

SYNAPSE

Hong Kong College of Physicians

October 2001

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RESTRICTED TO MEMBERS ONLY

Plague in Hong Kong in the 19th Century

During the 1890s a plague epidemic in Southern China was moving south towards Hong Kong. In the spring of 1894, about 100,000 dead were reported from Canton.

In May 1894, the disease erupted with violent intensity in Hong Kong's overcrowded Chinese quarter of Tai Ping Shan, currently the Western District.

Plague continued to be a problem in Hong Kong for the next 30 years.



Interior view of the Kennedy Town glassworks, which was converted for use as a temporary hospital during the period of Hong Kong plague, 1894.



An indicating plaque was erected at the entrance of the outside of the Blake Garden to illustrate the site of the "Great Plague" in 1894.

(Photos and information courtesy of the Hong Kong Museum of Medical Sciences)

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Editorial

A Time to Remember, A Time for Change

Few of our Fellows and Members, I presume, are aware of the fact that Hong Kong was once widely affected by the Bubonic Plague. This issue's cover photo and story reveals this disastrous infection that killed many in Southern China 2 centuries ago. It was a time that travel was not as efficient and convenient as today. Yet, the spread of the disease was aggravated by poor sanitation and hygiene, the negative impact of such far too familiar among Hong Kong people in the past few years with the 'Bird Flu' story. The reminiscence of the plague in 1890s still teaches us the lesson of the importance of controlling the infections at an early stage and preventing further spread with high standard of sanitation and hygiene. As physicians, that was for us a time to remember. We should always be on the alert of infections, previously plague and now can be any like Dengue Fever, just to take a recent example. Such infections can potentially spread from other areas to affect our patients in Hong Kong.

Another time to remember is at our College Annual General Meeting this year. We have two distinguished surgeons, our Academy President and the Vice Chancellor of Chinese University of Hong Kong addressing the College. This issue of Synapse proudly publishes these two speeches: "Burden and Hope for New Fellows" by Professor CH Leong and the Sixth AJS McFadzean Oration titled "Reflections of A Surgeon" by Professor Arthur Li. The two distinguished speakers have, among other things, both spoken of the time for change, be it to the medical profession or to the medical education.

Another Special article is the College Comments on our Academy's proposal of the Hong Kong Medical Council Reform as prepared by the Professional and Public Affairs Committee of the College. The comments as published here will let our fellows and members know of the College stand. The College certainly agrees it is a time for change in the Medical Council.

Dr. John Mackay, my Assistant Editor, has spent an afternoon in April this year with Professor Sir David Todd in Cambridge, UK. This issue's feature story covers many aspects of the recent life and thoughts about our medical profession of our most respected Sir David. I am sure you will find the article most interesting and stimulating. The photo is from my archive with Sir David in Cambridge at the season filled with the cherry blossoms.

This issue publishes the list of chairmen and members of the current committees and specialty boards for our fellows and members so that they can communicate with them for relevant matters. The Scientific section is very rich with several abstracts of the recent update lectures. As MRCP (PACES) examination will be first started in Hong Kong in October this year, we publish here the helpful hints for the benefits of our trainees. Please do read them.

We have a column of Viewpoints added for information of our fellows and members. This issue features the open letter to the Secretary of Health and Welfare on "Consultation Document on Health Care Reform" from the President of the Association of Private Medical Specialists of Hong Kong.

The College would like to let our fellows and members know about the achievements of some distinguished fellows. In this issue, we will congratulate Dr. Raymond Wu and Professor SK Lam.

The College sadly reported the loss of 2 fellows this year: Dr. Alex YM Chan and Professor JAJH Critchley. Also Professor James Petrie, a dear friend of the College, recently passed away. Their obituaries are published in the current issue. Here, we send our deepest condolences to their families.

Philip K.T. Li
Editor-in-Chief

Quotes

Preventive Medicine

The superior physician helps before the early budding of the disease.....

The inferior physician begins to help when [the disease] has already developed; he helps when destruction has already set in. And since his help comes when the disease has already developed it is said of him that he is ignorant.

Huang Ti Nei Ching Su Wen [2697-2597 BC]
(The Yellow Emperor's Classic of Internal Medicine)

Special Article

"Burden" and "Hope" for New Fellows

Mr President, Fellow Graduands, Ladies and Gentlemen,

May I begin by congratulating the graduands of today. Whether you have been awarded a Fellowship or a membership is an immense achievement, a turning point in your life and career. For as from today you are on your way to become a specialist in medicine, the *creme de la creme*, the first amongst equals.

It may be opportune for me to thank your President and the Council of the College for giving me this singular honour of addressing you tonight. Taking aside the fact that I represent the Academy of Medicine, I am still very much a surgeon. I am given to understand that Vice Chancellor Arthur Li will also be addressing the College later in another forum. Prof Li is undoubtedly a seasoned administrator and a shrewd politician. Yet to me, he is still very much a surgeon at heart if not in deed. To have two surgeons addressing the College of Physicians in your annual Fellowship conferment ceremony is not only epoch making but signifies a very much needed cooperation and bond between the different factions of the Academy and the brotherhood of the medical fraternity. So let us begin!

Mr President, one could not be too far wrong to label the last few years as the Dark Ages of the medical profession - the patients are demanding and insatiable; the politicians are taking every opportunities to denigrate our credibility; the media consider it a field day should there be a slight medical mishap; the businessman-orientated health corporates are eating into our income; the Asian financial crisis has put the last straw by dragging many into negative assets.

The profession itself cannot be absolved from blame - the all too unnecessary political bickering within our own rank albeit from a few to achieve their personal political agenda has resulted in the sour relationship between the Government and the profession; a chasm between the private and the public sectors, the specialists and the generalists, the senior and the junior doctors not realizing that a golden opportunity is set for the media to play Peter against Paul.

The final nail must come from the recent poor handling of the Medical Council. The public has thrown in the gauntlet. The respect and confidence they have towards the profession has plummeted to an all time low.

Yet, there is no point crying over spilt milk, nor is there anything to gain by continuing the gloom and doom. Instead, the profession must gather our wits, pick ourselves up and work to recover lost ground. You, I, the College and the Academy are all together in this battle.

Throughout the past month, many in our profession have aired their views on how to recover our lost grounds - from reforming the Medical Council, actively publicizing the many "good works" of our profession, putting up more guidelines, setting up independent mechanism to investigate medical mishaps, ensuring more stringent standard and quality vetting; to the more radical suggestion of "treating every patient as a potential complainant", "the media are sharks".

How much and how well these will work is uncertain. But one issue is obvious: if any patient could know for sure that no matter which doctor he sees, his health and life would be cared by professionals equipped with the highest standard and the fast medical advances, public confidence and respect to our profession would naturally follow.

Interesting enough, what the public demand is what the Academy has always been in pursuit. The Academy, through its constituent colleges, is empowered by law to determine standard, monitor and vet standard of our Fellows. This we do and fellowships are only awarded to those that have attained the highest.

Our forefathers who spearheaded the Academy, many are in the audience, must be given the highest accolade to have demanded that it must be stipulated in law that having an Academy Fellowship is not enough and that adequate attendance of Continuing Medical Education (CME) is a legal pre-requirement to specialist registration. Transparency of the highest possible standard is thus attained, for a specialist must not only need to be properly accredited by the Academy, but

also demonstrate spending enough time to keep up with medical advances.

Yet the Academy has to do more. The different Colleges will not only need to work in close collaboration with their international counterparts, but also demonstrate to the public that our approved standards are at par with the best in the world. Our approved CME programmes must be made more stringent to demonstrate to the public that the life long learning is quality education. Different Colleges must come forth with necessary clinical protocols and guidelines and determine accreditation criteria for new and specialized interventional techniques. The Academy must work with the Colleges to determine Quality Assurance.

The College of Physicians deserves to be congratulated in taking a leading role in these directions. As it is, there are now established criteria in your College for endoscopic examinations, intravascular dilation and stenting. Moves are now being finalized with the Hospital Authority on quality requirement of haemodialysis setup.

All these will mean more work for the Colleges, more coordination from the Academy, more time spent in training for our Fellows. It would also mean more rules and regulations for our Fellows to follow.

The profession should welcome such a move, for not only will it improve our service to our patients, but also prepare us to be better equipped. More importantly, the profession is taking all these on our own without the interference of the public and Government, demonstrating that we can put our own house in order, and justifying our determination for professional autonomy.

But all these developments should not only be limited to the Academy, the Colleges and our Fellows alone. The whole profession, be they specialists or otherwise, must move in such positive direction, for what is more superior than to "improve ourselves as doctors, and at the same time help others - our patients"?



The Academy is in the best position to bring all these about. We are above board, away from the controversies of politics; and we are the legal medical standard setting body. With your help, we will push ahead with all these. The honour of the medical profession is at stake. There is no turning back.

It has been said “國家興亡，匹夫有責”*. As a new member of this fraternity, the credibility of the profession is as much a responsibility of yours as mine. I apologise for having to place such heavy burden on your shoulder at the turning point of your career. I look forward to salute you in the course of time.

My congratulation again to the new graduands and the College of Physicians for delivering such promising Fellows.

C H Leong
President,
Hong Kong Academy of Medicine
1 June 2001

[This speech was made by Dr. CH Leong at the Fellowship/ Membership Conferral Ceremony of The Hong Kong College of Physicians to our new fellows and members on June 1, 2001.]

*: (Translation from the Editor: "A fellow citizen bears the responsibility for the fate of the country")

Sixth AJS McFadzean Oration Reflections of A Surgeon

Mr President, distinguished guests, ladies and gentlemen:

Introduction

It is a great honour for me, as a simple surgeon to be invited to deliver the McFadzean Oration of the Hong Kong College of Physicians. Although I do not personally know Professor McFadzean, I have heard a great deal about him and his disdain for surgeons.

As surgeons are not generally renowned for their intellect when compared to our physician colleagues, I feel certain that Professor McFadzean will regard my invitation here tonight as an attempt by the College to break down the blood-brain barrier.

I was very kindly given a wide choice of topics, and I chose the title "Reflections of a Surgeon". From the title you can deduce the subject matter is going to be vague and it is precisely because of its vagueness I thought it would be appropriate since I hope it would make physicians feel more at home!

Reflections can be sad or happy. Sad, not because of personal hurt or disappointment, but rather the lost of opportunities of what Hong Kong can achieve.

However, tonight I shall concentrate on happy reflections particularly my close relationship with my physician colleagues. Based on those happy experiences, perhaps I may be allowed to speculate on the future development of Medicine, Medical Education and the role of the colleges as a whole.

Background

Professor McFadzean was the Head of Department and Professor of Medicine at HKU. At that time it was the only medical school in Hong Kong and tertiary education was an elitist education. One can probably say that nearly all of us here tonight were brought up in this traditional elitist environment.

In other words, only the best can make it to university and only the creme de la creme make it to medical school. To a certain extent the creme may be a little soured but this still holds true even today.

Once in medical school, we were brainwashed to believe that there were really only two major specialties - Medicine and Surgery. We were told that anyone with ability will specialize only in one or the other.

Obviously physicians regard themselves as more intelligent than surgeons and they may well be right because where else would one do less work, with more free time and get the same pay?

In the traditional medical school, the general surgeon is regarded within the broad specialty of surgery as a prima donna. Gynaecologists are people who can't tell the difference between work and pleasure, and are always looking up old girlfriends, while the orthopaedic surgeons are just bone-setters with medical degrees.

However in Medicine, it is hardly any different. The psychiatrist is regarded as a bit of a crank. After all any person who wants to deal with mad people all the time obviously needs to have their head examined. As for paediatricians, unfortunately they haven't learnt to talk to grown-ups and they are probably too intelligent to be veterinarians.

These caricatures are very much a product of the traditional medical school. They are obviously biased. However they do provide us with a font of jokes about every specialty. Providing we don't really believe in them, they are a source of playful competitive rivalry.

I must admit that before Professor Gerald Choa recruited me back to Hong Kong, I had very definite ideas about physicians and surgeons. I regarded surgeons as physicians who can also operate while my physician colleagues regard surgeons as merely their technicians to be at their beck and call. For instance patients with haematemesis were often referred to the surgeons on Friday afternoon after the last of 40 units had been transfused!

Once back in Hong Kong at the Medical School that Professor Choa so ably piloted through its gestation and infancy, I discovered that the problems we faced were not those of traditional medical schools. In fact it was an experience one might have wanted to forget but was unforgettable.

First, we had a medical school but no teaching hospital because the construction of the Prince of Wales Hospital was delayed by litigation between the Government and the contractor. With no hospital of our own you could say we were a prototype for "Medicins Sans Frontiers". Second, there was no junior clinical staff allocated by the then Medical & Health Department because with their legendary foresight and wisdom, we were told by them that no graduate would want to work with us and they would start to weep on learning that they had to be transferred to us, like young brides being coaxed to get on their wedding sedan chairs. Third, our budget was extremely tight.

The end result was that we had containers on the lawn of the United Christian Hospital. These served as our offices and classrooms by day and our on-call rooms at night. I guess I shall always have the privilege of being the only Professor of Surgery who slept on a settee in a container while being on first call for all surgical emergencies. How I wish we had the Public Doctors Association then! If we had been attached to Kwong Wah hospital, I would probably have had to sleep in a cardboard box under the Princess Margaret Flyover! I guess we had to be grateful for small mercy.

However deprivations only served to stimulate and bring our fledgling departments together. As Samuel Butler put it: "All progress is based on the universal desire of every organism to live beyond its means"

We were fortunate to have Kowloon Hospital also to use as another base. It was there that we decided on our new strategy. Even though tradition dictates that surgery and medicine should be kept separate, it was the most logical and rational decision to pool our resources for the common good. In fact what was a recipe for survival became the main course for evolution, of the way of providing, and teaching, medicine.

Looking back to those early days it was understandable that we had a siege mentality. We felt that we were surrounded by an evil empire out to destroy young, gallant, and talented individuals whose quest was to help Hong Kong to revolutionize its archaic medical system.

Because we were young we did not have the wisdom to accept limitations. Because we were proud, we were foolhardy and willing to take on all comers. Above all, with Professor Choa desperately reigning in our worst excesses and our talents aside, we were extremely lucky.



Our President presented the medal to Professor Arthur Li after his 6th AJS McFadzean Oration in our ASM.

What emerged from that experience was a medical school proud of its non-conformity. Despite constant challenges to dogma and authority, there was tremendous comradeship, collegiality and co-operation. Because there was no internal politics we worked well together and pioneered many joint efforts such as the Combined Endoscopy Unit, combined clinics for breast and endocrine diseases, combined oncological clinics like hepatocellular carcinoma and nasopharyngeal carcinoma. Later on there were combined clinics for children with spina bifida, the elderly with osteoporosis, and so this trend is becoming the norm.

The supportive services like pathology, radiology, anaesthesia and intensive care were tremendous. We were lucky to have recruited some really outstanding young and dynamic individuals who subsequently proved their international stature and gained worldwide respect. They were partners in a team rather than handmaidens to surgery or medicine.

Since we were under siege and had no help, we had to be self-sufficient. So we had to develop expensive specialties like cardio-thoracic surgery, ENT surgery and ophthalmology. With the enthusiasm and support of the Department of Health and the then UGC this task was made even more difficult, but as they say, the rest is history.

We already know that our paediatric surgeons work more closely with paediatric colleagues than with other surgical colleagues. The same is true for the cardiothoracic surgeons. In other words, the traditional clinical departments like medicine and surgery will have to be redrawn. Instead of a big Department of Medicine comprising of cardiology, hepatology, nephrology and so on, there will likely be Departments of Gastroenterology comprising of both surgeons, physicians, pathologists and radiologists. Similarly there will be Departments of Neurosciences where neurologists, neurosurgeons, neuropathologists and neuroradiologists and even psychiatrists work together.

Hand in glove with such change came the necessary change in the way we taught medicine. In the traditional medical school we learnt anatomy, pharmacology, biochemistry and physiology in the pre-clinical years followed by bedside teaching in the various clinical specialties. However, how much more relevant is Starling's Law when confronted with a patient with heart failure on beta-blockers? Similarly anatomy and physiology of the gastric antrum is more pertinent when correlated with patients with peptic ulcer disease.

Our students were taught differently, and we would like to believe that this stimulated change in our older sister University that revamped their curriculum to a more modern problem-based approach.

Since our own tradition is to not to be enslaved to tradition, we cannot rest on our laurels but continue to change and adapt, and to increase the integration of what was previously classed as pre-clinical and clinical work into a more system based approach.

However change is not progress, and we must ensure that we are not dragged back into the quicksands of timeless tradition and that we ensure that our teaching methods are not veneers of educationalists' fashion but guarantee that our students learn how to pursue knowledge, and not allow knowledge to pursue our students. This is truer today than it has ever been in human history with the amount of information doubling at geometric rates and the obsolescence of information reciprocating at equally dizzy speeds.

In our passage from the Atomic Age to the Age of information the ability to keep on learning has become of

paramount importance and the traditional role of the colleges, as the guardians of professional standards suits them perfectly for this role. Already we are conscious of the importance the colleges have in what is currently termed Continuing Medical Education. I am sure that as fashions change this term will be replaced by other more trendy titles, but underlying all this is the principle of Life-Long Learning.

Medical universities and, clinical practice are evolving, and the colleges must be part of this evolution. Currently we already have specialty colleges on the scene, such as a College of Cardiology. This trend has to be guardedly welcomed but not allowed to get out of hand, or in the end we will even need a College of Ingrowing Toe Nail Specialists. Too many small colleges, each going its own way will weaken and destabilize our noble profession.

I believe that there is still a function for "Grandparent" colleges to ensure equivalent standards, and arbitrate between colleges in turf battles and prevent self-debilitation. Without this the medical profession could become an H5N1 chicken in danger of losing its head!

Tradition dies hard. There will always be a College of Physicians and a College of Surgeons. But it is important for the Colleges to face up to challenges and not be afraid of change.

At the end of the day we still need doctors who will look after the general patient or the patient with multiple organ problems. In fact the ideal specialist is one who can see his, or her specialty from a global perspective, and we shall always need doctors who cannot only teach and but also inspire, as so well exemplified by Professor McFadzean.

Unlike the doctor who when telling his patient that he had Alzheimer's Disease but could go home and forget about it, I hope you will not go home and forget the responsibilities we all assumed when becoming fellows of our own colleges.

Mr. President, Distinguished Guests, Ladies and Gentlemen: Thank you.

Arthur K.C. Li
Vice-Chancellor

The Chinese University of Hong Kong

1 June, 2001

College Comments on the Academy's proposal of the Hong Kong Medical Council Reform

23 August 2001

Dr CH Leong
President
Hong Kong Academy of Medicine

Dear Dr Leong

Hong Kong Medical Council Reform

The proposal by The Hong Kong Academy of Medicine was thoroughly discussed by our Council. The following were our comments on this issue.

1. CME/CPD

Continuous medical education is essential for all doctors in order to maintain a high profession standard. Its acceptance by both the public and the profession is now beyond debate. There are concerns on how compulsory CME should be implemented and worries on its association with the annual certification for medical practice. As a statutory body that must put quality and standards at the forefront, however, the Hong Kong Medical Council is obliged to take steps that follow this direction.

Our College recommends a three year cycle on the implementation of compulsory CME.

2. Representation in the Hong Kong Medical Council

Our College supports the proposal of the Academy to increase the representation in the HKMC from the present two to at least four. Furthermore, we are of the opinion that 80% of the members in the HKMC should be elected by compulsory voting.

3. Complaints Office

The current structure of the HKMC has led to problems, particularly on complaint handling, that triggered the quest for its reform. Changes should therefore be geared towards demonstrating fairness in complaint issues so as to rebuild public confidence in our profession. In this regard, separation of the processes of prosecution, investigation and judgment into distinct segments may be helpful.

We are of the opinion that setting up a Complaints Office under the HKMC would be expensive and that this expense might be transferred to members of the profession. A Complaints Office under the Department of Health is acceptable. Apart from cost concerns, it will be more suited to deal with complaints that are not pointed against the medical profession. A Complaints Office under the DH can act as a screening or triage body prior to sending appropriate cases to the Disciplinary Committee of the HKMC.

We propose that more doctors and fewer laymen be recruited into the Disciplinary Committee. The Chairman of this Committee should be able to lead the panel of doctors and laymen to come to fair judgment. A Chairman with legal background may help, especially in reestablishing public confidence. On the other hand a Chairman from the medical profession will be desirable in upholding professional autonomy.

With best regards

Dr H Yuen
Chairman
Professional and General Affairs Committee
Hong Kong College of Physicians

Council News

Your New Council

President: Prof. Richard YH Yu

Vice Presidents: Prof. KN Lai

Dr. EK Yeoh

Hon. Secretary: Dr. Loretta YC Yam

Hon. Treasurer: Dr. TF Tse

Council Members: Prof. SK Lam

Prof. WK Lam

Dr. Patrick CK Li

Dr. CS Li

Prof. Raymond HS Liang

Prof. Joseph JY Sung

Dr. ML Szeto

Dr. CP Wong

Dr. H Yuen

Dr. Carolyn PL Kng

Dr. Philip KT Li

Dr. Francis CC Chow

Dr. Matthew MT Ng

Hon. Legal Advisor: Mr. Peter WH mark

Hon. Auditor: Walter Ma & Company

Past President: Prof. Sir David Todd

Immediate Past President: Prof. TK Chan

New council members:

We welcome Dr Chow Chun Chung, Francis (Prince of Wales Hospital) and Dr Ng Mar Tai, Matthew (Tung Wah Hospital) as co-opted council members.



The College Council during the AGM on June 1, 2001:

(Front Row L to R: Prof. Raymond HS Liang, Dr. TF Tse, Prof. KN Lai, Prof. TK Chan, Prof. Richard YH Yu, Dr. EK Yeoh, Dr. Loretta YC Yam

Back Row L to R: Dr. Patrick CK Li, Prof. Joseph JY Sung, Dr. H Yuen, Dr. CP Wong, Dr. Philip KT Li, Prof. WK Lam, Dr. Carolyn PL Kng, Dr. ML Szeto, Dr. CS Li, Prof. SK Lam)

College Committees

Administration & Finance Committee

<i>Chairman</i>	Dr TF Tse		
<i>Members</i>	Dr KH Chan	Prof Annie Kung	Prof KN Lai
	Dr John Ma	Dr WC Ng	Dr Bell Tse

Education & Accreditation Committee

<i>Chairman</i>	Prof KN Lai		
<i>Vice-Chairman</i>	Dr CS Li		
<i>Secretary</i>	Dr Loretta Yam		
<i>Members</i>	Dr LY Chong	Prof Karen Lam	Prof WK Lam
	Dr Patrick Li	Prof Raymond Liang	Dr ML Szeto
	Dr CP Wong	Prof Lawrence Wong	Prof KS Woo
	Dr Richard Yu	Dr H Yuen	

Examination Committee

<i>Chairman</i>	Prof WK Lam		
<i>Members</i>	Prof KN Lai	Dr Patrick Li	Prof Raymond Liang
	Prof Joseph Sung	Dr Loretta Yam	Dr H Yuen

Membership Committee

<i>Chairman</i>	Prof TK Chan		
<i>Members</i>	Prof KN Lai	Prof WK Lam	Dr Archie Lo
	Dr CW Tsang	Dr SP Wong	

National & International Liaison Committee

<i>Chairman</i>	Prof WK Lam
<i>Members</i>	Dr Patrick Li
	Prof Joseph Sung
	Dr Kenneth Tsang

Professional and General Affairs Committee

<i>Chairman</i>	Dr H Yuen		
<i>Past Chairman</i>	Dr CS Li		
<i>Deputy Chairman</i>	Dr ST Lai		
<i>Members</i>	Dr SY Au	Dr KH Chan	Dr CH Cheng
	Dr Philip Li	Dr SK Li	Dr John Ma
	Dr Matthew Ng	Prof Rosie Young	

Research Committee

<i>Chairman</i>	Prof Raymond Liang		
<i>Members</i>	Dr KH Chan	Dr CC Chow	Hon Ms Audrey Eu
	Prof KN Lai	Dr CS Lau	Dr FH Ng
	Prof John Sanderson	Dr MW Tsang	Dr TF Tse

Scientific Committee

<i>Chairman</i>	Prof Joseph Sung		
<i>Members</i>	Prof Daniel Chan	Dr CC Chow	Dr KC Ho
	Prof David Hui	Prof Mary Ip	Prof YL Kwong
	Dr JY Lai	Prof Thomas Leung	Dr Philip Li
	Dr YW Luk	Dr Matthew Ng	Dr SC Tiu
	Dr Vincent Yeung		

Working Group in Traditional Chinese Medicine

<i>Chairman</i>	Dr TF Tse		
<i>Hon Advisor</i>	Prof Li Lei Shi		
<i>Members</i>	Dr Au Kit Shing	Prof TK Chan	Dr Ko Wing Man (HA)
	Dr Matthew Ng	Prof Joseph Sung	Dr Tiu Sau Cheung
	Dr Kenneth Tsang	Dr Tsui Ip Shing	Dr Yu Chau Leung, Edwin (College of Paediatricians)

Synapse

<i>Editor-in-Chief</i>	Dr Philip Li		
<i>Assistant Editor</i>	Dr John Mackay		
<i>Co-Editors</i>	Dr Henny Chan	Dr CC Chow	Dr Carolyn Kng
	Dr Patrick Li	Dr YW Luk	Dr CM Lum
	Dr ML Szeto	Dr WC Yu	

Notice to Members concerning Basic Physician Training registration

It is noted that there are several candidates who sat the MRCP(UK)/HKCP Intermediate (Written) Examination in July 2001 had never registered in the College and not paid their Basic Physician Training fees.

The application to sit for the MRCP(UK)/HKCP Intermediate (Written) Examination will not be valid until the member is currently registered in the HKCP Trainees' Registry for Basic Physician Training, which requires annual updating of the training status and payment of the required fees effective from 1 July every year.

In future, such non-registered candidates may be banned from taking the examination.

MRCP(UK) publications

The following publications for MRCP(UK) examination are now available to be purchased from the MRCP(UK) central office and the examination departments of the three Royal Colleges of Physicians:

MRCP(UK) part 1 examination syllabus

MRCP(UK) part 1 examination papers and free interactive CD Rom

MRCP(UK) part 2 written examination 1999 edition

MRCP(UK) part 2 clinical examination (PACES) 2001 edition

Specialty Board Corner

Recognised training institutions for Advanced Internal Medicine

Accredited Training in the Specialty	Recognised Training Institutions/Units	Duration Accredited (months)	Recommendation / Remarks
Advanced Internal Medicine 62nd E&AC (2 Feb 2001) 115th CM (22 Feb 2001) & 65th E&AC (10 May 2001) 118th CM (24 May 2001)	AHNH	36 months	Acute
	CMC	36 months	Acute
	FYKH	9 months	Non-acute
	GH (Med + Card)	12 months	Non-acute
	HOHH	12 months	Non-acute
	KWH	36 months	Acute
	NDH	36 months	Acute
	OLMH	15 months	12 months Non-acute, 3 months Acute
	PMH	36 months	Acute
	PWH	36 months	Acute
	PYNEH	36 months	Acute
	QEH	36 months	Acute
	QMH	36 months	Acute
	RH & TSKH	36 months	Acute and Non-acute
	SH	18 months	Non-acute
	TKOH	24 months	Acute (Effective 1 Feb 2001)
	TMH	36 months	Acute
	TPH	12 months	Non-acute
	TWH	18 months	Non-acute
	TWEH	18 months	Non-acute
UCH	36 months	Acute	
YCH	36 months	Acute	

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Amendment of Advanced Internal Medicine Training Programme

Approved at 63rd E&AC Meeting on 6 March 2001 and 116th Council Meeting on 29 March 2001

App 1 (Amended to replace Appendix 1 of P. 40, Advanced Training in Internal Medicine, Guidelines on Postgraduate Training in Internal Medicine, Second Edition)

1. The four components of the Core Programme for Advanced Training in Internal Medicine must be fulfilled.

- | | |
|--|--|
| <p>(i) <i>Primary responsibility for and adequate exposure to patient management in acute general medical wards with 24-hour emergency call admissions* including</i></p> <p>a) <i>Resident emergency on-call duties, at least 4 times per month, and</i></p> <p>b) <i>Responsibility for responding to medical consultation requests from other hospital departments.</i></p> | <p><i>Minimum 18 months</i></p> |
| <p>(ii) <i>Management of new and old cases attending general and specialty medical outpatient clinics which serve patients of all age group.</i></p> | <p><i>Minimum 5 hours/week for 18 months</i></p> |
| <p>(iii) <i>Experience of working in ICU/CCU/ICA or other high dependency units</i></p> | <p><i>Minimum 3 months and maximum 6 months (of which 3 months should be within the 18 months specified in 1(i) above) during Basic or Higher Physician Training</i></p> |
| <p>(iv) <i>Experience with aspects of extended care and/or rehabilitation.</i></p> | <p><i>Minimum 3 months during Basic or Higher Physician Training</i></p> |

* A general guideline is to be in charge of 10 or more beds in such ward.

2. To equip them with the skills required for the chronic care of medical illnesses, Internal Medicine trainees interested in ambulatory care should be exposed to various medical specialties during the 36 months of Higher Physician Training, including Rehabilitation Medicine and Palliative Medicine.

3. Trainees may opt for ambulatory care training for at least 50% of the time over a period of 15 months. During this period, the trainee should undergo a comprehensive and in-depth structured training programme as recommended by the Specialty Board, in medical outpatient clinics and outreach programmes for the elderly and patients with medical disability in the community. The term "Ambulatory Care Physicians (ACP)" has been designated to describe the future physicians, who after undergoing the appropriate training, will be practising in the community setting. They will be well-equipped to maintain health and reduce the hospitalization needs of patients suffering from chronic medical illnesses.

More details of the Guidelines for Higher Physician Training in Internal Medicine can be obtained from www.hkcp.org/guideline1.htm and <http://www.hkcp.org/highertrain.htm>

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	Prof KS Wong (PWH, SH)
	Dr MS Lai (AHNH, NDH, TPH)
	Prof SK Lam (Past Chairman)
Coordinator for Hospital Accreditation Visits	Dr WK Kwan

Advanced Physician Training Assessment Protocol

The captioned Protocol was printed in June 1998 to provide guidelines for trainers to assess their trainees' performance in their Annual and Exit Assessments. In 2000, major revisions have been made in the scoring system, assessment process and dissertation guidelines. The new 10-point system has been implemented in December 2000 while the revised dissertation guidelines will be adopted in June 2001. At its 118th Meeting held on 24 May 2001, the Council has directed that this protocol be publicised on the College's website "<http://www.hkcp.org>" for access by College Fellows, Members and trainees for reference.

Dr Loretta Yam
Hon Secretary

(The Advanced Physician Training Assessment Protocol is now available on the website www.hkcp.org/protocol.htm. Evaluation forms for Record of Advanced Physician Training can be downloaded directly from www.hkcp.org/form/recordaph.htm)

Exit Assessment Protocol for Higher Physician Training -

A clarification of last issue's table is attached here again for your reference:

Candidates should have passed two Annual Assessments before they are allowed to sit the Exit Assessment.

Overall result			Action	
Subsection result		Conversion Score		
Dissertation	Clinical viva			
Pass	Pass	> 50%	Pass	Eligible for admission as College Fellow
Borderline Fail	Pass	> 50%	Pass	Eligible for admission as College Fellow
Pass	Borderline Fail			
Borderline Fail	Pass	45%	Bare Fail	Remedial action and repeat Exit Assessment in failed section after an additional 6-month training in the relevant specialty
Pass	Borderline Fail			
Borderline Fail	Borderline Fail	45%	Bare Fail	Remedial action and repeat Exit Assessment in both sections after an additional 6-month training period in the relevant specialty, which should be undertaken in a programme and a training centre specified by the Specialty Board.
Borderline Fail Fail Pass Fail	Borderline Fail Pass Fail Fail	< 40%	Fail	Remedial action and repeat Exit Assessment in failed section(s) after an additional 12-month training period in the relevant specialty, which should be undertaken in a programme and a training centre specified by the Specialty Board.

7.3 Scoring System for Annual Assessment

Annual Assessment

Overall result	Verdict	Actions
Conversion Score		
> 50%	Pass	Proceed to next Annual or Exit Assessment
45% or failure in one section	Bare Fail	Remedial action regarding training programme
< 40%	Fail	Repeat Annual Assessment after an additional 6-month training in the relevant specialty

Ambulatory Care Physician Training Programme

At the 118th Council Meeting on 24 May 2001, the Ambulatory Care Physician Training Programme has been finalised and endorsed. The same programme has also been endorsed by the Hong Kong Academy of Medicine in June 2001.

Prof KN Lai
Chairman
Education & Accreditation Committee

Subcommittee in Clinical Pharmacology & Therapeutics

Subcommittee in Clinical Pharmacology & Therapeutics

Since the formation of the Subcommittee in Clinical Pharmacology in 1999, there has been no training nor accreditation activities in the specialty. The Council has therefore decided to absorb the functions of this Subcommittee into the Specialty Board in Advanced Internal Medicine which will handle all matters pertaining to this specialty as from 1 June 2001.

Prof KN Lai
Chairman
Education & Accreditation Committee

Scientific Section

Abstracts from Update lectures of College

Organ Transplantation

Peri-Operative Management in Renal Transplantation

Cheuk-Chun Szeto, Prince of Wales Hospital

Pre-operative assessments include general medical assessment, renal assessment and immunologic assessment. Baseline assessment of cardiovascular risk is needed. Serologic evidence of previous infections, including CMV, EBV, VZV, HSV, HBV, HCV, and HIV need to be documented. For HBsAg carriers, there is definite risk of hepatitis flare and cirrhosis, especially in those with pre-existing active hepatitis. Baseline investigations include ALT, ultrasound, and, when available, HBV DNA level and possibly liver biopsy. HBe status is of little use. Lamivudine has been tried as pre-emptive or therapeutic measures, with variable success. Particular attention should be paid on diseases with extra-renal manifestations, those can recur in kidney allograft, and those with urologic implications (e.g. small bladder, urinary diversion). Pre-transplant nephrectomy is occasionally needed, for example, in patients with huge polycystic kidneys. Immunologic assessment consists of tissue typing and cross-matching. Tissue typing aims to determine the HLA genotypes of the patient. Serologic method using defined anti-sera in a lymphocyte cytotoxicity test is usually applied. DNA analysis is more reliable, but the practical relevance is uncertain. Cross-matching aims to detect circulating antibodies against donor cells (represented by lymphocytes) in the serum of the potential recipient. Serial monitoring of sensitization by the so-called panel-reactive antibodies is generally used. Formal cross-matching between the lymphocytes of potential donor and serum of recipient is performed immediately prior to transplantation. In general, patients with multiple blood transfusion, pregnancy, previous allografts are at risk of sensitization.

After kidney transplantation, immediate technical problems include hemorrhage, vascular thrombosis, urinary leakage, lymphocoele, post-operative infections. The major concern of post-operative monitoring is fluid balance. In general, blood pressure, central venous pressure and urine output should be monitored closely. The rate of fluid replacement should be constantly adjusted according to the clinical condition of the patient. In some cases, low dose frusemide or dopamine are helpful in achieving satisfactory urine output. Delayed graft function is the most important medical complication immediately after transplantation. The most common cause is post-ischemic ATN. Other causes include vascular thrombosis, ureteric obstruction, and cyclosporin toxicity. It should be noted that cyclosporin can delay recovery of ATN.

Learning points - Important source of information

- * Human Organ Transplant Ordinance (Cap 465)
- * Operational Policy on Procurement, Allocation and Sharing of Cadaveric Kidneys (HA, 1998)
- * Human Organ Transplant Board

Long Term Complications from Renal Transplantation

Francis KM Wong, Queen Elizabeth Hospital

Cardiovascular disease (CVD) is the most common cause of death in RTRs. It has been shown that traditional risk factors for CVD are similar to those reported in the Framingham study cohort except that the relative risk associated with smoking and diabetes mellitus are significantly higher. Aggressive measures to control these risk factors should be implemented in order to improve long-term outcome after transplantation. Manske et al reported a significant fewer CVD-related events in patients who underwent revascularization compared to medical treatment in those patients with positive stress tests before transplantation. American Society of Transplantation (AST) recommended screening for CVD as part of the pre-transplant evaluation. However, the problem of ever lengthening of time of waiting on transplant waiting list in renal patients has made pre-transplant screening for all potential organ recipients impractical. Around 60-80% of RTRs have hypertension. There is a positive correlation between hypertension and bad clinical outcome after renal transplant. The goal of therapy should be <135/85 mmHg in RTRs and <125/75 mmHg in RTRs with proteinuria. More than 60% of RTRs have hyperlipidemia, which has been linked to CVD and chronic allograft dysfunction. Screening tests for serum cholesterol, LDL, HDL, and triglyceride should be done regularly. Dose of lipogenic immunosuppressive agents such as prednisolone, cyclosporin, tacrolimus, and sirolimus, which are all known culprits in terms of driving hyperlipidemia, should be reduced if possible. Another effective measure is control of proteinuria. Angiotensin-converting enzyme inhibitors and receptor antagonists have been shown to be effective in reducing proteinuria and indirectly improving serum lipid levels. Last but not the least, an effective low-fat dietary program and HMG CoA reductase inhibitor therapy have been very effective in controlling hyperlipidemia as reported in the general population. Aspirin prophylaxis has been shown to be effective in reducing all cause mortality in patients with history of ischemic events although the use of aspirin for primary prevention remains controversial. Since RTRs may have an increased tendency for thrombosis, AST guidelines recommended RTRs with known CVD and those without but are at high risk for CVD to take aspirin therapy.

Bone diseases can be a serious problem after renal transplantation. Five distinct patterns have been described in RTRs: osteoporosis, hyperparathyroidism, hypophosphatemia, calcineurin-induced bone disease, and avascular necrosis. Nearly 20% of RTRs may suffer from fracture in the first couple of years. The increase risk of fracture is produced by a significant decrease in bone mass after transplantation. There is a 5 - 10% loss of bone mass within the first year and most of the loss occur within the first 6 months. The causes include nutritional, surgical stress, immobilization, and immunosuppressive agents such as steroid. The effects of steroid on bone remodeling are complex. Basically, the main effect is a 3 - 4 fold decrease in bone formation rate while bone resorption rate remains relative normal or slight increase. The net effect is a nearly totally shutdown bone formation while resorption continues. As a result, there is a tremendous loss of bone mass. Treatment should include pre-transplant screening with DEXA scan to identify high risk patients, reduction in dose of steroid, calcium and vitamin supplement, hormonal replacement therapy in post-menopausal women, and bisphosphonate therapy for those with deteriorating bone density.

In Caucasian population, around 3 - 4 % of RTRs developed malignancies in the first year after transplantation. The corresponding figure at 5-year follow up is around 10%. Skin cancer accounts for nearly one third of all the malignancies while lymphoproliferative disorders (LPD) account for 15 - 25%. The median time to develop malignancies is around 5 - 6 years after transplant except LPD and Kaposi's sarcoma, which tend to occur earlier. According to the Hong Kong Renal Registry, we follow a very similar trend as reported in Caucasian population except that skin cancer is not a common complication. The salient features of post-transplant LPD are: more than 90% of B-cell tumors are Epstein-Barr virus-related and a high incidence of central nervous system involvement (20%). Other potential oncogenic viral infections in transplant recipients include Human Papilloma Virus (carcinoma of cervix), Hepatitis B virus (Hepatoma), Hepatitis C virus (Hepatoma), and Human Herpes Virus-8 (Kaposi's Sarcoma). The relative high incidence of malignancies makes it imperative to reduce intensity of immunosuppression in the late post-transplant period whenever possible. It is worth mentioning that certain cancers that do not appear to be more common in transplant recipients when compared to general population, do occur after transplantation. These may include breast cancer, prostate cancer, colorectal cancer, and lung cancer, etc. Appropriate screening and preventive measures should be adopted after organ transplantation.

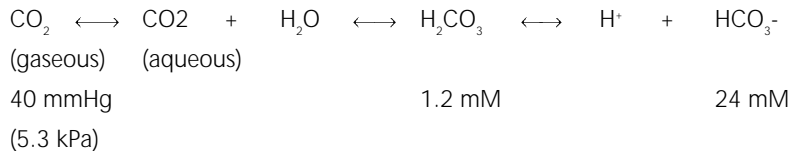
In conclusion, transplant recipients require life-long surveillance for potential complications and measures to correct potentially correctable risk factors in order to achieve long-term graft and patient survival.

Data Interpretation

Data Interpretation in Acid-base Disorders

Alex WY Yu, Alice Ho Miu Ling Nethersole Hospital

Normally, pH of the body fluids is regulated with arterial pH between 7.35 and 7.45. Maintenance of acid-base balance is important because many essential cellular processes such as certain metabolic enzymes and transmembrane transport processes are highly pH dependent. Acid-base balance in the body is maintained by the carbonic acid-bicarbonate system that is described by the following reactions:



Acidosis and *alkalosis* are a disease process that, if left unopposed, tends to lower or raise the pH respectively. They may still be associated with normal systemic pH as there are compensatory processes that try to keep pH within normal. However, when the compensatory process is incomplete or inadequate, the pH will be below normal (< 7.35) or above normal (> 7.45). The patient is then in a state of acidaemia or alkalaemia respectively.

To identify a major acid-base disorder, the direction of changes of the pH, HCO₃⁻ and PCO₂ has to be determined. After the major acid-base disorder is determined, whether the compensation for the primary event is appropriate or adequate is judged. The magnitude of the changes of the buffer pair member (HCO₃⁻ / CO₂) with the primary change in the other buffer pair member is compared. Appropriate responses correspond to those observed indicates the presence of simple acid-base disorder. Otherwise, mixed acid-base disorder may be present.

The compensation factor for each of these primary disorders is listed below:

Metabolic Acidosis

$$\Delta \text{ Pa CO}_2 \text{ (kPa)} = 0.16 \times \Delta \text{ HCO}_3$$

Metabolic Alkalosis

$$\Delta \text{ Pa CO}_2 = 0.08 \times \Delta \text{ HCO}_3$$

Respiratory acidosis

$$\text{Acute: } \Delta \text{ HCO}_3 = 0.8 \times \Delta \text{ Pa CO}_2 \quad 5\text{-}10 \text{ mins.}$$

$$\text{Chronic: } \Delta \text{ HCO}_3 = 3.0 \times \Delta \text{ Pa CO}_2 \quad 72\text{-}96 \text{ hr.}$$

Respiratory Alkalosis

$$\text{Acute: } \Delta \text{ HCO}_3 = 1.5 \times \Delta \text{ Pa CO}_2 \quad 5\text{-}10 \text{ min}$$

$$\text{Chronic: } \Delta \text{ HCO}_3 = 3.8 \times \Delta \text{ Pa CO}_2 \quad 72\text{-}96 \text{ hr.}$$

The next step is to check the anion gap and delta anion gap. Differential diagnosis of elevated anion gap metabolic acidosis can easily be remembered by using the mnemonic: KUSSMAUL, which is, Diabetic **K**etoacidosis, **U**remia, **S**alicylate intoxication, **S**tarvation ketosis, **M**ethanol, **A**lcohol ketoacidosis, **U**nmeasured osmoles (ethylene glycol, paraldehydes) and **L**actic acidosis. Causes of normal anion gap metabolic acidosis are represented by the mnemonic: USED CAR. They are **U**reterosigmoidostomy, **S**aline infusion, **E**ndocrine disorder (hyperparathyroidism, hypoaldosteronism), **D**iarrhoea, **C**arbonic **A**nhydrase inhibitor, and **R**enal tubular acidosis.

Delta anion gap is measured by subtracting the anion gap by 12. If the delta anion gap is greater than the magnitude of the changes in bicarbonate, concomitant metabolic alkalosis with metabolic acidosis should be suspected.

Interpretation of Lung Function Tests

Chung-Ming CHU, United Christian Hospital

The main function of the lungs is gas exchange - excretion of carbon dioxide and absorption of oxygen. However, none of the routine lung function tests measures this aspect of the lung function. Rather, they focus on the mechanical and ventilatory properties of the respiratory system. Other ways to assess how well the lungs are functioning (e.g., arterial blood gases analysis and measuring gas exchange during exercise) are not discussed in this review.

If we model the lungs as being composed of a Y-shaped tube connected to two balloons and then describe their mechanical properties, we would like to know the resistance of the tube and the compliance of the balloons. Airway resistance describes the relationship between the flow in the airway and the pressure difference between the mouth and the distal airway (flow vs. pressure). Lung compliance describes the relationship between the lung volume and the trans-pulmonary pressure (volume vs. pressure). Diseases that cause an increase in the resistance of the airway are 'obstructive' and those that cause a decrease in lung compliance (and hence reduced lung volume at any given pressure) are 'restrictive'. However, measurements of both airway resistance and lung compliance in this way require the measurement of intra-thoracic pressure (e.g. by intra-oesophageal pressure measurement), which is not feasible in most routine clinical situations. (Airway resistance can also be measured non-invasively by body plethysmography, which is less available than simple spirometry).

Most of the routine lung function tests have tried to give some reflection of airway resistance and lung compliance without invoking the pressure term in the above relationships. For example, indices obtained from routine spirometry such as forced expiratory volume in 1 second (FEV1) and forced vital capacity (FVC) are expired volumes in relation to time (volume vs. time). An airway with increased resistance ('obstructive') would have a lower flow for the same pressure than a normal lung, and therefore a lower FEV1, hence a low FEV1/ FVC ratio. Another example is the flow-volume loop, which looks at flow vs. volume. Conditions that give characteristic patterns in the flow-volume loop are mainly 'obstructive' conditions, in which the sites causing the obstruction could be in the intra-thoracic or extra-thoracic airways, and the obstruction can be fixed or variable.

Restrictive conditions would result in smaller lungs with a given pressure, e.g. lower total lung capacity (TLC) at maximum inspiration or lower functional residual capacity (FRC) at resting condition. TLC is the sum of inspiratory capacity (IC) and FRC. FRC can be measured by either inert gas equilibration or body plethysmography (using Boyle's law). Conditions that result in a lowered compliance of the respiratory system would have a low TLC, FRC and RV. These restrictive conditions could arise from within (intra-pulmonary-) or without the lungs (extra-pulmonary restriction), which can be further differentiated by interpreting the DLCO and KCO.

Therefore, obstructive lung conditions are characterized by an increase in airway resistance, low FEV1/ FVC ratio, raised RV and TLC (due to air trapping and hyperinflation). Obstruction is said to be reversible if either FEV1 or FVC improves by 12 % and 200 ml after bronchodilator or corticosteroid. Restrictive conditions are characterized by low FEV1 & FVC but preserved or increased FEV1/ FVC ratio, low RV and TLC. A low DLCO and KCO characterize intra-pulmonary restriction (e.g. fibrosing alveolitis, sarcoidosis), while low DLCO but high KCO reflects extra-pulmonary restriction (or 'constriction') as in kyphoscoliosis or neuromuscular disorders.

DLCO and KCO are also routinely measured and reported by pulmonary laboratories. High DLCO (corrected) and KCO occur in recent pulmonary haemorrhage or haemoptysis, heart failure and asthma. Low DLCO (corrected) and KCO occur in intra-pulmonary restriction, emphysema, pulmonary vascular disease and right to left shunt. Low DLCO but high KCO occurs in extra-pulmonary restriction. Another pearl in interpreting lung function is the diagnosis of bulla. As inert gas equilibration technique can only measure 'communicable' lung volumes while body plethysmography measures 'compressible' lung volume, the difference in TLCs measured by both methods represents 'non-communicable' lung volume such as a bulla.

Data Interpretation in Cardiac Diseases

Chi-Kin Chan, Alice Ho Miu Ling Nethersole Hospital

ECG interpretation is commonly encountered in the paper section of MRCP part II examination. To have a good and comprehensive interpretation of ECG, you should examine it systematically. Firstly, we should determine the heart rate (?tachycardia ?bradycardia Don't forget the sinus tachycardia) and the rhythm of the ECG (?sinus rhythm ?AF ?A flutter ?SVT ?VT). We then start to examine the ECG from the P wave (?P-mitrale ?P-pulmonale ?ectopic atrial tachycardia) follow by the PR interval (?1st degree heart block ?2nd degree heart block ?3rd degree heart block). QRS complex should be examined carefully and look for pathological Q wave, bundle branch block, delta wave, J wave, or frontal plane axis deviation. Then you should examine the ST segment (?ST depression ?ST elevation). If the ECG is apparently normal, do not forget to look for QT prolongation. Lastly, you should examine the T wave (?T inversion ?tall T wave) and U wave.

Determination of oxygen saturation (SaO₂) of blood samples from big vessels and cardiac chambers is an important part of cardiac investigation and mainly for detection of intra-cardiac shunting of blood. Left to right shunt of blood can be detected by "step-up" of SaO₂ which is defined as significant increase of SaO₂ of blood from proximal to distal chamber of the heart (>7% from SVC/IVC to RA; >5% from RA to RV; >5% from RV to pulmonary artery). Moreover, left to right shunt should be suspected if the SaO₂ of blood samples from right heart or pulmonary artery are >80%.

Data Interpretation in Endocrine Disorders

Vincent TF Yeung, Our Lady of Maryknoll Hospital

An array of endocrine cases touching on the topics of hyperprolactinaemia, acromegaly, hypothyroidism, diabetic ketoacidosis, and aldosteronism were discussed. The main points are summarized as follows:

Although pregnancy can be a physiological cause of hyperprolactinaemia, pathological causes include drug, primary hypothyroidism, prolactinoma, or stalk compression of pituitary.

Acromegaly can be confirmed by non-suppressed growth hormone levels on oral glucose tolerance test or IGF-1 measurement. Renal failure, cirrhosis, anorexia nervosa are other possible causes of raised growth hormone values which are not suppressed on OGTT. Elevated calcium levels in acromegalics can be due to concomitant hyperparathyroidism (MEN1) or increased endogenous calcitriol as a result of enhanced 1 α -hydroxylase activity. Hyperprolactinaemia in acromegalics can be related to stalk compression or the presence of mixed growth hormone/prolactin secreting tumour in 30 % of cases. Tests for assessment of pituitary reserves in these patients include free T4 and dynamic stimulation tests (LHRH, insulin tolerance test/glucagon stimulation)

In patients with hypopituitarism, hyponatraemia can occur because of secondary hypoadrenalism or hypothyroidism. Starting thyroxine treatment without attention to the possible need of steroid replacement could lead to adrenal crisis. Diabetes insipidus may manifest during steroid supplement for hypopituitary patients when the impaired free water excretory capacity in the absence of cortisol is reversed.

Hypothyroid patients can present with facial and limb puffiness together with muscle aches. Hypothyroidism is a common secondary cause of dyslipidaemia and can be confirmed simply by elevated TSH level. Elevated CPK can occur consequent to decreased renal clearance.

Diabetic ketoacidosis can lead to hyponatremia through pseudohyponatraemia (hyperglycaemia and hypertriglyceridaemia), renal sodium loss, and/or vomiting, whereas hyperkalemia in DKA is due to acidosis and lack of insulin. Interference by ketone bodies can lead to disproportionate rise in plasma creatinine relative to the urea, particularly in the older generation of assays. Modest increase in plasma amylase is probably due to reduced renal clearance and increased salivary amylase, but gross elevation suggests underlying pancreatitis precipitating or complicating DKA.

Hypokalemia in the setting of hypertension is commonly due to treatment with diuretics. However, the same phenomenon can be due to endogenous endocrine causes such as primary hyperaldosteronism and Cushing's syndrome. Physical examination should give hints to possible Cushing's syndrome. Simple screening test includes overnight dexamethasone suppression test and confirmation is by low dose dexamethasone suppression test, with the exact etiology of Cushing's syndrome established by high-dose dexamethasone test and ACTH measurement (with or without CRH stimulation). Primary aldosteronism is diagnosed by suppressed plasma renin and increased aldosterone, and paradoxical fall in aldosterone on adopting erect posture for four hours points towards Conn's syndrome. Diuretics, (-blockers, ACEI, AIIAs, and spiroolactone should be avoided in the course of investigation of primary aldosteronism.

Medical Illness in Pregnancy (II)

Gestational DM-Past, Present and Future

Nelson MS Wat, Queen Mary Hospital

Past - Pregnancy causes significant changes in carbohydrate tolerance. Glucose intolerance that is first diagnosed during pregnancy is termed gestational diabetes mellitus (GDM). Although the adverse effects of carbohydrate intolerance on pregnancy and foetal outcome were first described nearly 100 years ago, it was not until 1979 that GDM was formally recognised as a subgroup of diabetes mellitus by the National Diabetes Data Group (NDDG). Perinatal mortality rate among diabetic pregnancies has markedly fallen in the past decade when compared with that in the late 1930s, largely attributable to ketoacidosis, late intrauterine deaths and prematurity. Serious abnormalities (those causing death or handicap or requiring surgery), however, are 3-4 times more common in infants of diabetic mothers than in those of non-diabetic women. With the discovery of insulin in 1930s and after the introduction of glycosylated haemoglobin assays in the late 1970s, it became clear that poor glycaemic control in early pregnancy was associated with an increased risk of major congenital abnormality.

Present - Glucose monitoring is of paramount importance in the management of GDM women nowadays. Criteria for beginning insulin are based on the fasting and postprandial responses to the prescribed meal plan. Exercise programmes are considered safe as an adjunct therapy for GDM. Timing and mode of delivery are not only decided by the classic obstetric indications but also by the glycaemic control of the mother. Postpartum, insulin requirements and in 90% of women the diabetes will disappear. A glucose tolerance test 6-8 weeks postpartum should be performed to ensure that the woman is not left with type II diabetes. Prevention programme should also be introduced immediately postpartum to keep the women lean and fit in order to reduce their chances from 60 to 25% of developing type II diabetes as they age. The obvious way to reduce the malformation rate is to inform diabetic women about the need for good glycaemic control at the time of conception and during the first trimester and to help them achieve it. One approach is to set up pre-pregnancy care programmes, first suggested by Steel and colleagues. Besides, combined diabetic antenatal clinic run jointly by a diabetologist and obstetrician enables not only good preconception care but also coordinated care throughout the pregnancy, with both the physician and obstetrician being fully aware of potential problems before and during labour.

Future - With the introduction of strict blood glucose control and intensive monitoring during pregnancy, macrosomic babies are yet often encountered. Are we doing the right thing or are there other aspects of management in GDM, which we have not done enough? Diagnostic criteria for GDM and biochemical markers for monitoring of glycaemic control are discussed.

Viewpoints

Open letter on "Consultation Document on Health Care Reform" from Association of Private Medical Specialists of Hong Kong

To: Dr. Yeoh Eng Kiong
Secretary for Health & Welfare,
The Government of HKSAR

Re: "Lifelong Investment In Health" - Consultation Document on Health Care Reform

1. We concur with Government that the escalating cost of healthcare cannot be sustained indefinitely. We also concur that Government must continue to care for the old, the disabled, the poor and those who suffer from catastrophic illnesses. To do this we agree that means must be found to (i) better utilize resources on the one hand, and (ii) provide alternative sources of funding on the other.
2. Resources of the publicly funded hospitals and clinics are now stretched to the extreme. Apart from an aging population and development of new medical technology, we believe a main reason for this is the increasing use of public healthcare by those who can afford to pay for private services, thus crowding out those who must rely on public funds for healthcare. We have come to the conclusion that Government is faced with the following choices
 - 2.1 Failure to provide for adequate healthcare for the population,
 - 2.2 Increase in percentage of government spending on healthcare,
 - 2.3 Increase in tax to fund public healthcare spending,
 - 2.4 Finding a sizable additional source of funding with immediate availability, and
 - 2.5 Providing healthcare resources largely to those who cannot fend for themselves,
 - i.e, the old, the disabled, the poor and those who suffer from catastrophic diseases.

We believe 2.1, 2.2, 2.3 and 2.4 are not viable options. Government is thus left with option 2.5. We understand that Government cannot credibly refuse care for those who seek public healthcare. Thus we propose the following:

Government hospitals provide healthcare for all who seek it. Adequate essential services are provided, but no luxury at tax-payers' expense. All recipients of such service are charged at cost. Those who cannot afford to pay can apply for exemption based on the same criteria as for welfare.
3. The Government is keen on developing a healthcare savings plan as an additional source of funding. We agree that saving is an accepted and time-honoured part of our culture. However, we also agree with the general population that introducing this concept now as a mandatory scheme when the Mandatory Provident Fund is just begun is at an extremely poor timing. Besides, a savings scheme will take decades to become sufficiently sizable to be helpful to Government or individual. For the immediate future, we suggest that Government should take steps to encourage private healthcare insurance, including tax relief. We note that at present Government provides healthcare for all at no charge to the consumer, and the Hospital Authority advertises how good its service is. Thus the public has no incentive to purchase healthcare insurance. Step 4 below must be an integral part of the overall scheme.
4. The Government is keen on optimising the interface between the public and private healthcare sectors. We have reason to believe that in many areas at present, including many surgical operations, private healthcare is more cost-effective than the public sector. Government can out-source healthcare by partial payment for private healthcare, allowing the patient to make up for the difference. That means "money follows the patient." This would be a ready method to draw in additional funding while minimizing public cost for the same illness.
5. The allocation of public funds should be further scrutinized to maximize cost-effectiveness. With resources now being stretched to the limit, providing for every desired healthcare service is providing inadequately for all. We suggest that Government must decide what it must provide and what it will not. A clear definition of its role in healthcare enables the private sector and the insurance industry to provide satisfactory complementary service. Besides, we recommend that the budget for healthcare be divided into four sections:
 - 5.1 Routine service. This is government duty and should follow population growth.
 - 5.2 High-tech medical service. This must be varied from year to year according to what the economy can afford.
 - 5.3 Research. This should be put back squarely to the tertiary institutions.
 - 5.4 Training. This should be the duty of the tertiary institutions and the Academy of Medicine
6. By optimising resource allocation in its existing facilities and better utilizing the private health-care sector's manpower and resources, the Government can achieve the twin objectives of limiting total healthcare expenditure and providing better care for all.

Dr Tse Tak Fu
President
The Association of Private Medical
Specialists of Hong Kong

Diary

Joint Scientific Meeting

Hong Kong College of Physicians, Hong Kong College of Paediatricians
Hong Kong College of Family Physicians and Hong Kong College of Pathologists

Saturday 27th (9am) to 28th (10pm) October 2001, Hong Kong Academy of Medicine Jockey Club Building.

Our annual scientific meeting this year will be jointly organized with several other colleges and the themes will be Infectious Diseases and Ambulatory Medicine.

The programme includes the following symposia and special lectures:

Symposium I:	Respiratory Tract Infections Clinical Management of Community Acquired Pneumonia Rationalizing Antimicrobial Therapy in CAP Management of Ventilator- Associated Pneumonia	Dr. HS Chan Dr. Dominic Tsang Dr. Jane Chan
Plenary Lecture:	Global crisis of antimicrobial resistance: Facts and controversies	Prof. JH Song
Symposium II:	Infection in the Immuno- compromised Patients Infection in Renal Transplant Recipients Viral Infection After Bone-Marrow Transplantation Invasive Mold Infection in Immuno-Suppressed Host	Dr. KL Tong Prof. YL Kwong Prof. KY Yuen
Symposium III:	Miscellaneous Infection Antimicrobial Resistance Latest Development in Sexually Transmitted Diseases in Hong Kong Influenza in Hong Kong Children	Dr. PL Ho Dr. KM Ho Dr. Susan Chiu
Symposium IV:	Allergic Disorders Skin Allergy Aeroallergens and Childhood Asthma Update in Asthma Therapy	Dr. Henry Chan Dr. TF Leung Dr. Christopher Lai
Symposium V:	Functional Disorders Management of Chronic Pain Irritable Bowel Syndrome Autistic Spectrum Disorder in Children - Any early signals? Atypical Chest Pain	Dr. John Scadding Prof. Francis Chan Prof. Virginia Wong Prof. CP Lau
Lunch Symposium VI:	Cholesterol & cholesterol - lowering therapy	Prof. Andrew Tonkin
Symposium VII:	Drugs Selection in Hypertension And Hyperlipidemia Beyond Blood Pressure Control Power for long-term survival: " Complete" lipid control	Prof. Mark E. Cooper Prof. Russell Scott
Symposium IX:	Interactive Case Presentation	Dr. David Hui
Best Dissertation Award	The role of Helicobacter Pylori Infection in pathogenesis and management of gastroesophageal reflux (Gold award) P-glycoprotein and Multidrug resistance gene expression in Epilepsy (Silver award)	Dr. Justin Wu Dr. Patrick Kwan
Sir David Todd Lecture	Immunogenetics of IgA Nephropathy- Insights into its Pathogenesis and Progression	Dr. Philip KT Li

To promote trainee's postgraduate education, the council has decided to waive the registration fee of trainee and member; registration fee for fellow is HK\$100. Further information can be obtained from Ms. Lenora Yung, congress secretariat at Tel no: (852)-28718841, fax no: (852) 28718898, email: Lenora@hkam.org.hk or from the academy website at <http://www.hkam.org.hk>.

Dr Justui Wu

HONG KONG COLLEGE OF PHYSICIANS
Certificate Course in Internal Medicine for Family Physicians 2001-2002
2/F., Ballroom, Great Eagle Hotel, 8 Peking Road, Kowloon

Time: 1:00 - 2:00pm Lunch
2:00 - 4:30pm Lecture & Discussion

Session	Date	Topics	Speakers
Session I : Immunology & Rheumatology	13 Oct 2001	"Dermatomyositis & Polymyositis" "Systemic Vasculitides"	Dr Shirley K Y Ying, PMH Dr Gavin K W Lee, PYNEH
Session II : Respiratory Medicine I	10 Nov 2001	"Update on the Management of COPD" "Update on Asthma Management"	Dr Yu Wai-cho, PMH Dr Adrian Y Y Wu, QMH
Session III : Neurology	19 Jan 2002	"What's New in Stroke?" "An Update on the Recent Advances in the Diagnosis & Management of Epilepsy"	Dr Lawrence K S Wong, PWH Dr Gardian C Y Fong, QMH
Session IV : Geriatrics	23 Feb 2002	"Falls in the Elderly" "Delirium"	Dr Kong Ming-hei, WCHH Dr Felix Chan, FYKH
Session V : Nephrology	16 Mar 2002	"Management of Electrolyte Abnormalities" "Family Physician's Role in Diabetic Nephropathy"	Dr Cheng Yuk-lun, AHNH Dr Mak Siu-ka, KWH
Session VI : Gastroenterology & Hepatology	20 Apr 2002	"Approaches to Impaired Liver Function Tests" "Drug Hepatotoxicity"	Dr Chan Lik-yuen, PWH Dr Wong Wai-man, QMH
Session VII : Infectious Disease	18 May 2002	"Management of Genital Ulcers" "Urinary Tract Infections"	Dr Au Tak-shing, SYP Dr Angela Y M Wang, PWH
Session VIII : Respiratory Medicine II	22 Jun 2002	"Approach and Management of Chronic Cough" "Interpretation of Lung Function Tests"	Dr Kenneth W T Tsang, QMH Dr Thomas Y W Mok, KH
Session IX : Cardiology	20 Jul 2002	"Clinical Management of Congestive Heart Failure" "Risk Factor Modification in the Prevention & Management of Coronary Artery Disease"	Dr Chan Wai-kwong, UCH Dr Chow Liang, TMH
Session X : Diabetes & Endocrinology	17 Aug 2002	"DM Complication Screening" "Obesity"	Dr Lau Ip-tim, TKOH Dr Tsang Man-wo, UCH

Congress on "Challenges and opportunities in Pathology"

The Hong Kong College of Pathologists, Royal College of Pathologists of Australasia and the Hong Kong Division of the International Academy of Pathology jointly organized a Congress on "Challenges and opportunities in Pathology" during October 4-7, 2001 in the Hong Kong Academy of Medicine Building. Details to be found in: www.hkcpath.org/cop/intro.htm or Louisa Chiu at 2871 8815.

26th International Congress of Internal Medicine

The above conference will take place in Kyoto International Conference Hall from 26th to 30th May, 2002 in Kyoto, Japan. Further information can be obtained from the Secretariat, 26th International Congress of Internal Medicine, Shin-Marunouchi Building, 6F-21 5-1 Marunouchi 1-chome, Chiyoda-ku, Tokyo 100-0005, Japan. Tel no: 81-3-5220-3380, Fax no: 81-3-5220-3649, email: isim26@mx6.nisq.net or from web site: <http://www.icim2002.org>.

Examination and Results

Dates of PACES October 2001

Dates of PACES October 2001 are as follows:

15 October 2001	Prince of Wales Hospital
16,17 October 2001	Pamela Youde Nethersole Eastern Hospital
18, 19 October 2001	Queen Mary Hospital

Helpful Hints for MRCP IPACES)

For those taking the examination, read carefully the guidelines on what is required of the candidate, which is printed with the instructions on the mark sheet. Here is some additional useful advice.

** Take your time and aim for accuracy*

Do not miss signs as clinical accuracy rather than speed is marked highly. The 10 minutes allocated per case in Stations 1 and 3 is ample. For Stations 2 and 4 (History Taking & Ethics / Communication Stations), candidates have 14 minutes with the surrogate patient, 1 minute to reflect and recollect their thoughts, and 5 minutes for examiner's questions. Making full use of the 14 minutes is strongly advised in order not to miss important findings. Rushing through the clinical examination leaves more time for the examiners to bombard the candidates with questions!

** Be gentle with the patient / surrogate*

In the Communication station, never scare the surrogate. Be gentle. For example, to break the news of "cancer", never say "I am afraid I have bad news for you".

** Avoid leading questions*

Surrogate patients have been well rehearsed with a detailed clinical brief and will willingly share that information with you. Open-ended questions allow the surrogates the opportunity to do so while leading questions narrows their answers to a less helpful 'yes' or 'no'.

** Practise presenting in English*

Being fluent in history taking and presentation imparts a confident and competent image of the candidate to the examiner. Take every opportunity to practise presenting in English during ward rounds and with colleagues.

** Ethical issues*

Know the four principles of medical ethics

- o Respect of patient's autonomy
- o Do good and no harm
- o Act justly
- o Legal aspects

Good Luck !

Fellowship Pass List of the Exit Assessment in June 2001

Advanced Internal Medicine

Au Kai Man, Eric
 Chan Pik Kei, Osburga
 Cheng Cheung Wah
 Cheung Yuen Cheong
 Ho Yiu Yan, Andrew
 Hui Yui
 Lai Siu Wing
 Lam Muk Sum, Walter
 Lam Tse Fun, Cathy
 Lau Sze Ting
 Law Kwan Kin
 Leong In Son
 Leung Ho Yin
 Li Sing Tao, Thomas
 Mok Mo Yin
 Ng Ying Wai
 Tang Kam Shing
 Tang Wing Sze, Maria
 Tung Yau Man, Stephen
 Wan Wing Lun
 Wong Lap Gate, Michael
 Wong Siu Ming, Raymond
 Wong Yuk Hwa, Teresa
 Wu Che Yuen, Justin
 Yip Kin Keung

Cardiology

Tse Tak Sun
 Wong Bun Lap, Bernard

Endocrinology, Diabetes & Metabolism

Ma Ching Wai, Ronald

Gastroenterology and Hepatology

Chang Kwong Kuifa
 Leong In Son
 Li Tat Wing

Geriatric Medicine

Hu Hsing Cheng, Wayne
 Lee Ka Wing, Gavin
 Lo Kwok Man
 Sheng Bun
 Sy Chung Tai
 Tam Kui Fu, Stanley
 Wong Che Keung
 Yip Man Lung

Haematology / Haematological Oncology

Lau Sze Man, June

Nephrology

Tong Ka Hang, Matthew
 Tong Mei Wa, Gensy

Palliative Medicine

Ng Kam Hung

Rehabilitation Medicine

Fung Pui Man

Respiratory Medicine

Chang Kwok Chiu
 Ko Wai San, Fanny
 Lam Wai Kei
 Tai Kian Bun
 Tam Wai On
 Tong Wing Lok

Neurology

Kwan Kwok Leung, Patrick

Congratulations

The College would like to congratulate 2 distinguished fellows on their achievements:

Dr. Raymond WY Wu was conferred the Gold Bauhinia Star (GBS) by the Government of Hong Kong Special Administrative Region in 2001.

Professor SK Lam was elected the Dean of Faculty of Medicine, University of Hong Kong in 2001.

Synapse would like to let young fellows and members know more about the 2 distinguished fellows and publish here the achievements of Dr. Wu and some thoughts of Professor Lam on Medical Education: -

Dr Raymond Wai Yung WU MBBS, MRCP, FRCP, FHKAM, GBS, OBE, JP

Dr Raymond Wu was born in 1937 in China and graduated from the University of Hong Kong in 1963. He was awarded the Sino-British Fellowship for postgraduate training in London in 1968. He assumed private practice in 1974. He served as President of Physicians Society, President of Hong Kong Cardiological Society and from 1984-88 two consecutive terms as President of Hong Kong Medical Association.

Looking through his CV, he can be perceived as a passionate public minded venturous person who would un-hesitantly undertake pioneering projects that he considers to be of benefit to the community and yet has been ignored or undermined. Just to mention a few notable ones:

He founded the New Life Psychiatric Rehabilitation Association in 1965 that pioneered the practice of community psychiatry in the spirit of full integration, self help, community participation, and patient centred orientation. Under his leadership in these 36 years, the Association has grown to the present size of 500 strong staff, annual expenditure of 160 million, serving close to 4,000 patients every day and has built national and international reputation. For this he was awarded OBE in 1997.

In 1970 he introduced the concept of a heart foundation to attract community resources and expertise in the collaborative provision of health care services. He pioneered public health education through high profile health exhibition. The two memorable ones were "Your Heart is Your Health" at City Hall, and "Smoking or Health" at Ocean Terminal in early 70's. Subsequently influential dignitaries of our Society were inspired to found the Hong Kong Heart Foundation.

In 1985, he was appointed by the Chinese Government as a Member of the Basic Law Drafting Committee. He was greatly inspired and committed to build the future of Hong Kong under the "One Country Two Systems" concept. During the drafting years, he engineered towards the preservation of the professional system in Hong Kong through consensus building, structure standardization and drafting of the article 142 of the basic law. In addition he has much to do with the design of the political system of HKSAR, as he was the convenor of the political subgroup of the Basic Law Drafting Committee. In the subsequent years after promulgation of the Basic Law, he was continuously involved in the Preliminary Working Committee and the Preparatory Committee in building the HKSAR.

In 1997, he became a Member of the Basic Law Committee under the National People's Congress Standing Committee to continue to serve as a guard of the Basic Law implementation.

In 1998, he was elected a Deputy of National Peoples' Congress and participated in National affairs. It was for all these work over 15 long years that he was awarded the Gold Bauhinia Star (GBS) in 2001.

Apart from all the work at higher level he remains keenly interested in local matters just with same enthusiasm. In remedy of our traditional educational deficiency and to meet the need and challenge of the new economy. In early 90's, he started to play a tenacious advocacy role for gifted education and introduced the concept of multi -intelligence and talent education to identify and develop these potentials. By exploring local advocates, arousing public interest, inviting world experts and hosting the world congress he inspires and persuades the Government to initiate pilot projects in gifted education.

Hong Kong is facing a new dilemma and threat. In 2001 he has taken up a new project to capitalise on China's economic development and her access to World Trade Organization. With Hong Kong's strength in our professional services, we need to extend our professional services market to mainland China not only as a business and economic opportunity but more so an opportunity for professional development and excellence.

Professor SK Lam: On Medical Education

With the advent of biotechnology and the mapping of the human genome, biology will be to this century what physics was to the last century, when man took over the sky, went to the moon, computerized the world, mastered communication, and revolutionized medical imaging. The tertiary institutions in Hong Kong are well placed to take up biomedical research as a long-term development and to partner with the industries as a long-term investment for Hong Kong and Mainland China. My first remit as Dean is to bring people together, within and out with the HKU Faculty of Medicine, particularly amongst the UGC institutions and the health care institutions in Hong Kong, to develop a research culture that is synergistic and focussed.

"Education is not a means of showing people how to get what they want." said Ronald Reagan, "It is an exercise by means of which men will learn to want what is worth having". Putting learning, in fact life-long learning, before teaching, is the concept behind this medical school's new curriculum, which represents an integrated and system-based curriculum, with problem-based learning being one of its new pedagogy. The medical school is convinced, as much as well over 60% of other medical schools in the world, that this is the way forward. Consolidation and continuous improvement of the medical education and training system is my second remit.

In these respects of education and research, the two medical schools, and for that matter, the colleges of the Academy, the institutions of the Health and Welfare Bureau, have many common grounds for collaboration. Collaboration is what we shall all be after - for the common good of Hong Kong.

Letters to Editor



Royal College of Physicians

'PROMOTING THE HIGHEST STANDARDS IN INTERNAL MEDICINE AROUND THE WORLD'

From the President

Our Ref: NDCF/jm

18 May 2001

Professor Richard Yu
President
Hong Kong College of Physicians
Room 801, Jockey Club Building
99 Wong Chuk Hang Road
Aberdeen
HONG KONG

Dear *Richard*

Synapse: April 2001

Thank you for sending us this issue of *Synapse* which includes Jim Petrie's Sydney Watson Smith Lecture delivered at the "East Meets West" in November 2000. I re-read the lecture (which I delivered on Jim's behalf) along with my minor addendum at the end and found it still has quite a lot of interest to say. Needless to say, the rest of the journal also interested me particularly John Mackay's description of Dr Sun Yat Sen's early medical life in Hong Kong.

With kind regards

Yours sincerely

Niall

Dr Niall D C Finlayson OBE
President

Email: president@rcpe.ac.uk
9 Queen Street, Edinburgh EH2 1JQ
Tel: 0131-225 7324 Fax: 0131-220 3939 <http://www.rcpe.ac.uk>
Registered Charity No. SC009465

Obituaries

Dr. Alex Y.M. Chan

The recent untimely departure of Alex was a great loss not only to his family, friends and colleagues but also to the community of Hong Kong.

Among many of Alex's achievements and one always close to his heart was nephrology. After a slow start in Hong Kong, he went overseas and worked his way up through a highly competitive academic environment at Stanford. This resulted in the seminal publication in the *Journal of Clinical Investigation*, a holy grail of clinical researchers, on the effect of high protein intake on glomerular haemodynamics and barrier function. After returning to Hong Kong in the late 1980s, he devoted his time to improve the renal service both in the private and public sector. His active involvement in the Hong Kong Kidney Patients' Trust Fund and subsequent establishment and smooth running of the Hong Kong Renal Center was but one of many prime examples of his tireless efforts and triumphs in this area. This work and others have attracted praise and respect not only from patients and their families, friends and colleagues but also the community at large.

I first met Alex in 1986 and I was impressed by his friendliness, openness, honesty, compassion and professionalism. This feeling was shared by those who knew him. With his departure, members of the Hong Kong Society of Nephrology have not only lost a great friend and colleague but one who fought for quality and affordable renal service in Hong Kong. However, the legacy he left behind is a constant reminder of his achievements and sets an example to all nephrologists to follow in the future. I hope that his wife, Linda, son, Miles, and daughter, Amanda, could take comfort from this at this difficult time and I wish Miles and Amanda every success as they embark on their medical career.

Ignatius K.P. Cheng

Professor Julian Arthur John Hall Critchley

MBChB, PhD, FRCP (Edin, London, Glasgow), FHKCP, FHKAM (Medicine)

4 August 1950-13 July 2001

Professor Julian Critchley was born on 4th August 1950 in Kent, England and passed away in a tragic traffic accident on 13th July 2001. The loss of Prof. Critchley shocked the Faculty of Medicine at the Chinese University of Hong Kong as much as all his family and friends both in Hong Kong and in UK.

Prof. Critchley graduated from the University of Edinburgh holding both a science and a medical degree. He received his training in clinical pharmacology under the guidance of Prof. Lorry Prescott at the renowned Regional Poisoning/Intoxication Treatment Center in Edinburgh. In May 1989, Prof. Critchley joined the Chinese University of Hong Kong as chairman of the then Department of Clinical Pharmacology. During his 12 years of stay in Hong Kong, Prof. Critchley has built a strong division of clinical pharmacology in CUHK. He founded the Drug and Poison Information Bureau at the Prince of Wales Hospital providing 24-h information to health care profession in Hong Kong on poisoning and therapeutics. He chaired the Poisons Committee of the Pharmacy and Poison Board of the Hong Kong SAR Government, served on numerous committees in the Medical Faculty of CUHK, Medical Panel of the University Grants Committee and Research Grants Council. In the last few years, realizing the growing prevalence of diabetes, hypertension, dyslipidemia and obesity, Prof. Critchley has turned his research interest to diabetes and metabolism. With his enthusiasm and untiring efforts, he was able to bring together a large network including mass media, civil servants, lawyers, industrialists and businessman to promote diabetes care through research, education and quality care.

Prof. Critchley has always impressed his colleagues with heart-warming smiles and kind words. He has the ability to see things from other person's perspective and the natural eloquence to express it so much better. He has passion and tenacity for his work. Prof. Critchley has never hesitated to spend time to talk to his students and juniors who sought his advice. It is with his perseverance and passion that he built the clinical pharmacology unit from 2 to 25 persons, supervised over 30 post-graduate students and published over 180 papers in international peer-reviewed journals. These are the legacy that Professor Critchley has left us.

Joseph JY Sung

A letter from Dr. Niall Finlayson about Professor James Petrie

It is with the deepest regret and sadness that I have to inform you of the tragic death on Friday 31 August of Professor Jim Petrie, Immediate Past President of the Royal College of Physicians of Edinburgh (1998-2001) and Chairman of SIGN, after a short and sudden period of serious illness.

Jim Petrie's death is an extremely sad loss to his family, to whom Fellows, Members, staff of the College and everyone connected with SIGN, extends their deepest sympathy. It is also a loss to all who knew Jim and, indeed, a major loss to international medicine.

Jim's funeral service will be held on Thursday 6 September and the College will be represented by senior Office Bearers.

A brief message has been placed on the College website and of course a full tribute will be published in due course.

With kind regards

Dr Niall Finlayson
President
Royal College of Physicians of Edinburgh

A letter from our President to Dr. Niall Finlayson

Dr Niall Finlayson PRCP
President
Royal College of Physicians
9 Queen Street, Edinburgh EH2 1JQ
United Kingdom

Re: Professor James Petrie

We are very shocked and saddened to hear of the sudden departure of Professor Jim Petrie, our respected and dear friend. We shall miss Jim dearly, and will not forget his warm personality and great achievements. We shall continue his mission in striving to achieve excellence in clinical practice, research and training in internal medicine, and to foster a closer link between the Royal College of Physicians of Edinburgh and the Hong Kong College of Physicians.

Our most sincere condolences to Jim's family,

Yours sincerely,

Richard Y H Yu
President
Hong Kong College of Physicians

Events

Annual General Meeting

The 14th Annual General Meeting was held on Friday, 1 June 2001 at the Hong Kong Academy of Medicine Building and attended by honorary guests, 66 fellows and 28 members.

Dr Richard Yu delivered the President's Annual Report for the year 2000-2001. To meet the increasing demands and challenges of the profession as well as of the community, Dr Yu noted the hard work and contributions of the College's seven sub-committees and working groups. In his report, he highlighted some of the major achievements made in training, quality assurance and collaboration with other medical Colleges.



Dr Richard Yu, our President, presented Professor Vivian Chan the Honorary Fellowship.

After the presentation of the financial report by Dr Tse Tak Fu, Hon Treasurer, the meeting proceeded with the appointment of the nominated Office-bearers and Councillors

Professor SK Lam congratulated the College on its healthy financial reserves and enquired on future plans to utilize this effectively. The President replied that the Hon Treasurer is exploring the possibility of making appropriate investments for the good of the College. He also added good news for members and intermediate examination candidates collecting diplomas at this year's AGM. Their charges for the Annual College Dinner will be refunded !

Conferment ceremony

In the presence of the official platform party, new Fellows proudly received their diplomas from Dr Richard Yu, President. This year, an Honorary Fellowship was awarded to Professor Vivian Chan for her important contributions to medicine and outstanding work in molecular medicine at the Department of Medicine, University of Hong Kong. Then, Dr CH Leong, President of the HKAM, addressed the new Fellows with an inspiring speech.

The evening was rounded up with the Annual College Dinner where all were treated to good food, wine and speeches. For those who missed this delightful event, the script for the AJS McFadzean Oration by Professor Arthur Li as well as Dr CH Leong's speech are included in this issue of Synapse.

Report on the Extraordinary General Meeting held on 1 June 2001

An EGM was held preceding the AGM for the purpose of passing two proposed amendments to the Memorandum and Articles of Association. The first proposed amendment to Article 6 was passed unanimously, such that the words " who shall not have a voting right" be added after the words " ...five additional Fellows to be temporary members of the Council"

The second proposed amendment (Article 9) to enable voting by postal ballot for election of College office-bearers and councilors was defeated unanimously. A count of votes at the EGM showed no support from any Fellows for this amendment. All 59 attendees, together with 151 Fellows who appointed 10 of them as proxies, voted against the proposed amendment.

College Visit to Singapore for MRCP (PACES)

In preparation for the first PACES in Hong Kong this October, a delegation consisting of Prof WK Lam, Prof J Sung, Dr L Yam from our examination organizing committee led by Prof R Yu, the President flew to Singapore in June to observe how the PACES was run there.



Faces behind PACES (Singapore)

Dr Richard Yu, Dr Loretta Yam, Prof WK Lam and Prof J Sung (see if you can spot them in the photo) together with examiners for PACES, Singapore, June 2001. Seated to the immediate right of Dr Richard Yu in the front row are Dr Eric Beck (Senior Examiner) and Dr Chew Chin Hin (mastermind behind PACES in Singapore).

Nanjing Visit with discussion on Training and Continuous Education of

On July 10, 2001, Prof. Richard Yu and Professor KN Lai represented the College to participate in a Round Table Discussion in Nanjing University School of Medicine on " Training and Continuous Education of Doctors" . This was held during the Nanjing-Hong Kong Medical Forum 2001. Prof. Richard Yu and Prof. Lei-Shi Li (Nanjing) were moderators. Prof. James CM Chan (Virginia, USA), Prof. Lei-Shi Li, Prof. Jia-Qi Qian (Shanghai), Dr. Xin-Yao Liu (Nanjing), Dr. Ya-Yi Hou (Nanjing) and Prof. KN Lai were speakers. Prof. Lai spoke on Continuous Medical Education of Hong Kong. Prof. LS Li is an Honorary Fellow of the College.



Photo here showed Prof. Richard Yu and Professor KN Lai during the Nanjing-Hong Kong Medical Forum 2001 with Prof. Jia-Qi Qian and Prof. Lei-Shi Li on the first and second left of Prof. Yu respectively.

Feature Story

An Afternoon with Prof. Sir David Todd



Sir David in Cambridge with the enchanting cherry blossoms

Sir David Todd is a busy man. In March he was briefly in Hong Kong, so briefly that he was not able to make time for an interview amidst all his other commitments. As an alternative he said he would be happy to meet me later, in Cambridge, at a time when I had already planned to be visiting there.

So it was that on a wet and chilly day in April Sir David met me at the entrance to King's College in Cambridge and guided me next door to the historic University Convocation Room. Over lunch, and the rest of the afternoon in this most elegant room we talked about his present interests and his thoughts about the Hong Kong medical scene.

He told me that he had been in London the previous day to a concert; and the week before had been in Dresden enjoying opera. Living in Cambridge gave him easy access to London and the rest of Europe which allowed him to follow his interest in the arts, quite apart from the pleasure of living in a beautiful university town, and the opportunity to attend clinical presentations at Addenbrooke's Hospital.

Sir David has three official positions which he enjoys because they continue to give him a part to play regarding Hong Kong:

The S.K.Yee Medical Foundation

Sir David is Vice-Chairman of the Board of Trustees. This Foundation was established in 1995 with a generous donation from the late Mr S.K.Yee of the United Chinese Bank, with the objective of providing funds to care for the sick and poor of Hong Kong.

The Croucher Foundation

The Foundation was set up in 1979 by the late Mr. Noel Croucher, who was a well-known stock-broker in Hong Kong. Lord Todd and Lord Butterfield were past Presidents. It is presently being chaired by Professor Y.W.Kan.

Sir David is a member of the Selection Committee that interviews post-graduate student candidates applying for fellowships and scholarships in Science, Engineering and Medicine. It also funds research, and provides funds for students in tertiary institutions in Hong Kong who have emergency needs.

Sino-British Fellowship Trust

Sir David is a Trustee of this organisation which was started by The British to help Chinese during the Sino-Japanese War. The Trust awards many grants to support professional education and training of Chinese including those in Hong Kong.

The Royal Society in London helps the Trust to organise exchanges between the two countries of students and professionals, to do research in various disciplines, including the sciences and medicine.

Career

Sir David Todd qualified at Hong Kong University Medical School in 1952, and apart from time overseas on post-graduate training, has spent his entire career at the Queen Mary Hospital.

He remembered with affection his time in Glasgow when he was getting specialist training in haematology. He recalled the times when the fog was so bad that the only way to find his way home from the hospital was to catch a tram. He still keeps in touch with his Glaswegian colleagues.

At the time he joined the university in 1952 there were only four academic members of staff, Prof. McFadzean, Dr. Stephen Chang, Dr. Gerald Choa and Dr. C.C.Wong: by the time he left there were about 30. Over the same period of time the annual department Christmas Party had grown from 20 people to 150.

He was appointed to the Chair of Medicine following the retirement of Prof. McFadzean in 1974, standing down from the Chair in 1989 when he was appointed Emeritus Professor. He retired from clinical medicine in 1997.

For his services to medicine and education in Hong Kong he was knighted in 1995 by the Queen at a ceremony at Buckingham Palace, London.

The Hong Kong Medical Scene - Pluses

When asked what developments had taken place during his career that had most pleased him, Sir David listed several; the breakdown in the barriers between University and Government service; the rationalisation of post-graduate training, recognition that structured training was essential; the creation of the specialist colleges and the Academy of Medicine; the increased funding for research.

The Hong Kong Medical Scene - Minuses

Sir David was disappointed that research in Hong Kong was still relatively under-funded.

He felt that because of the present pay structure for doctors in the Hospital Authority there was little incentive for them to join academic units to do research.

There were fewer applicants for overseas scholarships because doctors thought it unnecessary to go abroad for longer periods to gain career advancement in Hong Kong.

With fewer overseas graduates coming to Hong Kong he was concerned regarding the possibility of 'inbreeding'.

Family Practice

Regarding Family Physicians in Hong Kong he commented that the College had qualified for admittance to the Academy of Medicine because it had the necessary fifty Fellows.

However the requirement of the Academy that six years of training should be completed before admission to Fellowship presented a problem. In UK the requirement was only four years. In Singapore likewise the training requirement was shorter because the Singapore College of General Practitioners was outside the Academy of Medicine.

He was in favour of more Family Physician teaching units to encourage that specialty.

Health provision in Hong Kong and Britain

Sir David was quite clear that the present system of funding the public medical sector in Hong Kong could not continue as at present. He pointed out that some well off people were getting virtually free medical care from the Hospital Authority. Those who could pay should do so. Family Practice was a more cost-effective way of delivering health care than hospital-based facilities.

The Hong Kong Hospital Authority staffing numbers were also too low. There should be better interaction between the Hospital Authority and Family Physicians - specialists should refer patients back to Family Physicians for continuing care. Hospital Authority consultants and specialists in private practice could do more teaching in post-graduate colleges. The Hospital Authority consultants were paid sufficiently well that entering private practice was not now an attractive option, leading to a narrowing of the promotion ladder for juniors.

The British National Health Service was similarly underfunded. There were not enough staff to cope with the National Health Service commitments, leading to long waiting lists, and poor morale. Remuneration for medical and nursing staff was relatively low.

Traditional Chinese Medicine

He approved of the registration of Traditional Medical Practitioners, and of a Council to maintain standards of training and practice, but felt that there is a lack of evidence-based traditional Chinese medicine. In UK there was a great public interest in 'Alternative Medicine', without much academic research endeavour, nor standardization.

College of Physicians

Sir David wondered if the College was not too examination orientated. He felt that the present Continuing Medical Education (CME) system was too rigid, lecture orientated; it must be cost-effective, have adequate funding; have outcomes monitored; and have sufficient numbers of educators willing to teach.

Properly detailed patients' hospital discharge letters were an excellent CME opportunity for private doctors. Regarding the value for CME of overseas meetings his opinion was that many medical meetings or conferences were largely a waste of time but that specialist meetings were, in general, more valuable.

Medical graduates educated in Hong Kong were comparable in skill and knowledge to those from UK, he believed, but the standard of spoken English was disappointing, less good than it used to be and certainly less good than some graduates of universities in China. The concept of professionalism is often lacking. To be a good doctor one has to have a missionary spirit, in the broad sense of the word.

Conclusion

Sir David Todd has a right to feel proud of his contribution to medicine in Hong Kong but you would be hard put to realise that from an afternoon of conversation with this modest man. For the record, he was Professor of Medicine at the University of Hong Kong from the time he took over from Prof. McFadzean in 1974, until 1989; he was the founding President of the College of Physicians in 1987 and the founding President of the Academy of Medicine in 1993.

Since moving to England Sir David has been a regular visitor to Hong Kong and still has a keen interest in our medical scene, particularly in the post-graduate medical education sphere that he has done so much to promote. Friends and former colleagues from Hong Kong are frequent visitors to Cambridge, keeping him in touch.

It was good to find that after his many years of service to the community of Hong Kong Sir David now has the time and good health to enjoy the better things in the life as a gentleman of leisure in delightful surroundings; and is able to indulge his interest in the Arts. Sir David was particularly happy that he had recently discovered a good Chinese restaurant just outside Cambridge.

I look forward to my next visit.

John Mackay