Qi 氣

2003

Annual Publication of the
Australian Chinese Medical Association (Vic.) Inc.

art & medicine

Editor: Deborah Cheung

Editorial board: Adrian Mar
Mee Yoke LIng
Jun Yang

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Annual Publication of the

Australian Chinese Medical Association (Vic.) Inc.

Qi ('chi') is the pinyin version of 氣 which is regarded as the life-force or pervasive vital energy which animates us.

The ACMAV logo depicts a Chinese dragon intertwined with the traditional serpent and staff.

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ACMAV Inc. was founded in 1985 as the Chinese Medical Society, with Dr Tom Tsiang as Foundation President; it became the ACMAV in 1987. The inaugural edition of the *Qi gazette* was published by Dr Joseph Cheung in 1991.

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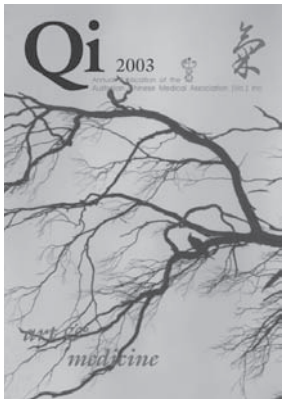

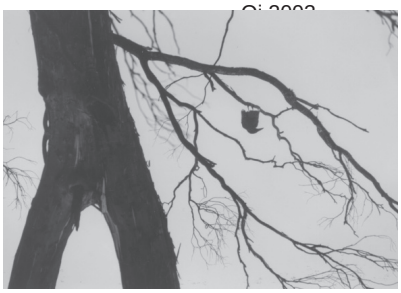

Front & Back Covers:
photos taken by Prof Y Lim
(see 'Distinguished Personalities')
of a bird in a tree which, when inverted, represent coronary angiograms with the bird as the 'aneurysm'. BC displays the angiogram seen anteriorly; FC is the angiogram rotated through 90 degrees.

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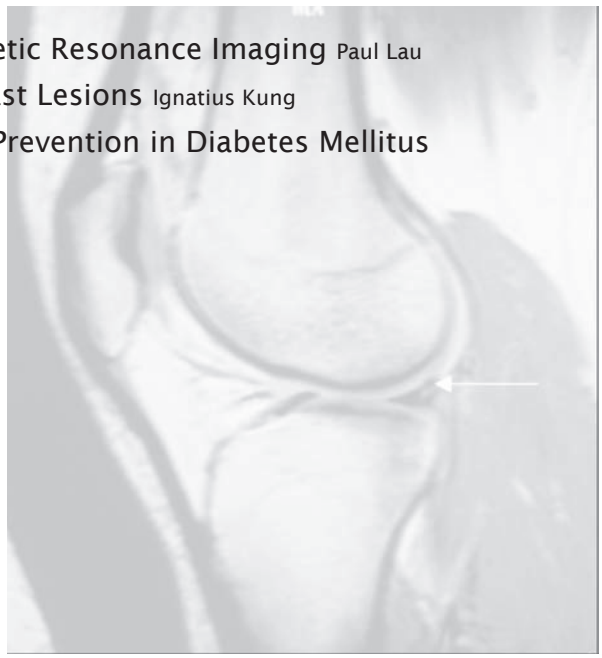
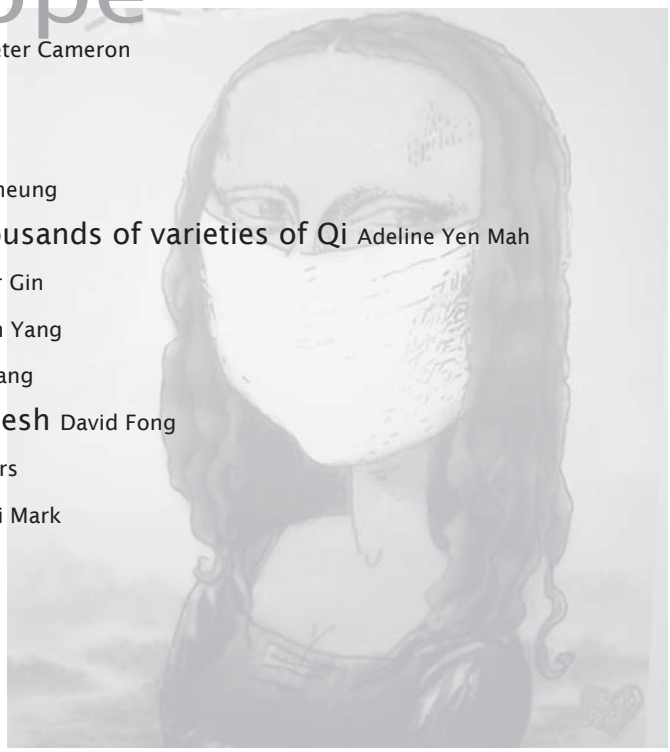
medical



kaleidoscope



editorial

In assuming the editor's mantle this year it seemed auspicious that my father, **Joseph Cheung**, had relinquished it just a decade ago. Qi in its infancy owed much to his energy and foresight; and by some rare felicity of events, the return of **Prof Y Lim** to these shores completes another cycle. It was he, of course, who provided the photo for the inaugural front cover, and fittingly has drawn on his collection to grace this year's edition.

Adrian Mar with whom I co-edited the previous three editions has continued to be supportive. He used to cast an eye at my baby- the *kaleidoscope* section- and remark that it would one day take over the magazine. Which has come to pass, at least for this year !

That ACMAV members be closely involved with this publication remains of the utmost importance. Medical articles have been selected for their relevance to Chinese health issues, and/or have been contributed by members. **Jun Yang** (who, as the ACMAV newsletter editor, wears two hats) has somehow found the time to do our journal review section which too has an Asian bias.

Mee Yoke Ling has been invaluable in soliciting some of the material for the official and medical sections, and we welcome **John Su** to the stable for his thoughtful work in photographing the committee members.

New to this edition is the website page, and the index to articles in Qi 1991-2002.

2003 is peculiarly seared in our memories because of the advent of SARS: its impact on Asia and on health professionals working there. Some of our members will know of doctors who succumbed to it. One of the first encounters with SARS as a new entity is recounted by **Peter Cameron**, who heads the emergency department at Hong Kong's Prince of Wales Hospital. Intrepid member **Khai Mark** visited China at the time of the outbreak and returned safely with photos.

Our guest writer is the distinguished Sydney paediatrician **John Yu**, well-known for his interest in the arts; and **Adeline Yen Mah**, the Chinese-born anaesthetist turned writer, has kindly allowed an abstract from one of her books to be reprinted, a discussion on the varieties of *qi*.

No Qi publication would seem complete without a contribution from **Trevor Gin**, whose adventures in Asia-Pacific have invariably been a highlight; he writes, in possibly his last article, of his trip to Kiribati. We are seriously thinking of sponsoring him on future trips- just to get another article.

I hope you will enjoy the glimpse that Qi provides of ACMAV activities and the many facets of its members who are the inspiration for this publication.

Deborah Cheung
Editor
deborahcheung@bigpond.com

Foreword

The Australian Chinese Medical Association of Victoria is one of the largest ethnically based medical associations in the state and can be proud of its efforts to improve the health and wellbeing of the community in general, and the Chinese community in particular.

The Australian Government's objective is to ensure everyone has access to affordable, high quality health services.

The Government will spend $35 billion on health this year, which is 18 per cent of the Federal Budget. An extra $2.4 billion has recently been added to strengthen and protect Medicare. The *MedicarePlus* package means more doctors and nurses, greater patient convenience, more opportunities for bulk billing, and a new safety net against big out-of-pocket, out-of-hospital medical expenses.

The community information seminars and publications organised by the association, mean that the Chinese community is better informed, more able to take control of its own health needs and more likely to benefit from the Australian healthcare system.

I congratulate the Chinese Medical Association of Victoria on another successful year.

Tony Abbott
Federal Minister for Health and Ageing

President's Report

What is the reason for the increasing numbers of patients seeking alternative therapies ? Has modern medicine separated itself from a part of the population whose needs are not met? Most patients only want a simple solution for their ailments. They want treatment with no harmful side effects. They want to be informed and most importantly they want to be involved in the healing process. Can we do anything to rectify the situation?

Some medicos have been vocal about alternative therapies. Statements like "unproven", "unsafe" and "why waste your money" are often heard. The medical profession is a caring one whose primary aim is to help patients to regain their health and "to do no harm" in the process. Sometimes conventional western treatment may not be the best for the patient's condition. If someone has a heart problem doctors have no hesitation in referring him to see a cardiologist for management. Similarly, alternative therapies should be included in the same referral base for the patients' benefit.

Doctors should have an enquiring and open mind. It is important to know what else is available for health and well-being. This may require contact with colleagues who have knowledge of Integrative Medicine. Nowadays alternative therapies are being taught in many world-wide institutions. More doctors are taking time to attend courses in alternative medicine. Once learnt they integrate this with their conventional treatment.

It will take time for doctors to change their attitude. For example it has taken over 30 years for mainstream medicine to accept that acupuncture has a valid place.

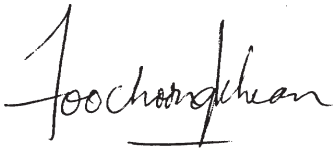
Other branches of alternative practice like meditation, hypnosis, herbal medicine, homoeopathy, dietary medicine and nutritional supplements have proven to be effective for many medical conditions. It is indeed very gratifying to note that Melbourne will be hosting the First World Congress of Chinese Medicine at the end of this year.

From the beginning of medicine, human beings were treated holistically. With the discovery of the germ theory, medical practice has moved towards finding "a germ for every ill". Over the past 50 years the human body has been relegated to a position of relative "insignificance". Doctors may lock horns with the disease while ignoring the patient. Sometime ago I read an article which stated, "The disease is cured but unfortunately the patient is dead". I hope we will not come to that stage in medicine.

The body is a marvellous creation which will heal itself if we provide it with all the nutrients it needs. We need to let the mind take charge of the healing process and allow the patient to control the situation. Healing takes place from within and not from without the body. Healing works through the "Mind, Body and Spirit".

I would like to make a plea to doctors. Please have an open mind. Listen to your patients with understanding and compassion. If you are unsure of the alternative methods please discuss the problem with other health practitioners. After all it is the patient's health we are interested in.

Finally I wish everyone a very rewarding experience in your healing career. May your healing hands touch many hearts and help all those who seek your care. May peace and happiness attend you always.



Choong Khean (Benny) Foo
ACMAV President 2003

Secretary's Report

2003 continues to be a busy year with our activities, starting with the Chinese New Year Yum Cha in February. We held 4 dinner education seminars, 4 update seminars and the Annual Conference at the Sofitel Hotel. The associated conference activities included a visit to the Melbourne Museum and the IMAX Theatre. New to this year was a session on a hypothetical case highlighting medical and legal issues encountered in Adolescent Medicine. Some of the seminars as well as the conference continue to attract CPD group 2 points. Overall the activities have been well attended and I thank all members for their support and participation. I would like to thank the numerous speakers who kindly donated their time.

This year saw a number of new activities. We had our first joint dinner seminar in May with the Vietnamese Australian Medical Association and anticipate 2 such meetings per year in the future. It is our aim to promote closer ties between the two organisations. There was also a weekend seminar organised on Careers in Medicine which was well attended by Hospital Medical Officers.

Our activities for the community continue to progress this year. Members have been contributing medical articles which are published weekly in the Melbourne Chinese Times and more are needed. The community project subcommittee has also organised numerous other activities. My gratitude to the volunteers, who have participated in our community projects.

This year the association represented by the President and the Vice President attended the joint ACCMA and ACMA (NSW) Annual Conference held in Canberra during Easter. ACMAV continues to promote closer ties with our sister organisations interstate and in New Zealand. It is our pleasure to announce that we will host the Joint ACCMA and ACMAV Conference in 2005 during the Queen's Birthday weekend.

Lastly, I would like to thank all our numerous sponsors who have kindly supported our activities. I would also like to express my gratitude to all the committee members in particular Benny, Kevin and Siew Keng for their support and assistance during the year. It is the support and commitment that has ensured the smooth running of the association.

Min Li Chong
ACMAV Secretary 2003

Community Services Report

In the past year the ACMAV Committee has initiated a number of successful community based projects. These activities are in keeping with the Association's vision for helping those in our community who may be disadvantaged, especially due to cultural or language reasons.

Every week a number of elderly Chinese citizens' groups meet for social events and classes. One of the largest is in Box Hill, and the ACMAV arranged for some of its members to provide health educational talks in Cantonese. This year's talks were given by Drs Alex Poon, Lawrence Wu and Yee Kar Chan, with help from the Chinese Health Foundation in translation of material.

The Melbourne Chinese Daily newspaper has been very supportive in enabling the ACMAV to contribute public health information. It has been encouraging to note the large number of members who have already had their articles published, including: Drs Alexander Poon, Boon Hong, Chee H Ng, Benny Foo, Frank Thien, Jun Yang, Khai Yuen Tang, Kong Wah Ng, Maggie Wong, Malcolm Clark, Min Li Chong, Newton Lee, Salena Ward and Siew Keng Chan.

The ACMAV was approached by the Buddha's Light International Association of Victoria to participate in its annual Multicultural Festival, held at Federation Square in May. The ACMAV booth was staffed by Drs Ng Seng Tarng, Helena Ng, Michelle Lui, Jenny Huynh, Cindy Lee-Wong, Jun Yang and Adrian Mar. Visitors were invited to have their BMI and blood pressure measured.

The Chinese Health Foundation (CHF) shares with the ACMAV the objective of promoting health issues within the local Chinese community, and both associations are now working more closely. Already the CHF has helped to provide translation for talks and publications, and the ACMAV has supported CHF promotions such as the "Breathe Easy Chinese Project". Dr Frank Thien has been involved with many of these developments and deserves praise and support for his ongoing efforts.

The ACMAV is currently involved with a number of other projects. The Royal Children's Hospital booklet on eczema management has been translated into Chinese by Drs Cindy Lee Wong and Tom Tsiang, and awaits printing. An anti-smoking information pamphlet has been published by the ACMAV in Chinese. "Project Vietnam" is a continuation of the marvellous work of committee member Dr Theong Ho Low to offer much needed healthcare to those in poverty-stricken provinces of Vietnam. Reusable acupuncture needles have already been donated to the Hospital of Traditional Medicine in Hanoi. Attempts have been made to assist a child with a tongue tumour needing further investigations and surgery. The ACMAV has also recently donated funds to the Austin Research Institute for research on the SARS virus.

Lastly, for the Christmas season, food hampers will be given to the Ascot Vale Chinese Hostel and Nunawading Chinese Hostel to assist them with their fundraising. Dr Jenny Huynh has been actively involved in these projects over the past two years and is thanked for her contribution towards their success.

The last few years have been important for the ACMAV as we have taken on a new direction in our commitment towards community based activities. This has been largely due to the leadership of our President, Dr Benny Foo, whose enthusiasm and compassion has been both a driving force and inspiration to those on the Committee. I am sure that the path already laid by Benny will take the ACMAV into the future as it continues in these very worthwhile endeavours.

Dr Adrian Mar
Chairman, Community Services Subcommittee

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ACMAV Committee 2003

Dr Choong Khean Foo (Benny)

MBBS MAppSci FAMAC

MCGP MASH

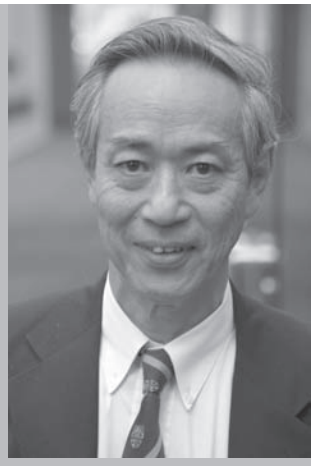
PRESIDENT

Choong Khean Foo (Benny) is a holistic practitioner. He graduated from Melbourne Uni(1960). Whilst working as a GP in Singapore he was the Foundation Secretary of the Singapore College of General Practice and served as a Censor also. When he returned to Melbourne in 1977, he incorporated western medicine into his whole-health practice with acupuncture, nutritional and environmental medicine, hypnosis, meditation, manipulative medicine, homoeopathy, bioenergy medicine, qigong therapy, Chinese & western herbal medicine. He is one of the first graduates in Master of Applied Science (medical acupuncture) at RMIT and is involved in the teaching programs of the Aust Academy of Holistic Medicine and the Acup. Foundation of Aust.

Mr Kevin Siu

MBBS FRACS

VICE-PRESIDENT



Kevin Siu was head of neurosurgery at the Alfred Hospital from 1988 to 2000. His present part-time appointment at the Royal Melbourne Hospital keeps him quite occupied as does his private practice. He was in the inaugural ACMAV committee of 1985 as secretary, and also served as president in 1988.

Dr Min Li Chong

MBBS FRACGP FAMAS

SECRETARY

Min Li Chong is a general practitioner in West Heidelberg with a special interest in medical acupuncture and neonatal paediatrics. She regularly moonlights as a sessional registrar with the Newborn Emergency Transport Service. She aspires to travel to all parts of the world to learn their history and culture.

Dr Siew Keng Chan

MBBS FRACGP DipObs

TREASURER

Siew Keng Chan has been a member of the ACMAV since 1990 and a life member since 1997. She works full-time in her father's general practice in Altona.

Photos taken by John Su at the ACMAV conference, 2003

Dr Maggie Wong
MBBS FANZCA

Maggie Wong is an anaesthetist who works mainly in the public sector with appointments at St Vincent's Hospital and the Royal Women's Hospital. In addition to clinical anaesthesia, she has an interest in medical education and medical ethics. Recently, she has completed a Masters of Health Ethics with the University of Melbourne.

Dr Salena Ward
MBBS

Salena Ward is doing 1st year BST (basic surgical training). Her current rotation is 6 months anatomy tutoring at University of Melbourne primarily to 1st and 2nd year medical students, but in addition she is working part-time at Royal Melbourne Hospital and part-time as a surgical assistant. Salena completed a Diploma of Anatomy in June 2003 at Uni of Melb, and will be sitting the BST exam 2004.

Dr Adrian Mar
MBBS FACD

Dr Adrian Mar is a consultant dermatologist currently practising in Footscray, Brunswick and Williamstown, and is a visiting medical officer at the Alfred Hospital and Monash Medical Centre. He enjoys teaching medical students, registrars, GP's … and anyone else willing to learn more about skin care. He is on the editorial board of Qi and the chairman of the ACMAV Community Services Subcommittee.

Dr Mee Yoke Ling
MBBS FRACGP MPH

Mee Yoke moved from Adelaide to Melbourne at the start of 2001 to work as a lecturer in the Department of General Practice, Monash University. In addition, she works several sessions a week at Brighton Family and Women's Clinic. Her interests include mental health in general practice and medical education.

Dr Theong Ho Low
MBBS

Theong Ho is a GP and works in Flemington.

Dr Jenny Huynh
MBBS

Jenny Huynh is a 2nd year resident at the Western General Hospital, after completing her clinical years and internship at the Royal Melbourne Hospital. She will be undertaking physician training next year at Austin and Repatriation Medical Centre, and has an interest in endocrinology and maternal medicine. Jenny has been a member of ACMAV since 2000, and is particularly interested in the compassionate projects for the underprivileged. She has a special interest in music and teaches piano in her spare time.

Dr David Lam
MBBS

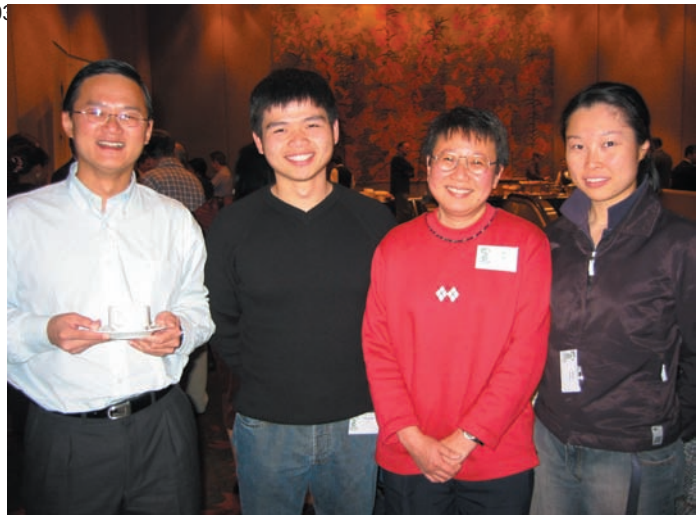
David Lam is an HMO at Monash Medical Centre currently training in anaesthesia.
He graduated in 2000 (Melb).
His work on ACMAV committee has included maintaining the ACMAV website; IT; manning the registration desk.

Dr Frank Thien
MD FRACP
FCCP

Frank Thien is a physician in respiratory medicine and allergy, and clinical associate professor of medicine at Monash University. He practises and teaches at the Alfred and Box Hill Hospitals and is in private practice at Box Hill.

Conference snapshots

Clockwise from top left (L to R): committee members Min Li Chong, Adrian Mar, Kevin Siu, Siew Keng Chan and Salena Ward; an attentive audience at Hotel Sofitel; eagerly digging into lunch; part of the organising committee - well done for your hard work; the young ones with Helena Ng, Samar Ojaimi, Looi Fen Ng, Alice Huang and Pam Yin; Pei Yu Chu, Louisa, Kirk Kee and Salena Ward at the conference dinner at Shark Fin House; a bright bunch - Helen Kuay, Helena Ng and Helen Ng.



Clockwise from top left (L to R): Hypothetical Panel with Prof Doris Young, Gary Eastaugh, Maggie Wong, Paul Komersaraff, Bob Milstein; Eng Tan, Cheng Hean Lo, Jean Low and Elaine Chong; Cao Ze Ming (an overseas doctor) with Joseph Cheung; Robert Padanyi and Peijian Zeng, Richard Hing; Benny Foo, Victor Kuay and Kenneth Wong enjoying lunch; Interstate visitors from Queensland, Katherine Bau and Lock Seng Wong; Kenneth Wong and David Chong having a laugh; Ted Mah, ACMA SA president with his fiancee Jane Zhang; Mee Yoke Ling with Han Mei Pan (another overseas doctor).

ACMAV Calendar of Activities 2003

Chinese New Year Yum Cha
Date: Saturday 15th February
Venue: Fu Long restaurant, Box Hill

Seminar 1 - Symposium on Breast Cancer
Date: Wednesday 26th March
Venue: Shark Fin House, Melbourne
Moderator: Dr Khai Yuen Tang
Panel: Miss Meron Pitcher; Dr Rick de Boer; Dr Michael Chao; Dr Ignatius Kung; Dr Donald Leung

Update Seminar - Nutritional Medicine
Date: Thursday 1st May
Venue: ACMA House
Speaker: Dr CK (Benny) Foo

Forum on Careers in Medicine
Date: Sat/Sun 3rd-4th May
Venue: ACMA House

Seminar 2
Date: Friday 30th May
Venue: King Bo Restaurant, Melbourne
Speakers: Dr Bernard Yan **Stroke Prevention**
Dr Paul Lau **MRI & Applications**

Forum on Medical Indemnity
Date: Thursday 5th June
Venue: Okra restaurant, Hawthorn East
Speaker: Dr Paul Nisselle

Update Seminar - The New Frontier in Pathology, Molecular Biology & Immunology
Date: Sunday 29th June
Venue: Chine on Paramount restaurant, Melbourne
Speakers: Dr David Beam **Recent Trends in Chemical Pathology**
Dr Keith Byron **Molecular Biology**
Prof Ban Hock Toh & Dr Pollard **Immunology**

ACMAV Calendar of Activities 2003

Seminar 3
Date: Wednesday 23rd July
Venue: Choi's restaurant, Hawthorn
Speakers: Dr Mario De Luise **New Insulin, New Gadgets**
Prof Jennie Brand-Miller **GI Factor: An Asian Perspective**

Update Seminar - Practical Skin Procedures
Date: Saturday 16th August
Venue: ACMA House
Speaker: Dr Adrian Mar

Seminar 4
Date: Wednesday 10th September
Venue: Chine on Paramount restaurant, Melbourne
Speakers: Dr Kevin Foo & Dr Alex Poon **Dry and Watery Eyes**

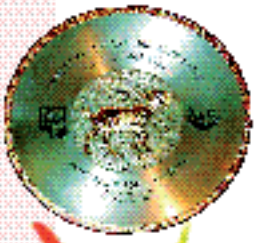
ACMAV Conference 2003
Date: Sunday 19th October
Venue: Sofitel Hotel, Melbourne
Conference Dinner
Date: Sunday 19th October
Venue: Shark Fin House
Conference Associated Activities
Date: Saturday 18th October
Venue: Imax & Melbourne Museum

ACMAV tennis tournament
Date: Sunday 9th November
Venue: National Tennis Centre

Annual General Meeting
Date: Thursday 20th November
Venue: King Bo restaurant
Speaker: Prof Steven Aung **Multi-dimensional Medicine for the 21st century: integrating the Eastern and Western approach**

鱼翅先生集团
SHARK FIN GROUP

The Award Winning Chinese Restaurants



Asian food FESTIVAL

2003 Asian Food Festival

The General Managers of the Shark Fin Group from left to right: Patrick LUI (Shark Fin Burwood), Gabriel CHAN (Shark Fin House), Chris ON (Shark Fin Keysborough), Vanessa LAU (Shark Fin Inn).

Seafood Category - GOLD
中餐海鮮類金獎
[illegible]

Hennessy Cognac Yum Cha Award - GOLD
軒尼詩干邑點心類金獎
[illegible]

Hennessy Cognac Yum Cha Award
SILVER & BRONZE
軒尼詩干邑點心類銀及銅獎

Meat / Poultry Category - SILVER
中餐肉／家禽類銀獎
[illegible]

Seafood Category - SILVER
中餐海鮮類銀獎
[illegible]

Vegetable Category - SILVER
中餐素食類銀獎
[illegible]

Shark Fin House
Chinatown - City
131-135 Lt. Bourke St
Melbourne 3000
Ph: 9663 1555

Shark Fin Inn
Chinatown - City
50-52 Lt. Bourke St
Melbourne 3000
Ph: 9662 2661 / 9662 2552

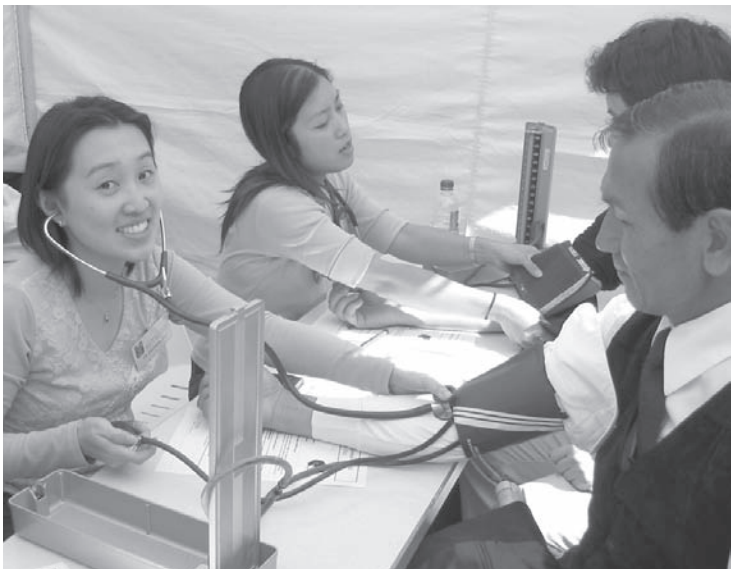
Shark Fin
Keysborough
326 Cheltenham Rd
Keysborough 3173
Ph: 9796 6766

Shark Fin
Burwood
151 Burwood Hwy
Burwood East 3151
Ph: 9666 5777

Shark Fin
Crown Casino
Crown's Foodcourt
Ph: 9645 6066

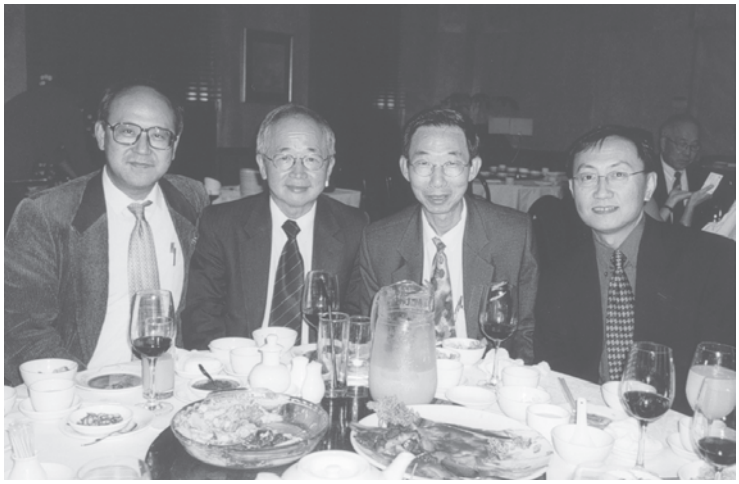
www.sharkfin.com.au

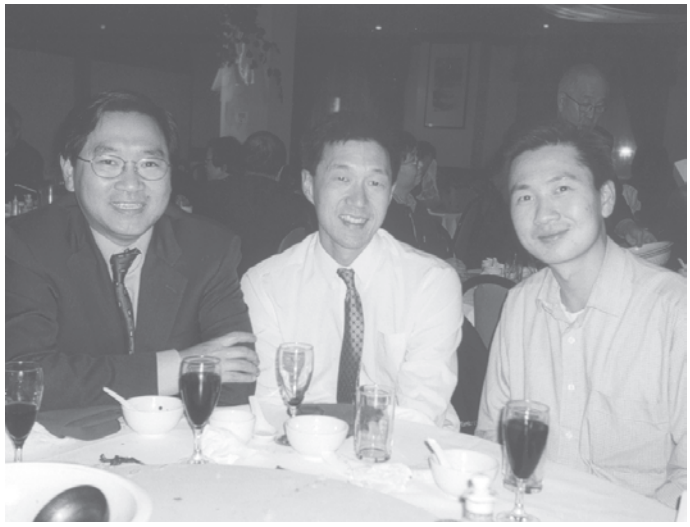
Anticlockwise from above, L to R: Jun Yang and Salena Ward; Meron Pitcher, Rick de Boer, Michael Chao, Donald Leung and Ignatius Kung on the panel for breast cancer symposium; Seng Tarng and Helen Ng; Paul Nisselle and Kevin Siu; ACMAV House secretary Isabel Ho with husband Edmond and son Marcus; Michelle Lui and Jenny Huynh manning the ACMAV booth on Buddha's Day; Nicole Yap, James Khong, ACMAV president Benny Foo with wife Pauline

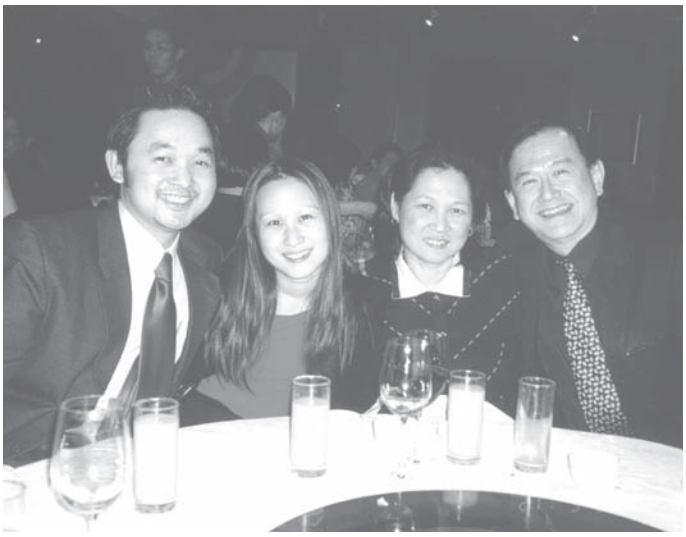


Anticlockwise from above, L to R : Mee Yoke Ling and David Lam; Diana Chew and Pauline Foo; Irmgard Chia and Dale Julien; Maggie Wong, Michael and Philomena Yii; Tony Yap and David Lim; Adeline and Ken Wong; ACMAV ex-presidents Richard Hing and James Khong

Facing page, anticlockwise from top left:(back) Elizabeth Chow, Ken Chuah, Linda Chow (front) Julie Ch'ng, Tony Tan and Janice Thean, Leong Goh ;Maggie Wong and Karen Lee; Frederick Cheung, Peter Wong, Boon Hong and Ken Wong;Ewa Tuszynski, Helen and Victor Kuay, Steven Cheng and Yong Wong; Erwin Loh and May Lum, with her parents Hoon and Lawrence Lum; Michael Yii, James Wong, Bernard Yeoh; ACMAV ex-presidents Happy Tang, John Chew and David Chong; Jocelyn and Michael Chong, Jean Low.





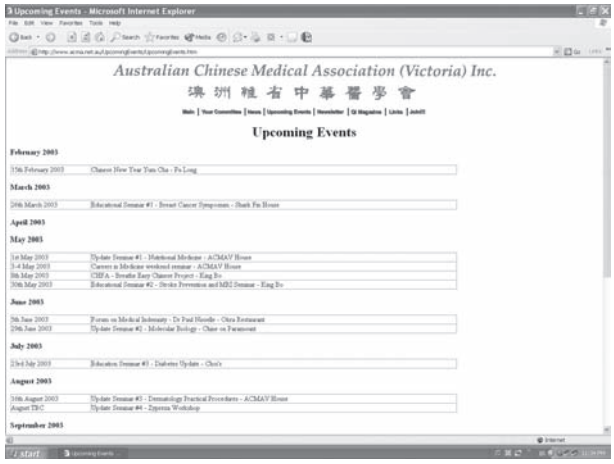


www.acma.net.au

The ACMAV website was created in 2002 by Dr Ian Chau to put our organisation on the internet in line with many other modern organisations. Since then, www.acma.net.au has been continually updated to provide our members with the latest news and upcoming events, as well as a place to download application forms and conference programmes.

Members can also access the website to contact the committee with any comments or recommendations. A list of email addresses are provided. For example, members are encouraged to:

- Give feedback on the various seminars or venues
- Suggest educational topics they would like presented
- Suggestions for the annual conference or socialevents
- Suggest ways in which ACMAV can benefit the Chinese community
- Let me know what you would like to see on the website
- Use the website as a means to recruit your colleagues to join



Several of the documents on the website are presented as Adobe Acrobat (PDF) files. For those who do not yet have Acrobat reader on their computers, you get can it either from the link on the website, or directly from www.adobe.com (it's free).

In 2003, the website has kindly been hosted by Dr Matthew Leong, surgical resident at Austin Hospital.

Future plans for www.acma.net.au include:

- Updating the Qi Magazine and newsletter archives
- Provide a means for members to:
  - Update membership details
  - RSVP to seminars
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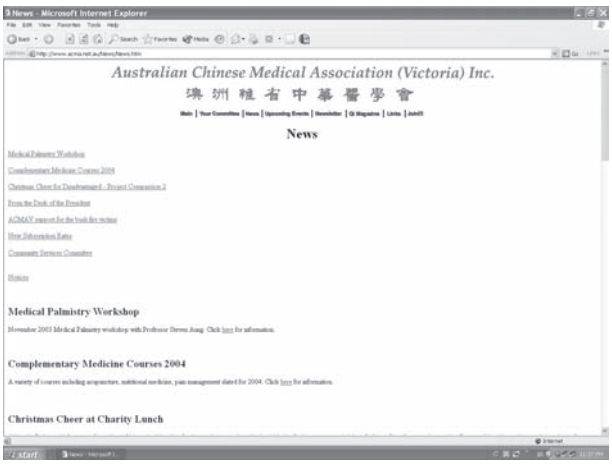

David Lam

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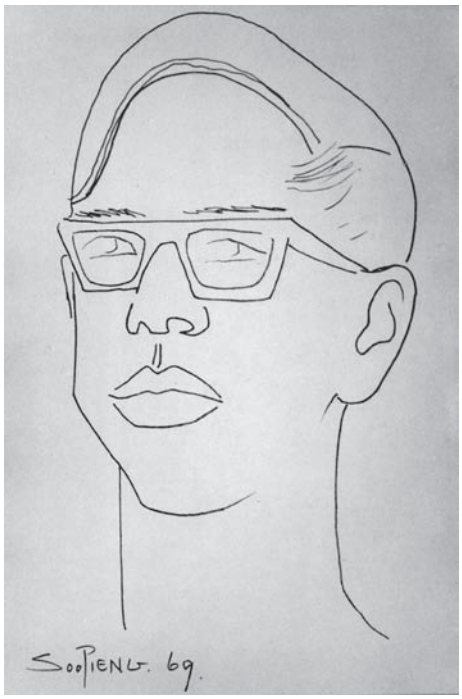


drawing of Prof Lim by one of Singapore's most famous artists, Soo Pieng

He has been described as a 'Renaissance' man; an eminent cardiologist with a passion for photography and the arts. His pioneering work in setting up numerous coronary intervention centres throughout China earned him the Order of Australia in 1997. The life of Prof Yean Leng Lim is extraordinary for its achievements, and his return from Singapore this year to oversee cardiovascular therapeutics at the Western/Uni of Melbourne has been widely welcomed.

Born 19th January 1948 in Singapore, he turned from architecture as a career choice to medicine after his father (a bank manager) died of liver cancer at 43. Polio in his childhood meant he spent more time in the arts than on the field. At 13, he was the youngest graduate of the Nanyang Academy of Fine Arts in oils and (western) water colours, whilst a full-time student at Catholic High.

Through a scholarship he came to Australia to study medicine and graduated from Monash Uni with the degrees of BmedSc (1970), MBBS (1972) and PhD (1977), the latter in postgraduate work in obstetrics and gynaecology.

He won several scholarships in his undergraduate years and trained at the Alfred hospital for his FRACP (1980).

Further scholarships took him to the Cardiac Unit at Harvard Uni, Massachusetts Gen Hospital, and he was to return to Melbourne to head a medical unit at the Alfred, and later, cardiology posts at the Box Hill and Epworth hospitals.

From painting he turned to photography, and by holding exhibitions of his work, he raised funds for the Epworth Medical Foundation. The plan ? To provide training in Australia for Chinese cardiac physicians and surgeons. Since 1986 he has been instrumental in the establishment of 13 coronary intervention centres in China, making many teaching visits in the process. He founded the Medical College of Xiamen Uni and was the inaugural Dean, and continues to serve as visiting professor to a dozen Chinese medical schools.

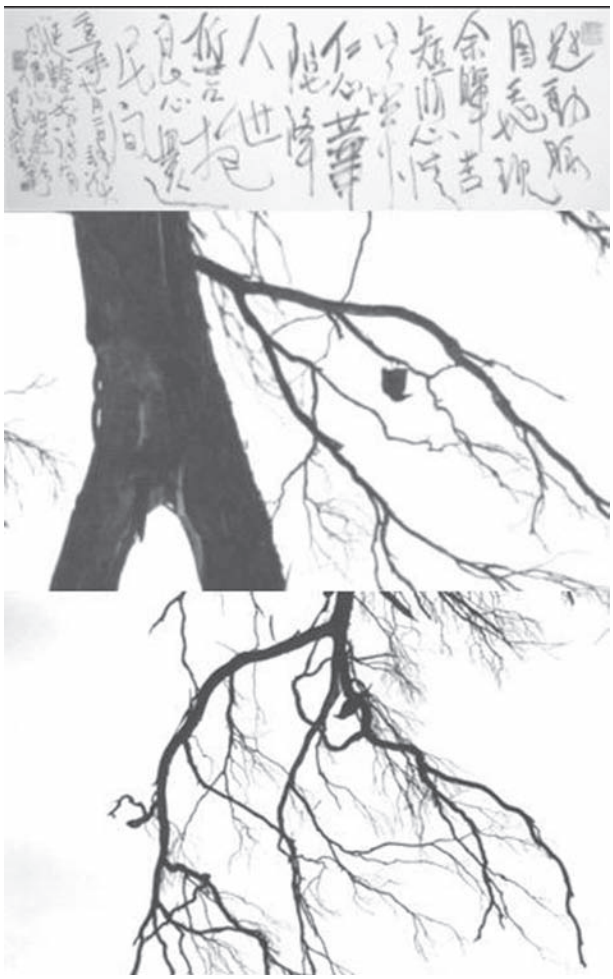
He was awarded the inaugural Monash Uni Distinguished Alumni Award in 1993, and Honorary Professor of Medicine at Monash (1994).

He returned to Singapore in 1998 to be director of its National Heart Centre and his numerous positions included that of Deputy Chair of the task force on TCM (Traditional Chinese Medicine).

Prof Lim was also, notably, Chairman of the Nanyang Academy of Fine Arts in Singapore. His passion for the arts has continued unabated, and

in 1995 he published 'Eastern Eye, Western Light', a collection of his photographic works and Chinese calligraphy, accompanied by poems in English and biblical verses. This was recognised the following year by his acceptance into the Royal Photographic Society of London as Associate Fellow. He now has a second collection of works to be published as 'Through the windows of my heart'.

A committed Christian, he has been particularly involved with the Chinese community in Melbourne through church and music. He taught bible classes and chaired the Chinese Christian Church. As choir master (bass baritone) previously for Chinese churches both here and in Boston, he went on to become foundation president of the Melbourne Chinese Sacred Music Association.



On behalf of ACMA he organised for the late Victor Chang to speak at dinner seminars and was previously on the committee.

He is married to a Chinese-born Taiwanese and has a son studying medicine in Australia.

The whole of his life, according to Prof Lim, **can be summed up by the poem and photo at left** (as featured on the covers).

The pictures are of a bird perched amongst tree branches, and when inverted, as shown, bear a striking resemblance to the coronary angiograms which are part of his daily work. The LAD and other coronary arteries are 'displayed' in the top photo, and similarly in the bottom one, when the angiogram is rotated through 90 degrees. The bird represents the arterial aneurysm.

Lin Siang Siong, a well-known artist in Singapore, wrote the poem dedicated to Prof Lim, which may be translated as follows:

Presenting the Coronary painting to the world
At the twilight of a life, so brief,
Like the benevolent Hua T'o, born to earth*
Vowing to return to common folk, goodness not grief

Acknowledgements:
Faces and Places, vol II, 1999, Ed. Bernard Gilligan; Heritage Committee, Alfred hospital

Deborah Cheung, with Tom Tsiang & Kevin Siu

* Hua T'o, China's first surgeon

ACMAV Tennis Tournament 2003

The tenth annual tennis tournament was held at the National Tennis Centre on Sunday 9th November. Owing to the uncertainties of weather, it was held indoors.

The tournament was played on a doubles format, with interchangeable partners in a round-robin fashion.

I would like to thank Mayne Health for their sponsorship.

The champion doubles pair : Yu Long Leow
Trevor Lau-Gooey

The runner-up doubles pair : Douglas Gin
Cheng Lo

David Chong

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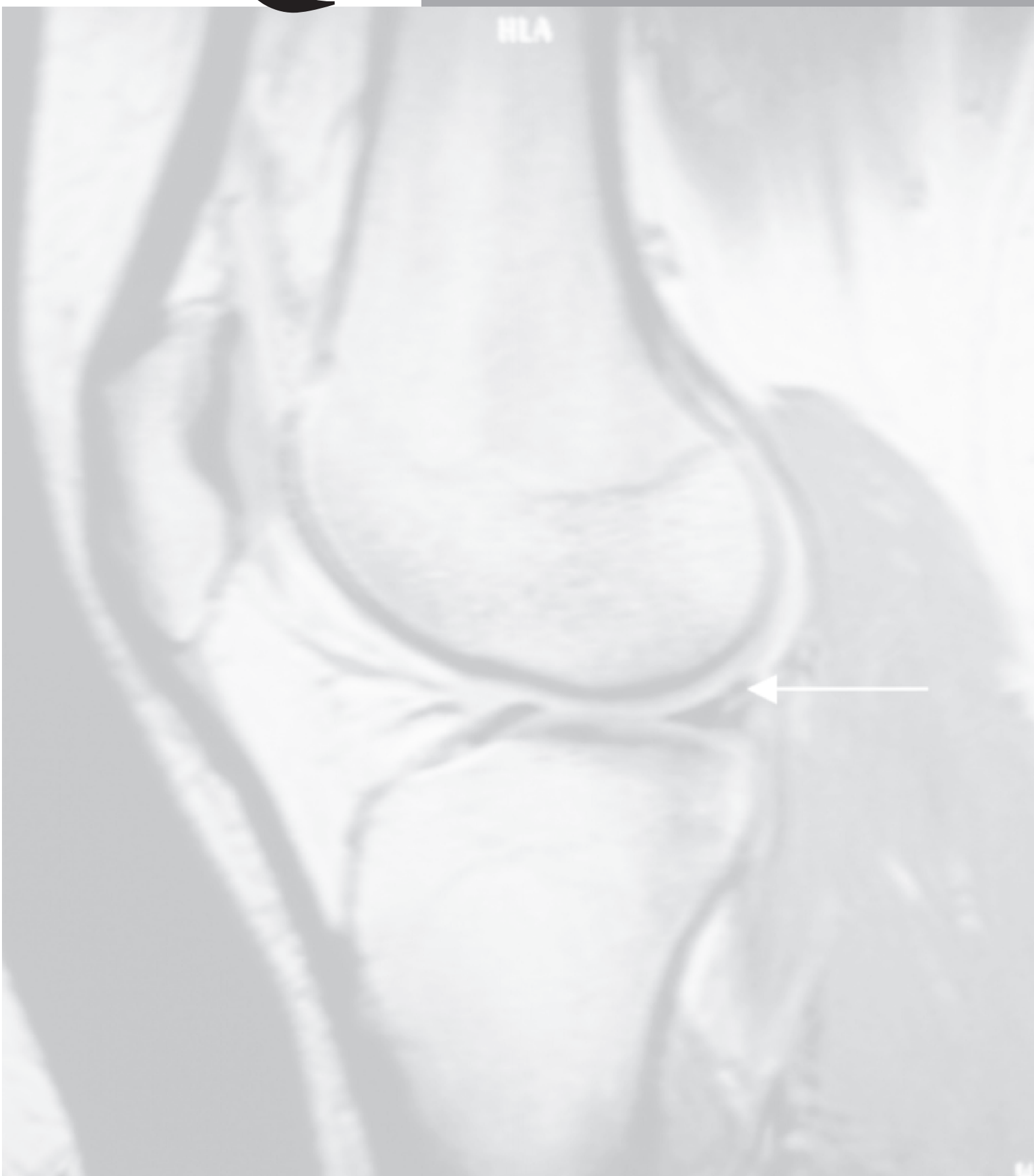


Current Applications of Magnetic Resonance Imaging (MRI)

Paul Lau FRANZCR

Introduction

Magnetic resonance imaging (MRI) has truly established itself as one of the important diagnostic tools in modern medicine. However, its use has been somewhat limited due to availability and the cost involved.

This article aims to provide a general introduction to this modality with illustrations to highlight some of its application in day-to-day medical practice.

Simple overview of the MRI examination

1. Patient is placed inside the magnet.
2. A radiowave is then switched on and then off.
3. Patient emits a signal.
4. This is received and used for reconstruction of images.

Pros

1. Multiplanar imaging
2. No radiation
3. Superb soft tissue contrast and definition
4. Alternative when patient is allergic to/ unable to have iodine contrast

Cons

1. Relatively longer acquisition time.
2. Motion artefact.
3. Claustrophobic patient.

Contraindications

1. Cardiac pacemakers
2. Intracranial aneurysmal clip
3. Cochlear implants
4. Recent arterial or venous stents
5. Marked obesity – weight and girth limit
6. Intra-ocular foreign body (iofb)

Sequences

1. T1 weighted – pre/post gadolinium.
2. T2 weighted.
3. Others – proton density (pd), flair, stir, gradient echo, fat saturation, diffusion.

Strength of magnet

- The higher the better
- 1.5 tesla is the highest strength in normal clinical practice in victoria

Billing issues

- Funded vs unfunded magnet
- Funded magnet - can bill medicare directly; however, need referrals from specialists.
- Unfunded magnet - patients pay for the whole cost; general practitioners / specialists can refer

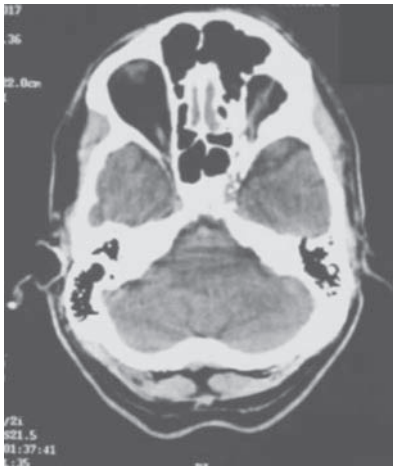
Indications for MRI

(Page 8 of "Imaging Guidelines")

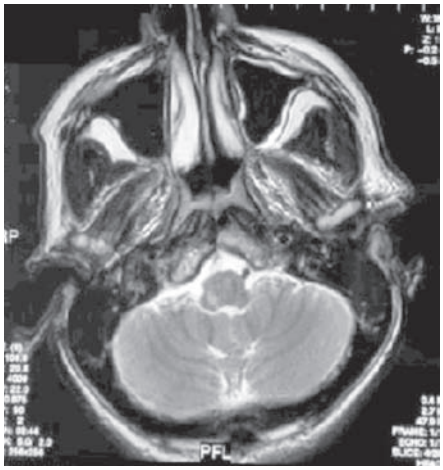
Dr Paul Lau is a partner radiologist at FMIG and visiting radiologist at Western Hospital

Case illustrations:

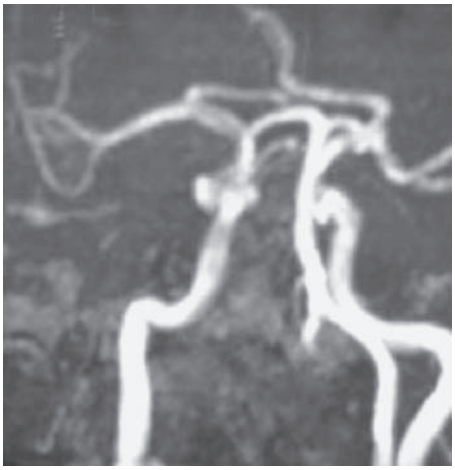
Case 1: *Lateral medullary syndrome*



Normal CT head

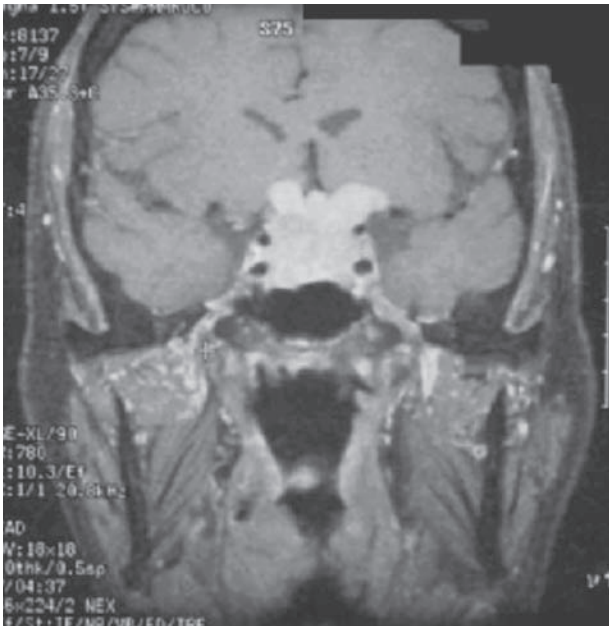


axial t2 image demonstrates increased signal area of the right lateral medulla



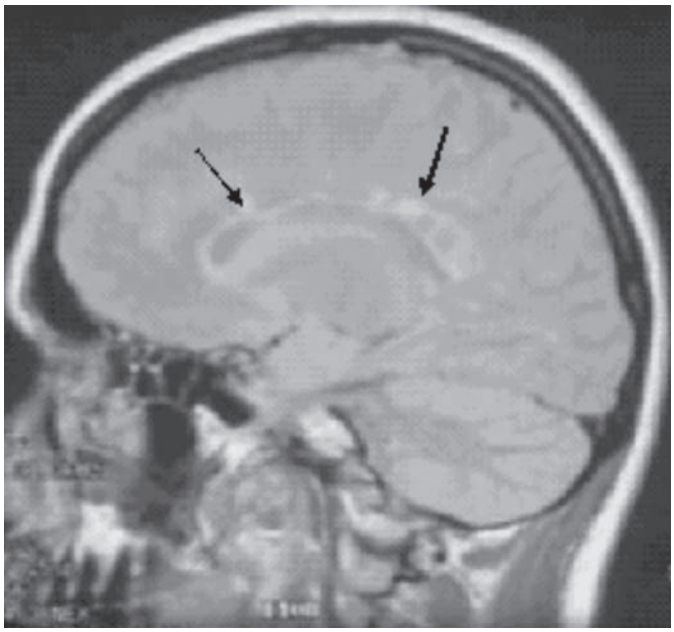
MRA shows occluded distal right vertebral artery

Case 2: *Pituitary macro-adenoma*



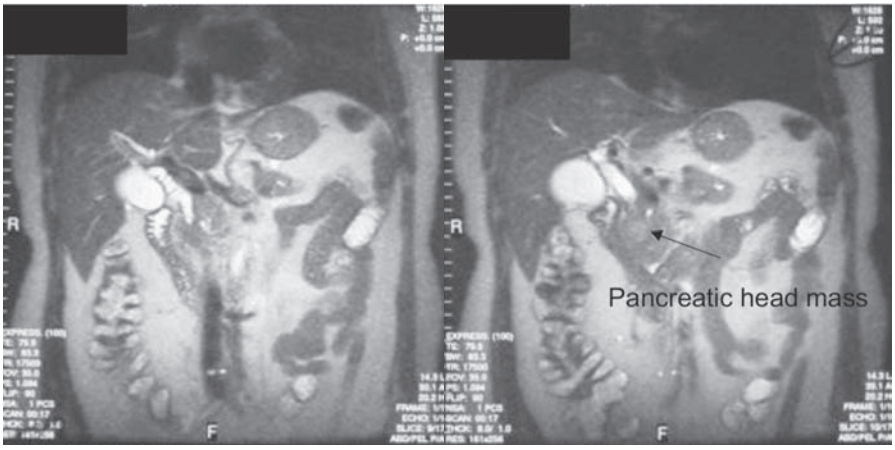
Post gadolinium image demonstrates a uniformly enhancing pituitary macro-adenoma extending to the adjacent internal carotid arteries and exerting mass effect to the cerebral gyri.

Case 3 : *Multiple sclerosis*



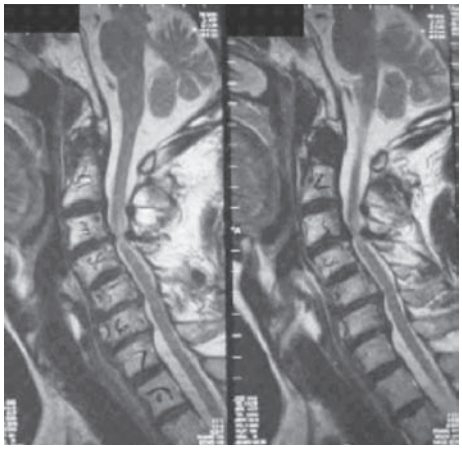
Sagittal view shows high PD signal areas (Dawson's fingers) at the calloso-septal interface- typical location for MS plaques

Case 4: *MRCP - pancreatic carcinoma*



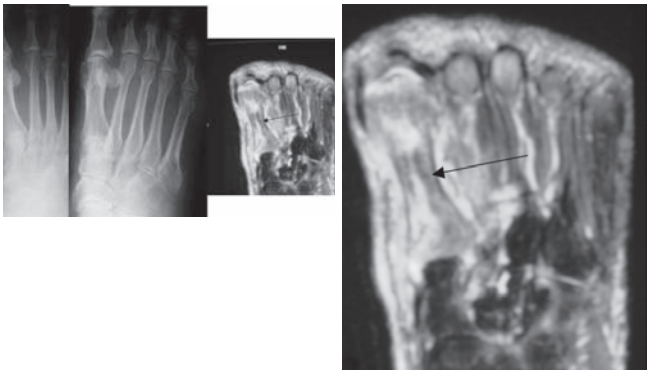
Coronal t2 images demonstrate dilatation of the common bile duct secondary to a slightly high t2 signal mass at the pancreatic head region

Case 5: *Cervical myelopathy*



Sagittal t2 images of the cervical spine demonstrate cervical cord compression at C3/4 level by disc/osteophyte complex with high T2 signal change of the cord at the C3/4 level, consistent with myelopathy

Case 6: *Stress fracture 1st metatarsal bone*

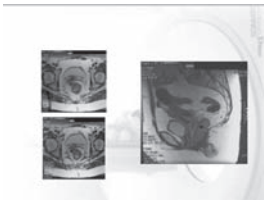


Normal X ray but abnormal findings on MRI examination

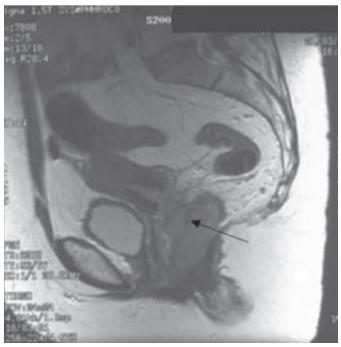
Plain films of the right foot show no fracture or abnormal periosteal reaction.

Axial stir image demonstrates serpiginous low signal lines within the right first metatarsal bone consistent with stress fracture. Reactive changes of the adjacent soft tissues are also noted

Case 7: *Rectal carcinoma with local spread*

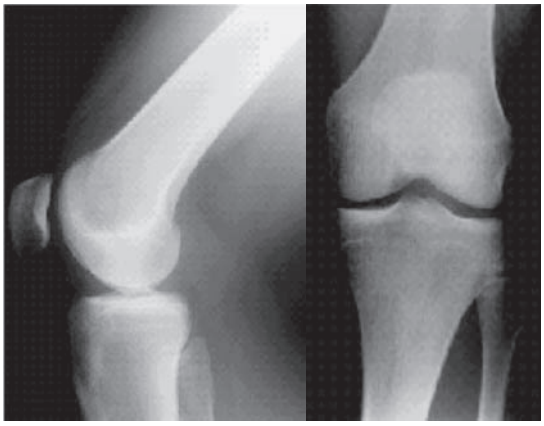


Coronal and sagittal t2 images demonstrate irregular rectal wall thickening with a right anterior nodule (see arrows) extending to the posterior wall of the vagina

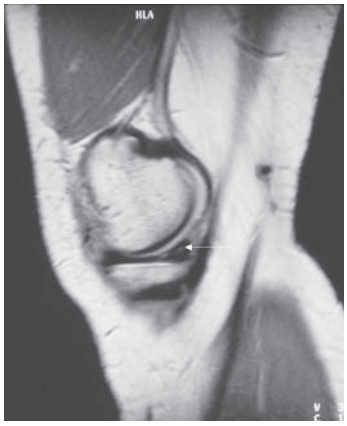


1. Central nervous system/spine: Stroke, demyelination, posterior fossa lesions, sellar or parasellar lesions, meningeal disease, acoustic neuroma, cord compression, MRA
2. Head and neck: Tumour staging
3. Musculo-skeletal system: Internal joint derangement, musculotendinous injury, avascular necrosis, occult fracture, post-op spine
4. Chest
5. Abdomen: MRCP, renal artery stenosis
6. Pelvis: Tumour staging of colorectal, urological and gynaecological malignancy, and rectal fistula

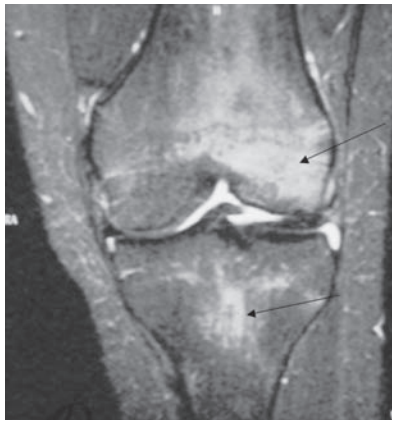
Case 7: *Sports injury - normal knee X ray but multiple findings on MRI*



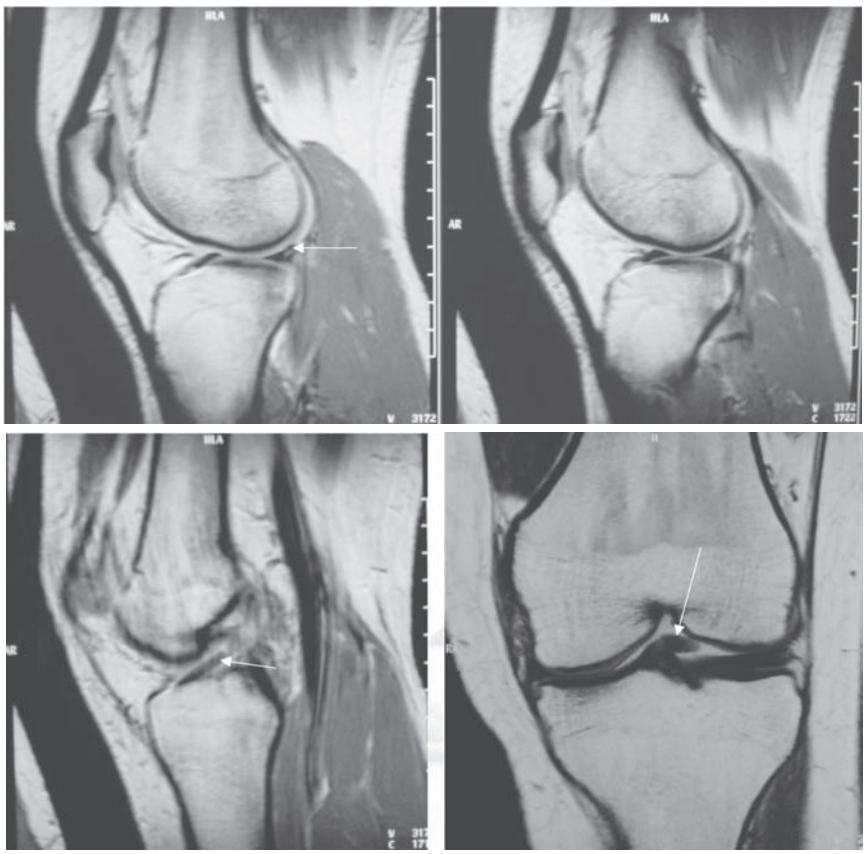
Normal X ray of the knee



Sagittal PD image demonstrates an horizontal tear of the posterior horn of the lateral meniscus



Coronal stir image shows extensive areas of bone bruising of the lateral femoral condyle and proximal shaft of the tibia



Left: Sagittal PD images demonstrate an horizontal tear of the posterior horn of the medial meniscus

Below Left: Coronal and sagittal PD images demonstrate complete rupture of the anterior cruciate ligament close to its femoral attachment with the proximal end now lying within the inter-condylar region

7. Breast: Tumour, implant

Other applications

1. Cardiac MRI
2. Fetal MRI
3. MR spectroscopy

Conclusion

MRI has no doubt been proven to be an excellent diagnostic tool, particularly in the area of neurology and musculo-skeletal system. It has not reached its full potential and with higher field strength magnet and improved computer power, the image quality will be better and the examination time will be shorter. Ultimately, the patients will find this examination much more tolerable.

References

1. MRI made easy, Prof. Hans Schild, Schering

Fine Needle Aspiration of Breast Lesions

Ignatius Kung

Not too long ago, because of the possibility of cancer, it has been the practice to excise all breast masses particularly those in older women. Most of these lesions were benign and thus many women were subjected to unnecessary surgery. This also meant that surgery had a high false positive rate.

With the advent of fine needle aspiration (FNA) technique and with increasing experience among clinicians in the performance of the procedure and pathologists in the interpretation of the cells, FNA becomes an integral part in the investigation of breast masses. Of course, nowadays, with the common use of mammography, FNA is also applied to nonpalpable mammographic abnormalities for the detection of cancer in screening programs. FNA is also useful in the evaluation of recurrence and metastasis of breast cancer.

Indications, contraindications and complications

Essentially the indication of FNA is to provide an answer to whether the breast lump is benign or malignant. There are in practice no contraindications. The only possible one is severe bleeding disorder which may lead to the formation of a haematoma. Minor bleeding is in fact the commonest complication. Haematoma is most common when the lesion is cancer. This can often be minimized if local pressure is applied to the area after aspiration. The other complication worth considering is pneumothorax. This most often occurs in thin patients with deep seated lesions in small breasts. This can be avoided by resting the lesion on a rib so that the needle will be arrested by the rib and will not slip into the thoracic cavity. Needling the lesion tangentially to the chest is also a good way to avoid pneumothorax. As in aspiration of other sites, seeding of malignant cells along the needle tract is extremely rare.

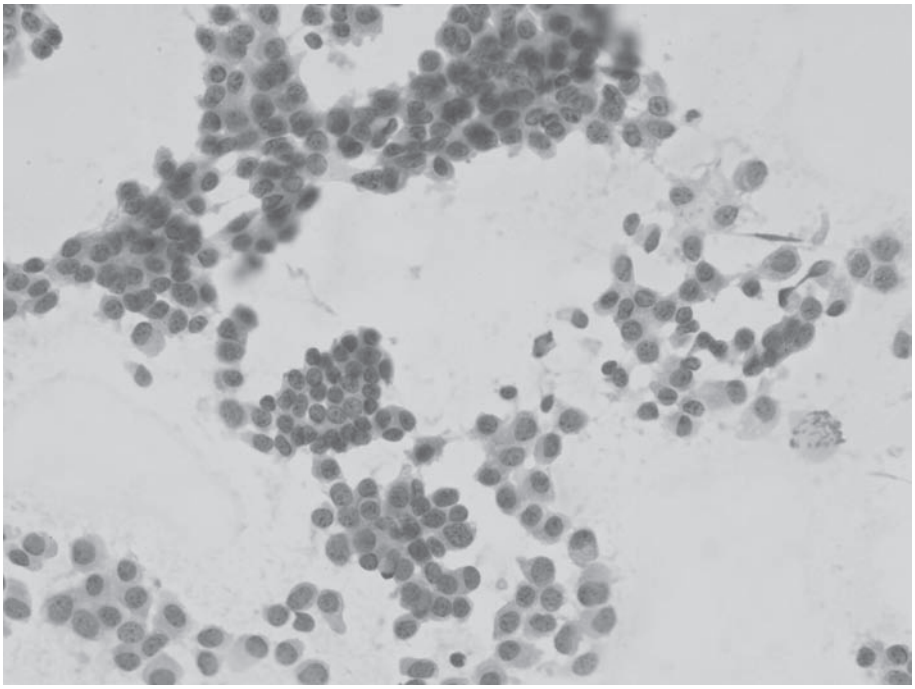
As local tissue injury such as oedema and haematoma can interfere with mammography or ultrasonography for up to a month, a question may arise as to which procedure should be performed first: mammography or FNA? In general, if the lesion is easily palpable and well defined, performing FNA first may be appropriate, allowing immediate morphological diagnosis and planning of further management. However, if the breast is diffusely nodular or the lesion is poorly defined, it may be advisable to do mammography first, followed by image guided biopsy.

Technique

The size of the needle used varies from gauge 21-23. Gauge 23 is the most popular. In very fibrotic lesions, such as schirrous carcinoma or dense fibrosis, a smaller needle (gauge 25) may paradoxically increase the yield of the aspirate. The needle can be used with or without the syringe. The author's recommendation is that if the lesion is likely to be cystic, a syringe attached to the needle provides a vessel to collect the fluid and will save the operator the embarrassment of fluid spillage on the patient and loss of the material for cytological examination. If the lesion is small and solid, using the needle without the syringe allows a better feel of the relationship between the needle and the lesion.

Whether there is a syringe or not, the most important factor in ensuring getting a good sample is to stab the lesion at the same spot as quickly as one can go, and then sampling different areas of the lesion at the same pass. The application of suction is not important in obtaining tissue; it will only draw blood which is in fact a contaminant.

The accuracy of FNA technique increases with the number of passes. Two to three passes will usually



yield a diagnosis. There is no advantage in performing more than four passes as little additional information is gained.

The aspirated tissue should then be squirted onto a glass slide and a smear made. Some laboratories prefer air dried smears while others spray fixed with alcohol. If in doubt, the smears can be left air dried and the laboratory can rehydrate them with saline, provided that the smears reach the laboratory in a few hours. If the smears are to be alcohol fixed, they should be sprayed as soon as possible; any air drying will introduce artifact, making interpretation difficult and the test may be ruined.

If a cyst is aspirated, the cystic fluid can be sent in a small container with or without preservative. The laboratory will centrifuge the fluid to harvest the cells.

Accuracy and limitations

In general, the sensitivity and specificity of FNA is above 90%. There is a false negative rate of about 5%. Most false negative results are due to sampling errors. In good hands, interpretation errors are rare. Compared to core tissue biopsy, FNA is slightly more sensitive in picking up malignancies, but the core biopsy is slightly more specific in the typing of the tumour. It is also worth noting that while FNA is very reliable in distinguishing between benign and malignant breast diseases, specific diagnosis can often be a problem. In benign breast diseases in particular, normal breast tissue, fibroadenoma, and fibrocystic changes with varying degrees of hyperplasia are difficult to distinguish from one another in a particular smear. Often the cytopathologist can only report the lesion as "Negative for malignancy". In malignancy, the lack of availability of architectural assessment also makes distinction between in-situ and invasive malignancy difficult. Subtyping of the various carcinomas is also problematic.

False positive FNA diagnoses do occur but fortunately are rare. Very cellular fibroadeomas, florid ductal hyperplasia, lactation, papilloma and gynaecomastia are common lesions mistaken for malignancies. If there is a discrepancy between clinical and FNA diagnosis, further investigation should always follow. Mastectomy should not be performed based on cytological findings alone.

References continued pp 44

continued from pp 31

References and suggested reading

1. DeMay RM. The Art & Science of Cytopathology: Aspiration Cytology. American Society of Clinical Pathologists Press. Chicago. 1996, pp847-938.

Strategies for Cardiovascular Prevention in Diabetes Mellitus

Stephen B Harrap PhD, FRACP

Diabetes – a global cardiovascular problem

Diabetes mellitus is a major and growing health problem. The World Health Organization estimated that in 1995 there were approximately 135 million adults with diabetes worldwide and projected that this number will rise to 300 million by 2025. Most of these new cases are expected to be type 2 diabetics, with particularly large increases likely in less developed countries of the world.[1] Individuals with type 2 diabetes are at substantially increased risks of both macrovascular disease (including coronary heart disease and stroke)[2] and microvascular disease (including retinopathy, nephropathy and neuropathy).[3] These complications result in increased rates of premature death, physical disability, blindness and renal failure.

Blood pressure and glycemic control

High blood pressure and poor glycaemic control (as assessed by plasma concentration of haemoglobin A_{1c} - HbA_{1c}) are common and important correlates of vascular disease in type 2 diabetic patients. For both these risk factors, the associations with vascular disease appear continuous, with no defined threshold of blood pressure or HbA_{1c} below which the risks of vascular disease do not continue to decline.[4,5] For example, in the UK Prospective Diabetes Study (UKPDS), across a broad range of systolic blood pressure from < 120 to ³ 160 mmHg, each 10 mmHg higher level of mean SBP was associated with an approximate 12% greater risk of myocardial infarction and microvascular complications.[4]

Randomised trials have shown substantial reductions in major vascular events following the lowering the blood pressure of hypertensive subjects with diabetes,[6,7] and there appear to be greater benefits from more intensive blood pressure lowering.[8] In addition, the Heart Outcomes Prevention Evaluation (HOPE) study has shown that ACE inhibitor therapy may confer worthwhile vascular benefits among diabetic patients whether hypertensive or not, even when the reduction in blood pressure is apparently modest.[9] Fewer studies have investigated the effects of intensive glycaemic control on vascular disease risk. In UKPDS, such treatment was shown to reduce the risk of major microvascular outcomes among individuals with newly-diagnosed type 2 diabetes, but the effects on macrovascular endpoints were less clear cut.[10] For every 1% reduction in mean HbA_{1c} concentration during treatment with suphonylurea- or insulin-based treatment, microvascular complications were significantly reduced by one quarter, but the smaller proportional reductions in myocardial infarction were of borderline significance.[10]

Unresolved issues

Hence, there remain several unresolved issues with regard to the effects of treatments for blood pressure lowering and glucose control on the risks of vascular disease among patients with type 2 diabetes. First, are there worthwhile benefits of blood pressure lowering when provided routinely to high-risk diabetic patients irrespective of the level of blood pressure? Second, are any such benefits additional to those conferred by background treatment with an ACE inhibitor? Third, does intensive glucose control therapy targeted to achieve HbA_{1c} levels of <6.5% reduce the risk of major macrovascular disease and confer greater protection against microvascular disease?

Professor Stephen Harrap is the Head of the Dept of Physiology at Uni of Melbourne and visiting physician at the Royal Melbourne Hospital

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References. 1. Shapiro G et al (2000). Am J Respir Crit Care Med; Vol 161:527-534. 2. Juniper EF et al (2002). Am J Respir Med: 1(6):435-440. 3. Nathan R et al (2003). Journal of Asthma; 40(7): 215-222.

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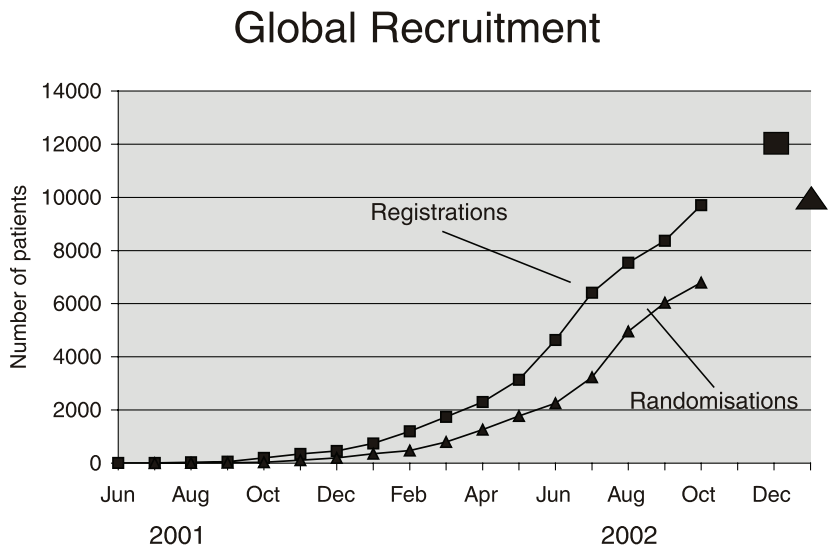
The ADVANCE Study

ADVANCE (Action in Diabetes and Vascular Disease: PreterAx and DiamicroN MR Controlled Evaluation) is a large-scale, 2 x 2 factorial, randomised controlled trial that has been designed specifically to address each of these issues.

The ADVANCE study is designed to include at least 10,000 adults with type 2 diabetes of 55 years or older who are at high risk of cardiovascular disease. Patient entry criteria have been designed to facilitate the enrolment of a broad cross section of high-risk individuals, including those with a history of major cardiovascular disease, microvascular disease or other known risk factors. Eligibility for the trial is not dependent on the level of blood pressure or the use of other blood-pressure lowering therapy; nor is it dependent upon the entry level of HbA_{1c} or fasting blood glucose or the type or number of oral agents used for glucose control. Additionally, eligibility is not dependent upon the need for or use of ACE-inhibitor therapy.

Figure Legend: Interim global cumulative recruitment for the ADVANCE study from June 2001 to 31st October 2002. Actual participant registrations are shown as filled squares with the target (represented by the large filled square) of 12,000 participants by December 2002. Completed participant randomisations are represented by filled triangles with the target of 10,000 randomised participants shown as the large filled triangle.



Treatment arms

The blood pressure lowering treatment chosen for study in this trial is a fixed low-dose combination of perindopril (2-4 mg) and indapamide (0.625-1.25 mg). This combination of an ACE inhibitor and diuretic was selected because of the established effects of both classes of drug on cardiovascular disease risks in various patient populations, and the greater blood pressure lowering effects of combination therapy compared with monotherapy. For any patient in whom an ACE inhibitor is thought to be indicated, open label perindopril (2-4 mg) will be provided and can be started at any time during the study. Whenever required, other classes of blood pressure lowering drugs may be prescribed at the discretion of the responsible clinician.

The glucose control regimen chosen for study is based on a modified-release sulphonylurea preparation (gliclazide MR 30-120 mg). Sulphonylureas are widely prescribed for blood glucose control in diabetes, and the modified release gliclazide formulation provides 24-hour glucose control in a single daily dose. Non-pharmacological therapy, other oral agents and then insulin can be added as required to achieve the target level of HbA_{1c} of 6.5% or less in subjects randomised to intensive control of glycaemia.

Outcomes

There are two primary outcomes for each randomised comparison: first, the composite of non-fatal stroke, non-fatal myocardial infarction or death from any cardiovascular cause; and second the composite of new or worsening nephropathy or microvascular eye disease. An Endpoint Adjudication Committee whose members are blinded to participants' treatment allocations will review evidence about suspected primary events. The secondary outcomes for each randomised comparison include major cer-

Region	Country	Number of Centres
Australasia and South East Asia		
	Australia	22
	India	4
	Malaysia	5
	New Zealand	3
	Philippines	4
China		
	China	47
Europe - Continental		
	Czech Republic	7
	France	9
	Germany	2
	Hungary	16
	Italy	1
	Netherlands	10
	Poland	16
	Slovakia	12
Europe - Northern		
	Estonia	2
	Ireland	5
	Lithuania	2
	United Kingdom	22
North America		
	Canada	14

ebrovascular disease, major coronary heart disease, heart failure, peripheral vascular disease, microalbuminuria, visual deterioration, neuropathy, dementia, and all-cause mortality. Data will also be collected on episodes of major and minor hypoglycaemia, other suspected serious adverse reactions, as well as quality of life and health care utilisation.

Follow-up

The scheduled average post-randomisation duration of follow-up will be 4.5 years. Those assigned the gliclazide MR-based intensive glucose lowering regimen will be seen at least once every three months, while those randomised to standard guidelines-based therapy will be seen once every 6-months for most of the scheduled follow-up period. Follow-up will continue until June 2006, with publication of final results anticipated early in 2007.

Summary

The ADVANCE study addresses important clinical therapeutic issues regarding the prevention of common macrovascular and microvascular complications of type 2 diabetes. The factorial design allows for suitably powered analyses of the independent effects of intensive blood pressure reduction and intensive glycaemic control and the interaction of these interventions. The recruitment of participants from of a broad range of racial, ethnic and geographic groups favours the broad applicability of the ADVANCE study results to the growing global population of patients with type 2 diabetes.

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*Additional efficacy of the combination of MICARDIS® and hydrochlorothiazide (HCTZ) versus the individual components.[2]

REFERENCES: 1. McGill JB *et al. Clin Therapeutics* 2001; 23(6): 833–850. 2. Approved Product Information for MICARDIS® PLUS (telmisartan/hydrochlorothiazide). INDICATIONS: Treatment of hypertension. Treatment should not be initiated with these combinations. CONTRAINDICATIONS: Hypersensitivity to any components of the product or sulphonamide-derived substances. Pregnancy. Lactation. Cholestasis. Biliary obstructive disorders. Severe hepatic impairment. Severe renal impairment. Refractory hypokalaemia, hypercalcaemia. PRECAUTIONS: Primary aldosteronism, fructose intolerance, aortic/mitral valve stenosis, obstructive hypertrophic cardiomyopathy, ischaemic cardiovascular disease, hepatic and/or renal impairment, renal artery stenosis; patients whose vascular tone and renal function depend on the activity of the renin-angiotensin-aldosterone system, volume and/or sodium deficiency, fluid or electrolyte imbalance, diabetic patients, hyperuricaemia, parathyroid function tests, systemic lupus erythematosus. INTERACTIONS: Other antihypertensive agents, digoxin, lithium, drugs affected by serum potassium disturbances, drugs that may interact with thiazides (see list in full PI). ADVERSE REACTIONS: Fatigue, influenza-like symptoms, dizziness, diarrhoea, nausea, angioedema, urticaria, others (see full PI). DOSAGE: One tablet once daily. MICARDIS® PLUS 40/12.5 mg for patients whose blood pressure (BP) is not adequately controlled by MICARDIS® 40 mg or hydrochlorothiazide; MICARDIS® PLUS 80/12.5 mg for patients whose BP is not adequately controlled by MICARDIS® 80 mg or by MICARDIS® PLUS 40/12.5 mg. In patients with mild to moderate hepatic impairment, the dosage should not exceed MICARDIS® PLUS 40/12.5 mg once daily. PBS DISPENSED PRICE: MICARDIS® PLUS 40/12.5 mg $24.08, MICARDIS® PLUS 80/12.5 mg $29.03.

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Adv. of Atacand

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Conference Abstract

Colorectal cancer – advances that really matter !

Joe Tjandra MD, FRACS, FRCS, FRCPS, FASCRS
A/Professor , Royal Melbourne and Royal Women's Hospitals, Epworth Hospital

Considerable improvements in the survival and outcome of colorectal cancer have been made in recent years. These have been the result of advances in early detection, investigations, intervention as well as in follow-up management.

Effective management of colorectal cancer depends on early detection. Screening for colorectal cancer saves life. While faecal occult blood testing has been the main instrument used in randomised trials on screening, the ultimate test is a safe and complete colonoscopy. Confidential reviews have revealed wide disparity in perforation rates and completion rates to caecum between endoscopists. CT colonography is evolving and potentially could be a useful screening tool in the future.

Accurate staging is particularly relevant in rectal cancer. This utilises an endorectal ultrasound (first established in Melbourne in 1995 by the speaker), CT scan and occasionally positron emission tomography (PET). Where rectal cancer has invaded deeply outside the wall of the rectum and/or regional lymph nodes, chemoradiation prior to surgery could be considered to further improve the oncologic results. For more localised lesions, a transanal excision rather than major resection should be considered.

Surgical techniques have evolved significantly. Improvements in endoscopy such as improved optics and magnifying features allow endoscopic resection of most premalignant tumours. These new features are only available in colonoscopes purchased in the last 1-2 years. Colonic stents inserted endoscopically offer a valuable option in treating patients with malignant large bowel obstruction. Laparoscopic techniques are being refined for colorectal surgery and should be limited to experienced laparoscopic and colorectal surgeons. In the speaker's experience, in appropriately selected cases, there is less postoperative pain, reduced ileus, shorter hospital stay and better cosmesis. The surgeon ought to be familiar with and adhere to the principles of conventional open colorectal surgery. It would be a tragedy if for the sake of a smaller incision, that the oncological outcome is compromised.

However, 30 % of patients who undergo surgery with or without adjuvant chemoradiation with curative intent will relapse and die of cancer. Meta-analysis of five randomised trials have shown that intensive follow-up have resulted in increased detection of treatable recurrences and improvement in survival. Surgery for recurrent disease is rarely easy and is not for the faint-hearted. In our laboratory, there is an exciting development of a novel serum test for the early detection of colorectal cancer. This could potentially detect recurrent disease at an even earlier stage, and further improve the survival.

The single most important advance in the last decade is the recognition that surgery for colorectal cancer requires considerable technical expertise. The recurrence rate between surgeons could range from 2 % to 80 %. The surgeon and his surgical ability is the single most important prognostic indicator in rectal cancer. In Europe, master surgeons have travelled to different centres to teach surgeons how to operate on rectal cancer. This education process has led to a significant improvement in cancer recurrence rate in participating European Centres from 35 % to 5 %.

Adv. of Lipitor

Conference Abstract

Ovarian cancer diagnosis, screening and management – an update

Deborah Neesham DCH FRACOG
Gynaecological Oncologist, Royal Women's Hospital

The focus of this presentation is ovarian cancer diagnosis, screening and management. I intend to mainly discuss the potential of new techniques to contribute to imaging in relation to ovarian cancer, current issues with respect to ovarian cancer screening programmes, recent advances in chemotherapy and new therapeutic options in ovarian cancer.

Ovarian cancer diagnosis is often difficult prior to surgery and appropriate triage is essential for these women, so that they have their surgery done by the most appropriate person. After the diagnosis of an adnexal mass, we rely on tumour markers such as the Ca125, (despite its lack of specificity), and ultrasound. A postmenopausal woman with an adnexal mass and an elevated Ca125 has a 90% risk of having an ovarian malignancy. It is more difficult to triage the premenopausal woman. Family history may be an important clue to an inherited gene mutation such as BRCA1 or BRAC2 or HNPCC if 2 or more 1st or 2nd degree relatives have an early onset cancer.

CT interpretation of omental caking can be difficult but can be very useful as an indicator of advanced disease if present, and will also give important information about lymph node enlargement. CT is not required prior to surgery as a routine. We are currently examining the role of MRI and particularly MRI spectroscopy in differentiating benign from malignant ovarian tumours. PET scanning is finding a role in the restaging of ovarian cancer, where there are rising tumour markers and no evidence of macroscopic disease on examination or on CT scan.

Ovarian cancer screening is still fraught with difficulties and there is no good population screening currently available. Large trials are ongoing in England looking at the rate of change of Ca125 in postmenopausal women. If a rise in the Ca125 level is found, a transvaginal ultrasound with Doppler flow is then performed. From the early data this does seem to be effective at picking up early stage ovarian cancers in the screened population. (1) Here in Australia we are currently using screening only for high-risk groups, which include those who carry a BRAC1 or BRAC2 gene mutation or the gene for hereditary non-polyposis coli HNPCC. The age of onset for screening is also controversial, currently it is recommended at 35 for BRCA1, 40 for BRA2 and 25-30 for HNPCC. The screening we use is a combination of annual physical examinations including vaginal examination, Ca125 and transvaginal ultrasound (with Doppler flow for any abnormalities found). Unfortunately pre-menopausally, many of these tests have significant problems with false positives. Even in high-risk groups, it is likely that up to 10 laparotomies will need to be performed for one cancer diagnosis. Women are also encouraged to consider prophylactic surgery at the end of childbearing, particularly as oophorectomy has been shown to reduce the risk of breast cancer by 50% in these women at risk. (2) While this does not protect against ovarian cancer 100%, it certainly reduces the risk by around 90%. Other strategies for risk reduction include the use of the OCP. There is some concern that this may possibly increase the risk of breast cancer with limited retrospective data to support this theory. (3) There is a huge amount of activity in the scientific world looking at the proteins produced by tumours and we are hopeful that a new marker for early detection of ovarian cancer will be found in the near future.

Treatment for ovarian cancer relies upon a multidisciplinary approach, which includes the involvement of surgeons, radiotherapists, medical oncologists, pathologists, social workers, counsellors, physiotherapists, and palliative care physicians. Accurate staging of the disease is required to give an accurate prognosis. Debulking surgery should be undertaken to minimise residual tumour burden for advanced disease, which is best carried out by gynaecological oncologists. Standard adjuvant chemotherapy is planned initially with 5 cycles of Taxol

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*In clinical studies of reflux oesophagitis comparing Nexium 40 mg with omeprazole 20 mg and lansoprazole 30 mg.

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PBS Dispensed Price: 40 mg 30s, $75.26; 20 mg 30s, $46.19. Sponsor: AstraZeneca Pty Ltd, ABN 54 009 682 311, Alma Road, North Ryde NSW 2113.

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*For the management of moderate to severe chronic pain unresponsive to non-narcotic analgesia. **Use:** Moderate to severe chronic pain unresponsive to non-narcotic analgesia. **Contraindications:** Acute respiratory depression; cor pulmonale; arrhythmias; acute asthma or other obstructive airways disease; paralytic ileus; suspected surgical abdominal condition; delayed gastric emptying; acute alcohol intoxication, withdrawal; brain tumour; raised cerebrospinal, intracranial pressure; head injury; severe CNS depression; convulsive disorders; hypercarbia; concurrent MAOIs (or within 2 weeks of their use); pre-op use, first 24 hours post-op. **Precautions:** Hypothyroidism: opioid dependence; hypotension, hypovolaemia; biliary tract disease; pancreatitis; inflammatory GI disease; prostatic hypertrophy; adrenocortical insufficiency; renal, hepatic disease; debilitated; 24 hours prior to cordotomy or other pain relieving surgery; abdominal surgery (post-op); non-malignant pain; prior substance abuse; pregnancy, lactation, children < 12 years. **Adverse events:** Tolerance, dependence: GI upset; CNS effects; hypotension; bronchospasm; rash; others, see full PI. **Interactions:** MAOIs esp non-selective (see Contraindications); anticholinergics; anti-hypertensives; CNS depressants; coumarins; metoclopramide; neuromuscular blockers; other opioid agonists. **Dose:** Adults, children > 12 years: usual starting dose 10mg 12 hourly: titrate dose. Renal hepatic impairment, debilitated elderly: 1/3 - 1/2 usual dose. Prior opioids see full PI. Swallow whole; do not break, chew or crush. **Presentation:** OxyContin Tablets 10mg, 20mg, 40mg and 80mg. Please review full Product Information and refer to state and federal regulations before prescribing. Full product information is available on request from Mundipharma Pty Limited, ABN 87 081 322 509, Lvl 26, 6 O'Connell St, Sydney NSW 2000. **References: 1.** Joranson DE *et al.* Journal of Pain and Symptom Management 2002;23:138-147. **2.** Roth HS *et al.* Arch Intern Med 2000;160:853-860. **3.** Hale ME, *et al.* The Clinical Journal of Pain 1999;15:179-183. **4.** Mucci-LoRusso P *et al.* Eur J Pain 1998;2:239-249. McCann Healthcare MUN0068 10/03.

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and Carboplatin which is relatively well tolerated, although many of our patients are involved in a large multinational trial which used 8 cycles of doublet or triplet therapy with varying active agents. Continued monitoring of disease status occurs with individualization of further treatment as required. This may involve a number of different modalities including chemotherapy, surgery and radiotherapy.

Assessment of disease recurrence often utilises the Ca125 in conjunction with CT scanning. If a CT scan is unhelpful, consideration is now given to using PET scanning, which assesses metabolic activity in tissues and has the potential to pick up small disease foci. It can now be performed in conjunction with a CT to give accurate localisation of the disease.

Second line chemotherapeutic agents include liposomal doxorubicin (Caelyx), Topotecan, Taxotere. The addition of hormonal agents such as high dose Provera (200mg bd) or Tamoxifen (20mg bd) also give up to 15% response rates as 3rd line treatment, which may be better than more toxic chemotherapeutic options.

Surgery for recurrent disease is limited to a small number of situations where the disease is localised eg. spleen, lymph nodes, or where a bowel obstruction has occurred.

Radiotherapy may be used for localised recurrence, which is not amenable to surgery, for example high paraaortic lymph nodes.

There continue to be exciting new advances in ovarian cancer, but still we are diagnosing this disease in its late stage in the majority of women. The current aims of research are to find a new marker of early disease, or to find new devices for treatment through gene therapy (p53, c-erbB2) or immunomodulation (vaccines). These women are best managed in tertiary referral centers with a multidisciplinary approach to management. Screening is currently only advocated for women at high risk due to genetic abnormalities such as BRCA 1 and 2, or HNPCC mismatch repair genes, and is undertaken with annual Ca125 and transvaginal ultrasound.

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Journal Review

Jun Yang

Risk Factors for Proteinuria in a Large, Multiracial, Southeast Asian Population.

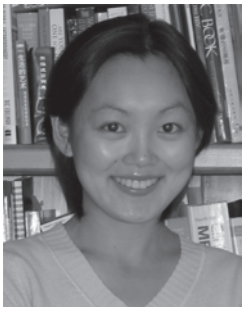
Ramirez S P, McClellan W, Port F K, Hsu S I. (2002) *Journal of American Society of Nephrology*. 13: 1907 – 1917

Proteinuria is a well recognised predictor of end-stage renal disease (ERDS) and identification of its risk factors may facilitate preventative and therapeutic efforts to delay its progression. However there are very limited studies on the risk factors for proteinuria among Asians, particularly among the Chinese population.

This particular study was carried out in a large, multi-racial Asian population (in Singapore) participating in a screening program aimed at the early detection of renal disease. 189,117 subjects were asked to complete a self-administered questionnaire providing demographic information, medical history and family history of renal disease. Their body mass index (BMI) and blood pressure were recorded, and urinary specimens collected. Proteinuria is defined as protein of 1+ or more on dipstick.

The results reveal that Malay race, increasing age, both extremes of BMI, family history of kidney disease (FKD) and higher systolic and diastolic BP measurements are independently associated with proteinuria. In particular, odds ratio (OR) for proteinuria increases progressively with age especially after 60. OR for proteinuria according to systolic and diastolic BP are significantly increased, beginning at levels of 110 and 90 mmHg respectively. FKD is also significantly associated with proteinuria, irrespective of a family history of diabetes or hypertension.

Comments: This is the first study to evaluate factors associated with proteinuria in an Asian population. It identifies several risk factors which differ from the Caucasian population. In particular, the mild BP elevations associated with proteinuria suggest that normal BP values for Asians are perhaps not equivalent to those established for Caucasians. In addition, for the Chinese racial group, each BMI category above 25 is associated with progressively higher OR for proteinuria, suggesting that the upper limit of normal BMI range for the Chinese is probably closer to 23. BP and BMI are modifiable factors and it is crucial that we recognise the need for a tighter control amongst the Chinese patients in the prevention of proteinuria or renal damage.



As a cross-sectional study, it does have several limitations. First of all, causation between any of the risk factors and proteinuria cannot be established. Secondly, the self-reported disease and family histories are not confirmed by the investigators. Also, the use of urine dipstick to define proteinuria lacks accuracy and represents only a semi-quantitative estimation of the severity of proteinuria. Despite these limitations, it is still an important study that defines some risk factors for proteinuria that are specific to the Asian population and guides the design of more

Phytoestrogen and Breast Cancer Prevention.

Ganry, O. (2002)
European Journal of Cancer Prevention. 11: 519 - 22

The incidence of breast cancer varies worldwide, with the rate for Japanese and other Asian women being a third to a half of that for Caucasian women. It is postulated that the consumption of phytoestrogen rich foods, especially in the Asian population, may reduce breast cancer risk.

Phytoestrogens are oestrogenic compounds found in plant foods and consist mainly of isoflavones, lignans and coumestans. Soy products and legumes are the main source of isoflavonoid phytoestrogen. Seeds, whole cereals, berries, tea and some vegetables like carrots and broccoli contain lignans, while coumestans are found in alfalfa and clover sprouts. Their tumour inhibitory effect has been demonstrated in breast cancer cell lines in animal models and arise from their ability to compete with endogenous oestrogens for binding with oestrogen receptors,

Dr Jun Yang is a second year medical resident at Monash Medical Centre

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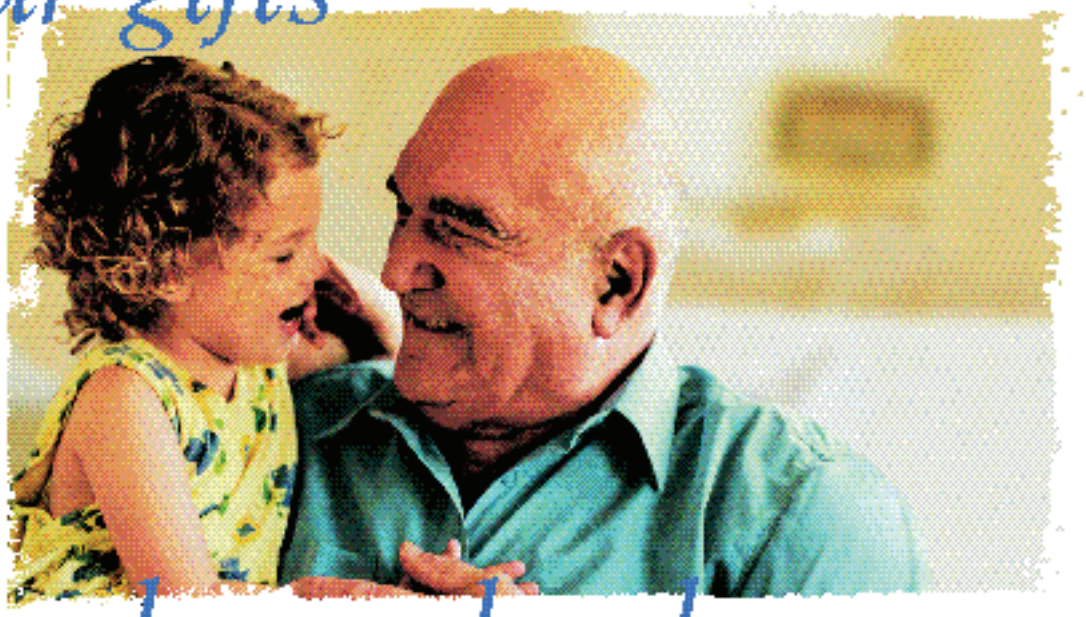

beyond value

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† These results should be considered in the context of an observational study in which AD status was based on caregiver report. As this is not a randomised controlled trial, the effect of donepezil on caregiver burden could be a selection effect or the effect of other unmeasured characteristics of the caregivers. This study was not supported by Pfizer Inc. or Eisai Co. Ltd.

Before prescribing, please review Approved Product Information available on request from the manufacturer. Aricept (donepezil) Use: Acetylcholinesterase inhibitor. Mild to moderately severe Alzheimer's disease. Contraindications: Hypersensitivity to piperidine derivatives. Precautions: Supraventricular arrhythmias including sick sinus syndrome; history of peptic ulcer, asthma, obstructive pulmonary disease; pregnancy; lactation; children. Adverse: The most common side effects in clinical trials were diarrhoea, muscle cramps, fatigue, nausea, vomiting and insomnia. Dose: Initially 5mg/day before bed; may be increased to 10mg/day after 1 month. PBS Dispensed Price: 5 & 10 mg $1.58.62. 1. Whitehead B, et al. A 1-year, randomised, placebo-controlled study of donepezil in patients with mild to moderate AD. Neurology 2001;57:489-495. 2. Gauthier S, et al. Functional, cognitive and behavioral effects of donepezil in patients with moderate Alzheimer's disease. Curr Med Res Opin 2002;18:347-354. 3. Wilkinson D, et al. A 1-year, placebo controlled preservation of function survival study of donepezil in AD patients. Neurology 2001;57:481-488. 4. Feldman HH, Gutterman EM, Brooks RL. Impact of donepezil on caregiving burden for patients with Alzheimer's disease. Int Psychogeriatrics 2000;12:389-401.

thereby reducing the hormonal effect of endogenous oestrogens that are much more potent than isoflavonoids.

Several epidemiologic studies have shown consumption of traditional soy foods like tofu, miso soup or soy protein to be associated with a 20% – 75% reduction in breast cancer risk in Asian or Asian-American people. Most of these studies were done on pre-menopausal women. One study evaluated the effect of soy intake during adolescence and found a risk reduction for later occurrence of breast cancer in both pre- and post-menopausal populations. The quantity of soy intake varied between studies. Most studies considered 3 – 5 servings of tofu (or equivalent soy product) per week to be adequate, while others used more objective measures, such as milligrams of phytoestrogen per day. Urinary excretion of phytoestrogens has also been measured as a reflection of dietary intake, but results have been inconclusive.

Comments: It is commonly assumed that soy products with their phytoestrogen content protect against breast cancer because Asian women, who tend to consume more soy, have a lower rate of breast cancer. This relationship has been demonstrated in several epidemiologic studies. However, phytoestrogen exposure is often not the primary focus of these studies and results are based mostly on one or two soy based foods. Quantitation of phytoestrogen intake is therefore difficult. How much phytoestrogen does one need to consume to achieve a protective effect? Are there particular soy products that confer more benefit than others? These questions have not been answered in the studies.

In addition, there have not been any randomised controlled trials on the role of phytoestrogens, and only a few of the epidemiologic studies are carried out in non-Asian populations or in post-menopausal women. Prospective studies in large non-Asian populations accounting for menopausal status are needed to further define the protective effects of phytoestrogens.

Based on existing evidence, one can encourage the Asian population to consume soy products on a reg-

Soy for Heart

Zhang, X. Shu, X. O. Gao, Y. T. (2003) Soy food consumption is associated with lower risk of coronary heart disease in Chinese women, Journal of Nutrition, Vol 133: 2874 – 2878

Soy food intake has been shown to have beneficial effects on cardiovascular disease risk factors, such as in lowering serum lipid levels, lowering blood pressure, increasing LDL oxidation resistance, etc. However, there is sparse data directly linking soy food intake to clinical coronary heart disease (CHD). This population based prospective cohort study of 75,000 Chinese women from the Shanghai Women's Health Study examines the direct relationship between dietary soy intake and the incidence of CHD. Women with an existing history of CHD, stroke, diabetes or cancer are excluded from the study. The dietary intake of soy is assessed at a personal interview using a comprehensive quantitative food questionnaire that covers virtually all types of soy foods consumed in urban Shanghai. Cohort members are followed biennially through interviews. After a mean of 2.5 years of follow-up, 62 incident cases of CHD (42 non-fatal AMI and 19 AMI related deaths) are documented. After adjustment for age, the incidence of total CHD is found to be inversely proportional to soy intake. Compared with women in the lowest quartile of total soy intake (0.47g/1000KJ/d), the risk ratio (RR) of CHD is only 0.25 ($p = 0.003$) for women in the highest quartile of intake (1.99g/1000KJ/d). This inverse association is even stronger for non-fatal AMI, with a multivariate RR for the high soy consumers being 0.14 ($p = 0.001$). The authors state that this is the first study to provide direct evidence that soy consumption can reduce the risk of coronary heart disease in women.

Comments: This is a well conducted study with a large sample size, high participation rate, virtually complete cohort follow-up and comprehensive assessment soy protein intake from a diverse food range. Although many studies have shown the benefits of soy on CVD risk factors, this study fills the gap in data on the direct relationship of soy to clinical outcomes of CVD. As this is only a cohort study, and not a randomised double blinded trial, the potential for selection bias and follow up errors is unavoidable. However, the baseline characteristics of the study population are quite homogenous across the different quartiles of soy consumption, and follow up is meticulous with all medical reports reviewed by physicians who are unaware of the participant's exposure status. The results have also been analysed using multivariate modelling and stratification to minimise the effect of potential confounders such as blood pressure, BMI, waist to hip ratio, menopausal status, exercise level and fat intake. The follow up period is not long, at 2.5 years, but seems to have been sufficient to demonstrate the significant inverse association between soy protein intake and risk of CVD. This study therefore provides strong evidence for the recommendation made by the Australian Heart Association to increase soy food intake to promote heart health. Future studies in men would be welcomed.

Chinese Diet, Health & Disease

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TCM Theory on Health & Disease Prevention

"Traditional Chinese Medicine (TCM) can be characterised as holistic, with strong emphasis on the integrity of the human body and its relationship with the social and natural environment. There is recognition of the impact that physical, nutritional, psychological and genetic factors have on health and disease." Professor Ka Kit Hui (Director of the Center for East-West Medicine & Professor, Department of Medicine, University of California, Los Angeles, School of Medicine).

According to TCM an illness is due to the imbalance of the Yin & Yang forces. To a western-trained physician, Yin & Yang may sound "mysterious and mystical". It is really another way of expressing positive-negative, hyper-hypofunction, cathion-anion and so on. In western medical healing we talk about bringing things back to "homeostasis". That is actually what TCM practitioners mean when they bring Yin and Yang back to balance or equilibrium in order to achieve health. Health is when Yin & Yang forces are in equilibrium while Disease is when these forces are out of balance.

Other terminology that may confuse the western health practitioners are "Qi & Blood", "Hot & Cold" and so on. Qi could be equated to Energy or Prana while Blood is not only a substance but also regarded as a force, a level of activity in the body. Hot and Cold delineate the activity of the body and the quality of the disease.

Foods and herbs are classified as "Hot" or "Cold " depending not only on the temperature but also the intrinsic characteristics of the foods and herbs we eat and drink. In our youth our parents taught us about hot and cold foods. When a sore throat developed (hot condition) we were not allowed "hot foods" like chocolate, fried and spicy foods. Instead we were given "cooling foods" to counter the "heat" in the body. Vice versa when someone has asthma (cold condition) he is advised not to take "cold" foods like ice cream, fruits, fruit juices and even cold water. So in general to treat "hot conditions", cooling herbs and foods are prescribed and for "cold conditions", warm and hot foods and herbs are prescribed to effect a cure.

Chinese Eating Habits

When we were young, our families used to buy fresh foods from the vegetable market daily. The foods were so fresh that the fish were still swimming in the tubs, the chickens cooped up in the cages ready for sale, and vegetables were harvested just hours before being taken to the market.

However in certain parts of the world fresh foods are not available all the year round. People have to rely on preserved foods during the winter months. The effect of eating preserved foods may lead to the development of some medical conditions. Later on we will present the findings of different diseases affecting different parts of China.

The Chinese use many different herbs and spices in their daily cooking. Garlic, onion, spring onion, chive, coriander, turmeric, pepper and ginger are the most commonly used food-herbs in a Chinese kitchen. Over recent years the benefit of eating these food-herbs have been identified. The phyto-nutrients present in these foods play a very vital role in our quest for good health.

From ancient times, green tea has been the only beverage taken throughout the day by the Chinese and Japanese and has now been shown to be beneficial for good health. Tea contains hytochemicals

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which act as antioxidants, protecting DNA damage caused by free radicals in the body.

In one study green tea was found to lower the LDL cholesterol by 6% and to reduce by 25% a substance found in the urine of smokers. This substance (8-OHdG) measures the cellular oxidative damage in the body. Many other studies have shown that green tea has an anti-cancer effect by inhibiting the development and progression of different types of cancers including metastases. Green tea works singly or in combination with chemotherapy or natural compounds like curcumin or selenium.

Bad Chinese Cooking Habits

Why is it that when food smells nice and tastes good, it is usually bad for our health? Chinese chefs love to see flames jump into the wok. By allowing flame to jump onto the food while cooking, a more "fiery" flavour is added to the food. Similarly the Chinese love their roast pork, (char siew, siew yoke) and roast duck. The lovely aroma from roast meat is the result of the glycation process (browning effect). Glycation is due to the binding of a protein molecule to a glucose molecule resulting in the formation of damaged protein structures. The 'browning effect' causes the protein to lose its elasticity, and cross link to form insoluble masses that generate free radicals. The resulting Advanced Glycation End products (A.G.E.s) accumulate in collagen and skin, cornea, brain, and nervous system, arteries and organs as we age. Because A.G.E.s are toxic to the body a better term to describe them would be "glycotoxins". Normal ageing can be regarded as a "slow cooking" process in our body.

It was reported in the November 2002 Proceedings of the National Academy of Sciences that consuming foods high in glycotoxins may be responsible for the induction of low-grade chronic states of inflammation.

In another experiment published in the 2000 Free Radical Biology Medicine, diabetics fed with a low glycotoxins diet lose weight; their blood sugar levels drop and LDL levels are reduced by 33%.

Common Diseases in Chinese

The incidence of Nasopharyngeal carcinoma (NPC) is high amongst Chinese especially from Southern China. However NPC does not exclusively affect the Southern Chinese. Other parts of the world that have a skewed higher incidence of this condition are the Eskimos and natives of the Arctic region, natives of southeast Asia and mainly Arab populations of north Africa and Kuwait. There is now convincing evidence that dietary factors may be the cause of NPC among Chinese. Following a series of case controlled studies in China it was shown that ingestion of salted fish and other preserved foods by the Chinese constitute the most important cause of NPC. Early indications from studies in the other regions also point to preserved foods as a possible cause. Other cancers that occur more commonly in the Chinese community are oesophageal, stomach, lung and liver cancers.

In a recent article published in Journal of National Cancer Institute (vol. 95, no 18, pp 1414-1416), researchers conducted a randomised nutritional intervention trial in Linxian, China. They had 1072 patients with oesophageal and squamous cell carcinoma, gastric cardia cancer and gastric non-cardia cancer with 1053 control subjects. They found that those participants who received a combination of selenium, beta-carotene and vitamin E (alpha tocopherol) had a significantly lower cancer mortality rates than those who did not receive the supplements.

Breast cancer rates in Chinese and Japanese have been significantly lower than their female counterpart in the west. However with "westernisation" of the East, the incidence of breast cancer is slowly catching up. Both the Singapore Chinese Health Study and China Study I & II may have given us the reasons as to why this is so.

Singapore Chinese

A landmark Singapore Chinese Health Study involving over 60,000 subjects followed over a period of

10 years resulted in the publication of 17 articles in peer review journals. Among the findings were:

- § Eating fish regularly may reduce the risk of breast cancer, probably because of the protective effects of omega-3 fatty acids.
- § The enzyme angiotensin II has been linked to higher rates of breast cancer and prescribing angiotensin II inhibitors can help to lower the levels of angiotensin II which may reduce the risk of breast cancer.
- § Eating cruciferous vegetables (choi sum, cauliflower, broccoli, gai laan, cabbage, and watercress) may reduce the risk of colon cancer, probably because of the presence of isothiocyanates present in these vegetables. (Chinese eat 10 times more cruciferous vegetables than westerners)
- § Eating yellow-orange fruit (papaya, oranges and tangerines) may reduce the risk of lung cancer due to the presence of the antioxidant beta-cryptoxan thin which is found in high concentration in these fruits.

Another paper published in the American Association for Cancer Research Journal showed that tofu and other soy-based foods significantly lower the levels of oestrone (a class of oestrogen normally associated with breast cancer risk) in 144 postmenopausal Singapore women. The researchers warned that "the effect of soy on breast is controversial" and more work needs to be done before any specific dietary recommendation can be made.

China Studies

Over the past 20 years a flurry of research activities have taken place in China. The largest ongoing study was started in 1983 to explore dietary causes of cancer which has since been expanded to include heart, metabolic and infectious diseases and from that study came the report "China Study I".

China Study I

In 1983 the first epidemiological study, scientists from China, Oxford University and Cornell University embarked on a study on Dietary, Lifestyle and Disease Mortality Characteristics in 65 Rural Chinese Counties (6,500 subjects). This is an epic study with the data filling a volume of 920 pages published by Cornell University.

Some of the major findings include:

- § A plant-based eating plan is more likely to promote health than disease.
- § Obesity is related more to what people eat than how much. The main dietary differences are fat & fibre. The Chinese eat about a third the fat compared to the Americans, while eating twice the starch. The data imply that a maximum of 20% (preferably only 10 to 15%) of calories from fat should be consumed to curb the risk of heart disease and cancer.
- § Eating a lot of protein especially animal protein is linked to chronic disease. Those Chinese who eat the most protein, (largely animal protein), also have the highest rates of heart disease, cancer and diabetes.
- § A rich diet that promotes rapid growth early in life may increase a woman's risk of developing cancer of the reproductive organs and the breasts.
- § Dairy calcium is not needed to prevent osteoporosis. Osteoporosis is uncommon in China despite an average life expectancy of about 70 years. It was suggested that people need less calcium than we think and can get adequate amounts from vegetables.
- § Consumption of meat is not needed to prevent iron-deficiency anaemia. The average Chinese adult consumes twice the iron Americans do but the vast majority of it comes from the iron in plant food.
- § Plant-rich Chinese diet contains three times more dietary fibre than what Americans typically consume (average 33 grams). (Scientists were concerned that a high fibre diet may interfere with absorption of essential minerals like iron.) They found that those with the highest fibre intake had the most iron-rich blood.
- § Chronic infection with hepatitis B virus

and high cholesterol levels are the primary causes of liver cancer.

§ There is a relationship between herpes simplex virus infection and coronary heart disease.

§ There is a relationship between yeast infection and nasopharyngeal cancer.

China Study II

A follow up study was presented on June 16 at the Congress of Epidemiology 2001 in Toronto. This study compared the dietary habits of Taiwan and mainland China and measuredthem against the time when fewer meat and dairy products were available in rural China. According to Dr. T. Colin Campbell, a nutritional biochemist from Cornell University and the American mastermind of the Chinese diet study, this "living laboratory" will continue to generate vital findings for the next 40-50 years. "The Chinese Investigation covers the whole diet panoply as it relates to all diseases", he said.

A preliminary results of China Study II is listed below:

§ In poorer parts of China, infectious diseases remain the leading cause of death but in more affluent regions, heart disease, diabetes and cancer are most prominent.

§ With limited refrigeration, bacteria and mould contamination are more common, large amounts of salt and nitrites are used to preserve foods and hot spices are used to mask the flavours.

§ Cholesterol is a good predictor of the kinds of diseases people are going to get. The higher cholesterol levels are prone to the diseases of affluence - cancer, heart disease and diabetes. Low cholesterol protects against heart disease and colon cancer. Cholesterol in China range from 88 to 165 mg per 100 ml (2.28 to 4.29 mmol per litre) compare with 155 to 274 mg per 100 ml (4 to 7.12 mmol per litre) in USA. Plasma cholesterol in the 90 - 170 mg per 100 ml range (2.34 to 4.42 mmol per litre) is associated with most cancer mortality rates.

§ In Rural China the diet is typically plant-based with low animal products and has a lower incidence of western health problem like cardiovascular disease, some cancers, obesity and diabetes. Even small increases in the consumption of animal-based foods were associated with increased disease risk.

§ Breast cancer is associated with dietary fat and inversely with age at menarche

§ For those with liver cancer, increasing intake of animal-based foods and/or increasing concentration of plasma cholesterol are associated with a higher disease risk.

§ Cardiovascular diseases are associated with lower intakes of green vegetables and higher concentration of apo-B which is associated with increasing intakes of animal protein and decreasing intakes of plant protein.

§ Colorectal cancers are consistently in versely associated with intakes of 14 different fibre fractions.

§ Stomach cancer is inversely associated with green vegetable intake and plasma concentration of beta-carotene and vitamin C obtained only from plant-based foods.

§ Western-type diseases, in general, are highly significantly correlated with increasing concentration of plasma cholesterol which is associated in turn with increasing intakes of animal-based foods.

From this study, a policy recommendation is made

1. The greater the variety of plant-based foods in the diet the greater the benefits. Variety ensures broader coverage of known and unknown nutrient needs.
2. Provided there is plant food variety, quality and quantity, a healthful and nutritionally complete diet can be attained

with animal-based food.

3. The closer the food is to its native state - with minimal heating, salting and processing - the greater will be the benefit.

Concluding Remarks

There is so much we don't know about diet, health and disease. Over the ensuing years more papers will be published from the China Studies and Singapore Chinese Health Study. Meanwhile it pays us to take heed of the recommendations - to eat a wide variety of plant-based foods and to eat them as close to its natural state as possible.

If you enjoy eating all those lovely roast meats then make sure you drink many cups of green tea for the antioxidants and eat as many varieties of colourful fruits and vegetables as you can. For long term health it is better to lean towards "vegetarianism".

Optimal health is within our reach. It is up to us to take it or leave it.

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Multi-dimensional Medicine for the 21st Century: Integrating Eastern and Western Approaches

Steven KH Aung OMD PhD FAAFP

Family medicine—as is well known—is an inherently integrative specialty because its practitioners encounter and treat on a daily basis the diverse health problems of those seeking and requiring appropriate, efficacious primary health care. Family medical practitioners are also responsible for referring patients to more specialized disciplines, ranging from pediatrics to geriatrics, from sports medicine to oncology, from diverse psychotherapies to various complementary and alternative medicine (CAM) approaches, when and if necessary for each and every individual case—every patient is a unique individual presenting with their own idiosyncratic array of physical, mental and spiritual challenges.

This brief article considers the relatively new (some anonymous Zen master once noted that there was nothing new under the sun), innovative, evolving and emergent integrative model of family medicine within the context of natural medicine, evidence-based medicine, compassionate medicine and medical acupuncture. It does not offer a perfect solution or model, but only a perspective for ongoing discussion and debate among medical practitioners and healers.

Fringe practices are marginal endeavors, accepted only by their devotees (Figure 1). Alternative practices are nearer the center, accepted by some patients and physicians who have found these to be harmless or, in some cases, beneficial. Complementary practices overlap the center, accepted by a substantial minority of patients and physicians. The heart of this general model revolves around biomedicine as well as the traditional healing systems that have passed the test of time. It must be noted that while biomedicine is dominant throughout most of the world, it is—in principle—a traditional medical system.

Tentatively placing a specific CAM practice on this model depends on one's education and culture. For example, praying for others to enhance their health may be viewed as a fringe therapy by many physicians, but for some it is a natural, apparently powerful healing approach. In western medicine, the central injunction of the ancient—and still ethically highly relevant—Hippocratic Oath is to do no known harm to patients. This remains within the scope of responsibility of all physicians working together with their patients in the integrative healing endeavour. The legitimacy of CAM was first recognized by the British Medical Association in the mid-1980s, then by the American National Institutes of Health in the early 1990s.[1-3]

The more recent Canadian Department of Health consultations promote the concept—indeed vision—which goes beyond CAM into the integrative dimension.[4] It is a vision rooted and developed in the following criteria:

- Type 1 CAM therapies have the same fundamental biological orientation as biomedicine
- Type 2 CAM therapies are oriented more toward vital energy and spirituality
- Holistic healing (curing) is not incompatible with the use of either or both types or modalities of CAM therapies

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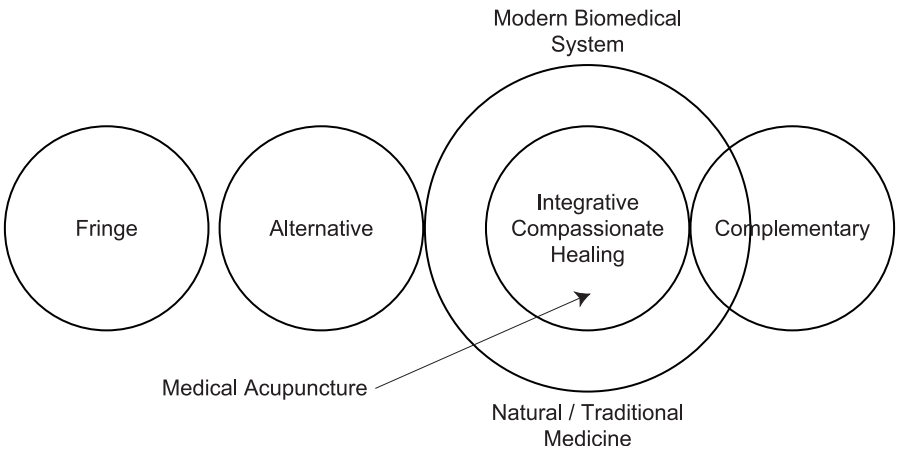

Figure 1. General model of integrative medicine.

- Integration occurs at different levels, namely, consumers and practitioners as well as the clinical, institutional, professional (regulatory) and health policy levels

- Prevention and health promotion, which includes disciplined self-care/self-cultivation are as vitally important as treatment

- Compassion is the integral heart and core of all integrative primary health care

Natural medicine perspective

Natural medicine—organic primary health care without unnecessary or irrelevant additives—is the qualitative heart and soul of integrative family medicine. The leading academic proponent of this initiative is Andrew Weil, founder and director of the Program in Integrative Medicine, University of Arizona College of Medicine, author of Natural Health, Natural Medicine and other works extolling the beneficial healing effects of nutrition, herbs and physical exercise.[5,6]

In a recent debate with Arnold Relman, editor-in-chief emeritus of the New England Journal of Medicine, Weil maintains that patients appreciate health care practitioners who are not oriented toward pharmaceuticals and surgery as the only feasible approaches.[7] Weil favours medicine which is sensitive to mind-body interactions. Relman argues that non-conventional methods are scientifically unproven, while at the same time acknowledging that biomedical practitioners often use methods that have not yet passed the accepted, "gold standard" of randomised controlled trials (RCTs). Regarding the placebo effect, Relman suggests that it is the expected spontaneous variation in symptomology. Weil, on the other hand, suggests that it may occur within the context of an individual's belief system.

Evidence-based medicine

The Weil-Relman debate, which is not out of date and will undoubtedly remain open to inquiry and various perspectives throughout this present era, points to the need for rigorous scientific medical research. Only RCTs provide proof of non-placebo, empirically curative effects. This is the fundamental quantitative foundation of scientific medical knowledge—and the rigorous RCT research design and implementation protocol is the basis of detailed, lengthy and expensive biomedical research projects.

The leading proponents of this approach with respect to non-conventional therapies are Edzard Ernst and David Eisenberg. Ernst is the director of the Complementary Medicine Program, University of Exeter, UK, editor-in-chief of the Focus on Alternative and Complementary Therapies journal.[8,9] Eisenberg is the author of Encounters with Qi[10]—and he is the leading light of the various Harvard Medical School academic initiatives in this area.[11,12]

Ernst and Eisenberg together with their teams—as well as other researchers and research teams the world—continue to be engaged in the challenge of understanding the relationship between conventional and non-conventional medicine and healing

therapies.

Compassionate medicine

Meanwhile, the family medicine healing endeavour continues every day, from country to country, from clinic to clinic, from practitioner to practitioner, from patient to patient. Qualitatively, this involves caring—concern for the quality of life and life chances of each and every patient. An eminent and inspiring proponent and practitioner of this approach is Bernie Siegel, author of Peace, Love, and Healing and other works.[13,14] Siegel learned, in his encounters with "exceptional patients" over many years, that while patients may grow comfortable in their sadness, it is a delusion that may be alleviated, not by denying it, but by choosing to live and to love.

The work of Deepak Chopra must also be highlighted within this context, since he is a physician who has so assiduously and conscientiously promotes the benefits of natural medicine in terms of the classical Ayurvedic expression of this complex traditional system of medicine. In Perfect Health: The Complete Mind/Body Guide,[15] Chopra suggests that nature is innately intelligent, that our underlying 'quantum mechanical human body' is directed by the mind toward either sickness or health and that physical, mental and spiritual harmony is of the utmost vital importance in preventing disease and helping to delay the aging process. The basis of this approach is herbology and dietetics, termed 'rasayana' in Ayurvedic medicine, which also encompasses daily exercise routines, breath control and meditation (collectively known as 'yoga') as well as various phonation and other ostensibly purification techniques.

In my own clinical experience of family medicine and medical acupuncture over the past two decades,[16] I have come to appreciate the fact that exceptional patients are often the most difficult patients, serving to challenge a physician's competence and compassion. Competence and compassion are like the two sides of the same coin—comprised of efficacy and safety—since family physicians must always strive to maintain their medical knowledge as "state of the art" and help guide their patients on the path toward intelligent self-care, prevention and health promotion.

Mutual respect, cooperation and communication between health care practitioners is the key to good practice. In regard to my own personal and medical background, I was always trained in the precepts of Buddhism and the application of compassion directly in therapeutics. This was reinforced for me personally in a meeting with His Holiness the Dalai Lama in Dharamsala, India, in 1993.[17]

Medical acupuncture

Excessive sadness, alluded to by Siegel above, is one of the seven internal emotional disease factors of traditional Chinese medicine (TCM), along with excessive joy, anger, fear, fright, anxiety and grief. In the TCM system, balancing these internal vital energies (Qi) in conjunction with repelling the invasion of external pathogenic factors is the foundation of good health.[18,19]

This involves the vital energetic harmonization of Yin and Yang. Yin is, opaque, cool, structural Qi and Yang is bright, warm, processual Qi. It is not a dichotomy, but complementarity, since Yin exists within Yang moving toward Yang and Yang exists within Yin moving toward Yin.

Acupuncture is the best-known TCM therapy in western societies, where over the past quarter century it has attained the status of a leading complementary therapy.[20] Acupuncture works from the outside in, from the superficial to the deep level of Qi (vital energy) flow/circulation. When performed in a competent, conservative and safe manner by physicians and other qualified health care practitioners, it is appropriate to refer to this therapy as medical acupuncture. It entails the shallow insertion of fine, solid, individually-packaged, sterilized and disposable stainless-steel needles.

The needles are inserted at specific acupoints (ma-

**	Acute tonsillitis, pharyngitis & laryngitis	*	Incontinence of urine
***	Alcohol addiction	***	Induction of labour
***	Allergic rhinitis	***	Insomnia
***	Athletics syndrome	**	Irritable bowel syndrome
**	Back pain	***	Leucopenia
***	Bell's palsy	***	Lumbago
**	Biliary ascariasis	*	Male infertility (azoospermia)
***	Biliary colic	**	Ménière's disease
***	Bronchial asthma	***	Migraine
***	Cardiac neurosis	***	Morning sickness
***	Cervical spondylitis	**	Myofascitis
***	Chronic locomotor pains	**	Myopia in children
**	Chronic pharyngitis	***	Nausea & vomiting
*	Constipation	**	Obesity (simple)
**	Correction of abnormal fetus position	**	Pain after tonsillectomy
*	Defective lactation	*	Pain during childbirth
***	Depression	***	Periarthritis of shoulder
*	Diarrhoea	***	Postoperative pain
***	Drug addiction	***	Premenstrual tension
***	Dysmenorrhoea	***	Radicular pain syndrome
**	Enuresis in children	***	Renal colic
**	Epicondylitis	*	Retention of urine
*	Female infertility	***	Rheumatoid arthritis
**	Gallstones	**	Schizophrenia
*	Gastroptosis	**	Sciatica
***	Headache	*	Sinusitis
***	Hemiplegia & other postapoplectic sequelae	***	Sprains & strains
***	Herpes zoster	***	TMJ dysfunction
*	Hiccough	***	Tension headache
***	Hypertension	***	Tobacco addiction
***	Hypotension (primary)	***	Trigeminal neuralgia
***	Impotence (defective ejaculation)	***	Urinary calculus

* Based on repeated descriptive reports or limited scientific evidence
** Based on controlled, non-randomized clinical trials
*** Based on RCTs

Figure 2. Worlld Health Organization List of Provisional Indications of Acupuncture.

jor centers of Qi flow) on the meridians (major pathways of Qi flow). The 12 regular meridians are linked to the 12 major internal organs, namely, Lung, Large Intestine, Spleen, Stomach, Heart, Small Intestine, Kidney, Urinary Bladder, Pericardium, Triple Energizer, Liver and Gallbladder. The Triple Energizer is a unique TCM organ encompassing the body cavity from the lungs to the intestines. There are 8 extra meridians which crosscut the 12 regular meridians and serve to harmonize one's total Qi flow. The most important extra meridians are the Conception Vessel (Ren - the front midline, from the top of the head to the anus) and the Governor Vessel (Du - the back midline, from the anus to the top of the head). The basic TCM concept of good health is to harmonize Qi flow in these meridians and their associated internal organs, and acupuncture is a valuable, time-tested tool for this endeavor.

The provisional list of over 60 acupuncture indications, suggested by the World Health Organization (WHO) during its most recent international consultation on acupuncture, includes both painful conditions and non-painful conditions (as illustrated in Figure 2).[21,22]

The TCM explanation for the apparent beneficial effects of acupuncture for such a wide variety of conditions pertains to the harmonization of Qi flow. The main scientific explanation for its efficacy is that the needling stimulus causes the brain to release natural, powerful analgesic neurotransmitters such as endorphins, enkaphalins and serotonin.[23,24] This helps regulate the sympathetic and parasympathetic nervous systems, normalize blood biochemistry, enhance immunity, increase the phagocytic activity of the reticulendothelial system and manifest anti-allergic and overall harmonizing effects for the whole person. So far, two intensive meta-analyses of the acupuncture research findings have been conducted, one study[25] finding that acupuncture is efficacious in various conditions and another[26] finding that it is similar to the placebo effect.

The complementary approach to medical acupuncture practice involves using it as an adjunct therapy to enhance one's practice, especially in the area of

pain control. A more comprehensive integrative model is that of a physician fully trained and certified in both biomedicine and traditional Chinese medicine who receives referrals from medical colleagues. Such a physician is a sub-specialist within the family medicine specialty.

Conclusion

Acupuncture and the various other traditional and complementary medicines have their own unique way of healing, encompassing natural medicine, evidence-based medicine and compassionate medicine. For example, Ayurvedic medicine revolves around the judicious use of natural nutritional herbal remedies, traditional Buddhist medicine focuses on compassion as a vital component of all therapeutic modalities and the North American Native medicine sweat lodge, vision quest and other healing rites are oriented toward spiritual purification. Traditional Chinese medicine has always emphasized the essential integrity of body, mind and spirit.

These and other traditional and non-conventional approaches are evidenced-based, but the relevant standards of value, largely pertaining to vital energy, are qualitative. Biomedicine, in contrast, is more technical, quantitative and, indeed, it may often be reductionist in its theory and methodology.[27] Medical acupuncture, when properly practiced, is itself a form of family medicine, due to its wide variety of indications and applications.

It would appear the best policy is to appreciate the best out of all the traditional and complementary approaches integrated with biomedicine in the spirit of natural, evidence-based initiatives, compassion—and healing. There is no reason why legitimate, qualified practitioners of various CAM methods should not work together in a harmonious, integrative manner to utilize the best out of all healing systems in order to achieve the best healing effect with appropriate tools and maximum concern for safety and the enhanced well-being of our dear patients. Undoubtedly, family medicine practitioners from around the world will continue to help integrate primary health care as it evolves throughout this present era.

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Who Exactly Are The 'Inscrutable'? A Comparative Study of the Chinese, Japanese and Australians

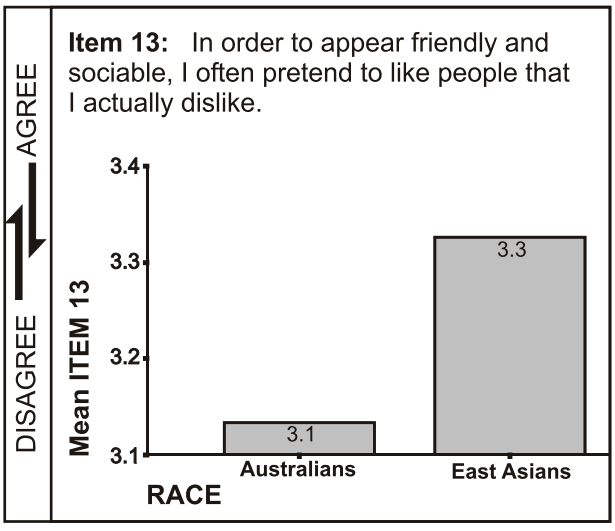
By Stephen K. K. Cheng PhD, MAPA

"The element of uncertainty, which in the West makes for lies about self and for guessing into the motives of others in telling their lies, is missing from Chinese relationships. The game of one-upmanship is impossible to play. A man who can be lied to is not involved enough to know the difference." Stover 1974 [1]

As a result of the ascendancy of the East Asian economy, there has been a growing interest in East Asian culture in Australia and other Western countries. Unfortunately, East Asian studies in the West have been confined to the humanities and language courses, with little input from the social sciences. As a result, the field of East Asian studies has been fraught with speculative theories, untested assumptions and unchallenged perceptions. There is an acute need to put to scientific test the numerous myths about East Asians that are often assumed to be facts in the minds of Westerners. In this brief article, the author has singled out the most entrenched of such myths for analysis: the so-called 'inscrutable Oriental', based on findings from his doctoral thesis on the social psychology of East Asians[1] [2].

The 'inscrutable Oriental' has never ceased to exercise the minds of Western observers. Even the Soviet technicians who worked in China during the 1950s called the Chinese 'vacuum bottles', as it was difficult to tell from their appearance whether they were hot or cold inside. While the notion of 'inscrutability' has been used to characterise East Asians for a long time, its validity has never been empirically tested. Nor has the question ever been asked whether Westerners might be equally or more 'inscrutable' than East Asians.

If we define inscrutability as projecting a false image of oneself in order to conceal or mask one's true feeling or thinking out of a need for sociability, the author's study has actually found Australians more inscrutable than East Asians (see Figure 1). In a comparison between Caucasian Australians (N=218) and East Asians (N=1673), the Australians have exceeded the East Asians in their pretentiousness (or should we say 'inscrutability') by about 5%. Admittedly, it is not a big margin. However, the mere fact that the Australians surpassed the East Asians (consisting of Hong Kong Chinese, Indonesians, Japanese, Koreans, Mainland Chinese, Malaysians, Singaporeans, Taiwanese, Thais, Vietnamese) in the survey is enough to explode the perennial myth of the 'inscrutable Oriental', which has stigmatised East Asians since time immemorial!



How do we explain this? The most likely explanation may be found in the inverse relationship between filiality and sociability [3]. In filial cultures such as Confucian East Asia, with the exception of Japan, the affective needs of the individual are generally

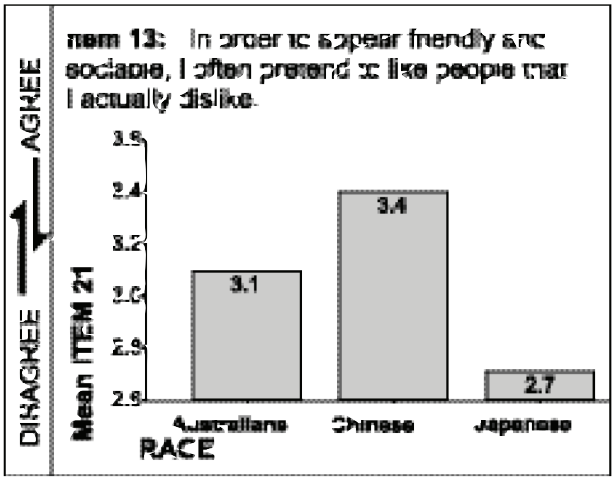
Dr Stephen Cheng is the director of East Asia Access Consulting in Western Australia

met within the family. There is generally not much need for the individual to seek affective satisfaction or affirmation from unrelated peers outside, even less through deceptive means.

However, this is not the case with non-filial cultures, such as the individual-oriented Westerners and the group-oriented Japanese, whose societies encourage them to loosen their filial bonds with their parents and to seek affective satisfaction from outside their family, albeit for different reasons. For the Westerners, they are expected to leave home after reaching the age of independence and live outside as autonomous individuals. As for the Japanese, their culture also induces them to leave home to seek affective satisfaction or a sense of belonging from groups outside the family, owing to their unigeniture inheritance system[2], and non-kinship based dozoku[3] and iemoto[4] organisations that virtually replace role of the biological families of their members.

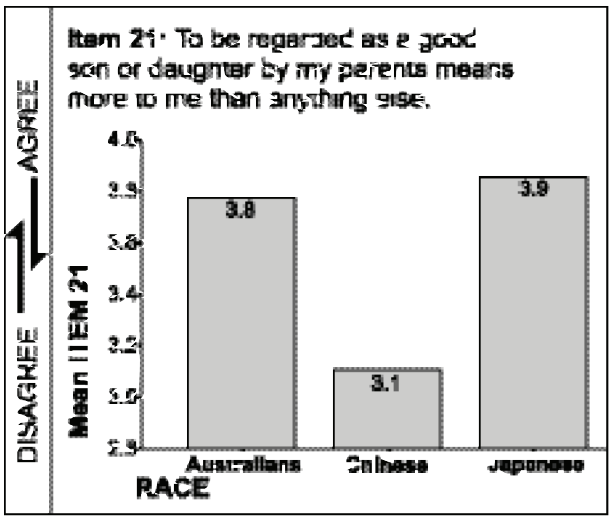
In both cases, the Australians and Japanese have a distinct need to compensate for the loss of filial bonds by cultivating substitute bonds with their peers, friends, colleagues or even employers, in order to secure their acceptance and affection. In other words, they have a stronger motivation to seek and maintain their social popularity than people from familistic cultures, even to the extent of resorting to what appears to be pretentious, deceptive and inscrutable behaviours.

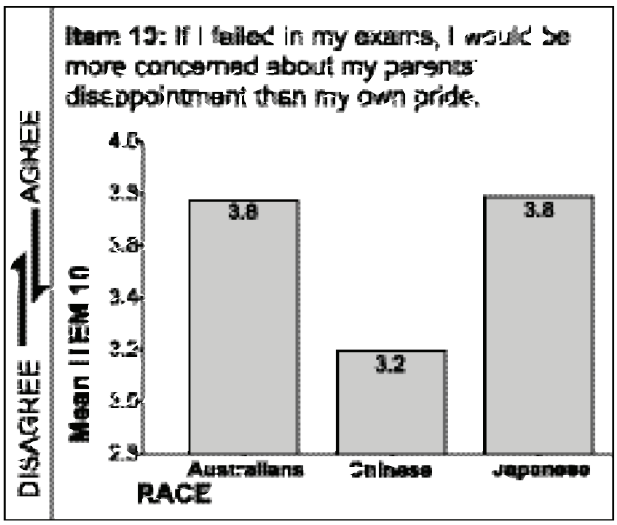
Figure 3:



To provide empirical evidence for such an explanation, Figure 2 presents two bar charts showing the outcome of a three-way survey of Australians (N=219), Chinese (N=884) and Japanese (N=316) in terms of their responses to two key filial items. In both charts, the striking difference clearly characterises the Chinese as a familistic culture and the Australians and Japanese as non-familistic ones[5]. Furthermore, in Figure 3, we have also found the familistic Chinese considerably lower in inscrutability than the non-familistic Japanese and Australian, actually beating the Japanese by 14% and the Australians by 6% respectively[6]. The outcome confirms our hypothesis that inscrutability increases with the need for sociability, as in the case of non-familistic cultures.

Figure 2:





One may well wonder whether or not the process of Westernisation (referring here to being brought up in a Western country) would have altered the above pattern, thus drawing the Australian born Chinese closer to the norms of Western sociability. However, the contrary has tuned out to be the case. Instead of drawing closer to the Caucasian Australians, the Australian born Chinese have moved farther away from them than even the Asian born Chinese, actually doubling the magnitude of the difference (see

Figure 4:

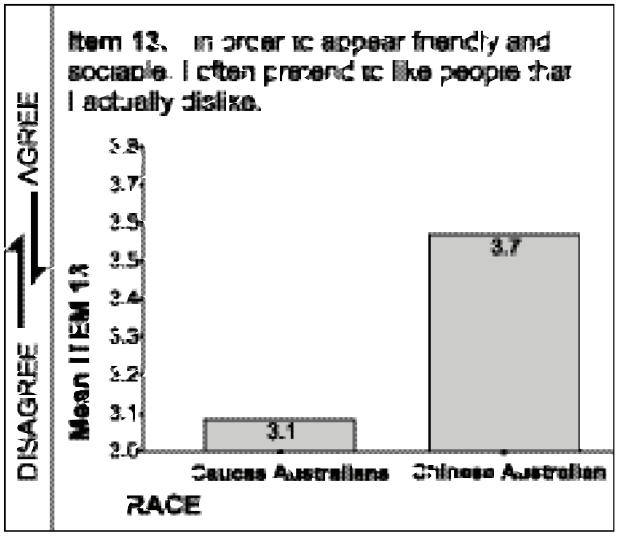


Figure 4). The finding suggests that the low sociability pattern of the Chinese has not only continued in the immigrant situation, but has in fact become much more pronounced in Western born Chinese individuals, making them less sociable, less inscrutable, and more transparent than even their parents. This is bound to have enormous and far-reaching implications to the Australian born Chinese, some of which have already become evident in their career choices, with most ethnic Chinese finding themselves in field-independent rather than field-dependent jobs and professions, where sociability skills are not of paramount importance.

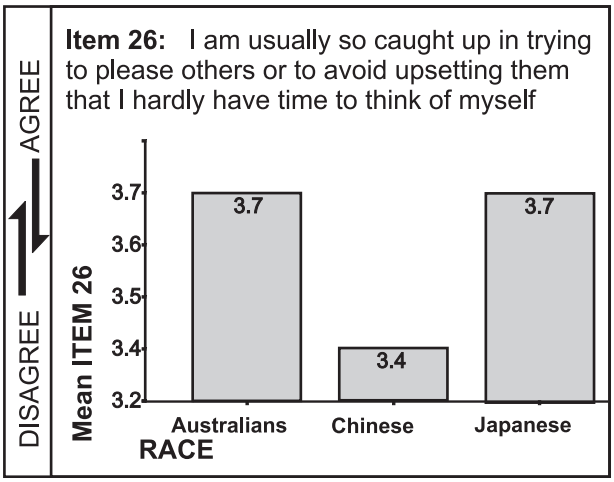
To provide further evidence for our case, let us examine the pattern of correlation of this item. It is interesting that while the Chinese have found a significant negative correlation between inscrutability and true self, neither the Japanese nor the Westerners have found any significant correlation at all between these two values. How do we interpret this?

First, the lack of correlation with the true self in the non-familistic cultures suggests that for them, being inscrutable or pretentious may have little to do with their 'selfhood', but merely an inherent part of their sociability or civility, aimed at gaining social acceptance by projecting a positive public image. It has no moral implications at all.

Second, as for the familistic Chinese, their significant negative correlation between filiality and inscrutability suggests two things. On the one hand, it may be interpreted that they regard inscrutability as a betrayal of one's true self, involving an element of hypocrisy or deceit. On the other, it may also be interpreted that the Chinese do not know or care very much about their true self at all.

In fact both interpretations are plausible. In the

Figure 5:



case of the former, since the familistic Chinese are not predisposed towards sociability to the same extent as the Japanese and the Australians, they are more likely to regard social pretence as an act of falsehood rather than one of civility. In the case of the latter, one may suggest that as the Chinese

tend to be so busy with fulfilling their family obligations and expectations, they normally do not have much time even to think about their 'true self'. In their Confucian culture of prescribed roles and rules of propriety, the Chinese are much more likely to be inter-personally rather than intra-personally oriented; much more concerned about their roles rather than their feelings, their persona rather than their psyche[7], their 'face' rather than their 'self' (see Figure 5).

For this reason, the most likely explanation why Westerners often find the Chinese 'inscrutable' is that they tend to assume erroneously the Chinese to be hiding their psyche, or the true self from them, which in fact, in most cases, is either never there or so diminished or atrophied that it is no longer detectable [4]. In other words, it is not that the Chinese are inscrutable, in terms of masking their true self, but that there is nothing much to be scrutinised behind the mask. For them, the persona is the person. It's a case of 'you get what you see'. That may well explain the extraordinary importance of 'face' to the Chinese, which is probably all that matters to them.

Conclusion

In defining inscrutability as a behavioural consequence of an individual's need for sociability rather than a racial characteristic, we have found in our study that the Australians have actually surpassed East Asians in their mastery of the art. We have also found that inscrutability increases with sociability and decreases with filiality, as demonstrated in the high inscrutability of the socially oriented Australians and Japanese and low inscrutability in the filially oriented Chinese. In regard to the Chinese, they appear inscrutable not because of a strong intra-psychic disposition, but the lack of it. Being filially rather than socially dependent, the familistic Chinese lack both the motive and the training or skills to put on an inscrutable front.

To debunk such an entrenched myth as the inscrutable Oriental is a complex task. We have, nevertheless, provided both the theoretical framework and empirical foundation critical to any future research on this important subject. However, it must be pointed out that the real reason for the writing of this article is not only to explode the myth, important as it is, but also to use it as a launching pad from which to explore the rich cultural tapestry of East Asian psychology and behaviour. It is hoped that, for the thoughtful reader, this article would also open up new pathways and modalities for reflection and research on comparative East Asian studies. Finally, in the current climate of intense international/intercultural paranoia and mistrust, the best hope for a better and safer world for us and for our children is to cultivate a greater mutual understanding across all boundaries of culture, colour and creed. Such a task, however, invariably starts with an understanding of ourselves, and how our own culture has shaped our values, thinking and behaviour. Like charity, it begins at home.

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Footnotes: refer to pp 119

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Qi

2003

kaleidoscope

in the eye of the storm

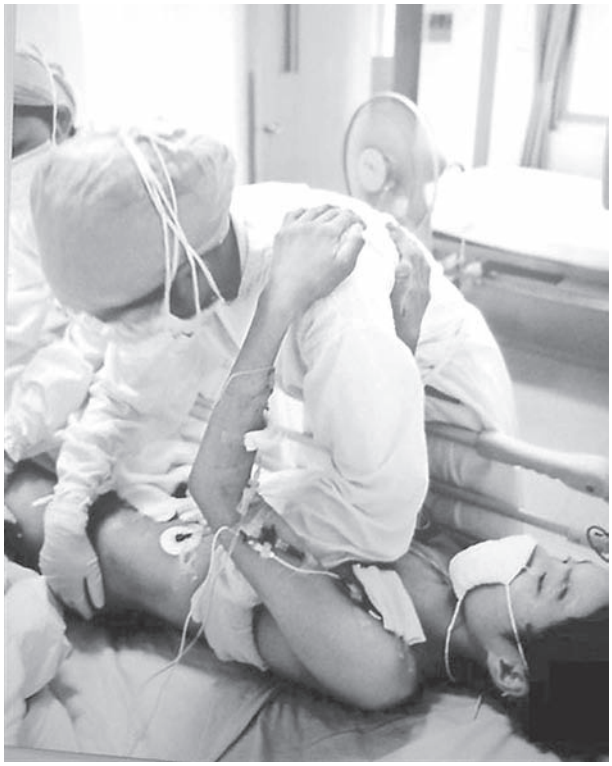
Peter Cameron

As an emergency physician, I am used to managing the unexpected. This year I found myself in the midst of a disaster I could not have anticipated. I was working as the Professor of Emergency Medicine at the Chinese University of Hong Kong as well as the Chief of Service for the Emergency Centre at the Prince of Wales Hospital in Shatin. I had been at PWH for just over a year and had not worked previously in Asia. I had been enjoying my time in Hong Kong and learning a lot about the local culture as well as trying to influence changes in the development of emergency medicine. My wife and three children were with me and they also were enjoying the new experience and culture.

On March 11, my life changed when I received an unexpected call from the Professor of Medicine, followed by a call from the CEO of the hospital. They were concerned that a few medical and nursing staff members were coming down with an influenza like illness. They thought that the emergency observation ward was a good place to accommodate them because it had a separate air-conditioning system and a separate entrance. I could see a number of reasons not to use the Observation ward: first, it would completely disrupt the function of my emergency department; second, it was not ideal in terms of space and toileting facilities. There was room for 24 beds but only if spaced less than a metre apart with no barriers between the beds. There was only a single male and female toilet. The other problem I had was that I wasn't sure that we were dealing with anything unusual. It was not uncommon for a few staff members to get the "flu" every winter, so what was different about this?

I insisted that the medical team at least characterise

Dr Peter Cameron is a Melbourne-trained emergency physician working in Hong Kong



Caring for the SARS patient

what was going on before it disrupted my department. The medical team called all its doctors and nurses from the ward back into the hospital that night and found that all of the initial group of staff had changes on their chest Xrays. About 30 staff were affected in this initial group. I then became a little concerned and went through my own staff and found five doctors and three nurses with similar symptoms and Xray changes. At this stage we had no idea whether this was an influenza viral infection or a novel infection not previously characterised. None of the initial tests showed any common organisms. The epidemiologists were quick to pinpoint ward 8A as the most likely source of the outbreak but it wasn't clear which patient was the index case. Patients and relatives who had been to 8A also began to get sick. Further medical staff, some not connected with 8A, contracted the disease. There was a hidden killer in our midst; we didn't know how it was spread or whether people survived the infection. In the first week, it seemed that everyone just continued to get worse. I visited my staff each day on the wards and tried to convince them that they were going to get better, even though I could see their Xrays getting worse. By the end of the first week, one of my staff members was in ICU critically ill requiring 100% oxygen. I had to prepare the emergency department for the likelihood that he was going to die.*

It became clear that we were all at risk, it was possible that every staff member might contract the disease and that all those who had visited the hospital could possibly have contracted the disease. The question of quarantining the whole hospital and staff was raised. The consequences of doing this would have been enormous, with the possibility that staff and patients may try to "escape" and make matters worse. We decided to keep staff on side and appeal to them to behave rationally and present for screening if they had any signs or symptoms. The CEO of the hospital called twice-daily "Council of War" meetings of all departmental heads to decide on the best way forward. These were very effective in coordinating responses, disseminating information and informally debriefing senior staff. It was apparent that in the absence of accurate information, rumours flowed freely. The rumours were always worse than the truth. Therefore daily factual bulletins were posted electronically as well as at staff fora .

Many staff (including myself) were concerned about the impact on their families, particularly the chance of acting as a vector for the disease. Some chose to stay away from their families; many slept in their offices whilst others went to hotels. I went home to my family but slept and ate separately. The stress that this caused was the most difficult part. Eventually Janet and I decided it would be easier if the family went back to Australia whilst I continued to work in Hong Kong. (I returned to Melbourne temporarily in early May for a disaster conference, and sent the material from HK to the authorities here)

Colleagues at Prince of Wales Hospital

*he was to recover fully and was back at work in the ED after two months

In the initial phase the emergency department was closed. When it was reopened, things remained quiet-no-one came because of worry over contracting the disease. All EDs in HK had roughly a 50% attendance rate during the SARS epidemic. We ran a screening clinic for SARS as well but overall the workload was considerably lightened. The morale of my staff was remarkable, especially in the short term when there was good leadership.

From the beginning we assumed that it was a "droplet spread" infection and so basic infection control procedures were implemented. We had on gown and gloves, N95 masks and caps. It was not necessary to wear "space suits" or use negative pressure ventilation rooms. There appeared to be some situations that facilitated spread: for example, the use of nebulisers or ventilators helped to aerosolise the virus and make it spread more widely. Despite the fact that simple control measures worked, the outbreak highlighted the major deficiencies in infection control training and procedures in all the general hospitals. There was one particular instance at the "Amoy Gardens" Housing Estate where the mode of spread probably related to faulty sewage systems but the explanation is still not clear. As usual in panic situations all sorts of possibilities were raised about possible modes of spread, including cockroaches (this particularly appealed to Janet as she hates them), rats, cats, dogs and so on. It was a very dangerous time for rodents!

Pictures from an exhibition: selected works of Chinese artists in a SARS - affected world. Anti-clockwise from top left: Radiographer; Ambulance crew; Mona Lisa.

An issue that was not clear at this time was how long the outbreak would last and whether it would spread widely to other countries. It seemed to us that it would be inevitable that it would continue for many months, if not years. The rapidity of spread also suggested that the disease would not be localised to Hong Kong. I was concerned that authorities both in Hong Kong and internationally were not taking this seriously and were distracted by other international events – principally the Iraq war. Eventually we were able to draw media attention to this problem and finally got the authorities to take basic precautions against the spread of the disease.

This experience taught me a lot about infectious disease and how little is known about even basic aspects. Conflicting opinions were given by the experts on simple things such as whether to wear masks, what type of masks to wear, whether windows should be left open or closed and so on. When questioned about the evidence base for controlling diseases such as "the common cold" and the RSV infections that happen every year, there was a lot of opinion and very little fact. With regard to the virus, despite confident claims by different scientific groups, the initial virus isolated was the wrong one. The diagnostic tests developed were less than 20% sensitive and claims of a vaccine being available quickly seemed laughable. No scientist has been able to tell me why four of my doctors contracted the disease and nearly died, without touching the index patient, whilst the rest of us, who worked in the same vicinity and were presumably equally exposed have had no serological conversion or symptoms. The outbreak started with a very high infection rate amongst close contacts: for example, in ward 8A, nearly all the medical staff exposed contracted the disease. Subsequently, many close contacts with high exposure did not contract the disease. After the first cases, no ICU or emergency staff subsequently contracted the disease despite ongoing exposure.

The disease appears to have come and gone without any valid explanation. The Chinese almanac forecasts a recurrence in November. This seems to be as likely as any other forecast, especially as the almanac explicitly forecast the initial outbreak in March.

Being involved in a disaster like this has allowed me to reflect a little on some important aspects of being a healthcare worker. I hadn't previously appreciated how much we expose ourselves to danger, especially working in emergency and critical care areas. This also potentially exposes our families to danger. It was also an opportunity to be involved in public advocacy, to ensure that public authorities protect their citizens as best they can. Although it is something I would prefer not to have endured, in retrospect, I feel privileged to have been involved. My major disappointment is that authorities in Hong Kong are now choosing to blame each other for an act of God, rather than congratulating each other for managing a disaster very well.

July 2003

Castlemaine is set in central Victoria amidst towering ironbarks and golden wattles. It was the first home of some of Australia's earliest Chinese immigrants. Miners brutally ravaged the fields there in the 1850s in the pursuit of gold and happiness. Most found neither of these there. Castlemaine has a train station. In world terms, today, it lies roughly halfway between New York and Jerusalem.

Waiting for the train,
Waiting for a love that never came,
Waiting for master to come home,
Waiting alone,
Waiting to die.

What lies beyond
the grief of Castlemaine?
There flowers lie,
washed by tears,
smudged all the more.

The people waiting side by side
with restless hands and smiling eyes.
One bench,
One laugh,
but aching hearts too far apart to cry.
The boy who died beneath the train

March 2003

was someone's son.
Someone waits,
waiting to hear:
your baby lies beneath the heroin bed.

No golden wattle grows
from where he lies.
Why did he die?
A hurt old man left behind, waiting,
because of him who went ahead.

I am waiting too,
for happy days,
when hearts won't rend.
And will you wait with me?
The prophets say that God is love.
Our Love has come
and will come still:
The Love that will not let us go.
Love that died for you and me… Love that arose,
waiting:
Waiting for us to come.

John Su
Dr John Su is a dermatologist and paediatrician practising in Box Hill, Essendon and at RCH

GUEST ARTICLE

Dr John Yu is a paediatrician and former chief executive at Sydney's Westmead Hospital. He has earned not only the distinction of being Australian of the Year in 1996, but was also awarded the honours of Companion of the Order of Australia(2001) and Member of the Order of Australia (1989).
He currently holds the position of Chancellor of the University of NSW. He is also vice-president of the Board of Trustees at the Art Gallery of NSW and Chairman of the Institute of Asian Culture and Visual Arts (VisAsia).
Born in China, he migrated to Australia as a child; and has had a longstanding interest in Western art which has included Australian paintings, English porcelain, and Asian textiles.

anyone for a cuppa tea?

Before the European immigration of the 1950-60s, everyone drank tea and the billy can of tea brewing over a camp fire was the romantic image of life in the Australian bush . During World War II, coffee was all but unknown; but the war, immigration and the resulting cultural diversity have led to a growing popularity of coffee in contemporary Australia. But tea retains its devotees and a cuppa tea or *cha* is still the traditional Australian gesture of hospitality.

China has always been associated with tea though much of the tea drunk in Australia in my earlier days was from the then British colonies of Ceylon or India. But how did the Chinese custom of drinking tea arise, and what of the etiquette of making and drinking tea that was so important in Victorian times and still remains so in Korea and Japan?

Tea was made from the young leaf shoots of *camellia sinensis*, a species of camellia with a small yellow flower that flourished in the highlands of Yunnan province in Southern China. Wild camellias, azaleas and rhododendrons can still be seen growing there today though the species found in the wild lack much of the colour and drama found in our garden varieties. That owes much to extensive and skilful breeding and hybridisation.

Tea may be just a beverage but its popularity was at the core of the great China trade of the 17th and 18th centuries. Indeed the demand for tea and its growing use in England were important in the development of the extensive potteries of the Midlands in the 19th century.

Tradition credits the Emperor Shen Nung (2737-2697 BC) as the discoverer of the special properties of tea. He is said to have noticed that some leaves had fallen from a nearby camellia tree into a kettle of boiling water and that this had resulted in a pleasing aroma. Later he drank the infusion which, according to the great tea historian Lu Yu " gives one vigour of body, contentment of mind and determination of purpose, when taken over a long period of time".The Chinese tradition of tea drinking had begun.

Like most popular activities, tea drinking has changed and evolved over time, meeting the needs and fashions of the day. Tea bags are a modern innovation but had they been invented three centuries ago, the ceramic history of Europe might well have been different.

In the reign of the Tang Emperors (618-906) tea was made in bowls similar in many ways to today's rice bowls and whisked into a frothy brew. As tea-making fashions changed, the much smaller bowls or cups of

> **the infusion which, ... " gives one vigour of body, contentment of mind and determination of purpose, when taken over a long period of time"**

the 17th and 18th centuries became more widely used. Tea was purchased in cakes or blocks and then cut into smaller pieces and ground into powder. The powder was added to boiling water in the tea bowl and then whisked. Tea can still be bought in blocks not only in China but also in Asian shops here.

Infusing tea from dried and prepared tea leaf is the other popular way of making tea. Tea can be placed into a bowl, cup or teapot and boiling water added. Brewing tea in a cup or bowl is still a common method in China. The tea leaf floats on the top of the water until the wa-

Anti-clockwise from top:

A Chinese globular teapot with figurative coloured enamel decoration. 18th century and typical of teapots made for the European market.

A red clay Chinese Yixing teapot, recently bought in Xian. Modern but well potted and with an attractive lid knob.

A First period blue and white Worcester English teapot made in the Chinese style. About 1770 and with an underglaze crescent mark.

A Chinese porcelain teapot in the popular globular shape and decorated underglaze cobalt blue and with enamel coloured decoration. The handle has been broken and replaced with a silver and wood handle designed for a coffee pot. Teapot and restored handle both date to the mid 18th Century.

ter soaks into the leaf, when it slowly sinks to the bottom. Sometimes the leaf does not sink and that is why some Chinese teacups have a lid which, when in place, prevents the tea leaves in the cup from being drunk.

But the demand for even greater convenience has meant that tea bags are now growing in popularity even though some of the aroma of tea and the subtleties of flavours are lost.

There are two types of tea, green and black. Green tea is dried and sometimes smoked. Black tea is allowed to ferment in the drying process and before smoking to further dry it.

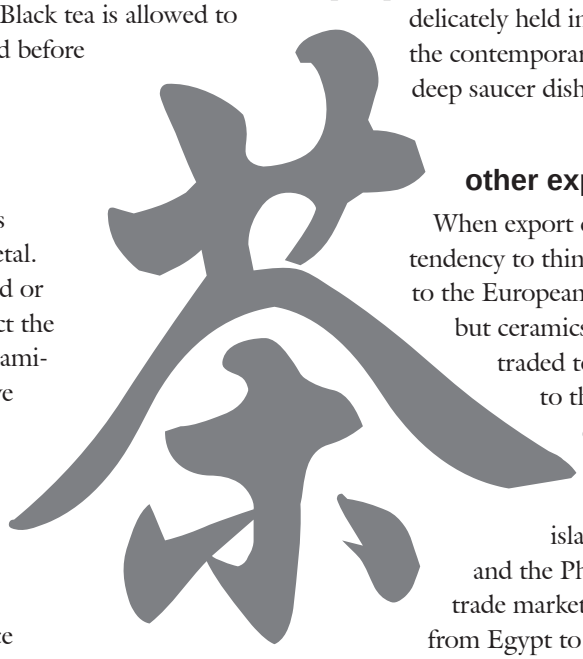
tea and the west

There are two common materials used for teapots: ceramic and metal. The most popular metal was solid or sterling silver which did not affect the flavour of tea or impart any contaminating tastes. Silver was expensive and so new manufacturing techniques were developed like Sheffield plate or electroplated silver which provided the appearance of silver and all its valued properties but at a more acceptable price to the growing wealthy classes of industrialists. Other metals remained a problem as teapots because of their toxicity or because of the metallic flavour they imparted to the tea.

Ceramic teapots were the most popular but only the true porcelain or hard paste porcelain of China was able to withstand the heat of boiling water. The struggle to emulate and copy true porcelain was a long battle in Europe with the first success being achieved by Frederick II at his Meissen factory in the German state of Saxony. But the first European attempts at making true porcelain were expensive and were not competitive with the established Chinese teapots. But Chinese porcelain was still costly for the average family and this was the driving factor in the continuing search for a cheaper product and the development of wares such as English soft paste porcelain and then bone china.

Tea was noted by Marco Polo in his 13th century travels to Cathay and it was also clearly recorded in the Arabian accounts of Hajji Mahommed in 1559. By 1660 Samuel Pepys wrote in his diaries *I did send for a cup of tea (a China drinke) of which I never drank before* and he thus firmly established the Western fashion for tea and its place in the society of that time.

The Flemish painters of the period were also recording the fashion of tea drinking and the use of Chinese export porcelain tea wares. They showed tea bowls being delicately held in the hand as well as recording the contemporary habit of pouring tea into the deep saucer dishes to cool.



other export markets

When export ceramics are discussed, there is a tendency to think only in terms of export wares to the European and later the American markets, but ceramics had many centuries earlier been traded to the southern parts of China, to the South East Asian countries of Vietnam and Thailand and to insular South East Asia especially to the Indonesian islands of Sumatra, Java, Sulewesi and the Philippines. There followed new trade markets in the Middle East, extending from Egypt to Arabia and Anatolia along overland routes and then with Song sailors. Teapots and tea wares were not common in these markets.

When it came to teapots, Europe, America and the Middle East tended to favour porcelain while in Southern China and S.E. Asia, stoneware ceramics were preferred especially the red stoneware teapots known as Yixing wares. These red pots come in a variety of shapes and sizes and were very popular in China itself. They are not as strong and robust as true porcelain and while they are today plentiful in the shops and markets of China, they often do not have the age of their porcelain counterparts. The majority of antique Yixing ware teapots have an appearance of age aided by oily stains and judicious application of wear.

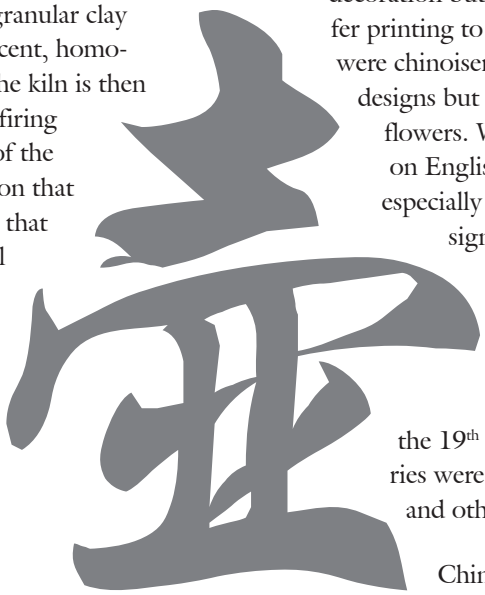
tea pots for the west

The commonest decoration on export teapots for

Europe was underglaze blue and white sometimes with added enamel coloured decoration. This same pattern of decoration is not unexpectedly seen in English and European teapots copying the popular Chinese products.

Blue and white is arguably the most successful and popular decoration found on Chinese export wares. The blue derives from cobalt and the physical characteristics of the cobalt pigment provides the clue to its favour.

In the manufacture of true porcelain, the raw clay object must be fired or heated in a kiln to about 1200-1300 degrees centigrade when the opaque granular clay and stone melts and forms the translucent, homogeneous and strong porcelain body. The kiln is then slowly cooled. During this process of firing and cooling, a significant percentage of the objects will be lost during the expansion that occurs with heating and the shrinking that takes place during cooling. Less skilful potters might lose 40 or even 50 percent of their pieces.



Cobalt oxide can withstand this level of heat and retain the brilliant colour of the new salts formed. Most other pigments are destroyed at such heat and so two kiln firings might be required, one to make the porcelain and the other to produce and fix the coloured pigment used in the decoration. The fewer the firings, the less the kiln loss and consequently the cheaper the porcelain production costs.

Blue and white wares sometimes had gold bands or decoration added, in the process of gilding. This was usually applied in London but some gilding was applied at source before being exported.

Coloured decorations required the use of enamel colours and these could often only withstand firing temperature of 800-900 degrees. This required two firings, one to create porcelain; then after cooling and enamel painting, another to fix the enamel colours. The greater production costs meant a more expensive final product. Coloured porcelains were dearer to make and thereafter remained dearer to buy. Centuries later they remain more expensive whether it be Chinese porcelain or English Worcester.

English teawares

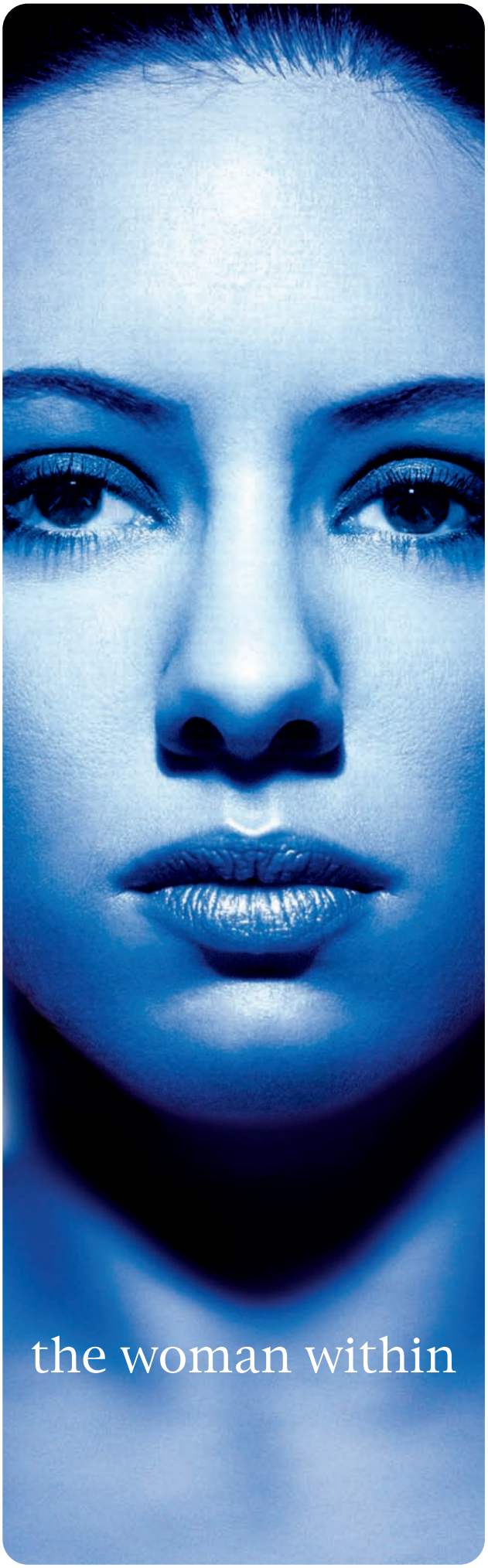
Worcester was a prodigious china factory which made many tea wares and boasted an extensive catalogue of designs and decoration. The Wall period or First period started in 1752 when Dr John Wall and apothecary William Davis made their first "Worcester porcelain". Dr Wall was a physician and had written several medical papers by that time.

Their greatest output was blue and white tea ware, initially following the Chinese practice of hand painted decoration but later trialing for cost reasons transfer printing to create decorations. The patterns were chinoiserie decoration with pseudo Chinese designs but later floral decorations used English flowers. When figures were painted or drawn on English ceramics they often had a naivety especially when using Chinese figurative designs which had its own charm.

Other factories which produced excellent tea wares in the 18th century were Bow, Lowestoft, Caughley and the Liverpool factories. In the 19th century Newhall and Coalport factories were prominent together with Minton and other Staffordshire potteries.

Chinese or English? Well that is a personal choice. Both have their own merit but if you are intending to use the tea wares despite their age and value, then think about Chinese wares as they are more robust and less likely to succumb to the challenge of boiling water.


Release



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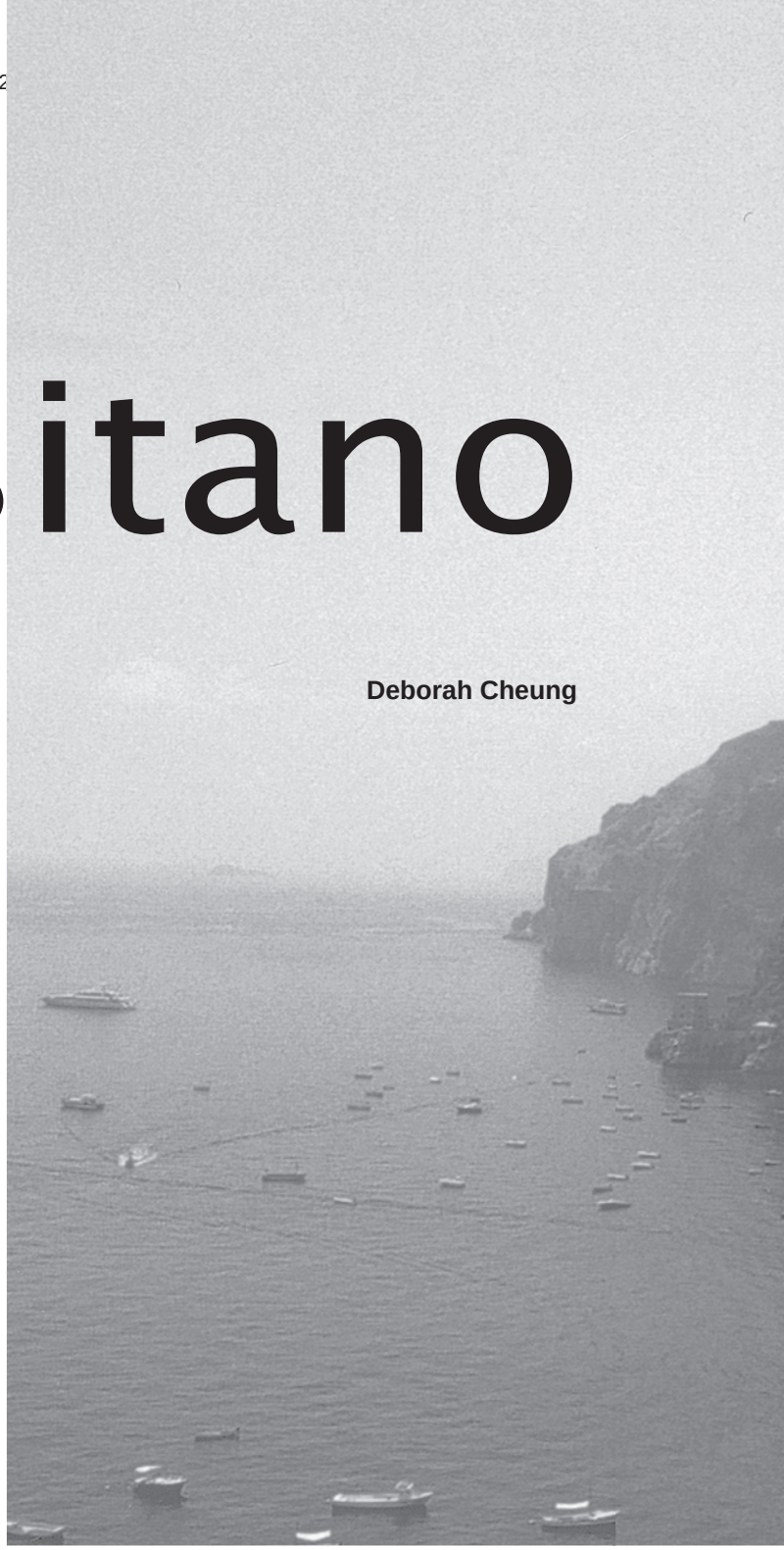
legally positano

Deborah Cheung



Tell an Italian that you're going to Positano for a conference, and the response is positively Pavlovian: take me with you, *per favore* (oh, please God). No-one cares that you are going to a 4 star hotel on the Amalfi coast for the express purpose of attending medico-legal lectures. The venue declared, the fantasy is set. The intention is that you go into the conference on Sunday, and emerge, bronzed and sun-dazed, the following Friday. Because in Positano, Italy, miracles do happen.

In the tome of notes you receive on registration, somewhere occurs the deathless line: 'we can't believe this is a conference'; but I suspect that was uttered by grateful attendees, rather than the organiser, the Queensland barrister Lorenzo Boccabella.

Copious pages on how to get there were squandered at the last when Lorenzo decided to organise a bus, which very nearly proved to be his undoing.

I had just spent two weeks in Florence being tutored in Italian and so caught the Eurostar back to Roma Termini, the main train station near where the conference delegates were to meet. I'd arrived half an hour early, and then proceeded to spend that half hour forlornly towing my luggage up and down the main street outside of the Hotel Royal Santini, looking for Lorenzo and his bus.

Lorenzo will be holding the Australian flag, his secretary had advised. He swore later that he had been, but then inadvertently stashed it in his bag: a quarto-sized piece of cardboard that his daughter had dutifully coloured in for him.

Across the road from the hotel was a row of stationary buses and I stopped by each of these to call out to the pensive driver within: *Sto cercando* Lorenzo Boccabella, *un australiano…lo conosci ?*

No driver appeared to know the name, so I trundled back to the Santini and after several futile attempts to ring his mobile, rang Lorenzo's rooms back in Queensland. An uncertain young man told me to look for someone who resembled 'Mario' ('you know, the board

Dr Deborah Cheung is a general practitioner and editor of Qi

game'), or Bruno Grollo. I turned around and Mario Grollo stood just four paces away. I was in the middle of the Australian delegation and suddenly the accents of the surrounding voices swamped me in a wave of nostalgia.

We waited for that bus to arrive for the next hour and a half, whilst an increasingly impatient Lorenzo paced the footpath, having repeatedly rung the bus company. It turned out that the driver had arrived two hours ago, and, astonishingly reticent for an Italian, had sat in his bus across the road from us without telling anyone that he was there. I guess he hadn't wanted to tell me either.

We were on our way.

grand hotel Tritone, Praiano

The drive from Rome took around four hours, with a break for lunch. Our bus driver, flushed from his earlier escapade, had to stop off several times to ask for directions to our conference venue, the Grand Hotel Tritone


N MORGAN

in Praiano, some seven kilometres south of Positano.

The oddest thing about the hotel was that from the roadside, where we were dropped off, there was nothing so much like hotel as a single tiled foyer, perched alone on a clifftop corner with a row of parked cars off each arm. The grizzled bellman with his seacaptain's whiskers pushed us by turn into the cramped elevator and we emptied out several floors below into the hotel foyer proper. The feel was old Mediterranean, with shiny patterned tiles, palms and wicker and floral couches, wide terrace balconies opening out wherever you looked.

And the views ? To a Melburnian used to overwhelming flatness in sea and cityscapes; to an adopted Florentine who had just spent a fortnight baked in terracotta and Tuscan stone: I hung on the balcony, limpet-like, drinking in the sunlit sea and coastal townscape as one parched, unbelieving that anything could be so beautiful. Like Positano, the steep hills that rose like backbones from the water were cropped by whitewashed houses in the town of Praiano, centred about the gleaming dome and cross of a small church. In the haze of heat and blinding afternoon sun, the hotel hung above the glittering waters in a suspension of light.

Paradiso, we thought then, and again that night on the stroke of twelve, when from the terrace we watched our first fireworks, the night sky bursting into flame and crackling like storm over the black sea off Positano. Another saint's day on which to give thanks.

life at the conference and other matters

In the midst of such spectacular beauty our learning fell by the wayside.

There were things of interest on the program which deserve a mention, ranging from the pertly titled 'Capricious litigation !' to the topical issues of the McBain decision (IVF for the single female) and the Pan Pharmaceutical recall.

If the taxman reads this article it will be in writing that Deborah Cheung attended everything. As it was I went to significantly more lectures than a Chinese couple I met on the bus from Rome (neurosurgeon married to a lawyer) who vanished soon after they had checked in to Tritone, and were to resurface only on our final night dining on the hotel balcony (oh *hello* !- yes we've had a very good week thank you)

One late afternoon midweek I recall floating in the pool face skyward, after a little snooze and a lemon slush proffered to me earlier. Lectures were officially from 3.30 to 8 pm which, translated into Italian time, meant from some time past 4 to some time after 7. In the softening light we were joined by one of the attending partners, an ABC journalist, who as she slid into the pool, gave us a rundown on the conference state of play. A momentary discomfiture: should we have gone ? would she dob us in on ABC radio on a slow news day ? –to be followed by the certainty of principle: not to turn your back on paradise, not in Positano.

In one sense you could have looked upon the scene as something close to a medico's nightmare. LAWYERS ! They were in the lounge with cocktails, they were draped in and around the pool; they traipsed the shops in Positano and jollied up the restaurants; you'd meet them on the bus, you'd meet them at breakfast and at tea. But as Lorenzo noted ruefully, it was hard to pretend to status here: the word 'barrister' sounds like the Italian 'barrista'- the guy behind the counter who makes your cappuccino.

Apart from a delightful psychiatrist who kept us hugely entertained- he had a story for every occasion- I barely rubbed shoulders with more than a handful of doctors. There was the colorectal surgeon who would not give out his occupation during dinner and said tightly 'business' whenever you probed. A couple of stray male medicos who went on solitary excursions.

I learned to have lunch with the legal people and their spouses, and remember many of them with affection. From the mischievous judge on the MABO case who leaned forward at the table to murmur, *money available, barristers only*; the lawyer-cum-ex-mayor with the booming voice who strode about organising us for dinner each

Facing page, clockwise from top left: the famous Positano vista as viewed from the water; 'Captain Morgan' who steered our water taxi; view of Praiano from Hotel Tritone; afternoon with friends and lawyers; Positano beachfront; cooking segment for Italian TV breakfast show

night; to the lawyer who came up from coastal NSW to work on his tan and proved such good company I could hardly bear to travel without him.

And then there was Maggie. She would not shy from my use of her name, such was her formidable repute it went before her like a banner. You could tower above her but she still managed to stare you down like a witness who needed to be brought to order. Maggie the barrister did her sums and, having concluded that we were paying like sheiks for the privilege of being there, organised a revolt against Lorenzo. She tackled us bleary-eyed at breakfast, drummed up support in between lectures; found us at the poolside to strenuously put forth her views on Lorenzo's almost criminal deeds of capitalism. Papers with better deals, comparative price ranges, were waved in our faces. She even organised a trip to the isle of Capri (rock-bottom rates) to rival that planned by Lorenzo for our last day.

It might possibly have been her doing that at some stage the hotel Tritone was dubbed 'Fawlty Towers' and the label stuck mercilessly for the rest of our stay…It was she, if I recall, who encountered the modish blonde at reception who, in reply to Maggie's slightly peevish (if real) complaint about the high cost of bottled water, said 'Don't drink, then'. Or it may have started with the bellboys who led us wordlessly through the warren of corridors and stairs and lifts whilst we struggled behind with our luggage. Or the reception blonde (again) who, having sold out of tickets to the SITA bus by mid morning, told us to walk to town (2 km away on a winding narrow road) to buy them there. I'm not sure that I should even mention the toilet paper unfurling in the waves at Tritone's exclusive beach access.

But the label was sealed when we met 'Manuel', the hapless Italian waiter who ducked and weaved around our tables like his namesake, and once presented the wrong dish to one of us with a magnificent flourish. And when someone thought, on our last night eating at the hotel, that they'd seen a mouse scuttling by on the balcony, nothing more had to be said.

Positano and other excursions

Praiano may have been the conference venue but every delegate had come with the expectation of venturing further afield. You could to this end choose Lorenzo's 'extras': an evening at the opera in Rome, pre-conference; a sweaty hike around the ruins of Pompeii; or the aforementioned trip in a flotilla of boats to the isle of Capri, rival tours notwithstanding. Or you could make tracks on your own to the Positano township, and following that, head out to the nearby coastal towns of Amalfi, Ravello, and Sorrento, and still have time left over for that dip in the pool. Few were hardy enough in this exceptionally hot July to try the mountain walking trails around Positano which are famous for their breathtaking views.

In the town itself – once you have collared the right bus to take you there- there is as much beauty and as much kitsch as any tourist could hope for. The villas which hug the slopes boast some of the world's most expensive property but even so, it is possible to eat well and cheaply at one of the many beachfront/oceanview restaurants, as it is to trawl the hopelessly touristy shops which cram the sides of the narrow streets. Roads here go up or down and are always winding. Driving can be tortured, and after a near-miss by our bus with a motorbike, being a passenger, hair-raising. Getting around on foot involves climbing many stone stairways, at times shaded beneath arbours of bougainvillea and wisteria.

All the signs point down to 'la spiaggia', the beach, from where the famous vista of the Positano mountainside can be perfectly captured. Italians flock to the grey gravel by the sea on which hundreds of bright umbrellas are set up over deck-chairs; they pay their fee and lay themselves out in the sun with complete abandon and every intention of being on show. Here also are the striped red and white bodies of the English, and the occasional American leather, but no-one knows like the Italians how to look so utterly glamorous in swimwear.

The region is alive with the scent of citrus, and the locals make a potent liqueur from lemons, *limoncello*, which is often offered after dinner as a digestive. The house wines are lilting and complement the sweet prawns glistening hot off the grill, and platters of smoky eggplant, red peppers and small zucchini splashed plentifully with EVOO. One local restaurant in Praiano, San Gennaro, which like many others offered transport to and back from our hotel, liked to pile our tables with plenty of chargrilled fish and calamari, and could turn

out a robust spaghetti puttanesca.

No visit to Positano would be complete without seeing the renowned Africana nightclub, where the dance floor is set with glass portholes through which you can see fish swimming beneath your feet, and where the cavernous (literally) room opens out, framed by rock, to the open sea. During the course of the night a huge net is trawled and lifted up like a centrepiece, in which the fish are flapping, albeit for a short time. It has naturally been visited by luminaries too numerous to mention.

.....

No-one really noticed when the conference drew to a close. The trip to Capri had had to be rescheduled to the last day because of choppy waters mid-week, which meant that scheduled last-day lectures got squeezed in after sunset.

Late into some nights when we used to sit out on the terrace balcony, drinks on the table, a slightly droopy Manuel wiping the bar counter with many sighs, a fleeting thought of our lives before Positano would occasionally intrude. But at week's end we barely knew those pallid days; and the vision of precipitous beauty that assailed our senses wherever we went was to transform our minds entirely. You come away, with the romance of that shining time part of you forever.

deborahcheung@bigpond.com

Hotel Tritone, Praiano

thousands and tens of thousands of varieties of Qi

qi xiang wan qian

氣象萬千

Adeline Yen Mah

When I was a little girl I lived in Tianjin, in north-east China. The summers there were dry, hot and sunny. On the few occasions when the skies were overcast, my Aunt Baba would take us children into the garden in the evening twilight to enjoy the cool breezes (*chun feng liang*). I remember watching the clouds hovering in parallel, horizontal white layers against patches of bright blue sky. I believe these thin strips of greyish-white clouds may have been the pictorial origin of the word *qi*, which initially meant 'air, vapour or gas'.

The strokes in *qi* may have evolved in the following way:

Later, the character for rice (米mi) became incorporated into the ancient form of the word *qi*氣. This may have come about from observing the 'nourishing' steam rising out of a saucepan of boiling rice. Thus, the concept of *qi* came to encompass and symbolise nourishment as well as vapour.

Qi (pronounced *chee*) is a difficult word to translate and probably no two scholars will agree on its exact definition. It is a unique concept fundamental to Chinese thought, and has no equivalent in English. In the west a 'rational' and 'scientific' way of perceiving reality is to divide it into

This is an edited extract from the book "Watching the Tree (to catch the hare)" by Adeline Yen Mah

Matter	vs	Spirit
Form	vs	Space

Matter and form are viewed as solid and concrete phenomena that can be seen and felt. Spirit and space are more ephemeral concepts. It is difficult to accept a word conveying something that encompasses matter, spirit, form and space all at the same time, but such a word is *qi*.

In the Chinese-English dictionary *qi* occupies more than half a page. Translated literally, the word means 'air, gas, breath or life-force'. Then there are physical types of *qi*, such as *kung qi*空氣(atmospheric air), *tian qi*天氣(*qi* of the sky or weather) and *du qi*毒氣 (poison gas); as well as abstract *qi* expressing human emotions, such as *guan qi*官氣(*qi* of a bureaucrat throwing his 'weight' around) and *pi qi*脾氣(*qi* of the spleen or temper). Every artist attempts to capture the incomparable vital force of nature called *yuan qi* 元氣and incorporate its essence into his work. When a painter succeeds we tell him 'he has arrived' and is exhibiting *qi xiang wan qian* 氣象萬千 (thousand and tens of thousand varieties of *qi*). Sometimes, however, when this occurs and he is appointed to paint the portrait of the governor, he may start to cultivate notions of his own importance and show signs of *qi ling xiao han*氣凌霄漢(spewing overbearing *qi* all the way to the sky). It is possible that when the governor sees the work he will be unimpressed and refuse to pay. This gets our artist upset and *sheng qi*生氣(his *qi* is generated and stirred up). He bursts out with anger (*qi shi ziong ziong* 氣勢兇兇); so much so that his hair bristles with rage against his hat (*nu fa chong guan*怒髮衝冠)! Altogether a very bad hair day!

Qi can be divided into two primary types. This innate *qi* or *yuan qi* of a person is the basis *qi* he has inherited from his parents. (The concept of *yuan qi* is so ingrained among the Japanese that instead of saying, 'How are you?' or, 'How is your health?' a standard greeting in Japan is, 'How is your *yuan qi*?')

Acquired *qi* is the qi a person gets from air, food and social interaction. It can be replenished by a healthy diet, physical exercise, undisturbed sleep, good friends and laughter.

The Early Han dynasty writer and philosopher Dong Zhong Shu董仲舒(179-104 BC) defined *qi* this way:

Within the universe exists this *qi* of *yin* and *yang* in which man is constantly immersed, just as fish are immersed in water. The only difference between *qi* and water is that water is visible whereas *qi* is not. But man's existence is as much dependent on this *qi* as fish's life is dependent on water. *Qi* is found everywhere in the universe but is less visible than water. Thus although the universe seems to be empty, yet there is substance at the same time. Man is engulfed in this vortex and, regardless of whether he is orderly or disorderly, is carried along on and on, in a common current.

The Song dynasty philosopher Zhu Xi朱熹(1130-1200) had this to say :

'At first there was form (形*xing*) and matter (質*zhi*). *Qi* then infused form and matter. *Qi* is the primordial

energy which is the source of all beginnings.'

The concept of *qi* is integral to Chinese thoughts on medicine and philosophy. The theory of Chinese medicine is based on traditional Chinese beliefs of *yin/yang, qi* and the five elements. *In the Yellow Emperor's Classic of Internal Medicine (黄帝内經 Huang Di Nei Jing)*, from the second century BC, *qi* plays a prominent role. The ancient Chinese thought that *qi* had its own circulatory system separate from that of the blood, although the two systems were intimately intertwined. They believed that the movement of *qi* (breath or air) influenced the flow of blood. What, then, directs *qi*? It is directed by *yi* 意 (intention of the mind). Thus, *qi* was seen as a psycho-physiological force connected to the flow of breath, blood and inner thoughts…

…Although there is no anatomical evidence for the existence of a separate circulatory system for *qi*, it is generally acknowledged that we humans do possess an intimate 'mind-body' connection. Studies have shown that depression, anxiety and stress may cause or aggravate numerous systemic diseases (such as hypertension, angina, arrhythmia, rheumatoid arthritis and asthma), whereas tranquillity, laughter and happiness can alleviate pain, promote health and improve immunity.

According to *Huang Di Nei Jing*, all illnesses are due to insufficiently balanced *qi*. It asks,

'If the true *qi* is harmonious, how can illness arise?… True *qi* will come if you remain calm and imperturbable. Develop your inner spirit and you will have well-being.'

When *qi* is weak, exhausted or inadequate (a condition described as *xu* 虚), its flow becomes disharmonious and the patient is susceptible to disease. When angry, *qi* is aroused. When happy, *qi* is strengthened (*gu* 固) and flows smoothly. When sad or anxious, *qi* is diminished. When frightened, *qi* is confused. Chinese medicine aims to transform *qi* (*qi hua* 氣化) through a healthy diet, physical exercise and peace of mind. If *qi* is in harmony (*qi he* 氣和), immunity is replenished. The Classic also states:

The function of the tract-channel system of the human body is to promote a normal passage of blood and *qi* so that the vital essentials derived from man's food can nourish the *yin* and *yang* viscera, sustain the muscles, sinews and bones, and lubricate the joints… What we call the vascular system is like dykes and retaining walls forming a circle of tunnels, which control the path that is traversed by blood so that it cannot escape or find anywhere to leak away.

The Chinese believe that the balance of *yin* and *yang* within the body is the fundamental condition of harmony. When *qi* is obstructed, its flow is impeded and an imbalance of *yin* and *yang* is created. Through proper diet, herbs and acupuncture, the flow of *qi* is restored, thus re-establishing harmony through the balance of *yin/yang* energy…

…Just about everyone in China, from the poorest peasant to the greatest scholar, believes in the power of *qi*. In *The Art of War* 兵法 *(Bing Fa)*, a remarkable book written by Sun Zi 孫子 2500 years ago, *qi* is much emphasised. At one time this treatise on war and strategy was reserved for rulers and not permitted in

"Watching the Tree" (Flamingo, Harper Collins, 2000) is an account of the writer's 'views on Chinese philosophy, writing and language', through interpretation of books and personal experience.

Adeline Yen Mah was born in Tianjin, China, and lived also in Shanghai and Hong Kong. She went to medical school in London, England, but left for the US when she was 26. She passed her exams in internal medicine but went on to become an anaesthetist (anesthesiologist); and practiced for 26 years in Anaheim, California where she still lives with her husband. She is now 65, and has also written an autobiography, "Falling Leaves", and two other books, "Chinese Cinderella" and "A Thousand Pieces of Gold".

private hands. If the book was discovered in the secret possession of an ordinary individual it was construed as evidence of a military conspiracy; thus its contents had to be transmitted orally. Eventually, when censorship became less stringent, it was transcribed onto bamboo slips or pieces of silk and stored in imperial libraries. A few copies have been discovered buried in caskets next to the bodies of ancient kings together with their precious jewels and cherished swords.

For over 2000 years *The Art of War* has remained the most important military treatise in China, assiduously studied by all her military leaders. Its fame spread to Japan and Korea and it became a sort of ageless international bestseller on warfare. Translated by a French missionary 200 years ago, it was reputedly read by Napoleon, Bismarck, Nazi generals and the Japanese army, as well as by West Point cadets in the USA. Chiang Kai-shek and Mao Zedong were both familiar with its text and based their military strategies on its teachings. According to the British historian Basil Liddell Hart, 'Sun Zi's essays on war have never been surpassed in comprehensiveness and depth of understanding. They might well be termed the concentrated essence of wisdom on the conduct of war.'

'If a country is to wage a successful war,' wrote Sun Zi, 'then the people in that state must be well governed by a compassionate and dynamic ruler who enjoys support and loyalty from his people and his officials. The soldiers will then march into battle filled with morale, momentum, determination and intensity. This is known as military *qi*.'

In the opinion of Sun Zi, *qi* ebbed and flowed constantly. He advised that the enemy should be attacked when their *qi* had abated:

The *qi* of the enemy can be snatched away, the commanding general's mind can be seized. For this reason in the morning their *qi* is ardent; during the day their *qi* becomes indolent; at dusk their *qi* is exhausted. Thus one who excels at employing the army avoids their ardent *qi*, and strikes when it is indolent or exhausted. This is the way to manipulate *qi*.

In Chinese philosophy, *qi* is the counterpart of *li*. *Li* means principle, reason or logic. *Qi* means both energy and matter. It is considered to be the fundamental substance, the powerful life force that exists within each and every one of us…

…I shall now relate to you a personal story involving my own *qi*:

My stepmother Niang died of cancer of the colon in 1990. Exactly one day before the reading of her will I discovered that I had unexpectedly and mysteriously been disinherited. In addition, I later found out that there had been a conspiracy on the part of my siblings to hide the truth from me before her death.

Two of my attorney friends approached me and advised me to challenge my Niang's will. They said they would charge me nothing because they were convinced I would be given a portion of my parents' estate if I allowed them to file a caveat on my behalf.

At first I was sorely tempted because I was simply outraged by my family's deception. There is nothing worse than the knowledge that you have been deliberately duped and robbed by those you trust, who you believed would guide and protect you. I was depressed, angry and desperately unhappy. I suffered from insomnia and loss of appetite. Again and again I tried to talk to my brother James, who was the executor of our parents' estate. However, he was in denial and had no wish to speak to me.

Full of resentment, I flew to Shanghai and unburdened myself to my Aunt Baba, whom I loved very much. I spoke to her of lawyers and jurisdiction, of my agony at being victimized and my quest for justice. This is what she said to me:

'If you take your siblings to court, I predict that you will become more unhappy; because even if you were to win after a long, legal battle, it would be a hollow and negative victory since money is not the issue nor your motivation. Besides, no court on earth can ever compensate you sufficiently for your emotional pain.'

'Let me remind you of our ancient Chinese concept of *qi*. What is *qi*? It stands for the vital energy that perme-

ates the universe, regulating and balancing each person's vitality. Used correctly, the word *qi* means the foundation of courage, will and intention.'

'*Qi* is dependent on moral conviction. If you feel in your heart that you are right, you will go forth even against thousands and tens of thousands. But if you feel in your heart that you are wrong, you must stand in fear even though your opponent is the least formidable of foes. Right now, your whole being is infused with your *qi*. Go and do something positive with it. Life is similar to a game of chess. Think clearly before you act. By giving up this pawn, you might conceivably end up winning the entire contest. Always bear in mind what our great scholar Sun Zi wrote in his book *The Art of War*. Being unconquerable lies with yourself, being conquerable lies with the enemy. One who knows the enemy and knows herself will not be endangered in a hundred engagements. But the best way is to win without fighting.'

So, instead of suing, I started writing long letters to my brother James, to which there was never a reply. Then a strange and exciting thing started happening. The more I wrote about the problems of our family being torn apart and in conflict with itself, the calmer I became as I went about my daily tasks. Gradually, as the months went by, my insomnia vanished. My appetite returned. My outlook improved. I started playing tennis again and sleeping more soundly. Even my bowel habits became regular. At the end of two years I realised that I had the first draft of a publishable manuscript in my hands. So I gave up my job as a physician and started looking for an agent. Call it bibliotherapy. Call it serendipity. But that's how I became a writer. In a way, you could say that my book *Falling Leaves* is a visual manifestation of the integration of my *qi*.

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Creating wealth through gearing

by Peter Tsiglopoulos CPA FPS, Senior Financial Adviser
Authorised Representative of MASU FINANCIAL MANAGEMENT PTY LTD, Licensed Securities Dealer, 231140

While property is still the most popular gearing route, shares are now vying for the attention of those who borrow to invest.

Aside from tax benefits, negative gearing offers the potential for portfolio diversification and long-term wealth creation. Increasingly, more and more people are borrowing to buy property as one way to financial independence. Others are diversifying into a geared share portfolio, building wealth via the sharemarket and then using their equity in the sharemarket to buy property.

There are a couple of factors that, on average, rate property above shares when making an investment decision, even though historically, shares have performed at least as well as property over the long-term. With property investing, you don't get the level of volatility you do in shares, however with shares, assets are more readily bought and sold. While sharemarket investors do need to consider which companies they will invest in and whether to buy direct shares or managed funds, the level of decision making they face is often not as great as for the investor buying a property.

Having made the decision to invest in shares, the next question to ask is 'Why gear?' The answer is simply to create wealth. Negative gearing is not just about tax benefits, it also offers the potential for portfolio diversification and long-term wealth creation. Negative gearing occurs when the interest on the borrowing in a year is greater than the investment income, which can produce a net tax reduction.

It is important to note that while gearing into shares increases your potential for greater returns, it can also increase the potential for greater losses if the share investments you choose perform poorly. In the short-term, the sharemarket is volatile and gearing your share portfolio will expose you to greater risk in a falling market. However, if you manage your risk by diversifying your investments and monitoring your gearing levels in light of your personal situation and current economic climate, gearing can be a highly useful long-term strategy.

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kiribati eye camp

Trevor Gin

I've done an eye camp in Kiribati. Now, before you wonder why I am doing an eyecamp in the residential grounds of Australia's prime minister, that's Kirribilli, not Kiribati. Besides, what would you do for John Howard? A repeat eyebrow-ectomy? (what did happen to those large hairy caterpillars that lived above his eyes?). No, Kiribati is a small set of islands located in the middle of the Pacific Ocean. And it is not pronounced as it appears, but thus: 'Kee-ree-bus'. This is because that part of Micronesia have their own 13-word alphabet, and pronounce '-ti' as '-s', and in fact 'Kiribati' is the Micronesian form of 'Gilbert', as the group of islands were formerly known as the Gilbert Islands. Just to check whether you have got the hang of it, the islands known as the Christmas islands in Micronesia are now known as the 'Kiritimati' islands. Confused?

So, Kiribati is a collection of 33 large bits of coral but small bits of island on the Equator in the Pacific Ocean. 1 25 N, 173 00 E, to be exact. It is in an area known as the doldrums, which was coined because of the lack of winds that occur in that region making it laboriously slow to sail through the region, so much so that time seemed to stand still. So it does have quite a few similarities with Kiribilli house (apart from the lack of wind). In total area it is 811 square kilometres and has a population of 84,000 people, most of which are wonderfully unaware of the rest of the world.

the plane trip that was funny if you weren't on that plane

As you can imagine, getting to Kiribati is not easy. First you fly to Fiji, which in itself is quite easy. Especially for my colleagues, Tony Hall and Ben Clark, who were in first class. I had decided to swap my ticket for economy so that I could get a ticket for my wife to go to Fiji for a holiday, the plan being that I would meet her there after my work trip. I, the economy doctor, decided to venture forward to the first class section to see what life for my friends was like there. I was kneeling in the aisle when a stewardess with a large plate of filled port glasses came up to me with a large smile on her face. 'Excuse me, sir…..'. Yes, I thought to myself, I would really like an after-dinner liqueur. I gave her my 'thank you' smile and lifted my hand to select the second glass from the left. 'Could you please return to your seat, this area is for first class passengers only'. She didn't even break her smile! I lifted my hand past her tray and scratched my left ear. 'There, that got it', I said

Dr Trevor Gin is an ophthalmologist practising in Melbourne, Doncaster and Frankston

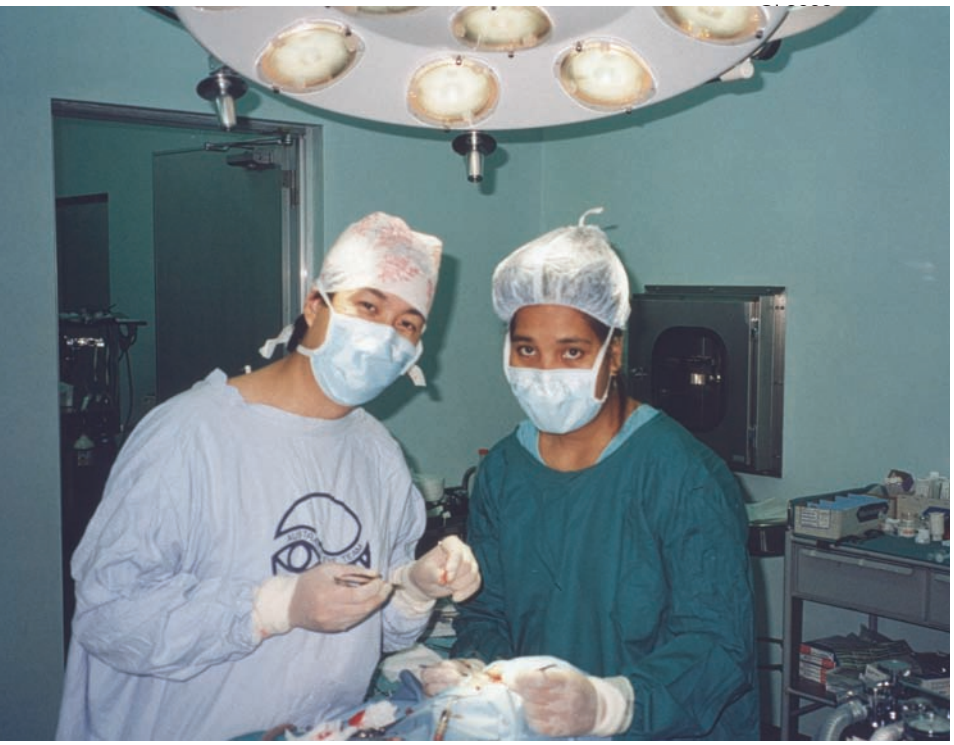
as I struggled to my feet and left, taking my economy butt with me.

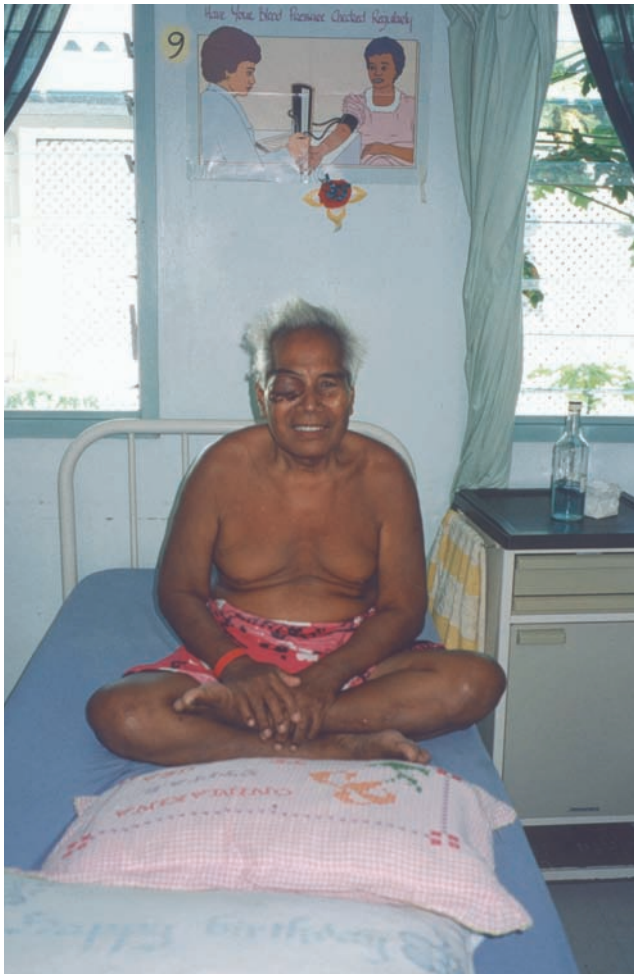
In Nadi, Fiji, we transferred to the plane that was supposed to take us to Tuvalu, then Kiribati. The airline is called Air Marshall Islands, and the small plane we got on had the unfortunate name of 'Fokker'. The pilot was French and the co-pilot was Indian, which apparently is the ideal combination for guiding a small airborne vessel that looks like it could be opened with a canopener over vast quantities of Pacific Ocean to find small specks of land in the middle of nowhere. They appeared to have no communication problems, even though the French guy was speaking French and the Indian guy was speaking Indian. The fuselage was a little wider than a Chinese doctor's armspan, had a single row of single seats down the right side and a corridor full of junk, luggage and slabs of Coke cans. Climbing over this mass to get to the front seat, Tony picked up a book lying on the ground next to him. It was the plane's instruction manual! Tony looked at me with his eyebrows arched. I took a photo, mainly for my amusement but also, just in case, for the aviation coroner's records. There were no stewards, so if we needed attention, Tony had to lean forwards and tap one of the pilots on the shoulder to wake him up.

We got to Funafuti, the capital of Tuvalu, a small bunch of coral not far from Kiribati. As you can imagine, there is not much land on these islands and not much room for an airstrip. Consequently, the Tuvalu airstrip is grass, about 400m long, 30m wide and both downhill and sidehill, with what appeared to be a multitude of grassy knolls, the kind that would make an American president nervous. In my mind, I apologised to the pilots for underestimating their skills, as they managed to land on this quite well. Getting out of the plane and doing a Papal kiss of the ground, I looked back up the airstrip again to see groups of people walking back out onto the grass, with some laying out their picnic blankets again and one group putting their volleyball net up so they could continue with their game! This seemed a little odd at first, but later I would realise that the airstrip was the only open ground on the entire island, so of course it was used for many social activities. It is no different to us playing cricket on the road and having to stop and move the stumps when a car wants to go through, except a car will not suck you into its engine. A local shoved a flattish piece of wood in my hand with the number '12' painted on it. I looked blankly firstly at it and then at him. 'Boarding pass', he said. I secretly kept it as a memento, but had to later send it in to claim my 'frequent flyer' points. Only joking.

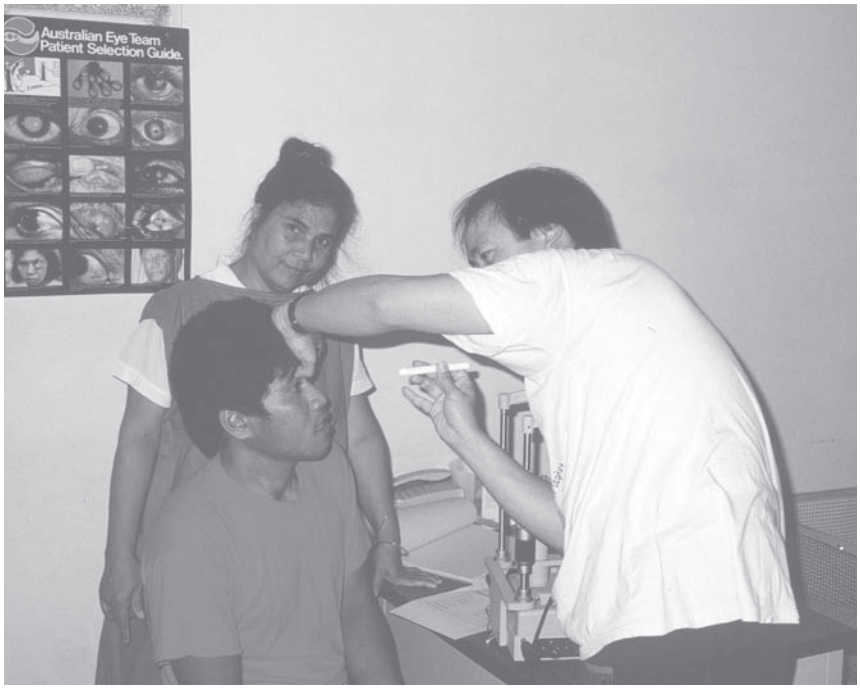
We then looked back at the plane, to see a steady trickle of oil flowing down the side of one of the engines. 'Oh', I thought. The French pilot got a ladder out that appeared to come from the movie set of the Flintstones and climbed up and removed the top of the engine. 'Oh, oh', I thought. Then a series of dramatic shoulder shrugs and Inspector Clouseau-type grunts, combined with indiscriminate hammering of the engine. 'Oh, oh, oh', I thought. French swearing was being punctuated by Indian yelling from below. 'Oh, oh, oh, oh' I thought. My internal thoughts were starting to sound like a steam engine train. Soon the word came through

picnic on the airstrip





Anticlockwise from top left: under the lights; sunset over the island; between operating sessions with the crew; tony hall learns how to fly the plane; patient with large orbital tumour



- we were not going anywhere in this plane and we had to stay the night on this island. A new plane was to come from Fiji with vital parts. 'Aaaaah!' I thought in relief, as my internal thought train pulled into station.

I hired a motor scooter for half a day to explore the island, but I was back to the hirer within an hour, having seen everything. It's not a very big island, to be honest. I remember losing the key from the ignition but found I could start the engine if I just jammed a piece of wood into the ignition and turned it. You can use wood for anything!

Tuvalu is not an exciting place. It is probably best known for the fact that it is slowly sinking and that the government is endeavoring to make enough money from internet franchising to buy another island. How does that work? Well, Tuvalu's domain abbreviation is 'tv', in the same way that Australia's is 'au'. For some reason, the U.S. television stations want an internet address that ends with 'tv', such as ABC.tv. Consequently, Tuvalu is paid a lot of money and has offices on its shores of the American television station. Crazy? Well, it could only happen in…well, Tuvalu.

We were relieved the next morning to see the new plane from Fiji, which was new and bigger than the original Fokker we had arrived in. One plane was to go to Kiribati, whilst the other was to continue on to the Marshall Islands. Success! We were to board the new plane later that morning. As we saw the original plane set off for the Marshall Islands, we could see black fluid spewing from its left engine. I never did find out what happened to that plane.

Several hours later our non-Fokker plane landed in Kiribati, and I was relieved to see an asphalt airstrip with lines and even some lights! The main island of Kiribati is Tarawa, which is actually a group of islands surrounded by a coral atoll. The airport is known as Bonriki, and sits on the southeast corner of the main island. We are taken to the main hospital and meet with the great group of nurses that we will be working with during our time there. I know this is terrible, but I can't for the life of me remember their names, as their names are Micronesian and barely pronounceable let alone able to be spelt. The Kiribati people are known as I-Kiribati (ee-kee-ree-bus), and are very dark, short and solid. They have tight curly hair and very wide noses. Before we got to the island, Tony gave me the cryptic sentence 'You'll love their feet'. I look down - they don't wear shoes often, mainly because their feet are ridiculously wide. It was as if they forgot their shoes and started walking and their feet melted! The soles of their feet are thick and hardened and built up in a way that would have been very fashionable in the 1970's. No wonder firewalking started in the Pacific!

The weather is hot, hot, hot. It is consistently around 40^{o}C during the day, and ridiculously humid so that breathing feels difficult. We are given a Toyota Corona to take us around the island, and when I drive it I have the strange compulsion to wear a lawn bowling uni-

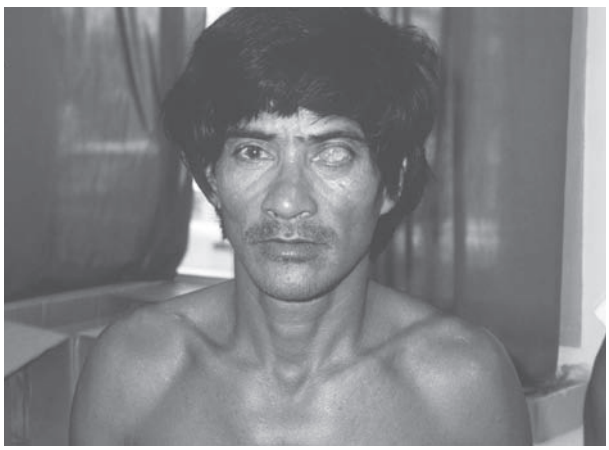
theatre staff

form, complete with sensible white wide-brimmed hat. We drive to our hotel, called 'the Otintaai' in South Tarawa. It was originally called the Oceanside, but in Micronesian that becomes 'Otintaai'. Thankfully they have just built some new rooms - WITH AIRCONDITIONING! I don't often hug inanimate objects, but I was not backward in my affection to the airconditioning unit and the bar fridge. It didn't matter that the fridge was empty, apart from my feet (just joking - I didn't really put my feet in there, it was much cooler to place my head half in). We met a Lithuanian doctor family, the father an ENT surgeon and the mother a paediatrician. They had two children, a boy and a girl in their pre-teen years. With their blond hair and blue eyes they looked as out of place as a Jamaican in a kilt shop. The father was a redhead - blond hair, but a red head. Sunscreen was a rare commodity in Kiribati. The family had been in Kiribati for two years, having been sent there by the W.H.O. They told me that this was their first work for the W.H.O., and the only specification they had put on their application form was 'not too hot'. They only had two months to go, and their next assignment was the Aleutian islands, between Alaska and Russia. Clearly there was someone at the W.H.O. with a very warped sense of humour. Either that, or they were part of an experiment on human temperature tolerances. They couldn't speak much English, and I really couldn't work out how they were consulting their patients.

strange sexual practices

We started the clinic, and unfortunately the only room available for the volume of examinations we were doing was not airconditioned or ventilated in any way. With our direct and indirect ophthalmoscopes, we set to work on a steady stream of patients who had been told of our arrival by radio and by word of mouth. Most patients knew some English, but other helpful patients would interpret for those who could speak only in Micronesian. We were organising mainly cataract surgery, but then I noticed a number of patients that required lacrimal surgery (dacryocystorhinostomy, or DCR) for epiphora due to obstruction of the nasolacrimal duct. This seemed like an odd condition to be common in the middle of the Pacific, but I was soon told why this was so. It was due to an odd sexual practice unique to Kiribati. Interested now?

Kiribati has a very unusual courting practice that involves the eyes. Kiribati has a special grass that has a very thin stem with what looks like a fluffy ball on top. Don't ask me how this was discovered, but the I-Kiribati find it oddly alluring to cannulate their lacrimal cannaliculi with the stem of the grass (and twirl it for good measure) and to tickle the underside of the everted upper eyelid with the fluffy part. As a result, they get all sorts of vegetable matter in their lacrimal drainage systems, with resultant lacrimal stones and nasolacrimal obstructions. So the Australian eye teams end up doing surgery for watery eyes instead of surgery for saving sight. I had to do 8 in a row, and they are hard enough in Caucasians, because a small window has to be created in the bone between the lacrimal sac and the nose. Believe me, in a Pacific Islander, it can feel like drilling through concrete! As it turns out, it has become quite a status symbol on Kiribati to have the scar of a DCR (about 2 cm long, on the lateral side of the nose) - I



patient post enucleation of L eye (due to trauma)

From left: Lithuanian couple from WHO, Alastair Walpole, author Trevor Gin and Ben Clark

guess it means you're quite a player. Rumour has it that the president likes to be photographed on the side that he has two such scars (hubba, hubba!). Of course, I didn't believe any of this until a couple demonstrated it on each other at lunch. I must admit, I would be a little concerned here if someone came to me with a watery eye and started groaning rapturously whilst I was syringing their lacrimal system. Beware the I-Kiribati with epiphora!

Thankfully the operating theatre had a functioning airconditioner and we were able to operate in comfort. In fact, I wanted to sleep in there but I was afraid I'd wake up with a DCR scar (hmmm….but that would get me in to the trendy Kiribati nightclubs…..). Operating in shifts, we steadily got through the workload. Some of the patients were interesting. We found the first I-Kiribati with diabetic retinopathy (Dick Galbraith, the founder of the Australian South Pacific Eye Camp group, had said he had never seen this disease in this population). There was also a young girl with internuclear ophthalmoplegia and other neurology typical of multiple sclerosis, which is very rare near the equator.

for the public toilets, you need 20c and very good balance

Exploring the island, it really is a nice Pacific haven. The people have not been spoilt by their connection to the West, and have not become very large like the Nauruans. They are very friendly (of course, this is the standard line everyone has about any Pacific islanders) and lead a very happy, simple lifestyle. The kids seem to be forever on the beach and swimming, except near this brick wall on one part of the beach. It was two bricks wide, about three foot above the water surface and extended 20 foot out into the sea. I couldn't quite work out what it was for, until a boy walked out on it, dropped his pants and ……(how can I put this delicately?)…performed an ablution! 'Did you see that?' I said to Tony. 'Great balance', he said, nodding sagely. Great balance indeed, as there were no handles or bars to hold onto. I guess the penalties of imbalance are so high, and certainly so horrible to ponder, that the cerebellum has your full attention for those few minutes. Anyway, enough about that topic, I feel quite ill thinking about the consequences of falling.

speed bumps on the airstrip

One night we were out for dinner (fish, fish or perhaps fish) and got slightly drunk and on the way back for some reason thought it would be a good idea to go speeding along the airstrip in our Toyota (OK, OK… but in our defence, it seemed like a good thing to do at the time). So we went to the airport, onto the maintenance road and ended up on the airstrip. We were just building up speed when suddenly we saw all these eyes on the asphalt. We then realised the eyes were attached to a dozen or so people who were lying on the airstrip. We did well to stop before we ran over them, and they were just as shocked as we were. As it turns out, on cloudless nights the heat escapes quite quickly (down to about 20^{o}C - very cold for I-Kiribati), and in order to stay warm, some villagers sleep on the warm tarmac, not really expecting mad ophthalmologists to try and run them over.

Betio Island

Betio island is connected to Tarawa by bridge and is where much of the industrial areas are. It is also where there are several war relics. Apparently Kiribati was an important Pacific military site and many battles between the Americans and the Japanese took place there. There were many concrete bunkers with large rusted cannons protruding out. It was quite spooky to sit in a bunker and look out through a small gap in the concrete and imagine what it must have been like waiting for the Japanese to attack. It just seemed very silly that so many lives were lost on a small island in the middle of nowhere. Even more bizarrely, I'm sure once the war was over, no Japanese or American ever knew, thought, visited or cared about this place. As a child once said, 'Humans make the worst people'.

coral cuts

On our day off, we decided to go swimming in the surf, but for some stupid reason we chose a coral beach. My colleague Ben went to the beach with his towel and beachgear in a briefcase, so looked quite odd with his pale skin, in his board shorts and with leather briefcase in hand, walking towards the sea. We walked carefully along the coral shelf, and as we got closer to the sea realised that the waves were a little higher than we thought. Foolishly, we still jumped off the coral into the sea, simply to be lifted up and dumped back onto the coral. We all received deep lacerations. If you know coral cuts (which we didn't really at the time) you would know that coral contains large amounts of bacteria and coral cuts become infected very quickly. Within two hours, the cuts became very painful and frankly purulent. The only antibiotic I had, for travellers' diarrhoea, was norfloxacin. Thankfully, it worked very well and the discharge was gone by morning.

don't try the sour toddy

By the end of the camp, we had performed around 120 operations, mainly cataract surgery but also a number of DCR's, pterygium removals and enucleations for blind, painful eyes (usually old trauma). The hospital staff held a large barbeque for us on our second last day (guess what - fish!). We were offered a local alcoholic brew made from coconut palm called 'sour toddy'. For some reason it has bits of insects in it (I think that was accidental, but they seemed to accept it as being part of the drink), and it has an indescribable taste that takes a burnt fish to take away (seriously, I tried everything - the burnt part of the fish scraped along my tongue was the only thing that worked!). I would find it hard to recommend, even if you had some burnt fish handy.

'he's just one of the staff'

The flight out was less eventful than the flight in. When I got to Fiji, I said goodbye to Tony and Ben and made my way to the Fiji Sheraton to meet my wife. Now, to this day, my wife regards her time at the Fiji Sheraton by herself as the best holiday she has ever had. This leaves me slightly miffed - imagine if your life partner describes her best holiday as the one without you, and consequently the holiday's status is downgraded once you arrive! She was spoilt and pampered, didn't have to talk to anyone except when ordering food and drink, kept to herself and pretty much pretended to be rich. When I arrived from Kiribati, I hadn't shaved for a week and was deeply tanned from my time in the sun and dressed like the local gardener. So, when my wife met me in front of the foyer, I was suddenly whisked away through the back corridors to our room, with my wife fervently looking around to make sure no-one would see me in my dishevelled state (or more to the point, saw her with me in my dishevelled state). I'm sure at one point she saw someone, laughed nervously and pointed at me from behind my back and mouthed 'he's one of the staff'. Anyway, thus began my holiday, even as it ended the best part of hers.

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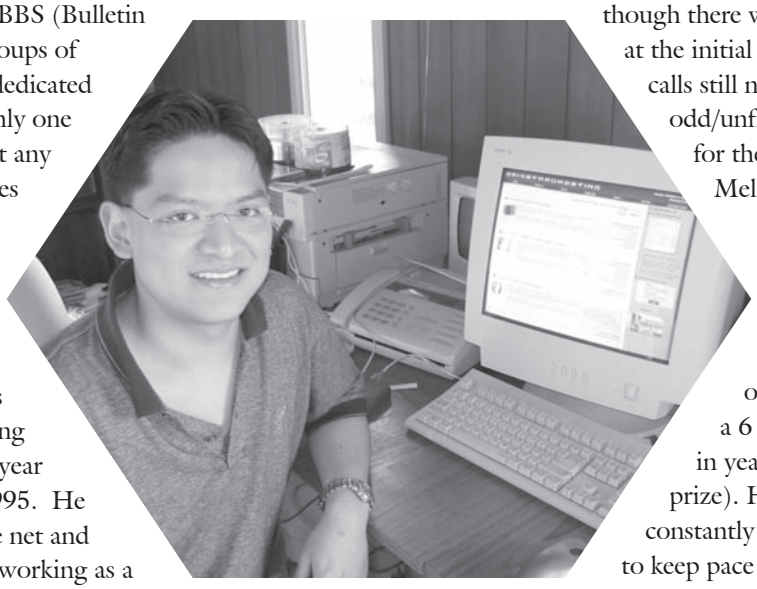
focus

net and med Matt Leong

Most medicos are renowned for their technology ignorance. However, there does seem to be a new breed of more advanced techno-heads among us, and Matthew Leong is one of them.

Matt has been fascinated by computers ever since the original IBM made XT, a much slower processor with less memory than your average mobile phone. In high school he began using BBS (Bulletin Boards) which were groups of home PCs linked to a dedicated phone line, allowing only one user to access the site at any one time. These services were so slow that it could take days for an email to reach somebody on a different BBS. Thus, you can imagine Matt's excitement in discovering the internet in his first year of medical school in 1995. He learned how to surf the net and took up a summer job working as a software developer for Greg Searle, a database engineer who developed in the early 1990s an Australian Law search engine that spidered the internet for information.



Greg Searle introduced Matt to the idea of combining medicine and IT as there were no medical search engines at the time. Matt has been progressively working on this idea with the goal of creating a medical version of Yahoo or Google – a portal where one can be directed to the most relevant sites. While working in the emergency department, Matt met a consultant who had plans to develop software that would allow medical practitioners to remotely access patient information so that crucial primary decisions could be made and early measures applied without the doctor being present. Matt saw the potential here and applied himself to make the software a reality. He has made much progress and has even held meetings with Microsoft and Hewlett Packard!

In addition Matt has also opened his own web-hosting company (check out www.drivethruhosting.com) using three servers based in the US to "provide customers worldwide with reliable network environment to host websites, emails, business applications and other web related content". He enjoys running the business although there was a steep learning curve at the initial set-up stage and phone calls still need to be made at very odd/unfriendly hours to allow for the time difference between Melbourne and the States!

It is hard to believe that almost all of Matt's computer knowledge has been self taught! His only formal training was a 6 month computer course in year 9 (for which he won a prize). He feels that you need to constantly upgrade your knowledge to keep pace with the modernisation of hospital systems. Indeed, his vision for the future is a hospital boasting seamless integration with GPs, allied health and other hospitals via the network, and computer terminals throughout the hospital to allow timely access to information.

Matt is also studying for his first part surgical exam which is still his number one priority, as he aspires to become a general surgeon (with possible specialisation). He insists that his interest in IT would be meaningless without an ongoing clinical connection. Thank goodness for that - one more computer-literate person to lend us a hand in the hospital of the 21st Century.

Jun Yang

focus

enlightened...Min Li Chong

Walk into the lounge room of Min Li Chong and you will be amazed by her huge collection of leadlight lampshades, tabletops and ornaments. Turn on the lights and in an instant the room becomes enchanted by the intricate patterns that light up with rainbow hues. All of these artistic pieces are in fact her very own handiwork.

Min Li Chong, better known as the Honorable Secretary of ACMAV, keeps a low profile on her leadlighting achievements. And who would have thought she could have the spare time to indulge in such a time-consuming hobby! Handling the workload generated by ACMAV is no easy feat, with its numerous committee meetings, education seminars and conference activities. In addition she still works nearly full-time in a busy general practice and remains on call for NETS (Neonatal Emergency Transfer Service) on weekends, *and* also managed to complete a Master of Applied Science (Medical Acupuncture) in her spare time!

So, where did the impetus for this come about? Sufficient time is a crucial requirement for such a hobby, hence it all started when she left the public hospital system in 1994. Then, her brother-in-law was learning to do leadlighting, and made a lampshade for her mother. Min Li adored it and asked him to make one for her as well. The wait for this was so long that she decided to make one for herself, and this was the beginning of her leadlight "career".

Min Li took four lessons in all and learned the basic technique of leadlighting in class before progressing to more complex and adventurous pieces on her own. She tells me that once you get the technique right, it simply takes time and practice to create more fanciful artworks. She explains that the steps involved are: planning the pattern; choosing the colours to match; cutting glass to desired shapes; filing the edges of the glass pieces so as to fit the framework; laying down copper foil over the glass and soldering them down; and finally fitting together the panels into a lampshade or other desired object. Certainly sounds time-consuming to me! Every step can take hours to finish, especially the glass cutting. Some glass shatters easily and causes quite a bit of frustration and delay (plus expense). A relatively small lampshade can take one or two days of continuous work to complete.

Her first project was a simple floral window panel, but since then she has made entire glass door panels for a grand entrance, tabletops with elaborate patterns, lampshades that glitter a thousand colours, delicate yet durable fruit bowls, and numerous other decorative pieces. The collection she has at home is just a sample of her artworks over the years. Others have been given away as presents or have been specially requested by friends and relatives. I was privileged to look through an album of her artworks and was truly inspired by the magic created by simple combinations of coloured glass.

Through leadlighting, Min Li feels that she has acquired more patience, determination and concentration. Once she gets started on a project, she often works continuously to finish it the same day. Nowadays she has less time for the hobby, but still squeezes in an hour here and there for glass cutting or other preparation work. Indeed, another new project is on its way. Let's hope Min Li will still have time to take leadlight orders from ACMA members, now that her secret is out of the bag!

Jun Yang

ACMAV secretary Min Li Chong at home with her collection of leadlight lamps and mosaic table (below)

pantoprazole
Somac®

* Versus ranitidine. Before prescribing, please review Approved Product Information. Full PI available from Pharmacia Australia Pty Limited. ACN 000 185 526, 59 Kirby Street, Rydalmere, NSW 2116. Somac: Pantoprazole sodium sesquihydrate. Use: Proton pump inhibitor. Duodenal and gastric ulcer, reflux oesophagitis, GI lesions unresponsive to H_2-receptor antagonists, Zollinger-Ellison syndrome; eradication for H. pylori in gastric, duodenal ulcer (combination therapy); maintenance of healed reflux oesophagitis. Contraindications: Severe hepatic impairment. Precautions: Exclude malignancy, hepatic impairment, prolonged use, pregnancy, lactation, children. Adverse reactions: Nausea, diarrhoea, abdominal pain, flatulence, headache, dizziness, sweating, dry mouth, asthenia, rash, pruritus, oedema, fever, blurred vision, depression. Presentation: Pantoprazole (as pantoprazole sodium sesquihydrate) pale yellow e-c. 20mg (30): Restricted Benefit - PBS/RPBS, price fully dispensed $30.39; 40mg (30): Restricted Benefit - PBS/RPBS, price fully dispensed $48.46. Dose: Somac 20-40mg once daily. 1. Koop H, et al. Comparative Trial of Pantoprazole and Ranitidine in the Treatment of Reflux Esophagitis. Results of a German Multicenter Study. J Clin Gastroenterol 1996; 20(3): 192-196. 2. Richter JE, et al. Oral Pantoprazole for Erosive Esophagitis: A Placebo Controlled, Randomized Clinical Trial. Am J Gastroenterol 2000; 95: 3071-3080. ® Registered Trademark 03/03 PHR00716.

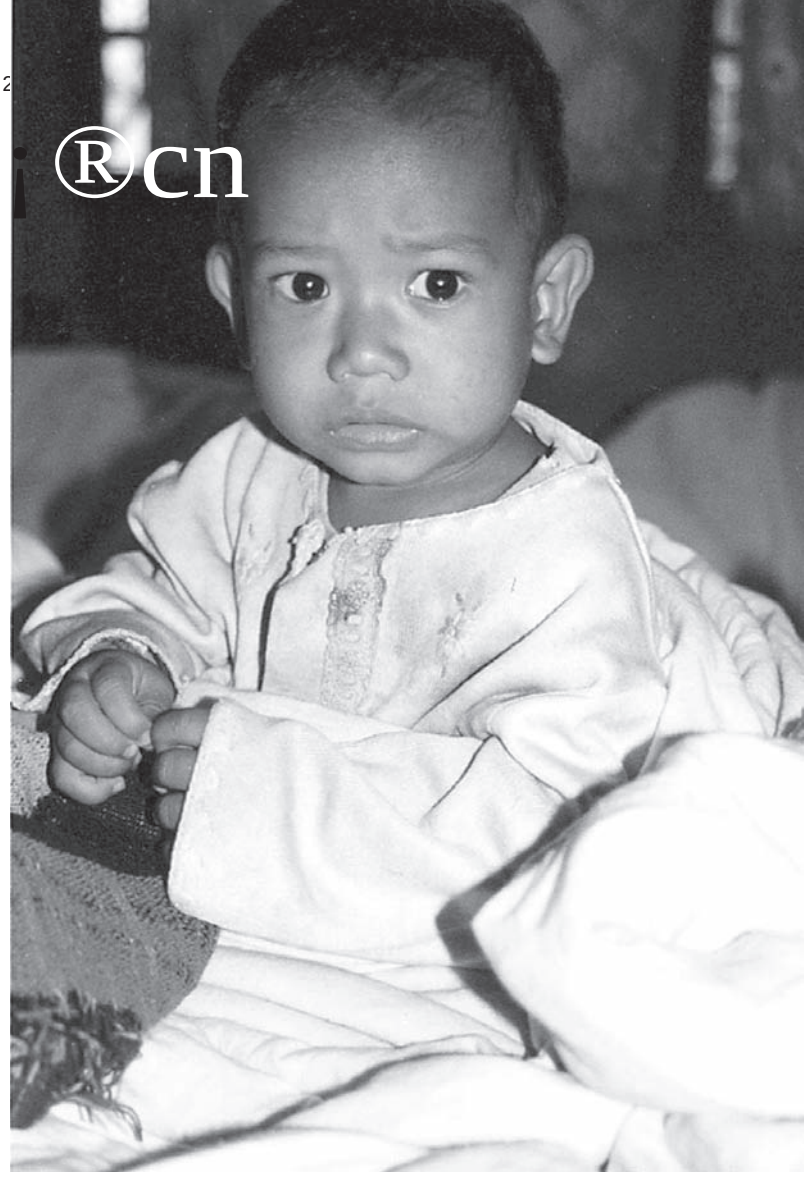
ALTANA PHARMACIA

PBS Information: Restricted Benefit. Gastro-oesophageal reflux disease; initial treatment of peptic ulcer; Zollinger-Ellison syndrome; scleroderma oesophagus.

ejú¡l h¡wm¡ ®cn

nomoskar (hello)

three months in



november 2002 – february 2003

David P.S. Fong

'Come to Bangladesh before the tourists'
Former Bangladeshi tourist slogan

Not many tourists go to Bangladesh, but that did not deter me when Interserve [1], an overseas service organisation, called to say that an opportunity had arisen to work in a Bangladeshi hospital. Somewhere, somewhere in Asia, was my first thought…My second, that given Bangladesh's disastrous floods, I'd have a chance at one of my favourite pastimes — sailing. Then, I *had* already been to Disneyland and seen it all; Bangladesh could only pale by comparison, surely. The reality turned out to be somewhat different.

a land of fertile plains…

Bangladesh incorporates the delta of the Ganges (Padma) and Brahmaputra (Jamuna) rivers. Formerly known as East Pakistan, it is separated from India by their predominantly Muslim, rather than Hindu, faith. The Bangladeshi people are very proud of their literary tradition. Bangla, the sixth most spoken language in the world, is related to Hindi and uses a Sanskrit-style script. It is the language of the Nobel prize-winning poet, Rabindranath Tagore [2], and the film-maker Satyajit Ray. The controversial feminist humanist author Taslima Nasrin [3] is perhaps Bangladesh's most famous modern-day writer.

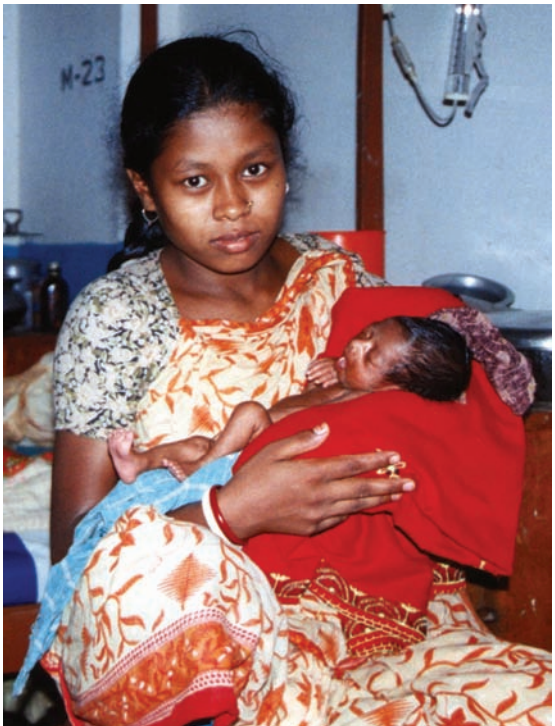
Bangladesh's fantastically fertile alluvial plains make flood-irrigated Victorian pastures look parched by comparison. Although the same size as Greece, Bangladesh supports a population of 190 million people, albeit in marginal circumstances. After winning a civil war of independence against Pakistan, Bangladesh has mostly been governed by an elected government. However, it has had difficulty attracting private foreign investment the way it has attracted foreign aid.

Nevertheless, economic progress has been made. A small middle-class has joined the ruling class in the pursuit of prosperity. Improved farming practices,

Dr David Fong is a general practitioner working in Kensington

Anticlockwise from top:a cold winter's morning at Rangpur train station; Bengali workers in the field; mother with her baby, born at 28 weeks' (estimated) gestation; general medical ward, LAMB hospital

Opposite page: child (courtesy of Dr Tim Chapman)



development and aid programs have reduced, but not eliminated, the level of malnutrition and mortality among infants. Some research and aid programs, such pioneered micro-loans), have been recognised as innovative and world-leading.

LAMB hospital

The LAMB (Lutheran Aid to Medicine in Bangladesh) community health and development project [5] is an aid program that was established in the early 1980s. It is a non-government private hospital supported by foreign funds to provide medical care to the poor. It has 75 beds and offers medical, obstetric/gynaecology, neonatal/paediatric and some general surgical care (with the help of a visiting plastic surgeon from Nilpharmari's leprosy hospital [6]). The hospital also has a busy outpatient department, physiotherapy/rehabilitation and an English-language primary school (for the children of both expatriate and local staff). It runs off-site 'static' (outpatient and delivery) clinics and 'mobile' (outpatient only) clinics. It is easier for LAMB staff members to use clinic cars and motorbikes to reach outlying clinics than it is for prospective patients to come by rickshaw!

LAMB hospital's seven-bed labour ward oversees more than 2000 deliveries a year and is regarded as a tertiary referral centre. Pre-eclampsia is so common that LAMB was involved in the worldwide trials of magnesium sulphate for its treatment.. Some mothers have already fitted before coming to hospital. Sadly, during the three months that I was there, several mothers died. One died soon after giving birth to her first child. Her own mother had also died in similar circumstances. The sight of the distraught great-grandmother holding the baby, sitting on the empty bed, was one of the saddest things I had ever seen.

A third of the babies born here are underweight or premature. LAMB has a Level-2 equivalent nursery. Most very low birth weight babies (<1500 grammes) survive. Occasionally even the extreme low birth weight infants (<1000 grammes, <30 weeks) survive. We had oxygen via nasal prongs and mostly-working phototherapy units for jaundice. I learnt more about, and had more practice in, resuscitating neonates and treating fitting babies during one month in Bangladesh than during six months in an Australian hospital. Fortunately, the LAMB hospital library is well stocked, with many of the same books as I had studied in Australia. I spent many nights reading neonatal care books from cover to cover!

The sole humidicrib's temperature control was faulty. Much more practical and economical was the use of 'kangaroo-care', whereby the mother herself provided the required temperature control through direct skin-to-skin contact. Unfortunately, it was really difficult to encourage mothers to adopt this technique consistently. A New Zealand nurse instructed the local nurses on the use of 'thermo-dots'. These re-usable dots were stuck onto the babies' skin and changed colour depending on the skin surface temperature: black if the baby was cold and green if the temperature was just right. They revolutionised our care of the neonates. It was almost fun, and definitely life-saving, doing 'cold-baby' patrols, looking for black dots, before I finished for the day. Thermodots proved to be more useful, if less cute, than the woollen skullcaps that the nurse had also brought from New Zealand; the skull-caps were too large for the LBW infants anyway.

I was not involved in antenatal care or delivery, obstetrics being the domain of women doctors and midwives. Lots of breech deliveries and twin deliveries were done vaginally. Previous Caesarean operations were not always done very well, and uterine ruptures happened occasionally. The obstetric team was also responsible for treating burns patients. When the weather was cold people often huddled close to the fires, resulting in quite serious or even fatal burns. Occasionally, the gynaecologists were expected to deal with other surgical emergencies as well. During one weekend a gynaecologist from Scotland, who was also spending three months here, had to deal with an emasculation.

staff

Local Bengalis worked in LAMB's departments. Among the 'long-term' expatriates were general physicians, paediatricians and general practitioners (most of whom had gained obstetric skills) from the United Kingdom, the United States and New Zealand. Expatriate nurses tended to be involved in training or administrative work rather than direct clinical care. Some short-term expatriates, like myself, came to provide some relief for the long-term workers working in the hospital or auxiliary services, such as the LAMB school. Others provided specific training in areas such as radiography/ultrasonography, pathology, physiotherapy, surgery or acute life support. It was interesting to meet other short-term workers who came to the hospital, most of whom had previous experience there. Some medical students do their elective at LAMB; just for one week, or occasionally for up to six months! Many former elective students come back to do another stint. During my stay there were two such returnees; one was a New Zealand graduate who had just completed his internship, and the aforementioned gynaecologist.

The local nurses were very skilled at inserting intravenous lines, even into small babies, for which I was continually thankful. LAMB trained its own nurses and midwives. Even the government sent its nurses and midwives here for some of their training. Although the government often forgot to pay LAMB for the training, the positive feedback from the nurses was considered reward enough.

The hospital also trains 'medical assistants' of both sexes. Educated in basic medical sciences and treatment, they were able to take a medical history and administer basic treatment. Their history-taking was sometimes better than that of the university-trained doctors! Fortunately, they had been taught at least basic medical English. They substantially reduced the work required to do patient admissions — sometimes I only had to write 'I agree' on the bottom of their admission notes. They also did much of the work in the outpatient departments. Local doctors tended to come from the more privileged families; the training of medical assistants was one way LAMB could provide specialised skills to some of the poorer people in the society.

The locally trained doctors, some of whom had been at the hospital for several years, were all helpful and generally had excellent English. The experienced were invaluable in telling me how things were done, especially for unfamiliar conditions such as kala-azar. They were also keen to help me improve my lumbar puncture and bone marrow aspirate skills. The practical training of local doctors prior to coming here was often rather sketchy and unfortunately the junior trainees receive very little supervision from their registrars.

people

Bangladesh has a few tourist attractions. The famed Bengal tiger resides in the Sunderban mangroves. Chittagong boasts the longest shark-free beach in the world.

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*The lowest irritancy scores were Hamilton Wash (0.05), Neutrogena Extra Gentle Cleanser (0.08), Sydney tap water (0.16), Bulactol Soap Free Wash (0.17) and Cetaphil Gentle Skin Cleanser (0.21). The difference between these scores was not significant.

Reference. 1. NT Hunyh et al (2003). Australasian Journal of Dermatology, in press, Hamilton Laboratories, 217 Flinders Street, Adelaide, SA. 5000. Phone (08) 8223 2957. Fax (08) 8232 1480. A Division of Hamilton Pharmaceutical Pty Ltd. ACN 008 204 65.

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References: 1. Berkowitz RB et al. *Allergy & Asthma Proc* 1999; Vol 20 No. 3, 167-72. 2. Nasonex Australian Approved Product Information. 3. Schenkel EJ et al. Pediatrics 2000;106(2) E22. 4. Spalding GK. J Allergy Clin Immunol 2001;Vol 108(1) S56-S64. 5. Data on file Schering-Plough Corporation.

essex pharma, a division of Schering-Plough Pty Limited
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PBS Information: This product is not listed on the PBS

Sylhet, or Darjeeling across the border, have picturesque tea gardens. LAMB hospital is relatively close to both Nepal and Bhutan. But I went to none of those places. Travel in Bangladesh was more about the experience, rather than the destination.

Lush green countryside, and endless number of people keen to share tea and English conversation are the rewards for travellers not on the 'beaten track'. Being something of a train junkie, I found train travel particularly relaxing and enjoyable. Every train station seemed to have at least one station master who knew English (and also wanted to share a cup of tea). Sometimes it seemed that absolutely anyone on the train who knew any English would come and join me in the compartment where I was sitting. I almost wished I had learnt a few song-and-dance routines to entertain them further.

The cooks at the LAMB guesthouse accommodated Western tastes — though in reality their 'normal' dishes were usually better than their 'fusion' dishes. The long-term expatriates brought in all kinds of food from overseas, but never enough chocolate! The American embassy was even good enough to send a turkey to help us celebrate Thanksgiving.

Hot snacks (such as samosa and shingara), biscuits, rice dishes and very sweet tea were widely available at small restaurants and shops. The local food tended towards the spicy side, but only once did I need to use some proton pump inhibitors. That was after eating some VERY spicy food at a wedding celebration. Incidentally, absolutely everyone is invited to weddings, the prestige of the wedding being proportionate to the number of guests.

There is not enough food for many, and even those with land might find it difficult to support the entire family. Women are not divorced, polygamy making it easy for men to abandon their wives instead. As a wealthy foreigner (and everyone in Australia is wealthy compared to a Bangladeshi farmer) I was an obvious target for beggars. However, there were relatively few beggars in

Bangladesh primary school children. In background, the newer high school building, opened 2000, with no teachers yet employed.

the LAMB hospital district. Quite disturbing were the well-dressed beggars who spoke good English whom I suspect were gang-members, perhaps with political associations. We also had to deal with the uncomfortable requests for financial assistance from local co-workers. In Dhaka, the capital city, quite a few children beg on the street. I sometimes gave them chocolate, although it was more expensive than giving some taka (the local currency). I felt more comfortable giving away something I knew the child would eat immediately, rather than money that they might be forced to give their 'minder' later.

preparation and getting there

I am thankful to all the people who helped prepare me for my time in Bangladesh. The rural training division and the general practice training program in Gippsland [7] approved and facilitated extended terms in paediatrics, ENT/opthalmology, and obstetrics/gynaecology. It also funded my participation in an APLS (advanced paediatric life support) (8)course which I can strongly recommend (alt. EMST/ELS course) to anyone who might need to handle a life-threatening situation by themselves.

General practice training registrars could conceivably do overseas service as a 'special skills post' if you have a sympathetic regional training co-ordinator. You also would need to take care to arrange appropriate supervision and learning goals . My total expenditure, including all air-fares and accommodation, was $3000. People under thirty who are concerned at the loss of income while doing overseas volunteer work can apply for government funding through the Australian Youth Ambassador scheme [9]. I was also able to apply for CPD/CME points with the RACGP.

My pastor, Colin Howlett, encouraged me and put me in touch with Interserve. I found the 'Perspectives[10]' study course an enlightening introduction to the theology and practicalities of cross-cultural mission. When all about seems tragic and hopeless, it is important to know why serving is important. It helped me to appreciate the thoughts and motivation of the long-term workers in Bangladesh.

I can also recommend the International Health and Development summer school [11] held in Adelaide. A former missionary doctor and emeritus professor, Dr. Anthony Radford, runs this. During three weeks in January I learnt a lot about 'basic' medicine and public health as it is applied in developing countries. It was encouraging to meet many other people who either planned to go or had already been on overseas service.

Lastly, thanks to Medical Services International (MSI) [12], who conduct shorter two-week mission trips to central China. I accompanied a small team to Shuangliu County (Sichuan) in May 2002. Day-by-day, short mission trips are actually more tiring than longer terms of service. However, the shorter trips are in some ways less confronting than longer trips. They are not so disruptive to normal work, and so allow a brief introduction to overseas service. During our time in China we saw plenty of patients for health screening. We also had an opportunity to deliver some lectures to both health-care workers and interested community groups. Our Chinese hosts welcomed us very warmly, just as if we were long-lost relatives coming home! Nevertheless, I found I got to know the local workers a lot better during a longer term of service.

going back

Working in Bangladesh will surely be one of the most rewarding things I will ever do during my life. The ability to utilise years of accumulated medical skills and share the knowledge and experience with both expatriate and local medical staff was highly satisfying. Three months of service might not seem much, but can provide much needed relief to the overworked long-term doctors already serving in the field. My favourite classical Chinese novel, the 'Shuihuchuan (The Water Margin)', has a character whose nickname is 'Opportune Rain'. Bangladesh might seem to have more than enough rain already, but no matter how few skills one possesses, there is ample opportunity to be a small blessing in a land which needs so much.

vkelim@bigpond.com

Bh¡l ®cM¡ q®h, h¡wm¡®cn

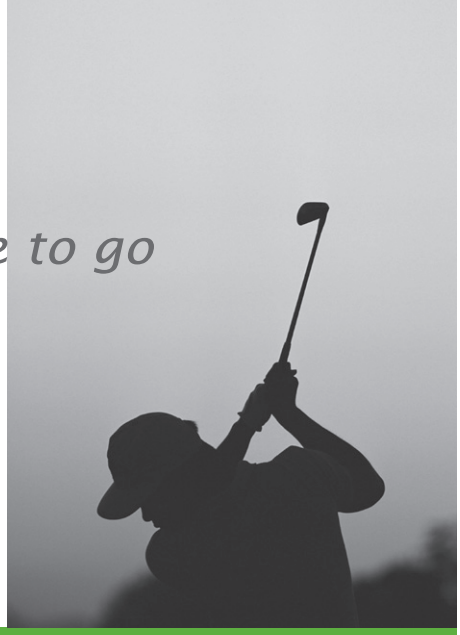
Abar dekha hobe, Bangladesh!

(See you again, Bangladesh!)

References

1 : Interserve — Multi-denominational Christian-service sending and support organisation. They hold several information evenings a year for anyone interested in knowing more about short-term service. Interserve can also help arrange medical

continued pp 121



ACMAV members show us where to go

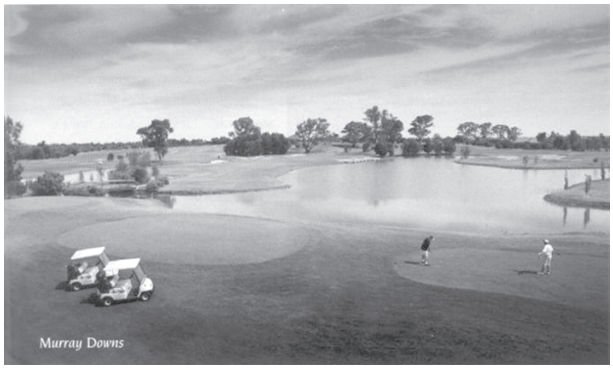
John Chin
Rick Hing
Victor Kuay
Khai Yuen Tang
Cliff Wong
Michael Yii

golfing greens

Murray Downs Golf & Country Club

Someone once asked me where to go for the ultimate golfing holiday. To my mind, such a destination had to at least include landmark attractions and places of interest, good accommodation options and great places to relax and unwind after a day's outing. For the past 18 years I have played at some outstanding golf courses in Australia and am delighted to share my experiences of these.

My first golf getaway was a two-week stay at the Murray River. Dotted along the banks of the meandering Murray from the headquarters at Khancoban to the point just beyond Mildura are 28 courses. We played at the **Murray Downs Golf & Country Club** which was voted the best course by professionals playing the Victorian PGA in 1995.



Murray Downs has wide, expansive couch fairways and cleverly positioned bunkers and trees in most landing areas. No two holes run in the same direction and the openness of the course leaves it very susceptible to wind, making this 6197-metre design course a great challenge to anyone. The one that sticks in my memory is the 194-metre par-3 5th. Its index 1 rating is fully deserved. Looking at the flag from the back markers, there is nothing to see but water, sand and more water. And they wickedly positioned the pin in the back quarter of the green; it is then a 210-metre carry over the water and bunkers to reach safety.

There are also other interesting golf courses nearby such as **Howlong Country Golf Club, Rich River and Country Club, and the Cobram-Barooga Golf Club**.

All these clubs offer enticing accommodation and entertainment packages.There is a wide range of deals, varying from onsite accommodation to quality motels nearby. At Rich River, once you have finished your game, enjoy a beverage, meal or snack at Tatalia Café Bar and Restaurant with the finest cuisine and spectacular views of the courses.

Another wonderful getaway would be a trip to the **Yarrawonga & Border Golf Club**. The 45 holes at Yar-

Clockwise from above: aerial view of Heritage GCC, Wonga Park; Henk Tideman & Richard Hing on 3rd tee of Nth Adelaide golf course; Keysborough GC, par 3, hole 11; Murray Downs GCC; Moonah Links Golf Complex

Bottom photos, Flinders GC. Left: The green of hole No. 12 surrounded by bunkers with the ocean in the background. Right: General view of Flinders GC

rawonga make it the largest golfing resort in Australia with lots of accommodation of different standards. We stayed at the Capri motel which overlooks Lake Mulwala and there are facilities for cruises and water-skiing as well as good fishing.

The 6085 metre Murray course at Yarrawonga is the most challenging of all. Huge river gums dominate the flood basin landscape and natural lagoons border many of the fairways.The par-5 5th is the most charming of the lot. It wanders along the edge of our mightiest river amid a Tom Roberts landscape of haughty gums.

Should you want some entertainment at night the club provides a good place to wine and dine; and if gambling's your bent, there are 110 pokies to pass the time. The Rutherglen wine region is also a short drive away.

Having a holiday such as this is a wonderful experience. It provides an escape from the stress at work. Imagine yourself looking at the sunset at the end of a day, reflecting upon the good and bad shots you've made; thinking about the challenges facing you on the golf course the next day; and wondering when you are going to retire from work and do this every day…

Victor Kuay

Keysborough Golf Club

Keysborough is perfectly positioned within Melbourne's sandbelt courses: 30 minutes from the Melbourne CBD and 15 minutes from Mornington Peninsula.

Playing golf is a love/hate affair. When you tee a good shot at par 3, land near the pin and putt in for a birdie, you feel great. *This is fun, I love it !* THEN you use your driver and draw the ball into the bush. You hate yourself now for having been forced to go into the bush to look for the ball.

It was the tranquillity and greenness that first attracted me to **Keysborough Golf Club**. The course is flat and intervened by some beautiful and picturesque waterways and reservoirs. In the course of play, you make new friends. Here also, besides the exchange of ideas, opinions, and gossip, and concurrent business dealings, there is always a bit of wagering to add interest to play.

At the18th hole par 4, KGC's signature hole, the green is multi-level and guarded by bunkers. On a good day you make Par. This is an achievement as it is such a difficult and challenging hole. And it's all it takes to make you feel like coming back the next week to do it again...

John E Chin

Heritage Golf and Country Club

There is an old joke about a golfer who was asked by a beauty queen if he would like to 'play around'. To which he replied, 'Certainly, but I haven't brought my golf clubs with me !'

Only a golfer can appreciate how consumed by this game you can get.

The most common reasons (?excuses: ed.) for playing are: the challenge and excitement of the game; the friends you make; the business deals; getting the exercise, enjoying the relaxation; and for some, the betting. Therein the golfer finds his satisfaction and fulfilment.

Golf is a game that requires precision, co-ordination, a keen awareness of your surroundings and a memory for rules and etiquette. It can be a real pain, and yet, be extremely addictive.

I play regularly at a private club in Wonga Park called the **Heritage Golf and Country Club**. It is an 18 hole (soon to be 36 hole) Jack Nicklaus-designed resort course with lots of water and bunkers to make life difficult. It has a hotel, restaurant, sauna, pool and tennis courts onsite to make up the complete package. However it is pricey, with resaleable memberships costing $37,000 and subscriptions at $200 a month. Guests may be invited by members at $77 a round.

They say that you haven't lived life to its fullest until you've tried golf. Give it a go, you'll not regret it !

Cliff Wong

Adelaide Municipal Golf Course

Adelaide Municipal Golf Course is one of my favourite courses. It's not particularly difficult but it is beautifully located adjacent to North Adelaide and has the city and Torrens River as its backdrop. The convenience of the course (5 minutes from Royal Adelaide Hospital) was one of its most attractive features. My mentor, Prof Tideman was an avid golfer and after Friday ward rounds, he insisted that all the OMS registrars spent time improving their golf game. I don't know that it really did that for me but I certainly became an expert in digging 20 cm long trenches with a five iron!

Richard Hing

Moonah Links

There is no doubt that Victorian golfers will increasingly become prisoners of the Mornington Peninsula. Many of the best courses in the country are already there, with plans for more. Importantly, some of these are even public ones. My favorite is **Moonah Links**, developed with the specific purpose of being the home of Australian golf.

It lies just one hour's drive south-east of Melbourne, in the heart of the 'cups region' of the Mornington Peninsula. There are 36 championship holes in this development. The Open Course has been in play for more than 2 years, and built to challenge the most serious golfers and punish the errant. The layout is impeccable, the fairways and green immaculate. Some mystic power draws me back after each game. It stems perhaps from some underlying streak of masochism; I have never come close to breaking par here, and wayward balls are regularly lost into the benign-looking rough. On the other hand, it may only be the desire to experience the perfection of the course.

The Legends Course has just been opened for play. I have not played on this but it claims to have a more user-friendly layout, taking the player on a 'scenic journey through ancient tracts of Moonah forest and out onto vast fairways'. The mystic aura already ensures a pleasant walk will not go unwasted, no matter how bad my golf may be on the day. Imagine what it would be like if I had a good day!

The Moonah Links Golf Complex provides the ideal weekend escape for the whole family. The world-class Peppers Hotel provides luxurious accommodation in which to soak up the resort-style ambience. There is an abundance of activities within a short drive to keep everyone entertained, including the beaches, walks, wineries, restaurants and spa resorts. This is paradise for me.

Michael Yii

Flinders Golf Club

There are many golf courses scattered throughout Victoria and all the ones I have had the pleasure of playing at are unique in their own way. The course at **Anglesea** is interesting and one plays amongst some very interesting natives – the kangaroos who hover around as one tees off. **La Trobe** is a well established course with fine, luscious, long and wide fairways and very well kept greens. However it is the course at **Flinders Golf Club** that I enjoy the most.

Flinders is about one hour's drive from Melbourne via the Western Port Highway through Hastings but

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Dorevitch Pathology

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Forbidden Palace, Beijing

postcard from beijing

april 2003

ACMAV member and GP Khai Mark visited China during April 2003, accompanied by his wife Betty and friends. He noted the paucity of information in the local media, and complete ignorance of local Chinese about the SARS outbreaks overseas and related deaths. During the hospital inspections by WHO personnel, at least one patient was witnessed being carted out and taken for a slow ride in an ambulance, shrouded mummy-like, to be returned after the visitors had left. There were certainly reports that SARS cases were being hidden.

Betty Mark recounts her experiences in department stores where she and her friends shopped. Wearing facial masks as a precautionary measure, they were taken aback by the rudeness of salesgirls who mistook them for infected victims.

Despite the constancy of the masks, Khai and his group enjoyed the trip immensely, as they benefited from the lack of crowds and greater flexibility in their touring arrangements.

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takes slightly longer if one goes by the Frankston and Moorooduc Freeways via Cape Schanck. It is situated in Bass Street Flinders. It is both a private and public course but one gets a discount if accompanied by a member.

The course is a links course set within a beautiful coastline and the eighteen holes are all very scenic with some of them running along the coast, with blue waters and rocky pools. It was designed by Dr Alister McKenzie, who also designed the Royal Melbourne and the 'old and ancient St Andrews' in Scotland. This year Flinders Golf Club celebrates its 100th birthday. There is a small but well stocked ProShop (the phone number is 5989 0312- and ask for Gavin, the very helpful Scotsman there). On weekends the adjacent area is very busy with surfboarders making use of the high waves on the bay, whilst overhead parasailors hover in the breeze.

Par for the course is 69 and the best score last year was 7 under par, according to Gavin. I will now describe a few interesting holes in this course.

Hole number 1 is 244 metres and is a straight par 4. It provides a relatively easy introduction to the course. The tee is set on high ground and there are not too many obstacles, with only two sand traps one on either side of the front of the green. Getting onto the normal sized green in two is fairly easy and one should not have any difficulty making par.

Hole number 4, a 263 metre par 4, is very challenging and is called "The Coffin". There is a dog leg to the left at about 200 metres. To the left of the straight portion of the hole, there is a gully which is about 15 metres deep, which splits the fairway into two mounds. The green is relatively small. To play this hole well one has to get the ball to the apex of the dog leg avoiding the gully. The approach shot is then striaght and with some accuracy one could hit the green in two. This of course is easier said than done and most weekend golfers have quite a time retrieving their balls from the gully and one would be lucky to end up with a double bogey.

Hole number 5, a 458 metre par 5, is one of the most scenic holes on the course. It runs parallel to the coast on elevated land which gives a panoramic view of the ocean and the beach below. This is a straight hole with a couple of sand traps on the left and right at around the 180 metre mark. Because the fairway is wide, it really is not a difficult hole. To the left there is a ditch, which is a natural hazard and the public road which runs through the golf course is to the left of this. It is out of bounds to the left of the road. The green is moderately sized and sand bunkers, though present to the front left and right, are not threatening.

Hole number 11 is unique. It is a 259 metre par 4. One tees off from an elevated position. However the green is not visible from the tee and one has to line up, with the help of a look-out tower situated beside the tee, if needed. After marking the intended line of flight, one has to hit the ball over some trees and shrubs. If one does not get a good shot, the ball will end in the rough. However if one hits a moderately decent shot the ball will drop on the fairway in front of the green and one can then get on in two and make par.

The final hole, hole number 12, I would like to describe is also a par three. It is 140 metres only but accuracy is required for this. The tee is high up on elevated ground, again with a panoramic view of the ocean and golf course. The green however is small and is bounded by four bunkers to the left and right, at the front and back of the green. One has to hit an accurate high ball which should drop and stop on the green, a not too easy shot to accomplish. My ball usually ends up in the sand bunker and unless my recovery shot from the bunker is a good one, my chance of making par on this hole is slim.

Being a links course, scores are obviously dependent on the weather and on windy days the score can soar and this can happen to proficient players. As we know, even Tiger Woods has on occasion made double bogeys and worse when the weather turns. However, I always look forward to a day's golf on this user-friendly, scenic course, followed by a drink at the Club House and then dinner at one of the fine restaurants in and around Flinders – "Sails" for example. I would recommend that all golfers should have at least one game at the magnificent Flinders course.

Khai-Yuen Tang

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Footnotes

[1] The thesis was not intended to be a study specifically on 'inscrutability', but to develop a much broader, overarching theory that explains East Asian psychology and behaviour from the perspective of Confucian values.

[2] One-son inheritance system in which the first son gets all the inherits.

[3] A non-kinship but family-like organisation characterised by inheritance of land

[4] A non-kinship like industrial organisation characterised by inheritance of trade or skill

[5] The low filiality of the Japanese is indicative of the failure of Confucianism in really taking root in Japan. A major reason has been attributed to the Japanese supreme loyalty to their Emperor, which is in direct conflict with the Confucian teaching of filial loyalty as the paramount virtue. However, the basic ethos of Japanese society, as mentioned before, is also not conducive to sociability rather than filiality.

[6] The Australians' lower inscrutability than that of the Japanese simply reflects the Australians' lower need for sociability. While the non-familistic Australians definitely has considerable need for sociability, their need for independence, however, prevents them from overly dependent on their peers. This is clearly not the case with the group-oriented Japanese who are much more dependent on social acceptance. Their greater need for sociability thus impels them towards a higher degree of inscrutability.

[7] Unlike the Cartesian West, the external orientation of Confucianism is hardly conducive to intra-psychic explorations. As a result, not only is there a lack of psychological thinking in East Asians, there is a lack of psychological vocabulary for them for them to do so.

[8] The shortage of references sadly reflects the scarcity of scholarly publications on this important subject.

Advertisers' Index

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Walking, from L to R: author David Fong, Dr Chanchal and family and Uni of Melb elective med student James Yun (courtesy of Dr Tim Chapman)

electives. *http://www.interserve.org.au*

2 : Rabindranath Tagor — *http://www.nobel.se/literature/laureates/1913/tagore-bio.html*

3 : Taslima Nasrin — Former Bangladeshi gynaecologist, poet and author. She has written many articles championing the cause of women's rights and religious equality in her home country. *http://www.emory.edu/ENGLISH/Bahri/Nasrin.html, http://taslimanasrin.com*

4 : Grameen Bank — *http://www.grameen-info.org, http://www.gdrc.org/icm/grameen-info.html*

5 : LAMB hospital and rural health and development project — *http://www.lambproject.org*

6 : Nilpharmari Leprosy Hospital — A leprosy mission hospital a short distance (by car) from LAMB. Some medical students do electives at Nilpharmari. An associated hospital supported by my church is the McKean Rehabilitation Centre in Chiangmai, Thailand. McKean's staff include two Australians, Trevor and Heather Smith, who have served in Thailand for more than thirty years! *http://www.leprosymission.org.uk/html/projects.php?itm=77, http://www.leprosymission.org.au*

7 : Centre for Rural Health, Monash University — *http://www.med.monash.edu.au/mrh/*

8 : Advanced Paediatric Life Support Australia — *http://www.apls.org.au/*

9 : The Australian government can provide training for volunteers on short-term assignment. The government can also provide much more money than is required for accommodation and living expenses. However, the FAQ makes quite clear that they will not provide a laptop computer! — The Australian government can provide training for volunteers on short-term assignment. The government can also provide much more money than is required for accommodation and living expenses. However, the FAQ makes quite clear that they will not provide a laptop computer! *http://www.ausaid.gov.au/youtham/*

10 : Perspectives on the World Christian Movement — Feel like serving overseas, but not entirely sure why? In what way can Christians participate in God's mission? *http://www.perspectives.org.au/*

11 : International Health and Development, an orientation to medical mission — 'This course provides knowledge, understanding and skills to enhance the ability of personnel to participate effectively in health and development programs in developing countries and in remote parts of Australia. The course is offered by INTERMED SA, a consortium of health professionals, health professional organizations, mission groups and Christian education institutions.' In the past, this course has attracted one hundred and eighty (180) CPD/CME points from the RACGP. *http://www.missionresourcing.net.au/pages/00000169.cgi, http://www.adelaide.tabor.edu.au/coursedesc.php?cdid=46*

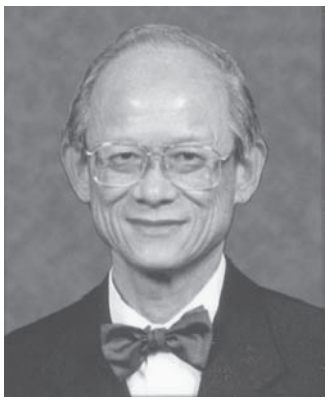
12 : Medical Services International — 'MSI (Medical Services International) is dedicated to serving medical and health related needs of peoples in China and East Asia, as an expression of Christ's love and the Great Commission. MSI teams work in partnership with national, provincial and local medical and health authorities in developing and upgrading medical and health services in needy areas.' MSI holds monthly meetings in both Melbourne and Sydney. Each year the Australian office sends one or two medical mission teams to central China (e.g. in April 2004) and also an English teachers team (possibly June 2004). *http://www.msiprofessionalservices.org*

13 : *http://www.mouseplanet.com* — excellent independent advice on how to enjoy your Disneyland holiday

OBITUARY

Lit Bun Leung

(30.10.41-18.10.03)



A man of faith. A man of love. A man for others. LB Leung walked this world as an ordinary man performing extraordinary deeds. His love reached out like ripples on the surface of a pond, touching the furthest boundaries.

Born in Hong Kong, October 1941 into a poverty-stricken family, he was the second son of five siblings. Through his family he learned the values of unity, love and compassion. He was offered a place in one of HK's prestigious schools, De La Salle College. Academic that he was, he also found comfort in the Catholic faith. His involvement with the Boy Scouts further matured his compassion for others.

He was accepted into medicine and despite being amongst the elite, he still kept his common touch. He always saw the humanity within a person, more than the disease itself. He often said that a doctor should treat patients with respect and dignity for the trust they bestow upon doctors. His motto throughout medical school was to provide "for the health and happiness of his patients".

LB was a person who always felt indebted to those who helped carry his burden. His older brother Patrick, in particular, sacrificed his university opportunities to work as a radio operator and so paid for LB's own uni fees. LB used to say that people should pay more attention to the good deeds others do unto you rather than the good deeds you do unto others.

LB graduated from the University of HK in 1968 and completed his internship at Queen Elizabeth Hospital before finding his niche in anaesthesia. It was his dedication to others that caught the attention of his to-be wife, Christine. His love for nature and wide open spaces made Australia an ideal home for him to settle in. In 1977, LB tied the knot with Christine and in the next 8 years, had three sons.

LB's dedication to his wife was evident by his actions. A while ago Christine was afraid to take the train into the city. LB eased that fear by following her from one station to another in his car. His love for Christine was like the shadow that stayed by her side – never to leave her. LB held dear to his heart that altruistic love called *agape*. The love that welcomes family, neighbours and strangers alike.

As a GP and anaesthetist, he was in an ideal position to allay those fears patients held preoperatively. He began his GP practice in St Albans when it was still a paddock and he had horses for neighbours. He was one to spend time listening to people's problems. His professional sense was evident when he did house calls: called out after midnight, he would get out of bed to change into a suit and tie. In 1994 he opened the Werribee Hoppers Crossing Endoscopy Centre. This was followed by another centre in Melton. Before he became unwell, he was almost exclusively giving IV sedation for endoscopy.

LB was also an enthusiastic ACMAV member, attending many meetings. Many will remember him as a well-dressed doctor with a bowtie and a smile, asking the speakers intelligent questions at the end of their talks.

Should there be a time when the sadness of day prevails, we will find joy in that corner within our hearts where LB's love lives. Forever remembered and loved by his family and friends.

We will miss this compassionate colleague. He is survived by his wife Christine, and his sons Albert, Christopher and Edmund.

OBITUARY

Bill Leung

(1943-2003)

Bill was the third child of an extraordinary family. He was born in Melbourne and was one of 12 siblings. Bill's father for many years ran the Rice Bowl Restaurant in Hawthorn. Bill and his siblings, as they grew up, helped the family by waiting on tables and cleaning up.

He went to the local state school and won a scholarship to Scotch College where he excelled in sport, as well as at school .

As a medical student he was a Prosector (prize winner) in anatomy and known to be conscientious and studious. Bill was keen on sport, played football with the Young Chinese League. He was an undergraduate at the Alfred, but each evening he would still go to the café to help at the end of the day.

In fifth year he was besotted with a very young Laraine who arrived on the scene and got married between fifth and sixth year. Laraine and Bill lived at his parent's house in Kew and were essentially surrogate parents to Andrew, Bill's youngest brother. Michael arrived and was a great joy to his parents.

Bill graduated with good marks and after a residency at the Alfred, decided the quickest way to support his family was by becoming a General Practitioner.

He went to the Women's Hospital for obstetric and gynaecology experience. Bill's family was expanding and he never regretted his decision to go into general practice, which he enjoyed. He was a GP who practised with honesty and integrity and was also fair to his patients whom he treated with respect.

Bill was a keen golfer who loved Heidelberg and played off a low handicap. He was a natural at ball sports. He also loved to fish with his mates and enjoyed enormously the trips they had together.

Bill and Laraine enjoyed an extraordinarily harmonious relationship. He himself enjoyed the role of father and adviser to his children and was proud of each individually.

He was pleased that he was just well enough to make a trip to Perth in February, but frustrated that his energy allowed him to do so little, but he still managed to go out and play with his grandchildren, despite the pain.

Bill was always a very active person and one of the things that he most resented about being ill was that he could not do much .Two weeks before his death he was still out pruning the garden in short bursts as his energy allowed. His mind remained sharp and his memory good until his last few days.

Bill died secure in the knowledge that he left behind four children, Michael, Sally, Scott and Mandy and their partners, who would care for each other and care for Laraine.

FAREWELL BILL WE WILL ALL MISS YOU.

John Rogers and Kevin Siu

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MEMBER INTERESTS

TRAVEL

MEDICAL ARTICLES RELATED TO THE CHINESE

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	Is Acupuncture Medicine?	Choong Khean Foo	1998
	Medical Acupuncture- the current status of an ancient discipline	CT Tsiang & CK Foo	2001
Asthma,	*Asthma, Allergy and Atopy in Asian Immigrants in Melbourne*	Roland Leung	1993
Atopic Dermatitis,	*The Cumulative Incidence of Atopic Dermatitis in the first 12 months amongst Chinese, Vietnamese and Caucasian Infants born in Melbourne, Australia*	Adrian Mar, Mei Tam, Damien Jolley & Robin Marks	2000
Cardiovascular,	*Cardiovascular Disease in China*	Yean Leng Lim	1994
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China,	*Project China-FRACS*	Gordon Low	1996
Chinese, overseas,	*Luo Di Sheng Gen*	Eng-Seong Tan	1993
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Medicinal Plants,	*The Medicinal Plants of "Pents'ao"*	Joseph Cheung *(part I)*	1992
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	Behaviour in Cancer Patients of Non-English Speaking Background	Eng-Seong Tan	1996
ROMAC,	*Rotary Overseas Medical Aid for Children*	Theong Ho Low	2001
Rubella,	*Rubella Information for Health Personnel: Rubella Education Project in the Chinese Community*	Eleanor McLean	1997
TCM,	*Is there a Place for Traditional Chinese Medicine in Modern Health Care*	CT Tsiang	1995
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MEDICAL ARTICLES

Atopy,	*Role of Allergens in Asthma & Allergic Rhinitis*	Francis Thien & Roland Leung	1994
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	Allergy Testing in the Diagnosis and Management of Paediatric Allergic Disease	Mimi LK Tang	1998
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	Future Trends in the Medical Management of Coronary Artery Disease	K Sudhir	1995
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	Treatment of Hypertension with ACE Inhibitors	Henry Krum	1999
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Complementary Medicine,	*Health & Nutrition*	Choong Khean Foo	1992
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	The Twenty-First Century Doctor	Choong Khean Foo	1996
	From Complementary to Integrative & Holistic Medicine	Marc Cohen	2002
	The Place of Nutritional Medicine in General Practice	Choong Khean Foo	2002
Dermatology,	*Fungal Nail Infection- Onychomycosis*	Douglas Gin	1994
	Epidemiological Studies of Atopic Dermatitis: Clues to Pathogenesis	Adrian Mar	1996
	Malignant Melanoma	John W Kelly	1996
	Psoriasis- Outline of a Common Disorder	Philip Lane	1997
	My Approach to Red Scaly Rashes	Michael Lee	1999
	Managing Atopic Dermatitis in Children	John Su	1999
	How to diagnose the Red Scaly Rash	Adrian Mar	2002
Endocrinology,	*Update on Osteoporosis*	Kong Wah Ng	1992
	Osteoporosis 95	Kong Wah Ng	1995
	Update on Diabetes	Serge Tang-Fui	1996
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	Update on Dyslipidaemia	Serge Tang-Fui	2000
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Gastroenterology,	*Helicobacter Pylori, Peptic Ulcers, Chronic Gastritis & Gastric Carcinoma*	Gideon Shaw	1994
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	Management of abnormal smears	Siew-Khin Tang	2002
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Haematology,	*The Myelodysplastic Syndrome*	Newton Lee	1992
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Immunology,	*Update on Immunology*,	Ban-Hock Toh	1995
Infectious Diseases,	*Update on HIV & AIDS*	Anne Mijch	1992
	Hepatitis B	Charles Su & LP Fong	1993
	Aspects of Atypical Pneumonia	Peter Stanley	1994
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	Typhoid Fever- a GP Case Study	Siew Keng Chan	1996
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	Epilepsy Update	Brian Chambers	1997
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	Advances in the Management of Epilepsy	Terence O'Brien	2002
Neurosurgery,	*Subarachnoid Haemorrhage*	Kevin Siu	1994
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Ophthalmology,	*Eye Conditions in General Practice*	Charles Su	1997
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Paediatrics,	*Care of the child with cancer*	David M Ashley	1999
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Pathology,	*Biochemistry Tests in an Ageing Population*	David Deam	1999
Psychiatry,	*Recent Advances in the Treatment of Depression: A Focus on Moclobemide*	John WG Tiller	1992
	Sexually Abused Children as Adults. Can GPs help ?	Gita Mammen	1995
	Depression	Edmund Chiu	1995
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Radiology,	*Mammography in the diagnosis of Breast Cancer*	Lawrence Lau	1991
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	Intravascular Ultrasound: Clinical & Research Applications	Krishnankutty Sudhir	1994
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Rheumatology,	*Cyclooxygenase 2 inhibitors- Efficacy & Toxicity*	Laurie Clemens	2000
	Rheumatoid Arthritis	Christopher Fong	2001
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Pui	Dr Suzy
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Tsiang	Dr Tom CT
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Wong	Dr Yang Huong

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Kuay	Mr Justine
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Qi 2003

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