

The Singapore Family Physician



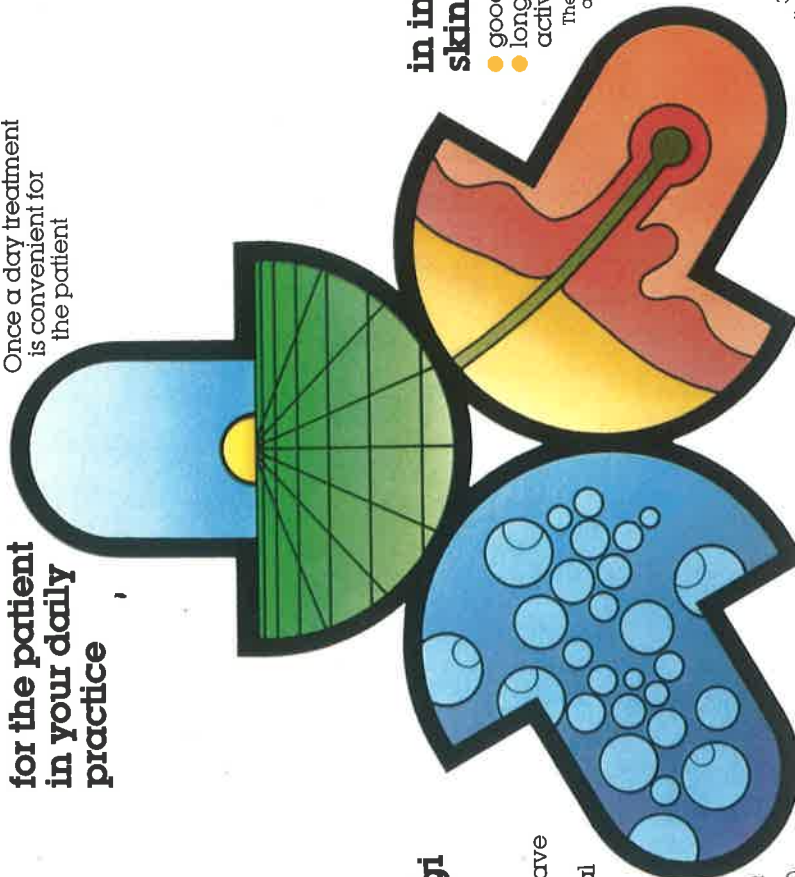
The College of General
Practitioners Singapore
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October/December 1985

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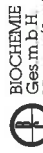
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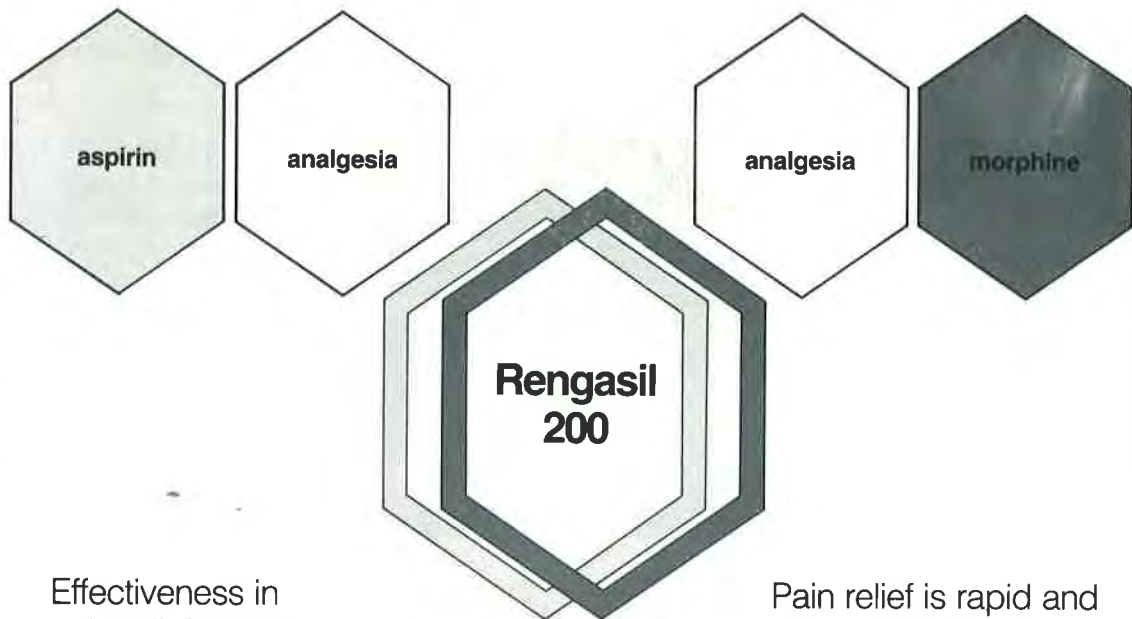
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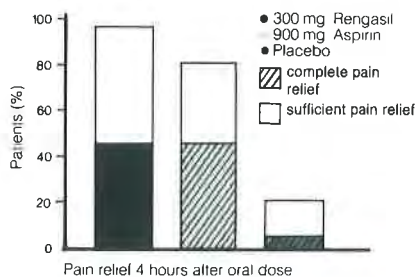
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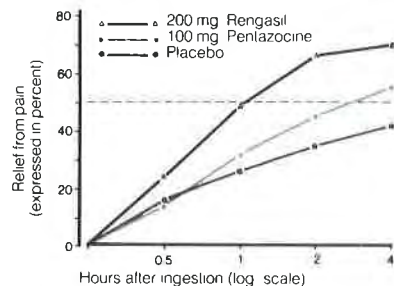
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1. Graham DY et al.: Am J Gastroenterol 76(6): 500-505 Dec 1981

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THE SINGAPORE FAMILY PHYSICIAN

**The College of General Practitioners Singapore
4-A College Road, Singapore 0316**

Vol. XI, No. 4 October/December 1985 Price to Non-Members \$5.00 MC(P)87/3/85

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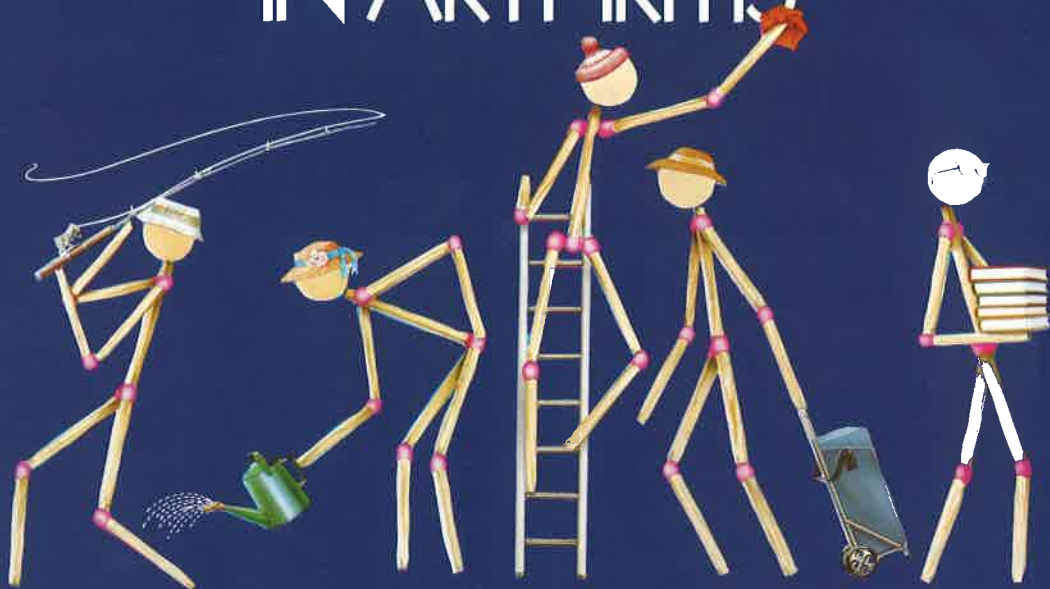
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EDITORIAL

ON CONTINUING MEDICAL EDUCATION

Continuing Medical Education is an essential part of the doctor's professional life. However, to be effective, CME programmes must be available when the doctor has time to learn, they must be relevant so that the cost/benefit ratio is reduced to the minimum and they must, as far as possible, be enjoyable. They should also be of sufficient variety.

The College CME Programme

Over the years, the College CME programme has evolved into modular courses. The scope of General Practice is quite wide. To cover the key areas once in two years requires some 10 modules. As a pilot project, starting this year, the CME Committee intends to run 5 modules a year, three as 'live' courses and two as distance learning courses. This will give the participants a wide enough choice.

One is not expected to do all the modules offered each year, since each area will be repeated every third year. If one can do 6 modules in three years, that would be good enough to receive a certificate of attendance. The number of hours for a typical live course consisting of 8 Friday night lectures and 2 weekend clinicals will be about 18. If a doctor does two live modules out of three in a year, he would have chalked up 36 hours. Add to this, the numerous meetings organised by drug companies and various specialist bodies and the figure of 50 hours CME a year (a figure suggested by the Dutch College of GPs) will not be difficult to achieve.

The Live Module

Attempts are being made to see that the content is relevant to General Practice. One way that is being done is to select the topics that are relevant. Another is to have a GP to be moderator of each lecture. He can play a useful role in highlighting aspects relevant to the practice, both during the lecture preparation stage by a specialist colleague and again during the introduction and discussion time.

Weekend Seminars

To cover several aspects that are closely related, the seminar has also been introduced in the recent Geriatric course. Seminars may reduce the number of times one has to come down to the learning centre. Areas that could be treated this way include the small disciplines like Eye, ENT, Occupational Health and Dermatology. The weekend seminar may also cater for our colleagues who are unable to take time off during the Friday evenings. The practical problem is that there are only 52 weekends a year!

Distance Learning

The best way to deliver CME was the subject of a study by the Scottish Council for postgraduate medical education who conducted a survey of 20% of all Scottish doctors. This survey clearly indicated that the preferential method was one which could be undertaken in the doctor's own home or surgery without the need to go to a postgraduate centre or attend an intensive course. The survey confirmed other surveys which have shown that reading at home far exceeds any other method of learning, with general practitioners spending an average of 140 hours per year in reading compared with less than 10 hours attending update courses. The value of small group meetings, however, as an educational method was not disputed and will be discussed later.

The applicability of the Scottish experience here will have to be confirmed. The close proximity of the doctors' workplace and the College does mean that travel time may not be a deterring factor. However, we do know that some of our colleagues work long hours; whether they feel energetic enough to cope with a sheaf of CME material or would prefer to hit the sack is a practical point. Anyway, there is no harm trying out distance learning programmes using for a start material that other centres like Dundee, Australia and

Malaysia have developed and supplementing them with our own.

The CLIPP Programme

The Scottish Faculties of the British College of GPs working with the centre for Medical Education in Dundee have in particular developed through its CLIPP Programme (Continuing Learning in Practice Project) over the last two years some innovative and interesting CME material. Professor Harden, Dean of the Dundee Postgraduate Medical Education Centre was here recently on a stop-over on the way home from Penang. Council members met him over lunch. He briefed members on the work the Centre is doing.

The innovative part of the programme is the sourcing of CME material, a method that we could well try out. Each Scottish Faculty was asked to form a group of interested doctors to examine a clinical area of practice and discuss clinical problems in that area related to specific cases from their experience which demonstrated problems in terms of contemporary practice and recent advances. Having discussed a number of cases and identified problems which would form the basis of continuing education in that subject, this information is then passed to the Centre for Medical Education in Dundee and a professional team prepares distance learning material based on the experience of the doctors in the Faculty.

The distance learning material is then developed in consultation with the group in the Faculty who are assisted by a resource specialist in that subject. The material is then tested against a much larger group of some 50 doctors in the Faculty in order to discover whether there is a consensus agreement in managing these particular problems. The results of that peer opinion are contained in the final programme which is now being distributed to members of the College throughout the United Kingdom. Prof Harden showed us samples of these.

The participating doctor who receives the published material can then test himself against his peers in a series of clinical situations within an area of medicine. He can if he wishes test himself further in a multiple choice questionnaire and send his answers to the University of Dundee and receive a personalised response, setting down, for example, an explanation of why his response has differed from that of the Faculty members.

Making a Start

Council has made a start of the CLIPP programme small group meeting strategy in a recent session on the Problem Oriented Medical Records amongst Council members.

A report of this workshop will be given in the next issue of the Singapore Family Physician.

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

Corrigendum

Vol. XI No. 3 pp. 121-129 Home Nursing Service for the Elderly

Some pages in the above paper were unfortunately mixed up in the numbering and in the sequence.

The numbering and in the sequence.

Page 126 should be page 125,
Page 127 should be page 126, and
Page 125 should be page 127

The error is regretted. Our apologies to Dr Rilly Ray.

Editor

SHARED ANTENATAL CARE IN SINGAPORE — A WORTH-WHILE OPTION?*

Viegas O A C MB Ch B, MD(UK), MRCOG, DA¹

Singh Kuldip MBBS, M Med, MRCOG²

Chang M Y, James MBBS, MCGPS, FCGPS³

Cheng, Mark MBBS, FRCOG⁴

Ratnam, S S MBBS, MD(S'pore), FRCSE, FRCSG, FACS,
FRACS, FRACOG, FRACOG, (Hon)⁵

SUMMARY

Two schemes of antenatal care in Singapore involving 1046 pregnant women have been compared. In one group (A), antenatal care was shared between family physician and specialist obstetrician. The other, (Group B) conformed to the existing pattern of antenatal care i.e. referral at variable gestations followed by total hospital supervision.

Shared antenatal care integrating the family physician was associated with significantly more patients being seen by the specialist before 20 weeks of pregnancy [70.3% cf 7.6%; $p < 0.0001$]. Thus, patients in Group A were seen significantly more often by the specialists than those in Group B but the mean number of hospital visits paid by the former [5.3 days] was in keeping with the proposed protocol and compatible with standard recommendations for routine antenatal care. Inpatient hospitalization was, on average, less in Group A. Apart from a significantly lower incidence of anaemia in Group A [0.5% cf

2.7%; $p < 0.05$], the incidence of antenatal complications were similar in both groups. There was no significant difference in the utilization of investigations in the two groups.

Patients in Group A had a lower incidence of emergency caesarean section [9.2% cf 12.9%], and lower rate of intrapartum fetal distress [9.2% cf 11.6%]. In Group A the incidence of induced labour was higher (9.4% cf 7.0%).

We believe the incorporation of family physicians in the provision of antenatal care could bring about the subtle benefits in overall patient care including consumer appeal and compliance.

INTRODUCTION

Maternity care in Singapore is provided for by the Ministry of Health and the Private Sector. Approximately 30% of deliveries are conducted in private hospitals mainly by private obstetricians whereas 70% occur in the five maternity Units of the Ministry of Health. Antenatal care (ANC) is provided for by the medical officers in the Maternal and Child Health clinics (MCHC), the general practitioners (G.Ps), the private obstetricians and the staff of the five maternity units in three Government hospitals. A pregnant woman on her own initiative and choice first

Reprints requests:
Dr James M Y Chang
Chang Clinic
1 Jalan Anak Bukit #B1-09/10
Bukit Timah Plaza, Singapore 2158.

*Based on the findings of a joint research project of Obstetrical & Gynaecological Society and the College of General Practitioners Singapore.

(1) Senior Lecturer, (2) Lecturer, (3) General Practitioner; (4) Consultant Obstetrician in Private Practice; (5) Professor and Head — all from the Department of Obstetrics & Gynaecology, National University of Singapore.

comes into contact with one of the primary health care providers (MCHC, G.P., private obstetrician). For many women, the purpose of the first visit is to seek confirmation of pregnancy. The subsequent antenatal care depends to a great extent on the advice given by the primary health care providers i.e. the GP and MO of the MCHC. It is theoretically possible to provide this category of women near optimum antenatal care with existing health care facilities.

The present ANC system provided by GPs does not allow hospital booking with a specialist in the first trimester; a woman confirmed pregnant may not get to see the specialist in hospital until the 30th week or later depending on how many cases the specialist is willing to or capable of accommodating. Alternatively, patients are referred to specialists at varying gestations at the discretion of GPs or at the request of the patients themselves. Failure by a GP to detect certain high risk factors early may result in adverse fetal outcome. Because of the long wait to see the specialist, complications may also occur without receiving attention.

The lack of coordination between GPs and the hospital staff in the present system is fraught with problems. The GPs record of antenatal progress of the patient is unavailable to the hospital staff and often, GPs are unaware of the treatment their patients are receiving in hospital; there is also the possibility of duplication of ANC including expensive investigations.

The role of GPs in providing primary health care is expanding under the present policy of the Health Ministry. Identification of the problems and deficiencies of the present system of antenatal care for those women under the primary health care of GPs, led to the undertaking of a joint project by the Obstetrical and Gynaecological Society and College of General Practitioners, of Singapore for the purpose of integrating GPs in the provision of antenatal care.

PATIENTS AND METHODS

One hundred family practitioners willing to participate in the study to provide joint antenatal care with the University Department of Obstetrics and Gynaecology were enlisted. They were randomly allocated to the two

schemes of antenatal care: 65 to Group A and 35 to Group B.

1. Group A (new scheme): Antenatal care was shared between the GP and the hospital obstetrician. In this group, the GP would refer the patient soon after confirmation of pregnancy preferably within two weeks of this visit. Subsequently, the patient would be referred back to the GP and antenatal care would be shared between him and hospital specialist using a common cooperation card retained by the patient. Provision was made for immediate referral to the specialist whenever this was necessary.

2. Group B (existing scheme): Antenatal care was left largely to the family physician until such time he felt referral to the specialist could be arranged [often after 30 weeks]. After referral, antenatal care was supervised totally by the hospital specialists. (Fig. 1)

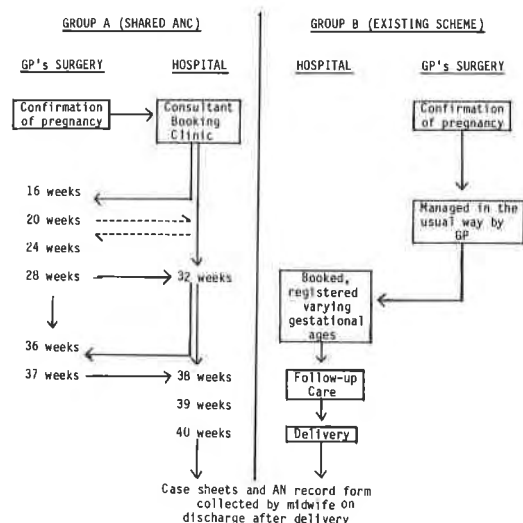


Fig 1. Plan of study.

A total of 1046 patients were recruited to the trial over a period of 14 months; there were 520 in Group A and 526 in Group B. However, in group A only 43% (223 patients) were referred to the specialist within two weeks. To enhance numbers in this group, the GP — specialist referral time was increased to six weeks resulting in a total of 381 patients (73%) in Group A which has been analysed for this study.

Statistical analysis:

Information on all patients was documented and computerized with a view to assessing the following end-points in the two groups:

- (i) perinatal mortality rate
- (ii) frequency of hospital visits made by patients
- (iii) utilization of investigations
- (iv) number of days hospitalized
- (v) incidence of complications and outcome of pregnancy and labour in the two groups.

Chi squared analysis and student's 't' test were used to determine the statistical significance of differences in the above end-points within the two groups.

RESULTS

There was a highly significant difference in the ethnic distribution of patients in the two groups; there being a preponderance of Chinese in group A. However, the distribution of educational status in both groups was very similar; likewise maternal age, parity and

past obstetric history were also remarkably similar. Hence the groups were comparable. (Table 1)

The incidence of the various antenatal complications in the two groups was broadly similar suggesting that there could have been no inherent bias that would influence outcome in the two groups. There was a significantly higher incidence of anaemia in Group B. Interestingly, the only patients in whom the gestational age was undiagnosed at delivery were in Group B (Table II).

In Group A the system of referral allowed a significantly higher number of patients to be seen by the specialist before 20 weeks of pregnancy (70.3% cf 7.6%; $p < 0.0001$) (Fig. 2). This resulted in patients in group A being seen significantly more often by the specialist than those in group B. However, the mean number of visits made by mothers in Group A (5.3) was in keeping with the original protocol. There were however no significant differences between the groups in the duration of inpatient hospitalization or in the utilization of expensive and sophisticated investigations (Table III). In terms of outcome of pregnancy

TABLE I DETAILS OF PATIENTS STUDIED

PATIENT CHARACTERISTICS	NEW SYSTEM GROUP A	OLD SYSTEM GROUP B
Number of patients	381	526
Maternal Age(yrs): Mean(SD)	27.3(4.5)	27.4(4.4)
RACE		
%Chinese	82.2	74.9*
%Malay	5.2	15.0
%Indian	5.0	9.1
%Other	0.5	1.0
PARITY		
%Primips	48	52.7
Mothers' Education		
None (%)	4.2	2.9
Primary (%)	42.3	38.5
Secondary (%)	44.4	52.4
Tertiary (%)	6.8	4.0
PAST OBST HISTORY		
%with previous stillbirth	1.0	2.1
%with previous abortion	20.2	18.1

* $p < 0.05$

TABLE II ANTENATAL COMPLICATIONS

PARAMETERS STUDIED (%)	NEW SYSTEM GROUP A n = 381	OLD SYSTEM GROUP B n = 526
IUGR	2.9	2.3
Wrong dates: diagnosed (undiagnosed)	5.8 (0)	5.7 (1.1)
Pregnancy hypertension	10.2	11.2
Anaemia (Hb 10g)	0.5	2.7*
Malpresentations	3.1	4.0
Gestational diabetes	2.4	2.7
Placenta praevia	1.5	0.6
Multiple pregnancy	0.6	0.4
Cardiac disease	0.8	0
Thyroid disease	0	0.4

* $p < 0.05$

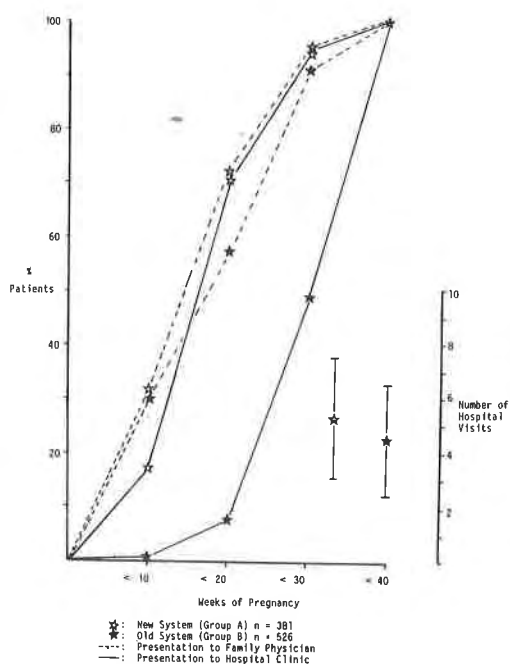


Fig 2. Presentation to General Practitioner and Hospital Clinic in relation to number of hospital clinic visits.

in the two groups, the number of patients was too small to ascertain statistical significance although there was a higher incidence of emergency caesarean deliveries in Group B (12.9% cf 9.2%) probably related to a higher incidence of intrapartum fetal distress in this group (11.6% cf 9.2%). In Group A there was a higher incidence of induced labour. The mean birthweight and gestational age of the babies in the two groups were very similar. There was one perinatal death in each group but no underlying factor could be indentified in either case.

DISCUSSION

The changing patterns of obstetric care in recent years has resulted in almost 100% institutional deliveries in most developed countries and also in Singapore. Generally, the decline in perinatal mortality has been directly attributed to this trend^{1,2} but more recently, the validity of such a conclusion has been questioned³. The belief that the quality of antenatal care is directly related to the number of visits to a clinic during pregnancy is also controversial; some evidence suggesting benefit⁴ whilst others showed the reverse⁵. Further-

TABLE III COST IMPLICATIONS

PARAMETERS STUDIED	NEW SYSTEM GROUP A n = 381	OLD SYSTEM GROUP B n = 526
% of mothers seen by specialist		
before 20 weeks	74.0	7.6*
before 30 weeks	95.0	49.8
Hospital Clinic Visits: mean (SD)	5.3(2.2)	4.5(2.0)*
Hospitalization (Days): mean (SD)	2.1(3.9)	2.3(4.7)
Investigations:		
% requiring ultrasound	27.0	24.1
% requiring X-rays	2.7	2.5
% requiring antenatal CTG	14.2	15.0

* $p < 0.05$

TABLE IV LABOUR PROGRESS AND OUTCOME

	NEW SYSTEM GROUP A n = 381	OLD SYSTEM GROUP B n = 526
Spontaneous labour (%)	89.0	91.3
Induced labour (%)	9.4	7.0
Elective Caesarean Section (%)	1.6	1.7
Spontaneous Vaginal Delivery (%)	74.3	72.2
Instrumental Delivery (%)	12.8	11.8
Diagnosed Fetal Distress (%)	10.2	11.4
Emergency Caesarean Section (%)	9.2	12.9
Crude Birthweight (g) Mean (SD)	3148 (470)	3157 (450)
No of perinatal deaths	1	1
No of maternal deaths	0	0

more, social scientists and various consumer groups have expressed much dissatisfaction in this pattern of obstetric care as well as in the hospital's obsessional search for pathology in what is often a normal pregnancy^{6,7,8}.

In a study involving 2000 randomly selected mothers the majority of patients

found hospital clinic attendance impersonal and inconvenient⁹. Several other studies also demonstrate a widespread desire for more personal care, better communication between women and their doctors and illustrate their dissatisfaction with hospital clinics^{10,11,12,13,14,15}.

The GP is particularly well suited for pro-

viding personal care because of the continuing relationship with a pregnant woman and her family and, given the necessary support by specialist colleagues, the overall delivery of both primary and secondary care by the GP will be enhanced. Such a working relationship between GPs and hospital specialists is therefore essential for the benefit of mothers and maximal coordination and integration should be encouraged¹⁶.

In this study, it is clear that the integration of GPs into the provision of antenatal care is in no way detrimental to mother or child. The numbers involved were small and therefore differences would not have achieved statistical significance at conventional levels. However some important trends emerge. The educational status of the patients in both groups of the study was similar and, indeed, all presented to the GP fairly early in pregnancy. This would suggest that the majority, if not all, of these patients could be incorporated into a system of antenatal care that involves GPs as in Group A. We were disappointed however, that only 43% of patients achieved the stipulated family physician — specialist referral interval of two weeks. It is likely that this was due to administrative difficulties rather than lack of information or motivation on the part of the mothers concerned so that with a more efficient appointments system (an integral part of shared antenatal care), better compliance is possible. A major advantage in Group A was the substantial reduction in the incidence of anaemia and we believe that this is due to early diagnosis and intervention made possible by early referral and the use of simple haematological investigations. It is interesting that the only mothers in whom the gestational age (which is of prime importance in antenatal assessment) was not known at the time of delivery were from Group B. This may be attributed to their late presentation to the specialist. The slight increase in the incidence of malpresentation in Group B may also have been due to late referral when intervention was not possible.

Although mothers in Group A were seen frequently by the specialist there was no significant difference in the utilization of investigations such as ultrasound, X-rays and antenatal cardiotocography between the two groups. In terms of cost-benefit the mean duration of hospitalization for mothers in

Group B was slightly longer and consequently more expensive and inevitably more stressful. In terms of intervention also, there was an increased incidence of emergency caesarean section in Group B. We have attributed this increase to a higher incidence of diagnosed intrapartum fetal distress in these mothers. The mean birthweight and gestational age in both groups was similar and consistent with corresponding values for a largely Chinese community. The difference in perinatal mortality rate not surprisingly did not reach statistical significance because of the small numbers involved but it is interesting that the overall perinatal mortality for the entire population of mothers studied was substantially lower than for the general hospital population (2.2 cf 14.7 per 1000). We feel this reflects the better socioeconomic status of patients involved in this study. These patients seemingly could afford the higher consultation charges made by GPs and specialists compared to the average women who seeks advice and referral from the Government subsidised Maternal and Child Health centres.

In this study we did not seek to ascertain the views of the mothers on the type of care they received but impressions collected to date suggest that they preferred the new system of shared antenatal care. This would be in keeping with the findings of Taylor¹⁷ (1982) and Morrell¹⁸ (1978). Patients found attendance more convenient and the waiting time was shortened; GPs appreciated the freedom of consultation with specialists and, in particular, the educational role this form of communication stimulated.

As we have shown no disadvantage in a shared pattern of antenatal care compared with the existing system, we would recommend that the former pattern of antenatal care be introduced. We believe that a shared system of antenatal care offers a more rational alternative to the current system of practice in Singapore. It has the potential of continued interaction and cooperation between GPs, mothers and specialist obstetricians and may help confine more specialist time to those patients at greater risk.

While it is widely accepted that consideration must be given to the clinical aspects of the pregnancy and to the past and present medical status of the woman, it is less often acknow-

ledged that the quality of care will depend crucially on the adequate appreciation of her family, home and social circumstances — aspects which lie predominantly in the province of the GP. A woman will derive little benefit or satisfaction from the care which, for a variety of reasons, she finds unacceptable or inaccessible. Antenatal care which focusses only on the concerns perceived by professionals, i.e. the identification of pathology is therefore of limited value and so the incorporation of the family physician into an integrated system of antenatal care is vital.

ACKNOWLEDGEMENTS

We are grateful to the Obstetrical & Gynaecological Society of Singapore and the College of General Practitioners of Singapore for their co-operation in this study and also to the general practitioners and specialists who participated in the project. We thank Miss Harjeet Kaur for valuable secretarial help. We are indebted to the Shaw Foundation and Lee Foundation for their financial support.

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THE CONTROL OF DIABETES: ITS CONTROVERSY AND IMPLICATIONS IN MEDICAL PRACTICE

Dr T M Chong
MBBS (Malaya), MD (Singapore)

Insulin was discovered in 1921, and with its introduction into general use in 1922, most doctors thought that the problem of diabetes had been solved and that diabetic patients could expect to live out a normal life if they took care of themselves. Within 10 years it was apparent that this expectation was incorrect. In the late 1930s there began a growing awareness that diabetic persons who lived for 10, 15, or more years after the onset of the disease developed with discouraging frequency microangiopathy in the small vessels of the eyes and kidneys and atherosclerosis of the coronary and peripheral arteries.

Some experts believe that these vascular complications "are related to the degree of control of the metabolic defect".

Others challenge this view. They assert that the undoubted association between poor control and excessive complications could be due simply to the fact that factors causing complications might also make the derangement of carbohydrate metabolism unstable and difficult to control. Since vascular degeneration may develop even before diabetes is clinically recognisable, there is little reason to believe that proper attention to the disordered carbohydrate metabolism will prevent complications. Till today there is no conclusive evidence in support of the value of strict control in preventing vascular complications.

After the introduction of the oral hypoglycemic agents in the 1950s the question was raised whether these agents, though limited in their hypoglycemic activities and having undesirable side effects, might be superior to insulin in their effect on the degenerative complication of diabetes. At the same time are these agents safe and effective?

The University Group Diabetes Project was initiated to test the relationship between the control of blood glucose and the vascular complications in patients with adult-onset diabetes. During 1959 and 1960 a group of interested clinicians and an epidemiologist statistician held a series of discussions during which the design foundations of the study were agreed upon. Over the next two years, a detailed protocol was written, study clinics were set up, and a coordinating center was organised. The first patients entered the study in February 1961. The University Group Diabetes Program had three major objectives:⁻¹⁴

1. Evaluation of the efficacy of hypoglycemic treatments in the prevention of vascular complications in a long-term, prospective, and cooperative clinical trial.
2. Study of the natural history of vascular disease in maturity onset, non-insulin dependent diabetes.
3. Development of methods applicable to cooperative clinical trials.

The trial was conducted at 12 University diabetes clinics which recruited a total of 1027 volunteers. The UGDP was to be the world's biggest and best designed clinical trial. When the UGDP began the general feeling in the scientific community was enthusiasm for its methods and goals.

There were five treatment groups:⁻¹⁷

1. Insulin variable — insulin administered in the amount required to maintain "normal" blood glucose levels.
2. Insulin standard — 10, 12, 14 or 16 units of insulin per day depending on the

patient's estimated body surface area.

3. Tolbutamide — 1.5 gm. per day (1.0 gm. before breakfast and 0.5 gm. before evening meal).
4. Placebo — dosage schedules similar to these used for the oral hypoglycemic agents.
5. Phenformin was included in the study 18 months after the beginning of patient enrolment for the other four groups.

The UGDP investigators ended the tolbutamide (sulfonylurea) study in 1969 and the phenformin study in 1971, when careful statistical analysis showed a death rate more than twice that expected for each drug when compared to the death rates in the three other groups in the study. Death rates in the placebo and insulin groups were similar. There were no significant differences in the rate of development or progression of chronic complications (retinopathy, nephropathy, neuropathy, arteriopathy) in the survivors of any of the five treatment groups.⁶

The following are the published reports of the UGDP:-

1. A Study of the Effects of Hypoglycemic Agents on Vascular Complications in Patients with Adult-Onset Diabetes. I. Design, Methods and Baseline Results. (Diabetes 19 Suppl 2 1970).
2. A Study of the Effects of Hypoglycemic Agents on Vascular Complications in Patients with Adult-Onset Diabetes. II. Mortality Results. (Diabetes 19 Suppl 2 1970).
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The Findings of the UGDP

1. The first report (Diabetes 19 Suppl 2 1970) was devoted to an evaluation of mortality results observed in the UGDP. Analysis of the results of the study indicated that the combination of diet and tolbutamide therapy is no more effective than diet alone in prolonging life. Moreover, the findings suggested that tolbutamide and diet may be less effective than diet alone or than diet and insulin at least insofar as cardiovascular mortality is concerned. For this reason, use of tolbutamide was discontinued in the UGDP. The mortality results for the two insulin treatment groups were nearly the same as those for placebo-treated patients.
2. In the Report on Clinical Implication of UGDP Results (JAMA 1971 218:9) it says: The results from the UGDP have given little hope thus far that the degenerative complications of diabetes are preventable by simple control of blood glucose level. In the maturity-onset diabetic, neither insulin nor oral hypoglycemic agents gave greater protection against these complications than diet alone. Use of additional therapeutic agents must be justified by reasons other than those of the prevention of cardiovascular complications. Oral hypoglycemic agents should be employed with more caution than in the past, with due consideration of possible harmful effects, and the patient should be informed of possible risks associated with this mode of treatment. Also many patients receiving long-term therapy with hypoglycemic agents experience secondary failure.

3. In the report of the Evaluation of Phenformin Therapy (Diabetes 24 Suppl 1 1975) it says: The observed mortality from all causes and from cardiovascular causes for patients in the phenformin treated group was higher than that observed in any of the other treatment groups. None of the analytic techniques employed to evaluate the phenformin treatment effects on mortality provided any evidence of beneficial effects and, in fact, provided evidence of adverse effects associated with the use of phenformin. In addition, there was evidence that phenformin therapy resulted in increased blood pressure levels and heart rate. The mortality findings coupled with the findings for nonfatal events gave no evidence that phenformin therapy, as used in the UGDP, was as efficacious than diet alone or than diet and insulin in prolonging life. For these reasons the use of this drug was terminated in the UGDP.
4. In the Supplementary report (Diabetes 25:12 1976) on Nonfatal Events in Patients treated with Tolbutamide it says: Review of all the findings for fatal and nonfatal events provides no evidence of benefit associated with the long-term use of tolbutamide.
5. In the VII Report (JAMA 1978 240:1) on Mortality and Selected Non-Fatal Events with Insulin Treatment it says: The UGDP findings provide no evidence that insulin or any other drug lowering blood glucose levels will alter the course of vascular complications in the type of diabetes that is most common, adult-onset diabetes. Weight reduction has been shown to be feasible and effective in lowering blood glucose levels; thus, dietary management deserves greater emphasis in this type of diabetes than it has received to date, as others have also suggested. In any case, the UGDP results suggest that the use of any additional therapeutic agent must be justified on grounds other than the prevention of macrovascular complications.
6. In its final report (Diabetes 31 Suppl 5 1982). The Evaluation of Insulin Therapy it says: The UGDP long-term prospective clinical trial provided little evidence that insulin treatment was any

better than diet alone in altering the course of vascular complications in stable adult-onset diabetes. This was true whether insulin was given in a fixed dose based on patient's height and weight or in doses adjusted to maintain blood glucose within defined levels. Mortality rates among the treatment groups were comparable. The differences in the occurrence of non-fatal vascular complications among the patients in these three treatment groups were small and only one of the drug-placebo differences was considered significant by the study criterion, and that was the insulin-standard versus placebo comparison for the occurrence of elevated serum creatinine levels. The occurrence of serious microvascular complications was surprisingly low. The latter finding as well as the slow progression of the macrovascular complications underscores the differences in the course and the nature of the two principal types of diabetes mellitus, the rather stable and non-ketosis-prone maturity-onset type and the relatively unstable insulin-dependent juvenile-onset type.

The UGDP Controversy

The UGDP has been the subject of controversy for more than a decade. Never in the history of modern medicine has a clinical study generated so much controversy. When the UGDP began, the general feeling in the scientific community was enthusiasm for its methods and goals. Soon later this enthusiasm turned sour; the UGDP came under bitter attacks.

The first two reports of the UGDP were to be presented at The Thirtieth Annual Meeting of the American Diabetes Association in St Louis in June 1970. Premature release of some of the information from the reports resulted in debates in newspapers and other media, and the publication of sensational newspaper articles.

On May 22, 1970 The Food and Drug Administration quickly endorsed the UGDP findings and said that it would take the following action.⁷

1. Require labelling changes for sulfonylurea drugs, to reflect the results of this study.

2. Inform physicians of the findings of this study.
3. Require the industry to institute long-term studies on the use of their products in various types of diabetic patients.
4. Continue to monitor all studies pertaining to the use of anti-diabetic agents in patients with diabetes mellitus of varying severity.
5. Continue an intensive examination of all new evidence in the field to be able to make prompt re-evaluation of these decisions as necessary.

At the conclusion of the Annual Meeting of the American Diabetes Association in St Louis on June 13-14, 1970, the President, after consultation with Ad Hoc Committee, issued a press statement on the papers presented by the UGDP which reported a relatively high mortality among diabetic patient treated with tolbutamide as compared with other groups treated with placebo or insulin:-

"The American Diabetes Association commends those persons who have reported studies concerning the effects of therapy on the course of diabetes and its complications at this Annual Meeting.

New data have been presented, some of which raise questions about the efficacy and safety of oral therapy. However, it is difficult to generalise from these unpublished data. Careful evaluation of the complete data and further study will be necessary to reach final conclusions.

At this point, the evidence does not appear to warrant abandoning the presenting accepted methods of treatment of diabetes — diet, diet with oral agents, or diet and insulin as indicated"¹

The Ad Hoc Editorial and Advisory Committee of the American Diabetes Association further studied and carefully evaluated the UGDP report and issued on October 7, 1970 an Editorial Statement and recommendations which accompany the publication of the two reports of the UGDP in its Journal, Diabetes. Regarding the greater number of cardiovascular deaths observed in the tolbutamide groups, the Editorial Statement points out the possibility that the tolbutamide population, by chance and despite randomiza-

tion, entered the study with more or greater risk factors than the other populations had, and this should be scrupulously investigated. Although this possibility has in the opinion of the ADA Ad Hoc Editorial and Advisory Committee, not been excluded, the weight of statistical analysis makes it probable that the excess cardiovascular mortality in this group is attributable either to the drug itself or to unconsidered and unknown factors. In the absence of evidence for the latter, suspicion would necessarily attach to tolbutamide. The mortality study is at least suggestive enough to put a damper on what appears to be the indiscriminate use of all oral hypoglycemic agents in the treatment of mild or moderate, adult-onset diabetes. In this therapeutic recommendations it says: "Tolbutamide, as well as other oral hypoglycemic agents, has no place in the routine treatment of chemical or latent diabetes, suspected diabetes, or pre-diabetes. Such therapy has never had a place in diabetic ketoacidosis or in those prone to it. The clearest indication for oral agents is diabetes of mild or moderate severity in a patient who proves to be poorly controlled with diet and who is unable or unwilling to take insulin. In adult-onset diabetes with hyperglycaemia and glycosuria, symptomatic or not, and in the absence of ketosis, a trial with an appropriate diet should come first. If this does not establish satisfactory control, insulin is to be preferred to other therapeutic agents because it is more uniformly effective in controlling hyperglycemia and the UGDP study indicates that it may be safer".²

The Food and Drug Administration issued a Report on Oral Hypoglycemic Agents on October 30, 1970:⁸

"Oral hypoglycemic agents should be used only in diabetes with adult-onset, stable, disease, which cannot be controlled by diet alone and for whom insulin is unacceptable or impractical. A recently published study shows no evidence that in diabetes with adult-onset stable disease, therapy with a fixed dose of one such agent (tolbutamide) and diet is more effective in prolonging life than diet alone. The study also suggests that such a regimen may be less effective insofar as cardiovascular mortality is concerned than diet alone or than diet and insulin combined". In its recommendations: "Pending results of such studies, the Food and Drug Administration recommends that the use of tolbutamide and other

sulfonylurea type agents should be limited to those patients with symptomatic adult-onset nonketotic diabetes mellitus which cannot be adequately controlled by diet or weight loss alone and in whom the addition of insulin is impractical or unacceptable. The oral hypoglycemic agents are not recommended in the treatment of chemical or latent diabetes, in suspected diabetes, or in pre-diabetes, and are contraindicated in patients with ketoacidosis. The initial and essential foundation for the management of adult onset diabetes mellitus is diet and weight control. When symptoms of the disease are adequately controlled by these measures, no other therapy is indicated. All oral hypoglycemic agents should be employed with caution and, if prescribed, then only when serious application of diet, or diet plus insulin, has been proven ineffective in the judgement of the physician. A physician using hypoglycemic agents should familiarize himself with the cautionary material in the package inserts for these drugs and should adjust the dosage according to the individual patient's needs".

A Statement regarding the UGDP study was issued by the AMA Council on Drugs on November 2, 1970:³

"Representatives of the Council on Drugs have evaluated reprints of the UGDP manuscripts and have discussed the data with interested parties including representatives of the FDA, UGDP, industry and the ADA.

Although some flaws exist in the UGDP study, it clearly demonstrates that every effort should be made by the physician to control the symptomatic, maturity-onset diabetic with diet alone. Should this fail, treatment with insulin or oral hypoglycemic agents should be undertaken. If oral hypoglycemic agents are selected for therapy the results of the UGDP study should be kept in mind. Therefore, the consideration of treatment with oral hypoglycemic agent should be secondary to the use of insulin".

The controversy dragged on and became more heated. Concerned that this was a threat to the practice of medicine, a group of diabetologists formed the Committee for the Care of the Diabetic (CCD) in order to contest the FDA's endorsement of the UGDP. In November 1970 the Committee for the Care of the Diabetic was formed by a group of

40 leading diabetologists who had decided to join forces in combating the UGDP. They retained a Boston lawyer, Neil Chayet, who specializes in medical-legal matters, to prevent the FDA from going ahead with its labelling proposal and to gain access to the UGDP's patient records. Chayet, has, by a number of legal maneuvers, been able to delay implementation of the labelling requirement for the past 8 years.

The National Institutes of Health asked the Biometric Society, a professional society of statisticians to review the UGDP findings and after 4 years of deliberation they published a carefully worded report supporting the UGDP study. In the conclusion,¹⁰ it says: "In the light of the UGDP findings, it remains with the proponents of the oral hypoglycemic drugs to conduct scientifically adequate studies to justify the continued use of such agents". The Biometric Society Report failed to satisfy the UGDP's critics.

The Nelson Committee Hearings in the US Senate (Sept. 18-20, 1974) explored the safety, effectiveness, and use of hypoglycemic drugs. A dozen witnesses, including the Food and Drug Administration Commissioner, Dr Alexander Schmidt, gave testimony concerning the implications of the UGDP articles for medical practice.⁶

The raw data of the UGDP were handed over to the FDA which conducted an audit. The FDA audit confirmed the conclusion of the UGDP study and reported this to the physicians in December 1978/January 1979 issue of the FDA Drug Bulletin.⁹

Early in 1979 the ADA asked the FDA to delay its implementation of placing warning labels on all oral hypoglycemic agents.

Legal action was brought against the Principal Investigator of the Coordinating Center and certain federal officials (Secretary of the Department of Health, Education, and Welfare, Commissioner of Food and Drugs, and the Director of National Institute of Arthritis, Metabolism and Digestive Diseases) for the purpose of requiring release of the original patient records as well as computer data files by the Committee for the Care of the Diabetic and Ciba-Geigy Corporation in separate petitions. The legal suits dragged on from 1975 to 1980 to Courts of Appeals. The

petitioners because of their vested interest were very determined in their fight against the decisions of the lower Courts and fought right up the Appeal Courts to the US Supreme Court. The issue was finally resolved by the US Supreme Court. The UGDP investigators took the position that this action must be opposed for two reasons: (1) to maintain confidentiality of all information related to individual patients in accordance with the legal and ethical requirements to do so, and (2) to defend the principle that the investigators should have the right to analyse the data they had collected before other investigators may have access to the data.

In its final report the UGDP asked why the UGDP findings precipitated such an unusually acerbic and long-lasting controversy, probably because (1) the results were contrary to the current view, (2) that vested interests have kept the controversy alive.²¹

The Implications in Medical Practice

Every aspect of the design, execution, analysis, and results of the UGDP has been subjected to intense scrutiny. Two audits of the study have been conducted; both concluded that any errors in data reporting or processing that did occur were infrequent and no more than might be expected in such a long-term clinical trial considering the amount of information collected in 12 centers over a period of 15 years, and that these minor problems did not invalidate the reported findings.

The non-insulin-dependent non-ketosis-prone diabetic is the most common group estimated to be about 80% of all diabetes.

The clinical evidence that strict regulation of the blood glucose prevents microangiopathy remains inclusive.^{4,11,12} Also the risk factors in the pathogenesis of atherosclerosis are not as firm as they are thought to be.⁵ Recently several reports of unexpected deaths have occurred in patients "tightly" controlled with open-loop insulin delivery devices.¹³ At least some of these deaths are believed to have been directly or indirectly attributable to hypoglycemia. Hypoglycemic encephalopathy has been a recognised risk since the introduction of insulin therapy. These reports, together with new understanding of the hormonal and metabolic lesions in treated and untreated type I diabetes, have raised legitimate ques-

tions as to the safety of efforts to normalize glycemia, whether by continuous subcutaneous insulin infusion or by multiple injections. With the UGDP findings — that the present methods of treatment do not prevent blindness, neuropathy, renal failure, atherosclerosis and death from uremia, congestive heart failure or vascular catastrophe, — then there is little justification for missionary zeal in the treatment of diabetes.

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THE EIGHTH SREENIVASAN ORATION

“TRENDS IN MEDICAL JURISPRUDENCE”

Justice Lai Kew Chai

It is extremely kind of the College of General Practitioners of Singapore to have invited me to deliver the 8th Dr Sreenivasan Oration. If I may say so, it is a distinction which I am afraid I may ill-deserve. I had accepted the invitation, however, because I have the highest regard for the life and work of the late Dr Sreenivasan, in whose honour is instituted this series of orations, and also because I have always had a healthy respect for members of a great and honourable profession, especially so when I was, on at least two occasions, critically unhealthy. It seems strange how people who are healthy or in the pink of health think poorly of doctors; how they do with unbridled levity tarnish a great profession just because of a few black sheep or because of a few isolated cases of negligence. There is another reason why I am speaking tonight. We lawyers lay great store in the doctrine of precedents, that is, we look to see for guidance what has been done before and by whom. I was told that all previous orators were not lawyers. So, in spite of rather limited experience, I decided to take the chance in the assured knowledge that at least for tonight there will be no precedent lawyer orator with whom I could be compared and contrasted.

My Themes

In any event, I do welcome this privilege to share with you some of my thoughts relating to certain doctrinal trends and tendencies in medical jurisprudence as are recently developed in the courts. My themes are two-fold. First, I strongly welcome the re-affirmation of what I would call the Bolam principle¹ governing the legal liability of physicians in the diagnosis, treatment and advice of patients. Secondly, I view with some concern the recent attempts at whittling down the Bolam principle in three respects, namely, (i) Lord Scar-

man in a dissenting judgment² might have introduced the thin end of the wedge when he pronounced the minority view or dicta that the law must recognise a duty on the part of a doctor to warn his patient of material risk or risks inherent in the treatment he is proposing, in particular in cases involving surgery; (ii) Lord Bridge of Harwich in the same case, although re-affirming the Bolam principle, postulated,³ however, that when questioned specifically by a patient of apparently sound mind about the risks involved in a particular treatment proposed, the doctor's duty must be to answer both truthfully and as fully as the questioner requires; and (iii) In *Thake & another v Maurice*⁴ a doctor was held by a court of law in England to have guaranteed by contract a total success of the proposed treatment, even if, as in that case, a vasectomy could be frustrated by re-canalisation through the natural actions of tissues and mother nature. God knows what they will expect of doctors next.

Before I proceed to make good the themes which I am advancing tonight, there are a few things I want to mention, if only to remind ourselves of the perspectives. I am the first to acknowledge that in your great profession literally millions of consultations and thousands of treatments have been successfully and competently done. Nearly all case sheets were closed, as they say, uneventfully. They are seldom heard of and even more seldom the subject matter of any adulation, seeing that you have to keep them confidential. The incidents which capture the headlines, alas, like those in every other discipline, are those where mistakes unfortunately are made. They are mindlessly blown out of all proportions. This is most regrettable where professionals are concerned, whose reputations are their only asset, and where the

slightest whimper is enough to reach the length and breadth of our little but rumour rampant island state. It may surprise you that lawyers understand doctors more deeply than any other professional; although, sometimes, I rather suspect that doctors like so many of the less informed find lawyers a necessary nuisance. And to assure you, you may like to know that it was a great jurist, the present Master of Rolls of the United Kingdom, who uttered this homily⁵ five years ago:

“There are very few professional men who will assert that they have never fallen below the high standards rightly expected of them. That they have never been negligent. If they do, it is unlikely that they should be believed. And this is as true of lawyers as of medical men. If the judge’s conclusion is right, what distinguishes Mr Jordan from his professional colleagues is not that on one isolated occasion his acknowledged skill partially deserted him, but that damage resulted. Whether or not damage results from a negligent act is almost always a matter of chance and it ill becomes anyone to adopt an attitude of superiority.”

You can hardly put the perspective better than in those words. Doctors work under time and other constraints: they practise a science and an art and they deal with the most unpredictable, the most demanding and a most variegated group of subject matter: the human beings. Last but not least: they often deal with life and death under the most pressing and distressing circumstances. I want to tell you that the law knows all these things. It has made allowances for all these considerations, including even evolving the doctrine of the ‘agony of the moment’.

The Bolam Principle

How does the law do this? It was all settled 28 years ago in the case of *Bolam v Friern Hospital Management Committee*⁶. It was held in that case that a doctor is not liable in negligence when it is proved that he has “acted in accordance with a practice accepted as proper by a responsible body of medical men skilled in (the) particular art.”⁷ That is one side of the coin. The other side of the coin sets out an equally valid and attractive proposition. In the same case it was also held that

such a doctor is still not negligent even if there was another body of competent professional opinion which might have adopted a different technique. A decision in a Scottish case⁸ was relied upon. Lord President Clyde said:⁹

“In the realm of diagnosis and treatment there is ample scope for genuine difference of opinion and one man clearly is not negligent merely because his conclusion differs from that of other professional men, nor because he has displayed less skill or knowledge than others would have shown. The true test for establishing negligence in diagnosis or treatment on the part of a doctor is whether he has been proved to be guilty of such failure as no doctor of ordinary skill would be guilty of, if acting with ordinary care.”

Let us examine the soundness of the Bolam principle. Doctors are allowed by law the privilege of having their performance judged by their peers who, by the fact of being peers, should be the best persons to know every matter which should or should not go into the scales when a particular incident is weighed and considered from the point of view of negligence. Nobody else is able to take an intelligent view of a particular treatment, diagnosis or advice. Judges have no knowledge of medical practice and we can only act on evidence. In these cases, we go by the evidence of expert medical witnesses who give us their opinions, their assumptions of facts and inferences and we, as a matter of law, evaluate their opinions against the reasons they give in support of them and make up our minds accordingly. I know of no other equally valid way of handling this question. To be sure, I will be against leaving these matters to the untrained minds of any jury, least of all, to some of the juries in the United States of America. I think we must do all we can to avoid the unacceptable face of medical litigation in the United States.

I should demonstrate how the Bolam principle was applied in the case. A voluntary patient underwent electro-convulsive therapy without the prior administration of a relaxant drug. The passing of an electric current through the brain resulted in violent muscular contractions and spasms, attended with a known, though slight, risk of bone fracture. Expert medical witnesses told the court the

different techniques which they adopted at the material time when giving E.C.T. treatment. Some used relaxant drugs, some restraining sheets, and some manual control but all agreed that there was a firm body of medical opinion opposed to the use of relaxant drugs and also that a number of competent practitioners considered that the less manual restraint there was, the less was the risk of fracture. The doctor was found not negligent.

The plaintiff in that case also claimed that the doctor had failed to warn him of the risk involved in the E.C.T. treatment. It was again held that the question depended on the standard of practice recognised as proper by a competent body of professional opinion, which was in favour of the doctor.

So you can see that the law has wisely left the professional standards of care to the opinion of a responsible body of relevant medical opinion. And that yardstick is also applied to the vexed question of what, if at all, the doctor should tell the patient. I should bring the matter into sharper focus by telling of the case of a lady BBC broadcaster who lost her voice. In *Hatcher v Black & others*¹⁰, Mrs Hatcher, an occasional BBC broadcaster presented at the St Bartholomew's a toxic thyroid gland. An operation was advised. She asked if there was any risk to her voice. The surgeon, thinking that it was all for her own good and that it was vital for the purposes of recovery that she should not worry, frankly admitted to Denning L.J. (as he then was and sitting as a trial judge) that he had told the patient a 'white' lie. In the event, the operation was performed but in the course of it, the nerve was so badly damaged that she could not speak properly. And she could not broadcast again.

The summing up of Lord Denning¹¹ is worth quoting for its outstanding lucidity:

"What should the doctor tell his patient? Mr Tuckwell admitted that on the evening before the operation he told the plaintiff that there was no risk to her voice, when he knew that there was some slight risk, but that he did it for her own good because it was of vital importance that she should not worry. In short, he told a lie, but he did it because he thought in the circumstances it was justifiable. If this was a

court of morals, that would raise a nice question on which moralists and theologians have differed for centuries. Some hold that it is never permissible to tell a lie even for a just cause: a good end, they say, does not justify a bad means. You must not do a little wrong in order to do a great right. Others, however, hold that it is permissible, if the justification is strong enough, and they point to the stratagems used in war to deceive the enemy. This, however, is not a court of morals but a court of law, and the law leaves this question of morals to the conscience of the doctor himself — though I may perhaps remark that if doctors have too easy a conscience on this matter they may in time lose the confidence of the patient, which is the basis of all good medicine. But so far as the law is concerned, it does not condemn the doctor when he only does that which many a wise and good doctor so placed would do. It only condemns him when he falls short of the accepted standards of a great profession; in short, when he is deserving of censure. No one of the doctors that have been called before you has suggested that Mr Tuckwell did wrong. All agree that it was a matter for his own judgment. They did not condemn him; nor should we."

Bolam principle re-affirmed

Over the last five years, two important decisions of the House of Lords unconditionally re-affirmed the Bolam principle. In the landmark case of *Whitehouse v Jordan*¹² concerning the standard of care of an obstetrician, it was a high risk pregnancy. After the mother had been in labour for 22 hours Mr Jordan decided to carry out a test to see whether forceps could be used to assist delivery. He pulled 5 or 6 times and then fearing for the safety of the mother and child he carried out a Caesarean section quickly and competently. But unfortunately the boy was born with severe brain damage, suffering from cerebral palsy and mental deficiency. He would need constant care and attention all his life. It was alleged against Mr Jordan that he had pulled too hard and too long. Mr Jordan was exonerated on the expert evidence of several obstetricians. On the other hand, Professor John Stallworthy and Sir John Peel, both of Oxford and both since retired, offered

the opinion that Mr Jordan was negligent. They, unfortunately, had made two wrong assumptions of facts. First, they wrongly thought that the baby's head was "not engaged" whereas those present at the delivery said in evidence that it was "engaged". Secondly, they again wrongly concluded that the mother was "lifted from bed", meaning that she was pulled down off the bed and lifted back on it again, whereas even the mother herself did not say so. Her only claim was that she was pulled to the bottom of the delivery bed, which was quite different, but which, at any rate, was disbelieved by the English Court of Appeal and the House of Lords.

The other case of the highest authority which applied the Bolam principle was *Maynard v West Midlands Regional Health Authority*¹³. I can briefly recite the facts. The patient presented symptoms of tuberculosis but both the consultant physician and the consultant surgeon took the view that Hodgkin's disease, carcinoma and sarcoidosis were also possibilities, the first of which if present would have required remedial steps to be taken in its early stages. Instead of waiting for the results of the sputum tests, the consultants carried out a mediastinoscopy to get a biopsy. The inherent risk of damage was to the left laryngeal recurrent nerve, even if the operation was properly done. In the event, only tuberculosis was confirmed. Unfortunately, the risk became a reality and the patient suffered a paralysis of the left vocal chord. The decision of the physician and the surgeon to proceed was said by their expert peers to be reasonable in all the circumstances.

The Bolam principle and disclosure

While the Bolam principle has been accepted without demur in the law governing a doctor's liability for diagnosis and treatment, there is a growing demand that in the sphere of a doctor's advice there should be more communication and disclosure to the patient of the risks in any proposed treatment so that the patient can make an informed decision and that the patient could be said to have given his "informed consent".¹⁴ This vexed question was dealt with by the House of Lords on 21 February 1985. It arose in this way. The plaintiff, who had suffered a pain in her neck, right shoulder and arms, underwent an opera-

tion which, even if performed carefully, carried an inherent, material risk, which was put at between one and two percent, of damage to the spinal column and the nerve roots. The surgeon decided not to inform the patient of the inherent risks. In doing so, the surgeon was following a practice which in 1974 would have been accepted as proper by a responsible body of skilled and experienced neuro-surgeons. By a four to one majority, the House of Lords followed the Bolam principle and exonerated the surgeon.

As I had said at the beginning of this offering, I see that Lord Scarman, a great jurist and one dedicated to the pursuit of the fundamental rights of the individual, was the dissenting Law Lord. He says that the law must depart from the Bolam principle and require a doctor as a matter of duty to tell of the inherent and material risk of the treatment proposed. This is quite a novel suggestion. It has little resemblance to the precept set out in *Decorum XVI* of the Hippocratic Corpus in which physicians are advised not to tell all because when told all "many patients ... [had] taken a turn for the worse." There is, obviously, a clamour for the patient's "right to self-determination".

Another Law Lord in the majority faithful to the Bolam principle, however, adopted a middle road and ventured an opinion which was not strictly necessary for the decision. Lord Bridge of Harwich dealt with the case of a patient of sound mind who has specifically asked of the risks involved in a proposed treatment. In that case, several features are clear. The patient wants to know and wants to be able to decide on the basis of what he is told. He does not want to leave it to the judgment of the doctor or to that of the doctor's peers.

What is my view? I am a faithful disciple of the Bolam principle. It has great merits to commend its continued acceptance. Whether there should be disclosure, when questions are put or not put by a patient, should be resolved by reference to the practice of the body of responsible medical experts. They are the best people to tell us what is the norm: they should say if in a particular case there should be disclosure. I should not like to see the law imposing a new duty of care to disclose arising in either set of circumstances referred to by the

two learned Law Lords. I must say, of course, that this is a tentative view which I have formed without the benefit of arguments by counsel which, if subsequently and cogently presented, may persuade me otherwise.

I now turn to the more alarming trend in which a doctor may be held in law to have contracted to provide a sure-fire remedy. In *Thake & another v Maurice*¹⁵ a railway guard and his wife had five children living in a three-bedroomed council house and were obviously not able nor keen to have another addition to the family. So Thake consulted the surgeon who made it clear that a vasectomy was final and that Thake after the operation would become permanently sterile. Although the vasectomy was properly performed, the effect of this operation was naturally reversed and, not unexpectedly, Mrs Thake conceived and Samantha was born. The learned trial Judge held that applying the objective standard the surgeon had contracted not merely to perform a vasectomy but had contracted to make Mr Thake irreversibly sterile. The learned Judge relied on the consent forms which stated that the vasectomy would be final. I must respectfully disagree with the learned Judge. In my view no surgeon could reasonably be held to have guaranteed irreversible sterility which must depend on the healing of human tissue. The consent, I think, was read out of context which was in reality aimed at telling both husband and wife not to change their mind later and complain if the spouse became permanently sterile. It is not uncommon to have come across couples who had sterilised themselves wanting to change their minds because their children had died or because they were seeing better days and they could go forth and multiply.

What is legally even more exceptional was the learned Judge's alternative finding of a collateral warranty given by the surgeon that Mr Thake would be irreversibly sterile. This was a doctrinal legal device used to get round the Bolam principle. Collateral warranties are agreements made alongside a main agreement: they are sometimes found by courts to exist to get round unfair contracts or certain objectionable terms therein. No such imperatives apply in the agreement in this case. I believe the case is under appeal in England and I look forward to its reversal.

REFERENCES

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2. *Sidaway v Board of Governors of The Bethlem Royal Hospital & others* (1985) 2 WLR 480, 495C-D.
3. *Ibid*, 503A.
4. (1984) 2 All ER 513.
5. *Whitehouse v Jordan* (1980).
6. *Supra*.
7. *Supra*, 587.
8. *Hunter v Hanley* (1955) S.L.T. 213.
9. *Ibid*, 217.
10. (1954) *Times*, 2nd July.
11. Lord Denning, *The Discipline of Law*, 243.
12. *Supra*.
13. (1984) 1 WLR 634.
14. See *Consent to Medical Procedures: Paternalism, self-determination or therapeutic alliance*, by Dr Harvey Teff (1985) 101 L.Q.R. 432.
15. *Supra*.

PRESIDENT'S ADDRESS

ELEVENTH COLLEGE CONVOCATION AND DINNER AND EIGHTH SREENIVASAN ORATION

Dr Lee Suan Yew

The Honourable Mr Justice Lai Kew Chai and Mrs Lai, distinguished guests, members and friends, 39 days ago we lost a very dear friend, Dr Victor Louis Fernandez, President of our College. We shall always remember his cheerful disposition, his smiling face and his infectious chuckle. His many years of dedicated stalwart service to the College will long be remembered. His loss is immeasurable.

As a token of appreciation of his services to the College, your Council has unanimously moved that Dr Victor Louis Fernandez be awarded the Albert Lim Award posthumously. In addition, Council has approved the setting up the Victor Fernandez Fellowship Fund. Victor was very keen on the up-grading of Teacher Training in the College. It is most fitting, therefore, that the Fellowship Fund be used to upgrade Teacher Training in General/Family Practice. Prominent Fellows will be invited to conduct teacher training seminars and workshops. In addition, the Fellowship Fund may award scholarships to research Fellows for the advancement of General/Family Practice. Those of us who are inclined towards donating to the Victor Fernandez Fellowship Fund may send their donations to the College.

I wish to thank Council for electing me President of the College on the 17th November 1985, exactly a week ago. It was with great diffidence that I accepted the office knowing full well how onerous it was to fit into the shoes so ably worn by the Past Presidents of our College. Council assured me that they would work doubly hard to make up for any of my deficiencies. I feel humbled and yet honoured by the privilege bestowed upon me to lead this fine team of young and enthu-

siastic Council members. Dr Alfred Loh, the Vice-President, should by right, have taken the office of President but he decided otherwise. He claimed that he is yet too young to be President of the College. He disclaims second echelon status!

What are the recent achievements of the College?

Firstly, the unqualified success of the Continuing Medical Education (C.M.E.) programmes. The lecture courses, seminars, workshops and hospital demonstrations relevant to General/Family Practice have been well attended by our members. The average registration for each course was around 120 members. There were 166 registrants for the latest course on geriatrics. This speaks well for the organisers, lecturers and the participants, who sacrificed much of their time and effort.

Secondly, the success of the post-graduate Diplomate Examination of the College. It is held once in two years. This examination helps to upgrade the theoretical and clinical skills and competence of the Diplomate candidate. Whether he passes or fails the examination, the very fact that the busy practitioner has disciplined himself or herself to study and attend courses means that he or she has already embarked on the right course to update and upgrade his medical knowledge. For those of us who think that the examination is easy, the College invites you to have a go at the examination. The next examination may begin next October.

There are over 40 Diplomate graduates. They have proved to be very good General/Family Physicians. Success here, is not necessarily measured in pecuniary returns, although I gather that their patients find them

so good that success included professional job satisfaction and other productive intake of patients.

Thirdly, the undergraduate course in General Practice is still being conducted once a year through the kind invitation of the Dean of the Faculty of Medicine. This brief exposure consists of lectures, attendance at the Government Out-Patient Polyclinics and a week's posting to designated part-time G.P. clinical teachers at their respective clinics. The feed-back on the course is being processed by our Honorary Secretary, Dr Goh Lee Gan, who is a self-confessed and self-taught computer expert of our College. He will be submitting his findings to the Council shortly. The College has recently purchased a computer, but Dr Goh is the only person who knows how to operate it.

Fourthly, the goodwill and excellent rapport built up over many years vis-a-vis the Ministry of Health together with the other medical bodies in Singapore and overseas have gained further momentum. The signal was well received when the Ministry of Health invited the College to reside side-by-side with the Academy of Medicine, Singapore, at the renovated Faculty of Medicine Building from the middle of next year. The Ministry of Health also invited the two academic bodies to form a Library sub-committee to set up and maintain a post-graduate reference library in the same building. This may well be a new era of further co-operation and conjoint effort to improve the medical health services in Singapore and to better serve the people of Singapore. The Faculty of Medicine Building may soon be the focal point for continuing Medical Education for General/Family Practice and for Specialist Practice both in the public and private sectors.

What of the future?

The main thrust as Council view it, is the improvement of Continuing Medical Education. We hope to formulate five modules a year. This is: 3 sets of courses of important and relevant topics and two home study courses. For every two year cycle ten modules would have been completed. This would also fit in very well for the candidates who are preparing for the Diplomate M.C.G.P. Examinations.

Council hopes to broach the subject of short rotation postings e.g. in medicine, paediatrics, surgery, obstetrics & gynaecology, ophthalmology, E.N.T. and Dermatology for would-be General/Family Physicians in the Ministry of Health. The vocational training will give the would-be General Practitioner a better grounding. Hitherto, there is no vocational training.

It has been said that the 5-year medical course in the University is adequate enough to train a General/Family Physician. This view is not subscribed by many of the more advanced countries like Australia, Canada, the United Kingdom and the United States. All those countries have some form of vocational training. Some even have a Chair in General/Family Practice. Many have post-graduate examinations. If we believe in medical excellence it should not only be confined to the Specialities but it should also include General/Family Practice. Surely, this is very cost-effective in managing costly health services in Singapore. To remain a status quo is to invite mediocrity.

Your Council hope to hold further discussions with the Dean of the Faculty of Medicine, Prof Edward Tock, to review and perhaps maximise the allotted time and facilities available for the teaching of Family Medicine in view of the expanding medical intake. If the average intake of medical students is around 200 per annum and assuming that all of them graduate as doctors, in 10 years from now we shall have an additional 1,000 doctors. Assuming that all of them become Specialists, will the Government and the people be able to sustain such large numbers of Specialists? Assuming that half of them become General/Family Physicians, should we not plan some form of vocational training to upgrade Primary Health Care?

Council hope to explore further avenues of co-operation and rapport with the Ministry of Health. This tradition has been and will be maintained so long as we have at the Ministry men and women of calibre with a vision to upgrade the Health Care of Singapore.

Ladies and Gentlemen, before I conclude, on behalf of the College, I wish to express our deepest thanks to the Honourable Mr Justice Lai Kew Chai for accepting our invitation to

deliver the Eighth Sreenivasan Oration. It is the first time that the College has invited a Supreme Court Judge to address us. There is no ulterior motive, I assure you! He is the first locally trained Law Graduate to be elevated to the Bench. We are naturally proud of his

PROCEEDINGS
ELEVENTH COLLEGE CONVOCATION
AND DINNER AND EIGHTH
SREENIVASAN ORATION

Once every year the College gathers for the Convocation and dinner to honour those who have served the College or those whose worthy thoughts and opinion on medical and other matters are highly regarded by the College.

This year this august occasion was held on 24 November at the Hyatt Regency and the Sreenivasan Oration was delivered by the Hon. Justice Lai Kew Chai.

Justice Lai is a warm personality and his lucid thoughts on "Trends in Medical Jurisprudence", the subject of the oration, drew rapt attention of all those present.

What went particularly well with the audience were his remarks on medical negligence. "I am the first to acknowledge that in your great profession literally millions of consultations and thousands of treatments have been successfully and competently done. The incidents which capture the headlines, alas, like those in every other discipline, are those where mistakes unfortunately are made. They are mindlessly blown out of all proportions."

For those unfortunate enough to have missed Justice Lai's oration, the full text of his speech is reproduced elsewhere in this journal. It is good that the profession now and again has an opportunity to see how others view us. It is excellent that this year the observations were made by a highly respected

achievements and we look forward to his oration.

Finally, I wish to thank all of you for gracing this occasion and for extending your hand of friendship to the College.

member of the legal profession.

The other highlights of the evening's programme included the address by our newly elected President Dr Lee Suan Yew who reminded those present of the importance of continuing medical education. Dr. Lee's speech is also reproduced in full elsewhere in this issue.

A sad point in the evening's function was the observance of a minute's silence for Dr. Victor Fernandez, our late President. He was posthumously awarded the Albert Lim Award and his wife Mavis was gracious enough to be present to receive it.

Several members of the College received letters of appreciation in connection with services to the undergraduate training programme while others were given certificates of attendance for completing up-dating courses conducted by the College.

Dr Moti Vaswani was conferred Fellowship of the College and this year's book prizes for medical students went to the following:

1st place — Pang Yoke Teen, 2nd place — Enoch Gan and 3rd place — Miss Yvonne Chan Gek Suan.

A convivial Chinese dinner rounded off the evening's happenings and this was enjoyed by all.



The Sreenivasan Orator – Justice Lai Kew Chai.



Mrs. Mavis Fernandez receiving the Albert Lim Award on behalf of the late Dr. Fernandez.



Fellowship – Dr. Moti Vaswani.



"To the College."



Dr. Mary Chan receiving her Certificate of Attendance.



Dr. Lee Suan Yew presenting Book Prize to top student Pang Yoke Teen.

HOME STUDY SECTION

X-RAY QUIZ

A 25 year old Chinese man presented with a history of persistent epigastric pain for about 9 months. A barium meal examination was performed in a foreign country and it was reported to be normal. His symptoms remained and when he returned, a repeat BMX was performed. Figure 1 shows a double contrast barium meal examination of the stomach.

1. What lesions can you identify?
2. What is the diagnosis?

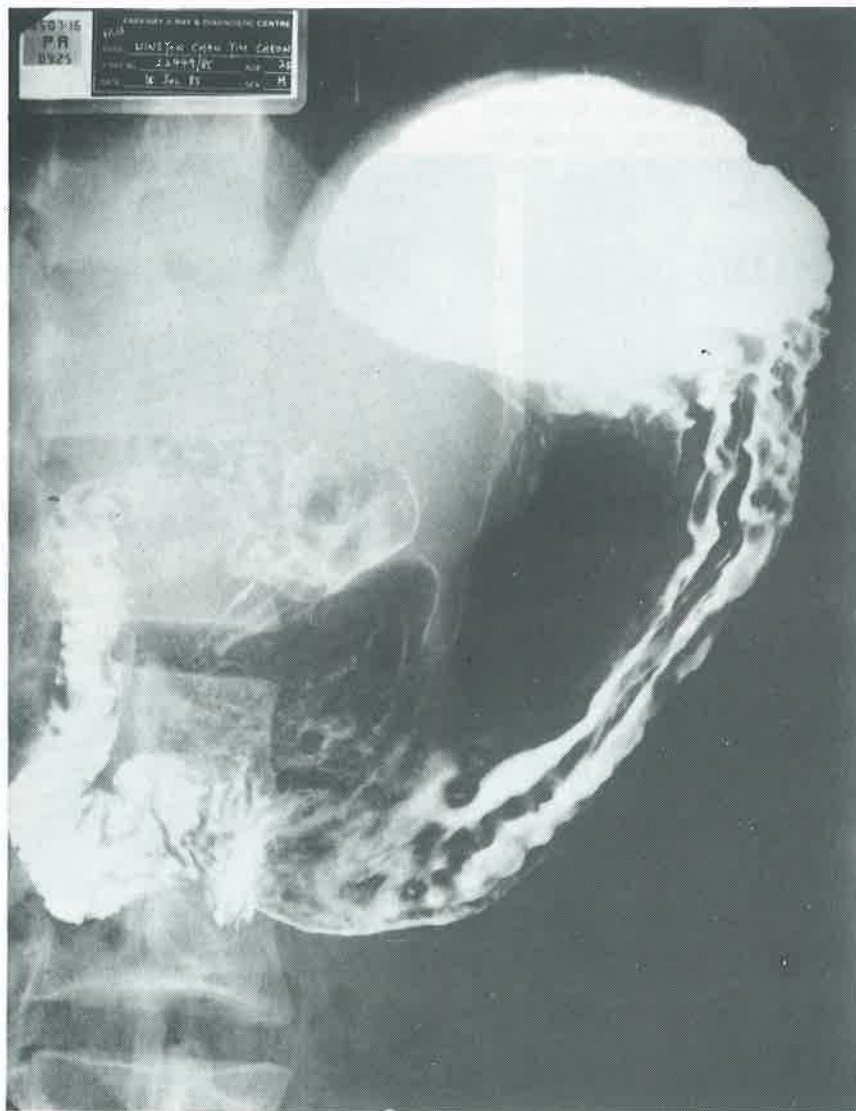


Fig. 1

ECG QUIZ

1. What are the abnormalities?
2. What is your diagnosis?





Fig. 2

ANSWERS TO X-RAY QUIZ

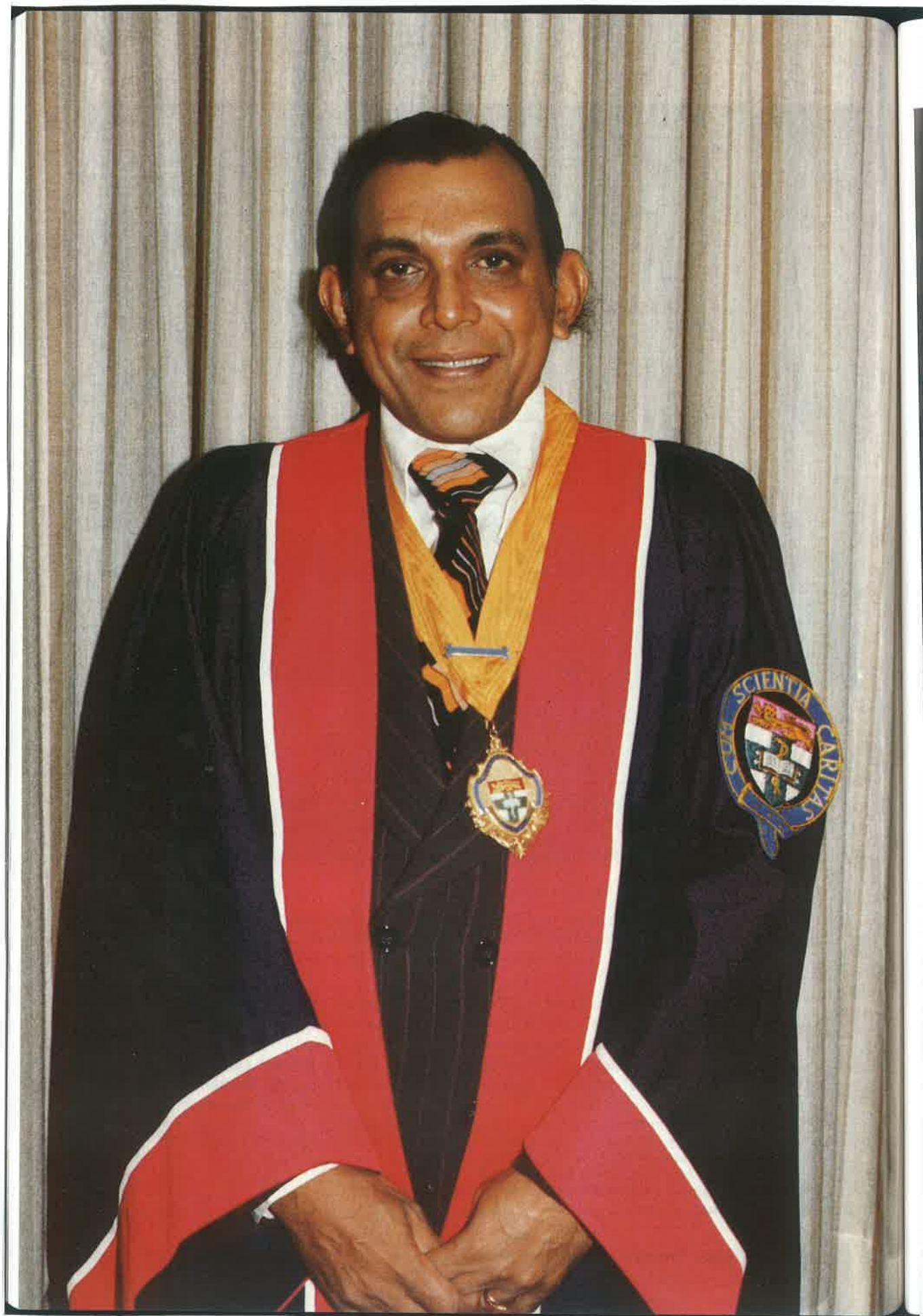
The patient has

1. Erosive (acute) gastritis.
2. Active duodenal ulcer.

The 'Target Lesions' (arrows Fig. 2) that you see in the body and antrum of the stomach each consists of a central collection of barium which represents the erosions surrounded by a radiolucent halo of mucosal edema. There is an ulcer with radiating mucosal fold in the duodenal cap (arrow Fig. 3).

A somewhat similar lesion may also be seen in Crohn's disease, metastasis and lymphoma of the stomach.

*Contributed by: Dr K. Param, M.B., B.S., (S'pore)
D.M.R.D. (Liv.), F.R.C.R. (U.K.)*



OBITUARY

DR. VICTOR LOUIS FERNANDEZ

Victor Louis Fernandez was born in Singapore on 27 January 1927. He received his secondary education in Victoria School and his medical education from the University of Malaya.

After his graduation from medical school, he began a lifetime of service to the medical profession and the people of Singapore. His name became a household word to many who lived in Serangoon Garden estate in which he practised. His dedication to the service of the unfortunate came to be counted upon in the many welfare bodies in which he served.

He was for many years the driving force behind the Lions Club of Singapore North. He was its Chairman of the management committee for the Lions Home for the Elders. He was also its organising chairman for the Lions Nursing Home for the Elders, a conjoint project with the Ministry of Social Affairs.

His work with the less fortunate in the community was not confined to work with the elderly. He served on the executive committee of the Singapore Association of the Blind. He was an honorary physician of several Catholic bodies. He also was the President of the Serangoon district of the Boys' Scout Association.

As if all this was not enough in addition to his work as a family doctor he also found time and energy to devote himself to the work of the College of General Practitioners. It was in this field that he excelled himself. He helped to set up the secretariat and the present College premises. For many years he served in

the finance committee, in the student teaching programme and on the executive council. He was elected President of the College in 1977 and served in this office till 1983. After a two year rest from the President's office, he was re-elected President, a position he held till his untimely death on 17 October 1985.

As Vice-Chairman and Hon. Treasurer of the Host Organising Committee of the Tenth WONCA World Conference on Family Medicine he put Singapore on the map by making the occasion a great success.

No one who has ever had the privilege of working with Victor ever failed to be impressed by the man's sincerity. His achievements both as a doctor and a humanitarian were many, but his chief distinction was his ready ability to relate to anyone no matter how lofty or humble his or her station in life. For them all, Victor always held out a ready hand of welcome and a disarming smile. And there was of course his laugh. A laugh so spontaneous and infectious that it set the mood for any meeting or chat with him.

As a doctor he was loved and respected by his many patients. As a fellow colleague he will be missed by many who knew him well.

Our sympathies are with Mavis his wife who will miss him more than the rest of us. Victor Louis Fernandez however will not pass away, his work continues to live on in the work of the College and the other organisations in which he served.

The sunshine of his disposition remains in our thoughts always.

EK

"His was the kind of life that made the recording angel take up shorthand".

WONCA — WHO RELATIONSHIP

INTRODUCTION, GENERAL INFORMATION POSSIBILITIES FOR A WONCA MEMBER COLLEGE WHAT IS IN IT FOR AN INDIVIDUAL DOCTOR?

Dr A Hofmans

INTRODUCTION

Since January 1984 — about 1½ years ago — WONCA became a non-governmental organization (NGO) in official relation with WHO.

In the June issue of WONCA NEWS an informative article was published in which the basis of the official relations of WONCA and WHO has been outlined by defining the broad objectives of our collaboration.

WHO/WONCA AGREEMENT

The main elements of the WONCA/WHO joint programme, based on these objectives (Content of Primary Health Care; Medical Education; Health Information System; Classification of Health Problems; Mental Health in Primary Health Care) are the following:

1. Defining and developing indices of health status and instruments, including suitable classifications, for the collection and compilation of relevant information, with the ultimate aim of strengthening the information support to the management of Primary Care within health systems based on Primary Health Care. (In non-official, non-bureaucratic terms: developing the family of international classifications in Primary Health Care)

*Liaison person of WONCA with WHO
Immediate Past President WONCA
Nietzschestraat 8, 3076 DS Rotterdam,
Netherlands*

2. The joint preparation of an expert report on undergraduate, postgraduate and continuing education of primary care professionals.
3. To develop programmes for continuing medical education in relation to auditing and quality assurance.

In the autumn of 1986 an assessment will be made of the extent of which the joint work programme has been implemented: WHO will assess our homework! This means that WONCA has bound itself to fulfil various tasks. (I will return later to these tasks).

I would like to make the following remarks referring to the before mentioned elements (1, 2 and 3):

1. The WONCA Standing Committee on Classifications under Jack Froom's leadership, and of which committee many members come from the Asia-Pacific Region of WONCA, has performed most outstanding work, which will as we all hope lead (soon) to the publication of the IC Process PC and the ICPC.
2. Dr Jack Marshall from Australia, chairman of the WONCA Standing Committee on undergraduate, postgraduate education and evaluation, started with his committee to design a draft of an expert report on undergraduate, postgraduate and continuing education of primary care professionals.
3. As an example of a programme for continuing medical education in relation to auditing and quality assurance, a study on rational prescription of essential drugs by family physicians was suggested and in-

troduced by me to the Netherlands College of General Practitioners, and the Department of General Practice of the Medical Faculty of Amsterdam University.

AGAIN NGO

The WHO is an agency of the United Nations. More than 160 Governments constitute WHO. Various organizations all over the world can effectively contribute to the attainment of the objectives of WHO. Such an organization in official relation with WHO is called a non-governmental organization (NGO).

At present there are some 130 NGO's in official relation with WHO. To give you an impression, the following rubrics to which the various NGO's refer, are mentioned:

- Organizations of health systems, based on primary health care, like World Federation of Public Health Associations.
- Health Manpower organization, like WONCA and the International College of Surgeons.
- Protection and promotion of the health of specific population groups, like the International Pediatric Association.
- Protection and promotion of mental health, like the International Council on Alcohol and Addictions.
- Promotion of environmental health, like the International Water Supply Association.
- Diagnostic, therapeutic and rehabilitative technology, like the International Federation of Pharmaceutical Manufacturers Associations and the International Federation of Clinical Chemistry
- Rehabilitation, like the World Federation of Occupational Therapists.
- Disease prevention and control, like the International Leprosy Association.

NGO'S GROUP ON PHC

A NGO's Group on PHC was formed in 1976. The Group assisted in preparing a position paper on the role of NGO's in PHC, which was presented at the Alma-Ata Conference in 1978. One of the common interests of the members of the Group is: Working towards Health for All by the Year 2000

through the instrumentality of Primary Health Care. In October 1984 WONCA became affiliated to the Group, which in October 1984 counted 32 active Members, including the International Hospital Federation, International Planned Parenthood Federation and the International Confederation of Midwives, and 30 corresponding members, among which is the World Federation for Medical Education. It seems to be of considerable importance for WONCA to be in touch with and to learn from the NGO's Group on PHC, because we in WONCA are at the beginning of a long way towards the goal of active participation of family physicians around the world in the achievement of Health for All by the Year 2000 by means of Primary Health Care.

PRIMARY HEALTH CARE

In the declaration of Alma-Ata on 12 September 1978 by the WHO/Unicef International Conference on Primary Health Care, Primary Health Care was identified as the key to attaining the target of health for all by the year 2000. National strategies would require action from all sectors to give effect to that policy. PRIMARY HEALTH CARE involves, *in addition to the health sector* all related sectors and aspects of national and community development, in particular agriculture, animal husbandry, food, industry, education, housing, public works, communication and other sectors; and demands the coordinated efforts of all these sectors.

Allow me just for a few moments to dwell upon the concept of primary health care. Let me start with a citation from item 77¹:

"Primary Health Care has to make full use of all available resources, and therefore has to mobilize the human potential of the entire community. This is possible on condition that individuals and families accept greater responsibilities for their health. Their active interest and participation in solving their own health problems are not only a clear manifestation of social awareness and self-reliance but are also an important factor in ensuring the success of primary health care."

Especially in communities where the general practitioner/family physician is acting as the doctor of first choice — like in the country I know best — one may wonder how they handle

this standpoint. Did or do they change their attitude in this respect, and do they try educating their clientele? in the above mentioned sense? I may come back to this aspect later.

We have to acknowledge that seven years after the Alma-Ata Declaration, the knowledge in the field about the content of Alma-Ata Declaration and Primary Health Care is, nicely said, quite poor. From an inquiry, performed in September 1984, about the knowledge of the Alma-Ata Declaration among professors from the 27 medical faculties in the German Federal Republic, 76% knew nothing, while 15% knew only little. From those answering to the question "To what extent you think the basis philosophy of the Declaration is relevant for the health care in the Federal Republic?", 70% answered that in their opinion there was none to little relevance.²

The attitude of those teachers in this part of the world is of great influence on the education of students and the functioning of future physicians with regard to the introduction of the principles of primary health care by the general practitioner/family physician. One can doubt about the result of such a questionnaire, performed elsewhere in the world — for instance a developing country. May be some of you will experience this suggestion as a challenge and start a questionnaire.

It is a pungent detail that during the Technical Discussions at the World Health Assembly in May 1984, devoted to "The role of Universities in the Strategy for Health for All," the necessity of changing the medical curriculum on a world wide scale was acknowledged by all delegates, of whom many represented various faculties from various universities all over the world. Relevant resolutions were adopted by the World Health Assembly.³

I have pointed out to you a few facts to demonstrate how wide the gap is between the theory of the Alma-Ata Declaration and the Primary Health Care Philosophy on the one hand and the practice of daily life on the other hand, especially in the education of students, the doctors of the very near future. A conclusion could be that WONCA, the Member Colleges of WONCA, and the individual general practitioner/family physician might perform some self search about its or her/his responsibilities towards that — still in size

decreasing — slogan, to begin with: Health for All by the Year 2000 by means of the instrumentality of PHC, and then: Health for all by the Year 2000, and further: Health for All 2000, and finally: Towards 2000, the theme of the 11th WONCA World Conference in London 1986.

POSSIBILITIES FOR A WONCA MEMBER COLLEGE

NATIONAL NGO

At the time WONCA became a NGO in official relation with WHO, each of the national Member Colleges of WONCA obtained that qualification. As outlined in my introduction, WONCA has bound itself to fulfil various tasks in the WONCA/WHO joint programme. These tasks have to be executed by individuals, family physicians, members of the national colleges. (I'll return later to this) As the liaison person of WONCA with WHO, I see it as a kind of a mission to advertise for volunteers: one of my reasons to visit Singapore and Melbourne.

RIGHTS

Representatives of Member Colleges of WONCA are invited to attend the yearly sessions of the WHO Regional Committee, and to participate in the Technical Discussions during the World Health Assembly, which is held every year in May in Geneva, Switzerland. For your information, Dr Judilherry Justam from Indonesia represented his College during the Technical Discussion this year.

The financial impact of an exercise like this is of considerable size for the College, but on the other hand there is an unique opportunity to widen one's and the College's horizon.

COLLEGE — WHO

Next I would like to seek your attention for future collaboration between a national Member of College of WONCA and the national WHO Agency. As I pointed out before, WONCA focus on three major elements in the WONCA/WHO joint programme. In the first element the WONCA Standing Committee on Classifications is intensively involved. In the field of undergraduate and postgraduate education, and in developing programmes for continuing medical education in relation to auditing and quality assurance, there is a comprehensive

field for research and experiments. Initiatives by national Member Colleges to take action would be very much appreciated as well by WONCA as by WHO.

It should be strongly considered by the Member Colleges to make a formal contact with the national WHO Agency, when such a contact does not yet exist. WHO is not a financial sponsor, but it has a great deal of expertise to profit by. WHO is willing and even obliged (just as WONCA is in respect to WHO) to assist and to advise in developing — for example — research activities or education experiments. It is self-explanatory that in the case of a national WONCA/WHO programme the liaison person of WONCA with WHO would appreciate receiving relevant feedback from the national WONCA Member.

ILLUSTRATION OF COLLABORATION

Just to illustrate this process, allow me to refer to an article, which will be published in the September 1985 issue of WONCA NEWS. The author, Dr Schade, a College Board Member, reports about WHO and the Netherlands College of Family Physicians.⁴ He visited Dr Alfonso Mejia, intermediary of WHO with WONCA in Geneva, to investigate developments within WHO which could be of assistance to the College and its members. In his article Dr Schade reports about continuing medical education, its structural aspects and those of quality improvements. Further he reports about Task Performance, which is closely connected with CME and Assessment. Finally attention is paid to work support (supervision) and unemployment in the health service. His conclusion is: For the Netherlands College of Family Physicians it is a challenge to cooperate in the development of instruments for quality improvements, which can also be used elsewhere in the world.

Finally, what kind of activities have further to be performed by the national College in relation to WHO? As a result of the discussion on "Collaboration with NGO's in implementing the global strategy of Health for All" during the World Health Assembly in May 1985, it was resolved by Assembly to call on the National NGO's:

1. To commit themselves in practice to the implementation of the strategies for health for all by the year 2000;

2. To establish close collaboration with governments, in a spirit of partnership, for the implementation of national health for all policies and programmes;
3. To encourage and support in all ways self-care and self-help groups at the community level for the effective implementation of primary health care;
4. To establish appropriate national coordinating mechanisms, such as national councils of non-governmental organizations, to provide a focal point for non-governmental activities in health and health-oriented fields.

To end this section I would like to suggest that Member Colleges follow WONCA in advertising the WONCA/WHO relationship in the Colleges' publications.

WHAT IS IN IT FOR AN INDIVIDUAL DOCTOR?

In the previous section I mentioned the needful involvement of the family physician in the execution of the various activities resulting from and referring to the National College/WHO relationship.

It is the individual physician, the member of his College of Family Physicians, the member of the Executive Board of the College, or the chairman or one of the members of one of the Standing Committees of the College who has finally to perform the job. It is always and everywhere in the world that the individual initiative, guided by scientific curiosity, by vision or simply by sound ambition, that really works, that inspires colleagues-collaborators and that finally results in substantial issues.

As I mentioned, I met Dr Justam from Indonesia recently. He is a young family physician from Jakarta and a member of the Board of the Indonesian Family Physicians Foundation. During our discussions it became clear that Dr Justam's main interest focuses on postgraduate training for family practice. We discussed ways how to deal with the various problems in this field. To begin with, the aim for a start could be the design of a position paper, and finally the programme for a postgraduate training for family practice in which primary health care as the strategy for the achievement of Health for All by 2000 is fully recognised.

The initiative of Dr Schade, which I cited in the previous section is another illustration of an individual initiative of participating in the challenge of making the WONCA/WHO relation a lively reality.

This paper was presented to the Council of the College of General Practitioners Singapore on Sunday, September 8, 1985, in Singapore, and to the Combined Colleges Meeting of the Asia Pacific Region of WONCA on Tuesday, September 17, 1985 in Melbourne.

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NEWS FROM THE COUNCIL

1. Changes in the Council

Arising out of the untimely demise of the late Dr. Victor Louis Fernandez, on 17 October 1985, Council at its meeting held on 17 November 1985, has unanimously elected Dr. Lee Suan Yew, to be the President of the College and Dr. Lim Kim Leong to fill the post of the Censor-in-Chief (vacated by Dr. Lee Suan Yew on his being elected President).

The composition of the Tenth College Council (1985-87) is now as follows:

President	— Dr Lee Suan Yew
Vice-President	— Dr Alfred W T Loh
Censor-in-Chief	— Dr Lim Kim Leong
Honorary Secretary	— Dr Goh Lee Gan
Honorary Treasurer	— Dr Paul S M Chan
Council Members	— Dr Sivakami Devi Dr Omar bin Saleh Talib Dr Soh Cheow Beng Dr Tan Kok Yong Dr Henry P H Yeo
Honorary Editor	— Dr Moti H Vaswani

2. Victor Louis Fernandez Fellowship Fund

The Council at its meeting held on 6 December 1985 resolved to perpetuate the memory of the late Dr Victor Louis Fernandez by setting up the "Victor Louis Fernandez Fellowship Fund". Dr. Fernandez was very keen on the upgrading of GP Teacher Training in the College and, therefore, this Fund will be primarily used to upgrade Teacher Training in General/Family Medicine. Prominent Fellows will be invited to conduct Teacher Training Seminars and Workshops. In addition, the Fellowship Fund may award scholarships to Research Fellows for the advancement of General/Family Practice. Your donation, big or small, will go a long way to realise the objectives of this Fund. Please send your cheques made payable to the College of General Practitioners Singapore. All donations will be tax exempt. Council looks to your support for the establishment of this Fellowship Fund.

3. Paediatrics Update

The next C.M.E. module will be on Paediatrics. It is scheduled to start on Friday, 14 February 1986. There will be eight theory sessions on Friday evenings and two clinical demonstrations on Sunday afternoons, as part of this course. Details are being worked out and when finalized will be circulated to members.

4. College Fellow

At the 11th College Convocation held at the Hyatt Regency Singapore on Sunday, 24 November 1985, the Fellowship of the College was conferred on Dr. Moti H Vaswani.

5. New Members

The following have been accepted by Council into membership of the College during October/December 1985:

Dr Tan Chong Bin	Associate Membership
Dr Balkis Akbar Ali	Associate Membership
Dr Khoo Swee Suan, Janice	Associate Membership
Dr Fung Mei Keng, Janet	Associate Membership
Dr Tan Soo Cheng	Associate Membership
Dr Kwee Lee Fung	Associate Membership



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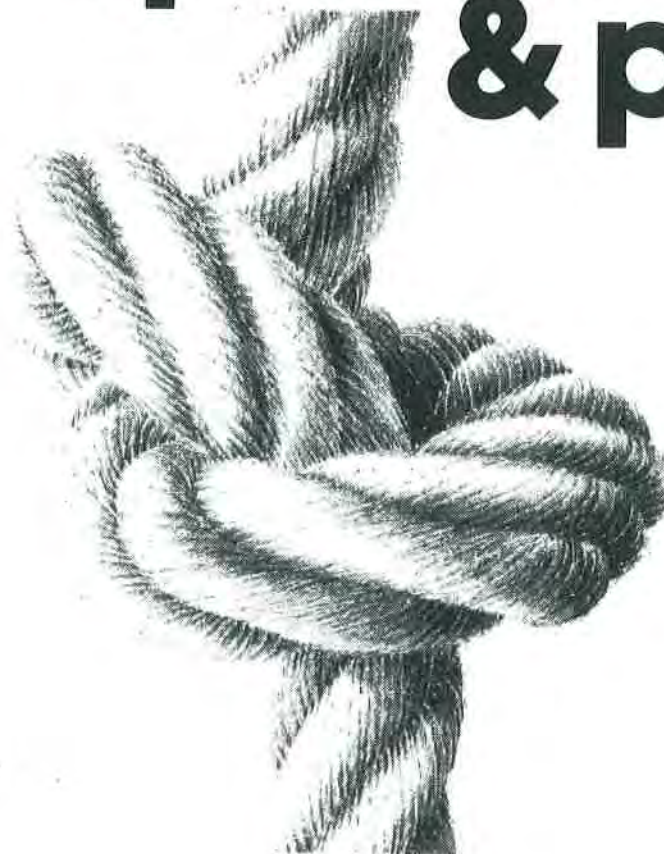
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decision and the importance for the health of the infant of using the formula correctly. Unnecessary introduction of supplements, including partial bottle feeding, should be avoided because of the potentially negative effect on breastfeeding.*

* WHO - International Code of Marketing of Breast Milk Substitutes, WHA 34.22, May 1981.



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