Shock — manifested by rapid and weak pulse with narrowing of pulse pressure (20mm Hg or less) or hypotension, with the presence of cold clammy skin and restlessness.

LABORATORY

- a. Thrombocytopenia (100 000/mm³ or less)
- b. Haemoconcentration — Haematocrit increased by 20% or more.

The presence of the first two or three clinical criteria with thrombocytopenia and haemoconcentration is sufficient to establish a clinical diagnosis of DHF. When shock occurs with high haem

matocrit levels (except in patients with severe bleeding) and marked thrombocytopenia the diagnosis of DHF/DSS is highly likely.

The presence of thrombocytopenia with concurrent haemoconcentration will differentiate the milder forms of DHF from normal or classical dengue.

(based on WHO Technical Guides for Diagnosis, Treatment, Surveillance, Prevention and Control of DHF, 1975.)

EFFECT OF PARACETAMOL ON GASTRIC MUCOSA

**Drs. Kevin J. Ivey, G.R. Silcoso,
William J. Krause
BMJ, 1978, 1, 1586-1588**

Paracetamol is commonly used as a substitute for aspirin. Paracetamol and aspirin have similar analgesic and antipyretic properties. While aspirin may cause gastric bleeding, inflammation, erosions and ulceration, paracetamol is reputed to be free from gastric side effects.

Drs. Ivey, Silcoso and Krause made a study of the effect of paracetamol on the gastric mucosa of seven healthy volunteers. The dose used (2 g instilled in 100 ml isotonic saline) was equivalent to about six tablets taken with water. Biopsy specimens were taken before and 10 and 60 minutes after instillation. The mean incidence of damaged cells in the control period was 1.7%. Ten minutes after instillation 3.5% of the surface cells were damaged. This increase was not significant. Light microscopy showed focal cell disruption and infiltration of red blood cells. Scanning electronmicroscopy showed minimal loss of normal cell apices. No erosions were seen on microscopy. Biopsy specimens taken 60 mins after paracetamol showed similar changes.

These findings differ appreciably from the extensive cell damage and microscopic erosions caused by therapeutic doses of 600 mg (two tablets) of aspirin. They conclude that large "analgesic" doses of paracetamol cause minimal ultrastructural changes in normal human gastric mucosa. The continued use of paracetamol in place of aspirin appears to be justified when there is a possibility of gastric mucosal injury.

A LISTENING EAR

Samaritans of Singapore started operations on December 1, 1969. The primary aim of the SOS service is to prevent suicide but a listening

ear is offered to anybody with a problem that could lead to a sense of hopelessness.

In its annual report of 1978, the director of SOS wrote that "people ring Samaritans of Singapore to find someone to talk to. They may be facing a problem or a moment of grave indecision — should I quit my job? ... How do I forget my ex-girlfriend? ... Should I divorce my husband? ... Is life worth living?"

She realised that what these people need are "not our expert answers to their questions but our listening, understanding and joining them in their search for the answers. Their present problem makes them stop, review their lives and consider the decisions they have made or left unmade along the way. With kindness and sensitivity the Samaritans supports them in their self-questioning and eases the pain of past failures. Where appropriate, information is given and referrals made to professional consultants but it is the whole-hearted, personal interest and concern that the Samaritan gives to the callers that is our most important offer of help. Callers terminate their contact with us with a better understanding of themselves, a sense of self-worth and confidence and renewed hope for living. Perhaps a suicide has been averted, certainly someone feels more positive about life".

Perhaps we family physicians should prescribe less drugs and listen more to our patients, with compassion and understanding.

JOGGING 'a dangerous mania'!

Dr. Christian Barnard, the heart transplant pioneer, said that joggers "are suffering from a dangerous mania no different from buying punishment from ladies with whips."

Sexual masochism, or a trip to a massage parlour, might be better and safer alternatives to jogging, he suggested in his weekly column in the Rand Daily Mail.

"A dangerous mania is spreading worldwide and has now reached the stage where it seems as if half the human race is doing it while the other half is either watching it, hoping to take part, or recovering from the effects," Dr. Barnard wrote.

For one thing, joggers ran the risk of being knocked down by passing vehicles while they were "far away in some pain-filled garden of the mind, voluntarily punishing themselves for some imagined lapse of health"

And he added: "I see no difference between this form of masochism and that bought for a simple fee from the ladies who specialise in chain-mail bras, leather pants and a rack of whips."

(from The Straits Times.)

TIPS FOR RUNNERS

Running and jogging — particularly among those who are out of condition — can cause foot injuries and hurting foot. Dr. Richard S. Gilbert, president of the American Academy of Podiatric Sports Medicine, suggests:

1. Buy the running shoe that best fits you. No one shoe fits everybody. To provide shock absorption, look for a shoe that has a thick, but not rigid, sole and an elevated heel.
2. Do exercises that stretch the calf muscles and hamstrings and strengthen the anterior muscles, both before and after running. The sustained stretch (yoga type) is more effective than the ballistic (violent flinging or jerking of the limbs) technique.
3. After illness or layoff, return to the level of previous efficiency in gradual stages. Do not rush.
4. With many conditions such as shin splints (aching pain in the lower leg brought on by running on hard surfaces) and Achilles tendinitis, reduced mileage is often adequate for treatment, rather than total rest.

5. If possible, avoid running high mileage on asphalt, concrete or even on running tracks. Find level earth or grass instead.

(from Reader's Digest, November 1978)

MORE ON GONORRHEA

The Malaysian Medical Association (MMA) expressed concern over the increase in gonorrhea cases with resistant strains that cannot be cured by penicillin.

MMA president Dr. S Selvarajah said if the current rate continued unchecked, it might be necessary to consider measures like registration and regular medical check-up of all prostitutes.

He said the first case of penicillin resistant gonorrhea was reported in Kuala Lumpur in 1977. Since then 40 similar cases have been identified in the country.

"What is really disturbing is that the last 8 to 10 cases have been reported during the last four weeks."

Use metric in medicine

A survey to gauge the progress of metrication in the practice of medicine was launched in November last.

The survey, jointly organised by the Metrication Board, the College of General Practitioners and the Singapore Medical Association (SMA), concerned only private practitioners because all government hospitals and outpatient dispensaries have been using the metric system since 1971.

Conversion has so far been voluntary. Last year the Metrication Board wrote to all members of the Singapore Medical Association and all private hospitals requesting that only metric units be used for clinical examinations and compilation of records. The current survey was to determine the response to this call.

Questionnaires were sent to some 700 private practitioners. They were requested to indicate the system of measurement they use for linear measure, weight, temperature, blood pressure and volumetric measure (for example, prescriptions).

Five hundred and seventy-five clinics responded to the survey. Five hundred and seventeen or 90 percent said they use only metre for measuring lengths; four hundred and five or 84 percent use the kilogram and gram for weighing; and five hundred and twenty-one or 91 percent use degree Celsius for temperature.

Four hundred and twenty-nine said they use the millilitre and litre for volumetric measures.

Seems like more work has to be done to promote millilitre and litre, but things are going in that direction with new metric medicine bottles (see article "Dispensing bottles").

If the private medical sector can make a determined effort to standardise the system of measurement it uses with that of the public sector, by adopting only the metric system, medical histories and records will be more easily read and compared.

Converting to metric units should not be an expensive process since non-metric instruments can be recalibrated at a nominal cost.

Dispensing bottles

A new range of metricated dispensing bottles for use in hospitals, dispensaries and private clinics are being sold locally since September 1978.

The new range comprises 5 sizes: 30, 45, 60, 90 and 120 ml. The bottles are of clear flint glass and have embossed graduation in 5 ml, 7.5 ml and 10 ml intervals.

The bottles are produced by Singapore Glass Manufacturers, the only glass container manufacturer in Singapore and distributed through Orglass Trading.

A survey by Orglass has shown that although the governmental hospitals and clinics have all changed to metricated bottles, a portion of the pri-

vate sectors still use bottles in imperial sizes, such as 1 fl oz, 1½ fl oz, 2 fl oz. Orglass says that the marketing of the new metric range will help swing the segment of the market into full metrication. There will be ample supply since high speed machinery used in the manufacture can turn out a minimum of 60,000 bottles per day.

The manufacturers say that the inherent property of glass will ensure the safety and stability of the packed contents and prolong their life. The bottles are clean and leakproof, and the transparency of glass eases inspection of content.

(Information from The Singapore Metrication Board).

Book Review

COLOUR ATLAS OF OPHTHALMOLOGY

Arthur S.M. Lim & Ian J. Constable.

Henry Kimpton, Publishers, P.G. Lim Medical Books.

Price: \$20.

Once in a long while a specialist writes a textbook which even a general practitioner can get excited about. Such a book is the new Colour Atlas of Ophthalmology by Dr. Arthur Lim and Dr. Ian J. Constable, the Lion's Professor of Ophthalmology of the University of Western Australia.

True to its title, this is an atlas of ophthalmology and the colour reproduction of the pictures is absolutely top-rate. The whole production is from the printing presses of one of our leading printing firms and bears comparison to any produced by top medical publishing firms overseas.

The text is uncluttered and easy on the eye. There are no long paragraphs for the busy GP to plough his way through. A wealth of information is given but the nice thing about this book is the attention to little things like for example, how to examine the eyes or evert the upper eyelid without fumbling about the job.

There is an extremely good collection of photo-

graphs showing such common conditions as chalazion, entropion, iritis and acute glaucoma. However the pictures which are truly superb are those of the conditions of the retina. Those of us who have always had difficulty recognising the things we see with the ophthalmoscope would do well to brush up with the aid of pictures of the diabetic eye, central retinal artery occlusion, retinal detachment or hypertensive retinopathy.

There is also an interesting chapter on eye diseases in children and some very remarkable pictures of injury to the eye. The section on neuro-ophthalmology is short and concise and perhaps could be expanded on but the chapter on refractive errors should be more than sufficient for a GP's needs.

One of the most useful features of the book is a table of the common therapeutic eyedrops comparing the main uses and usefulness or otherwise of the products.

This is a nice handy book to have around the clinic and should stir someone somewhere in Singapore to produce a companion book on a colour atlas of dermatology.

E. K.

Shame is the best contraceptive

After dark in rural Java the haunting *ning-nong* of a bamboo *gamelan* orchestra drifts across wet rice paddies from all-night village dramas. Javanese peasants, possibly the most cultured, artistic and mystical villagers anywhere, love theatre, especially the shadow play.

Most shadow plays depict tales from the Hindu war epic, the Mahabharata. These are portrayed as an endless struggle not so much between good and evil as between base animal passions and detached self-control. The shadow play is Java's most pervasive cultural influence, setting standards of ethics and a strong respect for authority. By using it to preach new attitudes towards birth control, Indonesia's family planners have quite spectacularly lowered the rate of annual population growth in Java and Bali, from 2.5% in 1970 to 1.4% this year.

Now, when the elegant Hindu king-puppets return home from battling demons and find their clown-servants with too many new babies, village audiences burst into cheers and laughter as the shamed culprits hang their heads in humiliation. In just eight years of government-sponsored family planning campaigns, the Indonesians have not only set conventional demographic wisdom on its ear; they have shown how village culture can be harnessed to promote change.

Since 1970 the average rate of child-bearing among 85m Javanese and 2.4m Balinese has dropped more than 20%. It is still falling. The proportion of women aged 15-44 using contraceptives has gone from nothing to almost 40% and in Bali has topped 60%. About 65% of these take the pill (the Americans have inundated Indonesia with 1,200m pills) and 20% use intra-uterine devices. Indonesia's overall annual population growth rate has dropped to 1.7%, raising hopes that it can be brought down to the 1.2% rate of East Java and Bali by 1985.

The 13,000 islands in Indonesia's 3,400-mile-long archipelago already have 137m people, making Indonesia the world's fifth most populous country. Some 65% of these many millions are jammed into Java and Bali, where the world's

highest population densities have reached the saturation point of 2,000 people per square kilometre in some areas. Under the late President Sukarno, who once frivolously boasted "the more the better", the government was forbidden to engage in family planning. When General Suharto and his Berkeley-Harvard-trained technocrats put together a birth-control programme in 1970, Indonesia's population was projected to reach 300m by the year 2000; this has now been scaled down to 190m.

Governor Sunandar of East Java, the province which has taken the lead in innovative birth control, feels that even this is too high; in the next five years, by averting 2m births through contraception and by moving 750,000 people to less populous islands, he hopes to hold East Java's population steady at 28m. Hindu Bali has lowered its average family size from six to three children in just seven years; its fertility rate has plummeted from 44 to 20 per 1,000.

Such success has stunned world population experts because it is happening in mostly Moslem villages with few if any doctors (less than 10% of fatally ill peasants ever see one), 40% illiteracy, infant mortality above 150 per 1,000 and per capita yearly incomes of less than \$200. The falling birth rate has not been accompanied by any sudden upsurge in industrialisation, which is thought to be the main reason for declining rates of growth elsewhere. The Washington-based Population Reference Bureau has called the 20-25% fall in fertility in Java and Bali between 1971 and 1976 "one of the most remarkable of all attempts to institute birth control on a mass scale". But some people still question whether the official family-planning effort deserves all the credit, citing the spread of traditional birth-control methods (abstinence, herbs, massaging the uterus).

Java did not hit on its winning formula right away. Most Indonesian leaders in the early 1970s felt (or were convinced by western economists) that rural incomes, education and health would have to advance before contraceptive use made any real headway. Then in 1973 a physician who

ran family planning in East Java. Dr Wasito, decided that conventional clinics were getting nowhere and that transforming Javanese village culture was the key. He opened training schools for shadow-play puppeteers; he got East Java's governor to put out the word to the army, police and civil service that everybody's neck was on the line; he worked with Moslem religious teachers. Soon family planning clinics were storming East Java with *gamelan* orchestras, classical dancers, shadow plays, with the local authorities standing imposingly by. Suddenly contraceptive use acquired status and village women were marched in for intra-uterine insertions or to have pills popped in their mouths.

Dr Wasito explained his conquer-by-culture campaign to your correspondent in 1973:

In Java there is a belief, instilled by the shadows play, that one must sacrifice to the spirits around one in order to achieve a harmonious existence. Who are the spirits in a Javanese village today? The police and army commanders, the village chief and the Moslem teacher. Get them on our side and we've won the battle.

At first this strategy stopped just short of coercion, and stirred resentment. But then the Javanese discovered what every anthropologist (but

almost no development economist) knows: the most potent force in every village is neither government fist nor religious belief; rather it is fear of the neighbours' censure or "what will people say?" So family planning was plugged into existing social networks and local leaders were given responsibility for spreading it. The traditional Javanese hierarchical structure and the social pressure it brings to bear did the rest. Jakarta's technocrats, having penetrated the Javanese village at last, now want to push other forms of development in the same way.

Today Indonesia has 40,000 family planning "cells" in 60,000 villages. Even remote islands are getting them. Since peasant culture varies from place to place, so does the programme. The soldiers and the police still matter in East Java; in West Java, where a uniform gets less respect, informal social leaders run things. In most of Java, the "cells" are composed of determined women, including thousands of trained midwives. In Bali, it seems, it is the men who have most influence. Each village pavilion in Bali now has a well-displayed map; pill-users are shown by red houses, IUD users by blue houses, condom users by green. The houses of non-users which are left blank, bear something of a social stigma.

Acknowledgement

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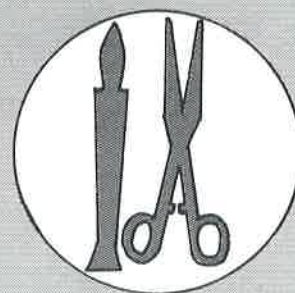
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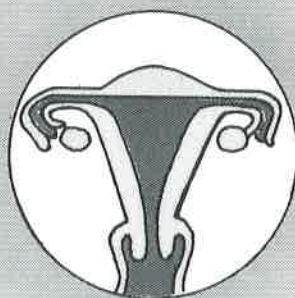


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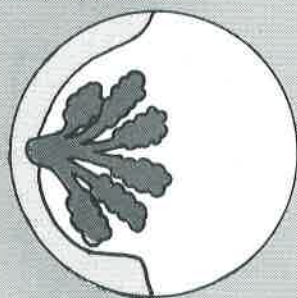
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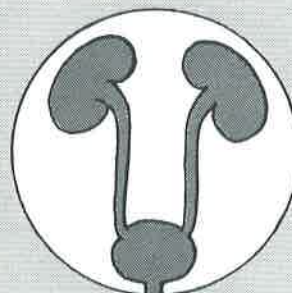
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A gleam of light for the hypertensive

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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.
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4. Lambert, D.M.D. (1974). *British Medical Journal*, 3, 685.



'Inderal' is a trademark for propranolol hydrochloride.

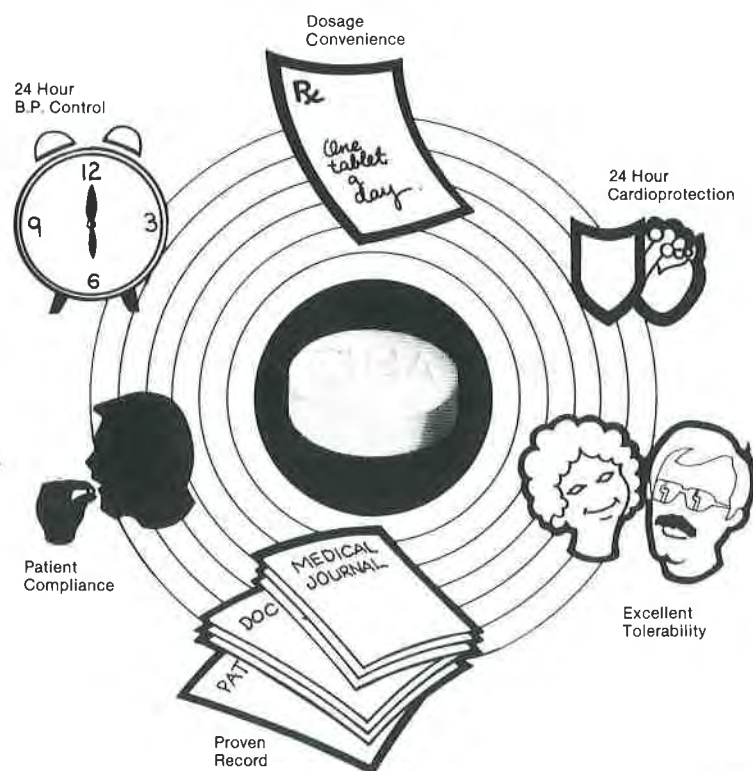
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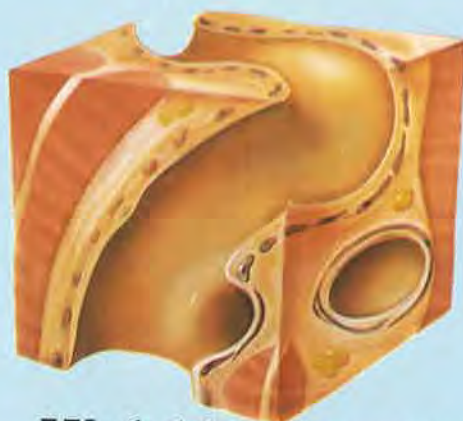
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References: 1. Brest, A. N.: Hemodynamic response to antihypertensive drug therapy, J. Amer. med. Ass. 192:41-44, April 5, 1965. 2. Tarazi, R. C. and Gifford, R. W., Jr.: Drug treatment of hypertension, in "Drugs in Cardiology," E. Donoso (ed.), vol. 2, New York, Stratton Intercontinental, 1975, pp. 1-41. 3. Brest, A. N.: Hemodynamic effects of methyldopa, in "Methyldopa in the Management of Hypertension," R. W. Gifford, Jr. (ed.), West Point, Pa., Merck Sharp & Dohme, 1972, pp. 27-34. 4. Onesli, G.: When hypertension is complicated, Drug Therapy 5:66-78, June 1975.

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