HONG KONG COLLEGE OF PHYSICIANS
香港內科醫學院

HONG KONG COLLEGE OF PHYSICIANS

AUGUST 2023

SYNAPSE

Photograph by
Professor Richard YH YU

Content Highlight

An Interview with the New President

Advance Care Planning and Advance Directives

Message from the Editor

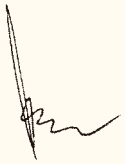
On 27 August 2022, a Symposium on Advance Care Planning and Advance Directives was jointly organized by the Working Group on Advance Directives, Hong Kong College of Physicians, and the Training Subcommittee, Hospital Authority Coordinating Committee in Internal Medicine. This issue of SYNAPSE is privileged to feature four articles contributed by the moderators and speakers, focusing on the practical aspects. The four stimulating articles are titled *"Advance Care Planning and Advance Directives: An Introduction"* by Dr Siu Fai CHEUNG and Dr Yuk Luk CHENG, *"Assessment of Mental Competency – What you need to know"* by Dr Mimi Mei Cheung WONG, *"How can we talk to patient and family for Advance Directives and Advance Care Planning – Practical Tips in Communication"* by Dr Annie Oi Ling KWOK and *"Advance Care Planning and Advance Directives: The Good, the Bad and the Professional Guidance"* by Dr Doris Man Wah TSE.

Dr Emmy Lau had an exclusive interview with Professor Daniel TM Chan, our new President, to learn about his vision and plans for the College. This article represents a visionary view of the College, and elaborates on several key priorities in the coming years.

We are also proud to feature in this issue the Gerald Choa Memorial Lecture *"Primary Care in Hong Kong – Another 30 years"* by Professor Donald Kwok Tung LI, Chairman of the Elderly Commission. This is an insightful article that you will all enjoy reading.

The Synapse and Communications Committee is now strengthened by three youthful and talented new Co-editors – Dr Thomas SY Chan, Dr CH Choi and Dr Jacqueline So. We express our gratitude to Professor Philip KT Li, the Immediate Past President, and Dr John Mackay for their guidance and contributions in the past years.

SYNAPSE continues to play an important role in fostering communication between the College and its fellows, members, and trainees. We would like to thank the President, the Council, all the Co-editors, and the College Secretariat for their support in making this issue of SYNAPSE possible.



Dr Kwok Keung CHAN
Editor

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An Interview with Professor Daniel TM Chan, the New President of the Hong Kong College of Physicians

Dr Emmy LAU

The Hong Kong College of Physicians has recently elected a new President, Professor Chan. I am excited to learn about his vision and plans for the College, and so I had an exclusive and cheerful interview with him.

"Congratulations on your recent election as our new President!" I am sure my opening pleasantries are shared by all members of the College.

"I am both humbled and thrilled to take on this new role," said Professor Chan. "I would like to express my gratitude to colleagues for their trust and support, and to my predecessors, previous Council Members and Past Presidents of the College, notably the Immediate Past President Professor Philip Li, for their exceptional leadership in establishing a solid foundation for the College. I look forward to working closely with everyone in the Council, various committees and boards, and all fellow members of the College."

The Roles of the College

Professor Chan referred to the visions and missions of the College, and shared with me his aspirations for the College, committed to not only supporting training and education to advance the professional standard and humanistic attributes of physicians, but also advising and advocating for better health policies, and to promote health through research and knowledge exchange. "With a focus on key priorities and collaborating with other stakeholders, the College is well positioned to promote excellence in profession standards, aiming to improve clinical outcomes and health of the community."

Advancing the Standard of Internal Medicine through High Quality Training

I asked him about his views on internal medicine and its development, and what role our College plays. "Medicine is the core discipline in all healthcare systems because of its breadth and depth of coverage across a wide range of conditions. Medicine is also continuously evolving to respond to the needs of the community as a result of changing demographics and disease patterns. The Specialty Boards of the College are playing critical roles to make sure that our training is fit for purpose and our physicians are on a par with the highest international standards. We regularly review and update our training curriculum and assessment methods to ensure they are valid, relevant, reliable and fair. Examination questions are carefully prepared and discussed before they are used. There is benchmarking and alignment between examiners before an examination."

"There are also training programmes and workshops for trainees, and we are aiming to increase the support to trainers. It was visionary that from the start our College has emphasized the importance of broad-based training in addition to specific specialties. This is especially relevant in the present day when clinical service becomes highly specialized, and the holistic care of patients could be jeopardized by fragmentation of the care pathways." Professor Chan highlighted the recent establishment of the new specialty in Genomics and Genetics (Medicine), to illustrate the College's dedication to make sure that our physicians are always at the forefront of medical advances, which underpins our service to the community.

Commitments to Fellows, Members and Trainees

How would the College connect with the increasing size of membership, across different specialties and healthcare settings, I asked. "The College is there to support its Fellows, Members and Trainees, not only in clinical training and CME/CPD but also in other matters related to physician practice", he responded. He added, "Indeed, with over two thousand College Fellows, the College of Physicians is the largest among all Academy Colleges. Our fraternity of physicians in different specialties, from both the public and the private sector, presents a formidable professional body that is well positioned to support its members. Their views are also important for the College to formulate its recommendations on healthcare policies."

He firmly believes in supporting Physician Trainers, which would improve the training quality and experience for Trainees. "The College is mindful of its duty to help senior members acquire and refresh competencies necessary in physician training and the nurturing of future leaders. To achieve this goal, the College will conduct workshops and devise other means of support to empower trainers on skills related to clinical education and training, and also effective communication and professional leadership."

Advocacy and Advisory Roles

I was curious to know about the place of the College in society, and was enlightened by Professor Chan. "While training and education are crucial components of our mission, the College also plays a vital advocacy and advisory role in shaping healthcare policies and addressing pressing concerns, the tackling of which often requires a multifaceted approach. The shortage of healthcare manpower is a case in point." He went on to explain that, in addition to increasing the number of medical school graduates and international recruitment, measures to retain talents in the public sector are critical not only for clinical service delivery but also for succession since clinician training is conducted through practice and the gradual build-up of experience. Attention to career development, working conditions, well-being, addressing differing needs and circumstances of individuals, prevention of burn-out, and utilization of novel healthcare technologies, should all be considered. The College will continue to be a cogent advocate representing the medical profession. It has also contributed to knowledge exchange and educating the public on healthcare issues, with COVID vaccination being a recent example.

Priorities in the Coming Years

For his tenure as College President, Professor Chan outlined several key priorities: enhancing governance and communication, engaging the younger generation, supporting training and education, addressing issues related to healthcare services, and strengthening national and international collaborations.

Enhancing Governance and Communication

On the day-to-day operations of the College, Professor Chan highlighted that "Changes are being introduced to enhance governance and communication. For example, at present not all specialty boards have representation in the

Education & Accreditation Committee, but they'll be asked to join an E&AC meeting as required. Over the past few months I've been working with Vice-President and E&AC Chairman Dr Johnny Chan, thinking of ways to improve governance and communication with specialty boards. Starting from July this year, the chairperson of all specialty boards will be de facto a member of the E&AC. The objective of this change in the E&AC structure is to facilitate communication and enhance the sense of community and fraternity in our College, as ours is a big College with over two thousand Fellows and close to twenty specialties. Also, in all committees or work groups, we would make sure that there is representation from different sectors, regions, and age groups - such as public and private, Hospital Authority and academic, regional clusters and hospital types, senior and junior, and so on. We are also mindful of ensuring diversity, succession and sustainability. Since last year we are moving towards electronic communication. We are getting the views of our younger members on other means of electronic communication in addition to emails. We will be updating the College website. Electronic web-based platforms for education and training are being developed." And I was told that there will be changes to Synapse, the College's publication, as well.

Engaging and Nurturing the Younger Generation

I know that Professor Chan is a strong advocate for connecting with the younger generation, so I asked him about the Young Fellows Committee of the College. He said, "The Young Fellows Committee has been established for about six years now. It has worked very well indeed! In addition to advising the College on its policies and proposing new initiatives, it also arranges activities such as career talks to medical graduates from both universities. By fostering collaborative projects, running mentorship programmes and organising social events, the Committee attracts new talents to the College and help build a strong and vibrant community of physicians, which is very important to the growth and development of the College." Professor Chan continued, "The increasing engagement with the younger generation is not only through the Young Fellows Committee. At specialty boards we would also increase the participation of younger colleagues. Importantly, these initiatives provide opportunities for the College to engage with the younger generation of physicians early. I'm sure many of them will become leaders in our profession, and take up leadership roles at the College as well."

Continuous Improvement of Training and Assessment

"The College is committed to making sure that its training and assessment programmes for physician trainees are of high quality and up to date", Professor Chan emphasised. "Over the past few years we have introduced new educational programmes for Basic and Higher Physician Training in Internal Medicine, such as the quarterly update seminars and the Advanced Medical Simulation Course. The online self-learning tool (SLT) platform had a revamp recently. We have just invited applications to become First Fellows in Genetics & Genomics (Medicine), and will roll-out training support funds to encourage more trainees in this rapidly advancing field. In the coming months we will organize training activities to prepare for the new PACES format (i.e. PACES23) which is going to start in October this year. Later this year, the specialty boards will update their training curricula, which is a regular undertaking happening once every few years. Our Training Subcommittee is also looking into gradually introducing workplace-based assessment, which is well-proven to improve training experience and outcome."

Addressing Issues in Healthcare Development

All eyes are on the current shortage of medical professionals. There is no disagreement about the importance to recruit and retain healthcare professionals in the public healthcare service. Professor Chan shares his views, "The College

Prof TM Chan and Dr Emmy Lau

has always been receptive to the recruitment of overseas-trained doctors. The assessment of training experience for quality assurance is well-established and transparent. We also welcome overseas medical graduates who have joined the public healthcare system to enter our training programmes, going through the same process as local trainees."

On the roll-out of the primary healthcare programme recently announced by the government, Professor Chan said, "A comprehensive and effective primary healthcare system is long overdue in Hong Kong. On the recently announced initiative, we have provided our input and we have representation in the relevant committees. We have highlighted that primary care and specialist care should not be viewed as two disjoint or sequential systems. Instead, at the level of individual patients, both systems should operate in parallel so that a patient seeks specialist care as required and after stabilization continues to be under the care of the primary care doctor. Also, we feel that primary care doctors should be adequately trained in common medical conditions to avoid unnecessary referral to specialist care."

International and National Collaborations

We came to discussions beyond the local focus. "Fostering a closer link with international partners, especially the UK Royal Colleges, is another priority. Many of our College Fellows are also Fellows of the UK Colleges. Immediately after relaxation of the COVID restrictions, our College hosted a Roll-signing Ceremony for Fellows of the Edinburgh College in February. Our partnership with the Federation of the Royal Colleges of Physicians of the UK in conducting the MRCP serves as an important benchmarking and quality assurance measure for our training programme, making sure that the high professional standard of physicians trained in Hong Kong are internationally recognised. Indeed, Hong Kong is an important international examination centre for PACES. After a gap of three years due to COVID, we welcomed back UK examiners in the March diet of PACES, which went very well. We are working on inviting colleagues from the UK Royal Colleges to join our Annual Scientific Meeting in October to share experience and good practice in physician training." Professor Chan added, "In addition to international collaborations, the College is also providing advice and recommendations to the development of structured physician training in the Mainland."

Final Remarks

It has been a joy talking to Professor Chan to hear about his plans. I'm confident that, under the stewardship of the College Council and Leadership, our College will continue to grow and develop, and to promote excellence in the profession. I'm sure our readers will join me and the Synapse editorial team in supporting our College and contribute to the many exciting initiatives.

Advance Care Planning and Advance Directives: An Introduction

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Advance care planning (ACP) and advance directives (ADs) play an important role in promoting patient autonomy and providing guidance for medical decision-making in end-of-life care. This paper aims to provide an overview of the concept of ACP, the significance of ADs, and the legal and practical considerations associated with these tools. It also highlights the benefits of ACP and ADs in improving patient-centered care and offers recommendations to enhance their implementation and effectiveness.

Advance Care Planning

ACP is a proactive communication process that involves individuals discussing and documenting their preferences regarding their future medical care and treatment in the event they are unable to make decisions for themselves.

ACP encompasses key components that ensure individuals receive medical care aligned with their preferences. It starts with open discussions between individuals, their carers or family members, and healthcare providers to express values, goals, and future care preferences. Appointing a healthcare proxy will empower a trusted person to make decisions on behalf of the individual if they become unable to do so. Creating a living will allows for detailed instructions regarding medical interventions, while medical orders for life-sustaining treatment translate preferences into actionable directives across different healthcare settings. Document accessibility is vital, ensuring that copies of the plan are readily available to healthcare providers and the designated healthcare proxy. Regular review and updates of the plan are recommended to reflect any changes in personal values or the appointed proxy.

Advance Directives

ADs are legal documents that allow individuals to express their preferences and make decisions regarding their medical care in the event that they become unable to communicate their wishes. These directives ensure that their healthcare decisions are respected and followed by healthcare providers and loved ones. A living will is a common type of AD. It is a written document that typically addresses end-of-life care, such as the use of life-sustaining treatments like resuscitation, mechanical ventilation, or feeding tubes. While ACP encompasses a broader process of discussing treatment options with healthcare providers, ADs provide written instructions for specific medical interventions.

Role of Healthcare Professionals in Facilitating ACP and ADs Conversations

Healthcare professionals play a significant role in facilitating ACP and ADs conversations. They fulfill several important functions to ensure patients' wishes and preferences are effectively communicated and documented.

Firstly, healthcare professionals educate patients about the significance of ACP and ADs. They provide comprehensive information, explaining the purpose of these discussions and helping patients understand the potential medical decisions they may need to make in the future.

In addition, healthcare professionals initiate these conversations with patients, especially those who are chronically ill, elderly, or facing life-limiting illnesses. They create a safe and supportive environment, encouraging patients to express their wishes, concerns, and values related to their healthcare choices.

During these discussions, healthcare professionals assess patients' values, beliefs, and personal goals. They engage in open and non-judgmental dialogue, exploring patients' preferences for specific medical interventions, end-of-life care, and factors influencing their quality of life. This assessment helps guide decision-making and ensures that patients' choices align with their values.

Healthcare professionals also play a vital role in explaining the available medical options and treatment interventions to patients. They provide detailed information, clarifying the benefits, risks, potential outcomes, and limitations of each option. By ensuring patients have a comprehensive understanding of their medical conditions and the implications of their decisions, healthcare professionals empower them to make informed choices.

Assisting patients in documenting ADs is another key responsibility of healthcare professionals. They help patients complete AD documents. This process involves explaining the purpose and legal significance of these documents and helping patients appoint a trusted person as their healthcare proxy.

Furthermore, healthcare professionals promote interdisciplinary collaboration by working with other members of the healthcare team, including but not limited to, nurses, social workers, chaplains, and palliative care specialists. This collaborative approach ensures that patients' physical, emotional, spiritual, and psychosocial needs are addressed, fostering a holistic approach to advance care planning.

Periodically reviewing and revisiting advance care plans is another important role of healthcare professionals. They assess whether the plans remain up to date and aligned with the patients' current medical condition, goals, and preferences. By maintaining ongoing communication and making necessary updates to advance directives, healthcare professionals ensure that patients' wishes are accurately documented.

Lastly, healthcare professionals advocate for patient autonomy throughout the ACP process. They serve as a voice for patients during difficult medical situations, acting as a bridge between the patients, their families, and the healthcare system. Their advocacy ensures that patients' choices and preferences are respected, promoting patient-centered care and preserving patient dignity.

Benefits of Advance Care Planning and Advance Directives

ADs provide a means for individuals to communicate their treatment preferences in specific medical situations. This helps to ensure that healthcare providers are aware of the individual's desires and can make informed decisions that align with their values, thereby

reducing the risk of unwanted or unnecessary treatments.

By documenting their healthcare preferences in advance, individuals relieve their family members of the burden of making difficult decisions on their behalf in times of crisis. ADs also provide clarity and guidance, reducing potential conflicts and emotional distress among family members.

Engaging in ACP and creating ADs can provide individuals with peace of mind, knowing that their wishes regarding medical treatment and end-of-life care will be honored. Advance care planning improves patient and family satisfaction and reduces stress, anxiety, and depression in surviving relatives[1].

Challenges of Advance Care Planning and Advance Directives

ACP and ADs face several challenges that need to be addressed for effective implementation.

One key challenge is the lack of awareness and understanding among the general public regarding ACP and ADs. Many individuals are unaware of the importance of planning for future healthcare decisions or the legal options available to them.

Cultural and religious beliefs also play a significant role in shaping attitudes towards ACP and ADs[2]. Different cultures and religions have specific traditions and beliefs that can influence decision-making about end-of-life care. Navigating these cultural and religious differences is essential when discussing and implementing ACP.

Engaging in conversations about end-of-life care can be emotionally difficult and psychologically distressing for individuals and their families. Fear, denial, and discomfort surrounding death and dying often hinder open and honest discussions about ACP.

Family dynamics and conflicts can pose challenges to ACP and ADs as well. Varying opinions within families or unresolved issues can lead to conflicts when making decisions. Resolving conflicts and ensuring all family members' voices are heard can be complex but crucial in the ACP process.

The legal complexities surrounding ACP and ADs vary across jurisdictions. Different countries have specific laws regarding the validity and enforceability of advance directives. Understanding and navigating these legal frameworks can be challenging, especially when individuals move or travel across different jurisdictions.

Healthcare provider attitudes and communication skills also influence ACP discussions. Some providers may lack training or feel uncomfortable initiating conversations about end-of-life care. Improving provider communication and ensuring adequate training can enhance the ACP process. Moreover, a systemic approach to embed ACP into routine care is very important.

Regularly reviewing and updating ACP and ADs documents is necessary, but it can be challenging to ensure accessibility and proper communication with healthcare providers and family members.

Additionally, when individuals lose decision-making capacity due to cognitive impairments like dementia, identifying appropriate substitute decision-makers and ensuring their informed involvement becomes crucial. For healthcare professionals, training of mental competency assessment is also important.

Advance Care Planning and Advance Directives in Hong Kong

The prevalence and acceptance of ACP and ADs varies significantly across countries. While ACP and ADs are increasingly recognized

and promoted as important components of healthcare systems worldwide, their adoption and utilization may be influenced by patient, healthcare professionals, healthcare system, cultural, and legal factors. To promote ACP and ADs, we need to address these barriers through public awareness campaigns, education initiatives, legal reforms, and cultural sensitivity.

A study conducted in US found that out of the 7946 respondents, 26.3% had an advance directive. The most frequently reported reason for not having one was lack of awareness[3].In the context of Hong Kong, a population-based telephone survey revealed only 0.5% of the participants reported AD. However, over 80% of those who had heard about AD had made or intended to make AD[4]. The finding urges for more active promotion of AD to the public. The government has recognized the importance of end-of-life care and has taken steps to promote discussion and planning for these issues in the community. The Hong Kong law acknowledges the importance of patient autonomy and the right to refuse medical treatment. Legislation of AD is also in progress. In cases where individuals have clearly expressed their wishes regarding medical treatment, healthcare professionals are generally expected to respect those wishes to the extent allowed by law. The Hospital Authority (HA), which manages public hospitals and healthcare services in Hong Kong, has provided guidance on AD and established guidelines on ACP since 2010 and 2019, respectively. A Working Group on ADs under the Hong Kong College of Physicians (HKCP) was also established.

Advance Care Planning and Advance Directives Training Organized by the Hong Kong College of Physicians and the Hospital Authority

To raise awareness and provide education to healthcare professionals, a symposium on ACP and ADs, jointly organized by the HKCP and the Training Subcommittee, HA Coordinating Committee in Internal Medicine, was held on August 27, 2022. In the symposium, local and overseas renowned speakers shared their expert advice on ACP and ADs, ADs related medical ethics, local ACP experience, professional guidance, and legal and practical aspects of ACP and ADs. The symposium received an overwhelming response.

This issue of Synapse published some of the presentations delivered at the symposium, namely, Dr Mimi Mei Cheung WONG discusses how to assess mental competency. Dr Annie Oi Ling KWOK gives us the practical tips in communicating with patients and their family. Lastly, Dr Doris Man Wah TSE shares her insight into the good, the bad and the professional guidance of ACP and ADs.

References

1. Karen M Detering, Andrew D Hancock, Michael C Reade, William Silvester. The impact of advance care planning on end of life care in elderly patients: randomised controlled trial. BMJ 2010 Mar 23;340:c1345
2. Carmen WH Chan, Martin MH Wong, Kai Chow Choi, Helen Y L Chan, Amy YM Chow, Raymond SK Lo and Michael MK Sham. Prevalence, Perception, and Predictors of Advance Directives among Hong Kong Chinese: A Population-Based Survey. Int J Environ Res Public Health. 2019 Feb; 16(3): 365.
3. Alissa Hurwitz Swota. Culture, Ethics, and Advance Care Planning 1st Edition, 2009.
4. Jaya K. Rao, Lynda A. Anderson, Feng-Chang Lin and Jeffrey P. Laux. Completion of Advance Directives Among U.S. Consumers. Am J Prev Med. 2014 Jan; 46(1): 65–70.

How Can We Talk to Patient and Family for Advance Directives and Advance Care Planning – Practical Tips in Communication

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Introduction

There has been an increasing awareness of the inadequacy of end-of-life (EOL) care particularly on poor knowledge of patients' wishes about their medical treatment at a time when they lose the capacity to make decisions[1-3], resulting in patients being cared for in a way they would not have chosen[2]. Advance care planning (ACP) refers to the process of communication among a patient with advanced progressive diseases, his/her health care providers, and his/her family members and caregivers regarding the kind of care that will be considered appropriate when the patient can no longer make those decisions[4]. Advance Directive (AD) is a document which the patient can specify the treatments that he/she is going to refuse in case he/she becomes mentally incapacitated to make decision with disease progression. The document is legally binding in Hong Kong under common law[4]. Studies including randomized controlled trial indicates ACP improves EOL of patient in terms of better quality of life, less distress, higher likelihood of receiving care consistent with their preferences and family satisfaction, reduces stress, anxiety and depression in surviving relatives[5-7]. This article will focus on when to initiate ACP, what and how to discuss ACP.

When to initiate ACP?

Misconception – Chinese elderlies in Hong Kong don't want to discuss ACP

Hong Kong, a special administrative region of China with most of the population are Chinese, deeply affected by Chinese cultures especially elderlies. We always have the conception that Chinese elderlies don't want to talk about death and dying nor ACP and prefer to discuss diagnosis and medical treatment with their children only. A population-based telephone survey of 1067 adults in Hong Kong found that 92.2% participants including elderlies prefer medical staff directly talk the diagnosis and end of life situation to patient; more than 90% elderlies prefer palliative care over prolong life when being diagnosed terminally ill; more than 80% participants never heard about AD, but more than 60% would prefer to make their own AD after explanation[8].

Misconception – ACP should discuss in inpatient setting when patient condition deteriorates

Patients hospitalized with serious medical illness are usually too ill to participate in complex medical decision and the task often falls on relatives who may be unaware of patients' preference and can feel burdened. Outpatient is a better setting for ACP when patients

are not acutely ill and have decisional capacity to communicate their goals and values [9].

The appropriate time for triggering the ACP discussions for patients with progressive disease depends on the state of the disease and the readiness of the patients. The approach should be individualized and voluntary. The discussion may be appropriately initiated in a range of situations including [4]:

- *Following the diagnosis of a life limiting condition with a more rapid downhill course e.g. advanced cancer, motor neuron disease.*
- *Early cognitive decline in dementia*
- *Significant disease progression in terms of functional decline, biochemical parameters, symptom burden, etc*
- *Discontinuation of disease targeted treatment*
- *Transition to palliative care*
- *Recovery from an acute severe episode of a chronic disease*
- *Following multiple hospital admissions*
- *Patient becomes institutionalized*

What are the core elements when we discuss ACP?

ACP is not only discussion of life sustaining treatments and completion of AD. It is a process of communication with empathy and respect to provide and explore information to and from patient and family. After the communication, patient and the family can be better prepared emotionally for future deterioration of the patient's condition. The core elements in ACP are:

Provide information to patient and family	*Explore information from patient and family*
Disease diagnosis and prognosis	*Patient values, concerns, worries*
Treatment options, risk, burden and benefit	*Patient and family's understanding of disease and prognosis*
Handle misconception, expectation gaps e.g. success rate of cardiopulmonary resuscitation (CPR)	*Overall goal of care*
Assure comfort care and palliation are available	*Expectation from treatment*
	Preference of treatment limit
	Preference of personal care, place of care
	Explore patient's prior wish from family for mentally incompetent patient

How to discuss ACP? – Practical tips in communication

ACP is an operator dependent process. The healthcare professionals act as facilitators of the ACP process, should have good communication skills in order to achieve satisfactory outcome[4]. Good communication skills including non-verbal, verbal communication and picking up cues.

1. Non-verbal communication

Scholar estimates that non-verbal communication most often conveys a larger share of information (65%) than verbal communication (35%). Words only make a portion of what is being said. What we don't say is more important than what we do say.

Nonverbal communication strategies[10]

Create appropriate environment

- *Ensure privacy, adequate time, prevent frequent interruption, sit down and face patient at eye level, do not multi-task*

Appropriate eye contact

- *This denotes emotional connection and help patient engage*

Posture, gestures and facial expression

- *Open posture, slightly lean forward towards the patient, place hands on your lap or on the arms of the chair and appropriate nodding of head.*

Appropriate touch

- *Gently touch arms, hands or shoulders especially when patient start crying can demonstrate empathy. Touch is a powerful form of communication, but aware of different cultures has rules about bodily contact.*

Active listening and allow silence

- *Listen without interrupting, be comfortable with silence and allow patient respond at their pace.*

2. Verbal communication strategies[10]

Voice tone, language and pace

- *Use a friendly and comforting tone, speak slowly, use short words and sentences, avoid medical jargon*

Speak honest and straightforward manner

- *It includes prognosis, we can provide a range and acknowledge our uncertainties*

Use broad open-ended questions

Respond to emotions by verbalizing empathy

- *e.g. " It should be a very difficult time for you and your family"*

Explore the meaning of ambiguous words and phrases

Paraphrase what you have heard

Summarize and check for understanding

3. Picking up cues[11]

Cues are something that the patient says or does that hint to you there is something more to explore

Nonverbal cues

Crying, sighing, frowning, look of despair, gazing away your eye contact

Verbal cues

- *Mention of psychological symptoms – 我好驚..我好擔心..*
- *Verbal hints to hidden concerns – 好難..*
- *Neutral mention of an important/ potentially stressful life event – 我個仔上個禮拜過咗身.*
- *Repetition of a neutral expression – 我冇事喎..我真係冇事，我ok嘅*

Structured ACP conversation guides

Different structured conversation guides were developed to support professionals to conducting ACP conversation like serious illness conversation guide, respecting choices, living well interview, etc. Exploration of patient's view on illness, living well, end-of-life issues, and decision making form the core part of ACP conversation guides[12].

An example of ACP conversation in Hong Kong setting:

Steps	Proposed open-ended questions
1. Permission	我而家想同你傾吓你個病情同埋將來嘅照顧計劃，可唔可以?
2. Assess understanding of disease	關於你自己嘅病況，你知道幾多，可唔可以講俾我聽?
3. Share prognosis • Assess readiness, ask open questions • Sensitive to cues that patient may not want to know • Allow silence, respond to emotion • Truth telling and reframe hope	病人：我諗我都時日無多，醫生我仲有幾耐命? 醫生：你點解咁問，你其實擔心啲乜嘢? 其實呢個病係唔可以根治，有幾耐時間我哋都唔可以好確定，我估計幾個星期至幾個月。 我同你一樣希望個病會有好轉，而家只係商討萬一情況轉差，你想我哋點樣幫你? 雖然呢個病係唔可以根治，但係有唔同嘅方法減低你嘅唔舒服，我哋嘅醫護團隊會一路喺你身邊幫你。
4. Explore goals, worries, fears, value • Be sensitive to cues that patient don't want to discuss	關於自己嘅病情，其實你而家最擔心最驚係啲咩呢? 將來個病真係轉差嘅時候，你希望治療個目標係啲乜嘢?盡量減低痛苦?盡辦法延長生命?
5. Explore overall preference of life sustaining treatment	
6. Explore preference of individual life sustaining treatment	
7. Close conversation, documentation, complete AD if ready, encourage disseminate to family members	今日嘅討論令到我更加明白你嘅需要同治療嘅目標，我建議… 我哋會同你一齊面對呢個病，減低你嘅痛苦 Reassure not abandon patient and continue support patient and symptoms palliation

N.B. ACP is a communication process, it usually takes more than one session to complete all the steps. Each step need to assess patient's readiness through verbal and non-verbal cues.

Conclusion

ACP is one of the essential component of high quality palliative and end of life care. ACP is operator dependent process. The healthcare professionals who act as ACP facilitators, should have good communication skills in order to achieve satisfactory outcome. When conducting ACP discussion, health care professionals should (1) PREPARE and gather information before the discussion; (2) LISTEN to patient and relatives before informing, including information behind the words; (3) EXPLORE and PROVIDE information; (4) use NONVERBAL and VERBAL communication skills and pick up cues (5) SUMMARIZE information and DOCUMENTATION. ACP is a process of communication, we should assess the readiness before initiation and be sensitive on each steps, it is not necessary to complete all information in one session.

References

1. The Support Investigators. A controlled trial to improve care for seriously ill hospitalized patients. The study to understand prognoses and preferences for outcomes and risks of treatments (SUPPORT). JAMA 1995;274:1591-8.
2. Winzelberg GS, Hanson LC, Tulsky JA. Beyond autonomy: diversifying end-of-life decision-making approaches to serve patients and families. J Am Geriatr Soc 2005;53:1046-50.
3. Singer PA, Martin DK, Kelner M. Quality end-of-life care: patients' perspectives. JAMA 1999;281:163-8
4. Working Group on ACP guidelines with Standardised ACP template. HA Guidelines on Advance Care Planning. Version 1.0. June,2019.
5. Wright AA, Zhang B, Ray A et al. Associations between end-of-life discussions, patient mental health, medical care near death, and caregiver bereavement adjustment. JAMA 2008;300(14):1665-1673
6. Mack JW, Weeks JC, Wright AA, Block SD, Prigerson HG. End-of-life discussions, goal attainment, and distress at the end of life: predictors and outcomes of receipt of care consistent with preferences. J Clini Oncol 2010; 28(7):1203-1208.
7. Detering KM, Hancock AD, Reade MC, Silvester W. The impact of advance care planning on end of life care in elderly patients: randomized controlled trial. BMJ 2010:340 (c1345);c1345. doi:10.1136/bmj.c1345
8. Chung RYN, Wong ELY, Kiang N, et al. Knowledge, attitudes and preferences of advance decisions, end-of-life care and place of care and death in Hong Kong. A population-based telephone survey of 1067 adults. JAMDA 2017; 18: 367.e19-367e27.
9. Berns SH, Carmargo M, Meier DE, Yuen JK. Goals of care ambulatory resident education; training residents in advance care planning conversations in the outpatient setting. Journal of Palliative Medicine 2017. Doi: 10.1089/jpm.20-16.0273
10. Goswami P. Advance care planning and end-of-life communications: practical tips for oncology advanced practitioners. J Adv Pract Oncol 2021;12(1):89-95
11. Arkless C, Goodwin J, Muir S. Advance care planning communication skills manual. Version 1.0. June, 2015
12. Fahner JC, Beunders AJM, Heide AVD et al. Interventions guiding advance care planning conversations: a systematic review. JAMDA 2019 (20); 227-248

Advance Care Planning and Advance Directives: The Good, the Bad and Professional Guidance

Dr. Doris Man Wah TSE
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Introduction

Advance directive, also known as the advance medical directive, is made by a mentally capable adult for advance refusal of specific life sustaining treatment(s) shall they become mentally incapable under certain preconditions. Advance directive is, therefore, not for request of specific treatment(s).

When risks and burdens outweigh the benefits of life sustaining treatments, their withholding or withdrawing according to patients' best interests allow patients to die from the advanced disease without undue sufferings. This is ethically and legally acceptable in Hong Kong and this is not euthanasia.

At present, an advance directive is legally binding under common law, but there are hurdles and barriers to overcome. The Consultation Report on Legislative Proposals of Advance Directives and Dying in Place released in 2020 set the scene for legislation of advance directives in Hong Kong.[1]

Advance directive as one of the means, not the end

Advance directive (AD) emerges in recognition of patient's autonomy. However, mere focusing on the completion of AD as the end result, only yield the refusal of treatment as an end product – *"the treatment that I refuse"*. This legal transactional approach should be shifted to the communication approach, where advance care planning (ACP) forms the overarching process communication among health care professionals, patients and their family members.[2] Expression of patient's preferences for medical and personal care and engagement of family members facilitates shared decision making. Patient may choose to make an AD after ACP. The ultimate aim is to facilitate goal concordant medical and personal care when patient is at the end-of-life – *"the care I prefer"*.

The Hospital Authority has extended the process of advance care planning to cover patients who are minors and adult patients who are mentally incapable, where doctors can discuss the withholding or withdrawing life sustaining treatments based on patients' best interests.[3]

Challenges of the advance directives

Although the AD exemplifies the right of a mentally capable adult to refuse treatment, people has criticised that the autonomous decision is only for the future, or prospective in nature. It may be difficulty for the maker, especially in the absence of serious/chronic illness experience, to envisage the future situation. At times, a mentally capable adult may make a decision that seems to be unwise or not in his/her best interests even when being properly informed of the consequences, the AD still has to be respected.

Patients are encouraged to express their values and preferences in ACP. The documentation of ACP provides a good reference for patient care, but unlike AD, it is not legally binding. An AD should only contain clear and unambiguous instructions regarding the specific precondition to be fulfilled and the life sustaining treatment refused, but not values and preferences for personal care.

The completion rate of AD in Hong Kong is reported to be 0.5% among 2,002 general public in a local study.[4] For AD to play an effective role in achieving goal-concordant medical care, it requires seamless operation in the health care system, awareness and knowledge of the health care professionals and education of the public.

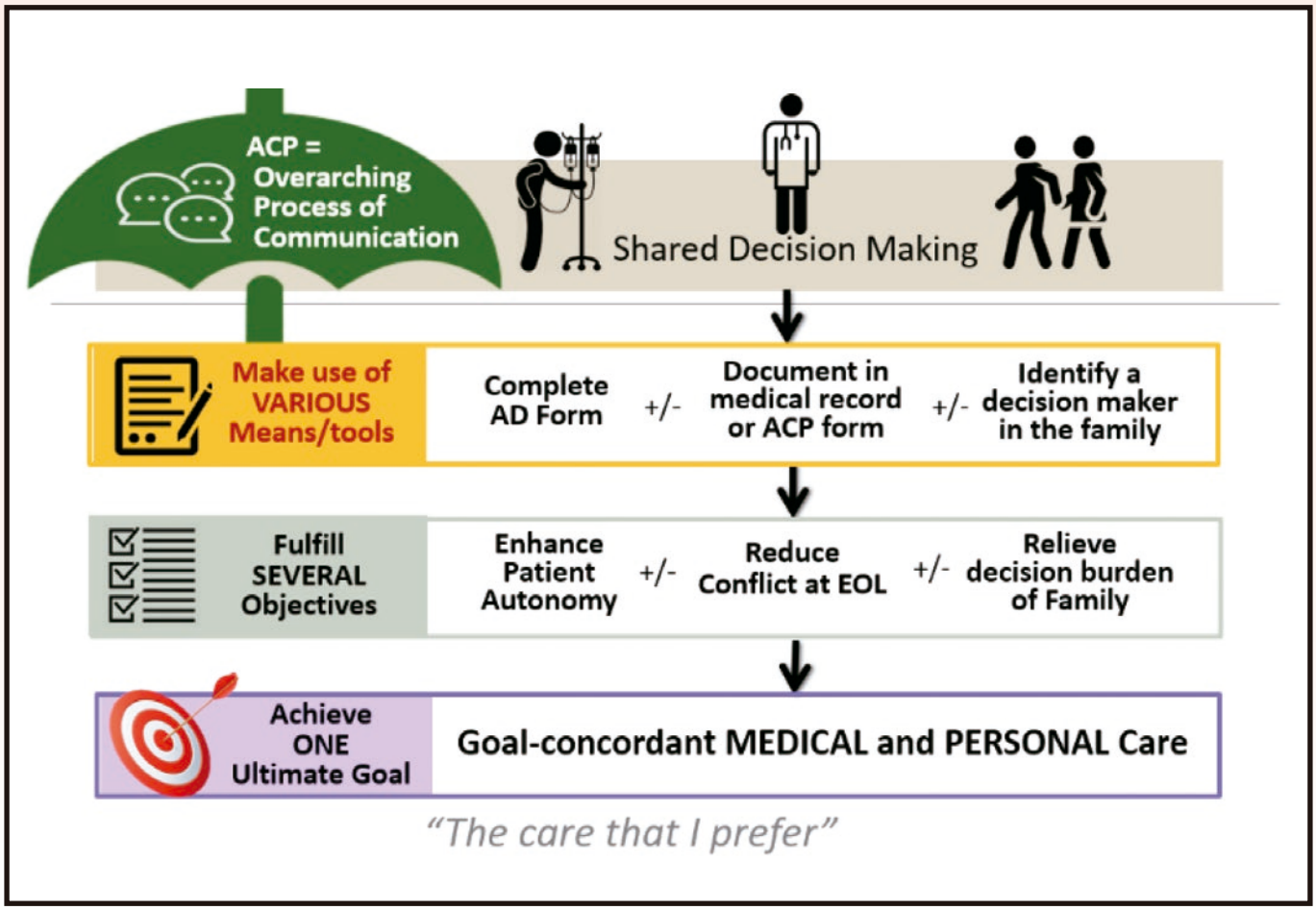
Professional role of physicians

This article serves to provide highlight the professional roles of doctors encountering patients during their journey, from ACP, making of AD to its implementation. It is envisaged that a more comprehensive professional guidance on AD shall be issued by the Hong Kong Academy of Medicine in response to the enaction of the Ordinance.

Facilitator of ACP

Good communication skill is the key to a fruitful ACP. For patients with chronic diseases, the doctor should consider triggering or revisiting the ACP if the patient has evidence of disease progression such as worsening of symptoms, significant functional decline, repeated episodes of hospital admissions or exacerbations of the chronic disease, discontinuation of active disease treatment or transition to palliative care, or when patient needs institutional care.

It is a good practice to invite patient's family members to join the discussion for facilitating their understanding on the patient's preferences, consensus building, shared decision making and to avoid unnecessary conflicts at end-of-life.



When making the AD after ACP

Before making the AD, the attending doctor should be satisfied that the maker is a mentally capable adult and not under pressure or coercion. All adults are presumed to have capacity to make medical decisions unless proven otherwise. When the mental capacity of the patient is in doubt, for example, he or she may be under the influence of drugs, depression, or cognitive disorders, the doctor should seek advice from other experts in the relevant fields. Some of these influencing factors may be temporary and treatable and discussion on AD may be resumed in due course.

To facilitate the maker to make an informed choice, the doctor has to provide sufficient and adequate information; the scope and depth is different from making a contemporaneous informed consent to a treatment procedure. The information should include that on:

(1) the nature and the effect of AD: the AD is a legally binding document made by the patient voluntarily for advance refusal of life sustaining treatments; an AD will only come into effect when patient is mentally incapable and the AD is assessed to be valid and applicable. While the patient can revoke the AD at any time, but it cannot be overruled by family members.

(2) the preconditions for applying the AD include: (a) the terminally ill, referring to patients suffering from advanced, progressive, and irreversible disease with a short life expectancy in terms of days, weeks or a few months; (b) persistent vegetative state or irreversible coma; (c) other end-stage irreversible life limiting conditions not belonging to (a) or (b) e.g. patients with end-stage organ failure or patients with irreversible loss of major cerebral function and extremely poor functional status.

(3) the life sustaining treatment(s) refused and the effect of refusal: life sustaining treatment refers to any treatment with a potential to postpone death of patient. Examples include cardiopulmonary resuscitation (CPR); artificial ventilation; transfusion of blood products; cardiac pacing; vasopressors; specialised disease specific treatments such as chemotherapy, dialysis; antibiotics for life threatening infection; artificial nutrition and hydration. Withholding or withdrawing life sustaining treatments allows natural death to occur without the burden of non-beneficial treatments.

The patient cannot refuse basic care such as oral feeding and other comfort measures. Patient should be reassured that making an AD will not lead to abandonment and palliation would be provided for symptom control. The doctor should take caution when patient wishes to refuse all life sustaining treatments and take note that refusal of artificial hydration and nutrition could be contentious.

The doctor has to reach consensus between the patient and the family members. Any conflicts arising from the discussion on AD should be resolved before signing.

For patient who refuses CPR, the attending doctor shall complete the DNACPR (Do-not-attempt CPR) form if cardiac arrest is anticipated. This requires the signatures of the attending doctor and another witnessing doctor, and one should be a specialist. The DNACPR order should be reviewed at a reasonable time interval, not longer than 12 months.

The completed AD, and the DNACPR order if applicable, is under the custody of the patient and family members. The attending doctor should advise the patient to be responsible to keep the hard copy intact and present to treatment providers as the proof.

When making a DNACPR order for mentally incapable adults without an AD or minors

For patients who cannot make AD, the doctor may assess whether CPR is in patient's best interest when cardiac arrest occurs and reach consensus with parents or family members. The DNACPR

form has to be signed by 2 doctors, one of which is a specialist. Signature of the parent or family member indicates that he/she agrees that CPR is not in patient's best interests as assessed by the doctor.

When encountering a mentally capable adult patient with an AD

When the patient is mentally capable, the AD made is not applicable as patient could make contemporaneous decisions as needed. It is a good practice to check if patient has changed his/her mind. The doctor should not presume that a patient with an AD to refuse CPR would refuse other treatments i.e. patients should not be deprived of their rights and indicated interventions should be discussed with patient. If an operation under general anaesthesia is contemplated, suspension of AD for operation should be discussed with patient.

When encountering a mentally incapable adult patient with an AD

To implement the AD, the doctor has to be satisfied that the AD is both VALID and APPLICABLE. A valid AD refers to one that is properly completed and signed, and not being revoked, damaged or falsified, and the patient has not done anything clearly inconsistent with his/her AD. For an AD to be applicable, the patient should be mentally incapable and meets the precondition as specified in the AD. The AD would not be applicable if the prevalent condition is not what patient had expected at the time of making AD e.g. patient becomes seriously injured after a car accident.

If the patient has revoked his/her AD for refusal of CPR, then the DNACPR order becomes invalid. Similar to the AD, the DNACPR is only applicable when the patient meets the precondition specified.

Dealing with doubts and conflicts

Doctors sometimes have to exercise professional judgement within a short time frame when handling the AD or DNACPR. In clinical practice, doctors may encounter situations such as when the hard copy of the AD is not available; the validity or the applicability of the AD is in doubt; disagreement raised by some family members etc.

Instead of looking for prescribed solutions, doctors are advised to follow some important guiding principles in decision making: (1) in case of emergency and reasonable doubt, the presumption is to perform CPR; (2) act according to the principle of patients' best interests; (3) be reasonable in what you believe; last but not least (4) good documentation.

Conclusion

In facing the challenges of the aging population, prevalence of multiple chronic diseases and increasing awareness of patient's autonomy, contemporary doctors have to embrace advance care planning in their clinical practice and be familiar with the operation of the AD and DNACPR. Hopefully, the future Ordinance shall provide the operation of the advance directive and the DNACPR order across different settings along the patient's last journey in a seamless manner, including the ambulance and the accident and emergency departments. It is also important in providing statutory immunity for treatment providers who act in good faith.

References

1. https://www.healthbureau.gov.hk/download/press_and_publications/consultation/190900_eolcare/e_EOL_consultation_report.pdf.
2. The Evolution of Health Care Advance Planning Law and Policy. CP Sabatino. Milbank Q. 2010 Jun; 88(2): 211–239.
3. HA Guidelines on Do not-attempt cardiopulmonary resuscitation, 2014.
4. Prevalence, Perception, and Predictors of Advance Directives among Hong Kong Chinese: A Population-Based Survey. CWH Chan, MMH Wong, KC Choi et al. Int J Environ Res Public Health. 2019 Feb; 16(3): 365.

Assessment of Medical Competency — What you need to know

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Why is it important to assess mental capacity?

Acting without a capable person's consent constitutes assault and battery[1]. On the other hand, if a person lacks the capacity to make a health care decision, doctors have a legal and ethical duty to act in the patient's best interests and to safeguard his or her well-being. Failure to do so constitutes negligence or a failure to perform professional duties[2]. It is therefore important for doctors to determine if the patient has mental capacity.

What constitute a valid consent?

Patient must be appropriately informed about the meaning and effects of the treatment proposed to him or her. He or she needs to have the mental capacity to make that decision and should be able to make the decision voluntarily and free from coercion[3].

It is necessary to give all relevant information to our patients, in manageable pieces, with the use of simple language, visual aids and non-verbal means if indicated. Hearing or visual impairment should be corrected and language barrier should be compensated with formal translator or relatives to assist communication. Adequate time should be given for the patient to understand and digest the information provided. The patient should also be allowed to communicate his or her decision freely and with the help of speech therapist for those with expressive dysphasia or a sign language interpreter if needed[4].

Who should assess capacity?

This is usually done by the doctor who proposes a treatment for the patient. Any doctor can do the assessment. Psychiatrists would be consulted to do the assessment for complex cases or when it is doubtful regarding the mental fitness of the patient[5].

When capacity assessment should be made?

When a patient displays risk factors for impaired decision-making such as having a psychiatric diagnosis, extreme of age, abrupt change in mental state or behaviour and when the decision made not only contradict to what most people would choose but also appears to contradict that individual's previously expressed attitude, capacity assessment should be made[4].

How to assess mental capacity?

Sometimes psychiatrists will encounter consultation referrals just asking if the patient is mentally fit to give consent, without indicating the medical procedure needed. Mental capacity to give consent is decision-specific[6]. We need to assess specifically about the patient's understanding of a particular treatment. It is also time-specific[6]. In a patient with progressively deteriorating condition like dementia, there is a need to reassess his or her mental capacity if he or she is noted to have change in cognitive function.

Doctors should use a two-stage test of capacity which include the diagnostic test and the functional test[6].

When performing the diagnostic test, the doctor needs to assess if there is an impairment of or disturbance in functioning of the mind or the brain. This includes a range of problems such as psychiatric illness, learning disability, dementia, delirium, brain damage or even a toxic confusional state related to use of alcohol or drugs. If there is no impairment or disturbance, the person is deemed to have capacity. If there is impairment or disturbance, the doctor then needs to assess if it is severe enough to result in the person being unable to make the particular decision by doing the functional test.

When performing the functional test, the nature of the problem, the recommended treatment, its pros and cons, as well as alternative treatment and their pros and cons are explained to the patient in a simple nature so that they can understand. The ability to understand is related to intelligence and cognitive function and may also be affected by mental illnesses and severe anxiety. It's not uncommon when we are doing the assessment for mental capacity, the patients cannot tell us what the doctors have told them about the medical treatment proposed. It may be problem with their ability to retain the information, or they are not told anything about the treatment yet. If the doctor assessing for mental capacity is not the one who has explained the proposed treatment to the patient, it is a good practice that the assessor can be present when the treating team is explaining the proposed treatment to the patient so that he or she will know what has been told and assess if the patient can retain the information. If this cannot be arranged, the treating doctor should document clearly what is explained to the patient for reference of the doctor who will assess the mental capacity of the patient. Doctors have a duty to give appropriately full information of the treatment proposed, and the likely risks. Withholding information or misinforming a patient may make a refusal invalid.

The assessor should also ask the patient how the choice is reached with emphasis on the reasoning of the process, not the outcome of the decision. The assessor should decide whether the patient can manipulate the information logically and rationally and not affected by distorted cognition, abnormal belief and impaired judgment as a result of underlying mental illness like dementia, psychotic disorder, or depression. A depressed patient may still have relevant and coherent speech but his or her judgment may be affected by negative cognition and the wish to end his or her life.

If the impairment of or disturbance in functioning of the mind or the brain is temporary, the doctor should decide if the assessment can be delayed. The patient's condition may be fluctuating so care should be

taken to choose the best location and time for the assessment and decisions should be made during lucid period[6].

The assessor should record the information, findings, and reasons for his or her conclusion clearly in the patient's record[6].

Involvement of patients' family members for patients assessed to lack mental capacity

It is a good practice to involve patients' family members if the patients are assessed to lack mental capacity. Even though the family is not the legal guardian of the patient and unable to give consent on behalf of the patient, the family member is able to provide valuable information about the patient which will assist the treating team to decide what will be regarded as the best interest of the patient. This is important when the doctor has to provide treatment in that patient's best interest.

Mental capacity assessment specific to making an advance directive (AD)

Patient must be appropriately informed about the meaning and effects of an AD, which is the advance refusal of medical treatments and directions on the kind of life-sustaining treatments that should be withheld or withdrawn when he or she is no longer mentally capable of making health care decisions and when he or she suffers from the pre-specified conditions. The patient should also be informed he or she has the power to alter or revoke that AD later which can be done anytime as long as mentally capable and is not under undue influence. The definition of life sustaining treatments should be explained to the patient and doctors need to make sure the patient can appreciate the consequences of making or not making the decision, particularly if he or she refuses all "life-sustaining treatments". A valid advance refusal must be followed.

Witnesses required for AD for Hospital Authority (HA) AD forms

For HA AD forms, two witnesses are required in which one of whom must be a medical practitioner. It could be a doctor other than the one who is treating or has treated the maker of the AD. The presence of witnesses aims to reduce uncertainty and risk of arguments when AD eventually becomes applicable. Before signing as witness on the AD form, the doctor should be satisfied that the patient is mentally capable. AD without witness could still be valid as it's not mandatory under common law framework but may be prone to challenge[7].

When AD will be carried out?

AD will be carried out when patient has lost mental capacity to take part in decisions about medical treatment and when he or she suffers from the pre-specified conditions.

Conclusion

All doctors need to recognise the increasing importance of properly assessing the mental capacity of patients for treatment and other areas of decision-making. When a patient is deemed capable of consenting to or refusing a treatment, his or her wishes need to be respected. On the other hand, the doctor would be failing in the duty of care to their patients if he or she does not give treatment in that patient's best interest just because the patient lacks capacity to make a decision about the treatment.

Table 1 Necessary steps in doing a comprehensive mental capacity assessment

Step 1
Describe the decision that the person is making

Step 2
Record the persons consulted

Step 3
Support given to make the decision / maximize capacity

When still doubt about capacity after giving all practicable support, proceed to next step

Step 4
Perform the diagnostic test:

To assess if there an impairment of or disturbance in functioning of the mind or the brain (Including a range of problems such as psychiatric illness, learning disability, dementia, delirium, brain damage or even a toxic confusional state)

If yes, proceed to assess if the impairment or disturbance is sufficient that the person is unable to make the particular decision.

Step 5
Perform the functional test:

To assess if the patient can **understand** the information relevant to the treatment

To assess if the patient can **retain** the information relevant to the treatment (The patient only needs to retain the information long enough to make the decision)

To assess if the patient can **use and weigh** the information to come up with a decision

To assess if the patient can **communicate** the informed decision in an understandable form

If yes to all functional test questions, the person is considered to have capacity about this specific decision at this time

If no to any of the functional test questions, the person does not have capacity to make this specific decision at this time

Step 6
Record the findings and reasons to support the conclusion

Reference

1. Kennedy I, Grubb A. Medical Law. 3rd ed. London: Butterworths; 2000:575.
2. Kennedy I, Grubb A. Medical Law. 3rd ed. London: Butterworths; 2000:774-990.
3. Legal principles on informed consent. HAHO. (HAHO-COM-GL-LSD-001-v03) Updated in 2021
4. Wong JG & Scully P. A practical guide to capacity assessment and patient consent in Hong Kong. Hong Kong Med J 2003;9:284-9
5. Wong MMC & Yiu MGC. Assessment on mental capacity to give consent in general practice - what doctors need to know: who, when and how. 2020. HK Pract ;42:38-42
6. Keene AR. (2015) Assessment of Mental Capacity: A Practical Guide for Doctors and Lawyers, 4th Edition. Law Society Publishing
7. Guidance for HA Clinicians on Advance Directives in Adults. Version 4. HA Clinical Ethics Committee

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Update from the Working Group on Genetics and Genomics (G&G)

Dr Maureen Mo Lin WONG
Co-Chairman
Working Group on Genetics and Genomics

"Genetics and Genomics (Medicine)", was finally approved as a new specialty by the Hong Kong Medical Council in December 2022!

Invitation letters have recently been sent out to all our college Fellows; Those who have interest and the necessary competence may apply as grandfathers (First Fellows) in Genetics and Genomics (G&G). The application deadline is set at 31 July 2023. Three domains will be assessed viz. (1) Relevant clinical experience in G&G (Must be at least 4 years); (2) Professional recognition; (3) Contribution to G&G research and publication. A four-member assessment board has already been formed in this connection, and we are eager to grandfather our first fellows in G&G before the end of this year, so as to jumpstart our formal training. Meanwhile, an interim specialty board in G&G with a chairman and a secretary has also been set up to do the needful.

To add to the good news, with Dr SV Lo and Prof Philip Li pulling thread, our College managed to receive a generous donation from the **Hong Kong Genome Institute** (HKGI) to support our Fellows and Trainees working in public healthcare institutions to have further training in G&G.

There are two kinds of support, either to Fellows and Trainees, or to their Clinical Departments. The first category aims to provide monetary support to Fellows or Trainees who aspire to have **overseas training** in G&G, yet the total training duration afforded by the department entails a period of **unpaid leave**. In a nutshell:

- For a total training duration of more than or equal to one year, with 6 months or upwards of unpaid leave, the ceiling of sponsorship is HKD $500,000.
- For a total training duration of more than or equal to 9 months, with 3-6 months of unpaid leave, the ceiling of sponsorship amount will be halved at HKD $250,000.

The second category will be in form of a **training grant** to the clinical department concerned. It will serve as a relieving fund to cover the Personal Emolument costs to support selected Fellows or Trainees to have a 3-month placement under the HKGI to participate in the Hong Kong Genome Project. The department can then use such fund of HKD $350,000 to pay part-time posts, or find temporary employment to maintain its service.

There will soon be announcement of the application details of the above HKCP-HKGI Overseas Training Scholarship or Training Grant for Excellence in Genomic Medicine (2024/2025) in June 2023. News will be disseminated to department heads of public institutions and posted on our College website. Fellows who have interests to apply may start to plan ahead - to obtain initial approval from the prospective training sites, department heads and the interim specialty board in G&G. Of note, awardees of overseas scholarship are expected to remain and serve in the public institutions for no less than 12 months after completion of overseas training.

Finally, with the concerted efforts from all Fellows, Trainees and patrons, we hope our tree of knowledge in Genetics and Genomics can plant deep, with full awareness of good and evil or ethics when it grows to blossom and bear fruits!

Joint Scientific Meeting 15 -16 October 2022

The Joint Scientific Meeting with the Royal Australasian College of Physicians was held successfully on 15-16 October 2022, in a hybrid format.

The highlights of the event included the prestigious named lectures. Prof Donald Li, Chairman of the Elderly Commission, delivered an insightful talk on “Primary Care in Hong Kong - Another 30 Years?”. Prof John Wilson, Immediate Past President of the Royal Australasian College of Physicians, presented the AJS McFadzean Oration on "The Medical Implications of Climate Change in the Asia-Pacific Region”. The Sir David Todd lecture was delivered by Dr Ko Ho on “Paving the Way for Disease-Modifying Therapeutics with Translational Neuroscience”, while Dr Elaine Chow presented her work on “Advancing Personalized Medicine in Diabetes - Old Drugs to New Technologies” as the winner of the Richard Yu Lecture. The event was a great success with valuable insights shared by notable experts in the field.

35th Annual General Meeting
24th Congregation

On 15 October 2022, the College organised a Conferment Ceremony in a hybrid format, with both live and online elements.

The Congregation was graced by the presence of the Secretary for Health, Prof Lo Chung Mau and the Director of Health, Dr. Ronald Lam. As a token of appreciation for their contributions to the College over the years, outgoing Council Members were presented with souvenirs during the ceremony.

Symposium 1

Dr Chan Tak Yeung

Prof Ivan Hung

Prof John Wingate Simon

Symposium 2

Prof Allen Kwan-chee Chan

Symposium 3

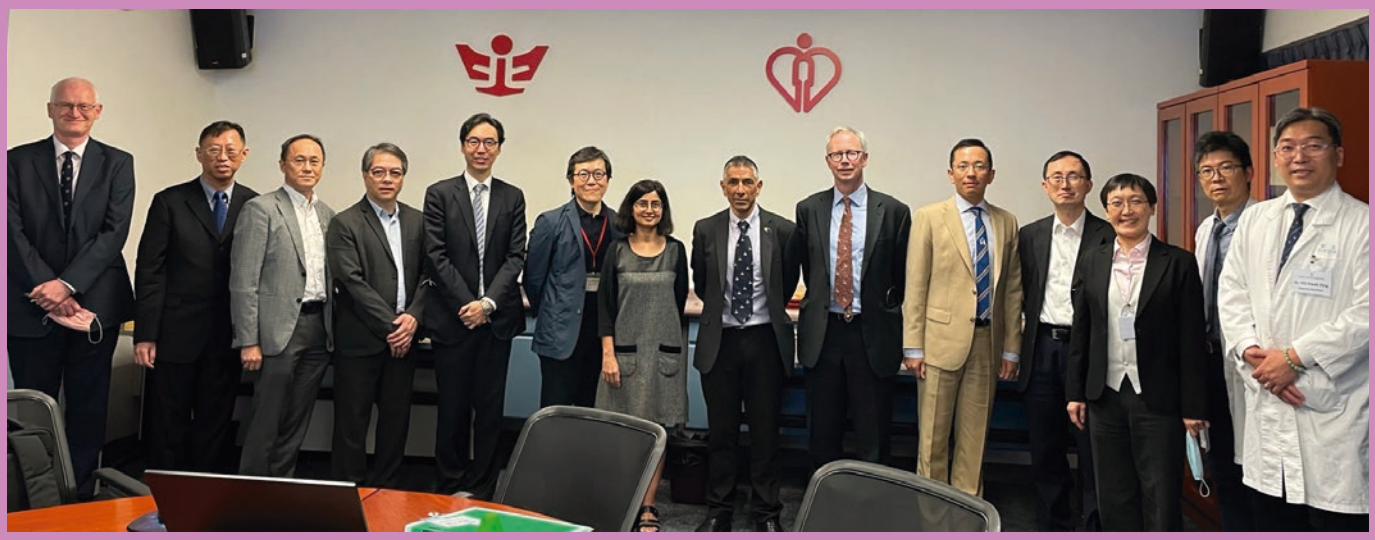
Prof Andrea On-yan Luk

Prof Wai-keung Leung

Dr James Shaw

PACES March 2023

The March PACES was held successfully from 20-25 March 2023, marking the first occasion of UK examiners' participation in the examination after the COVID-19 pandemic. The Chair Examiner, Prof Sunil Bhandari, presented the new format of PACES, which will be implemented in October 2023, at the examiners' meeting held on 19 March 2023. A joyful dinner was hosted for the UK examiners after the examination, and they all had a good experience in Hong Kong.



RCPE Roll-signing Ceremony 24 February 2023

Prof Andrew Elder, President of the Royal College of Physicians of Edinburgh, made a visit to Hong Kong in February 2023. The Edinburgh College organised a Roll-signing ceremony on February 24th. The event was well attended and approximately 100 newly admitted Edinburgh Fellows in Hong Kong signing the Roll at the Academy Building.

AJS McFadzean Oration 15 October 2022

The Medical Implications of Climate Change in the Asia-Pacific Region

Prof John WILSON
Immediate Past President
Royal Australasian College of Physicians

Prof Philip Li presented the AJS McFadzean Oration medal to Prof John Wilson who was online.

The news today is replete with stories of floods, soaring temperatures, bushfires and overwhelming evidence of a change in the pattern of our weather. Newsfeeds bring us views of world leaders at the Congress of the Parties (COP 27) recently held in Egypt now engaging the topic that has been a social and political 'hot potato'. Since the COP proposed a strategic goal of limiting global warming to less that 1.5°C above pre-industrial levels by 2030, there is a target and not just a vanishing end-point. We now know that greenhouse gas emissions have increased by 60% in the past 30 years (see https://news.un.org/en/story/2022/04/1115452). Some time ago, the greenhouse effect (see https://www.ipcc.ch/site/assets/uploads/2018/03/ar4-wg1-chapter1.pdf) as a potential cause for global warming (now climate change) was a debate. That is over.

Thinkers in this space have now moved on to the real question: 'What are we going to do about it?'. Whether optimist (plenty of time) or pessimist (it's too late), as physicians we need to act now that we have a diagnosis.

The medical effects of climate change need to be separated from the phenomenon of particulate air pollution, although their aetiologies are common through the burning of fossil fuels and they may coexist.

The Asia-Pacific region is key and fundamental to the global response to climate change, accounting for more than 50% of the world's natural disasters in 2014 and the need for human response often all but outstripping first-line and defence force resources (see http://www.pwc.com/asiapacific).

Much of the evidence upon which we depend to create climate change policy is derived from one of the most extensive information catalogues ever assembled. The most recent report involved 260 authors from 67 countries. The Intergovernmental Panel on Climate change (IPCC) has provided these regular reports on different aspects of a rapidly moving front (see https://www.ipcc.ch/report/ar6/wg2/) that have themselves been the subject of summary reviews in eminent journals (see https://www.nature.org/).

We may well ask 'What have our political leaders done to address the signs of climate change?' Other than the IPCC reports and COP aspirational targets, there is growing interest in global league table of policy development (see https://climateactiontracker.org/countries/).

Whether or not we are able to control the beast, as physicians we must be prepared for the consequences that will affect our community. The IPCC 6th Report details with 'high confidence' that specific conditions will increase (see https://www.ipcc.ch/report/sixth-assessment-report-working-group-ii/). These include vector-borne and water-borne diseases, malnutrition, mental disorders and allergy-related illness (particularly in the Asia-Pacific region). Increased temperature will bring with it higher all-cause mortality related to circulatory, respiratory, diabetic, infectious and infant illnesses.

Modelling presented in the IPCC 6th Report estimates changes at various levels of temperature rise by 2030. At the target limit of 1.5°C, it is estimated that biodiversity will fall by 14% (ie there will be extinction of species), 0.95 billion people will be affected by drought, rice yield will fall (primarily due to pests and disease), areas of burnt land attributable to fires will rise by 40-54% and that the sea level will rise by 0.28-0.55m. In addition, shortages of food (and ironically water) as well as forced migration will inevitably lead to conflict situations with health consequences.

But there may be a solution. The big 3 are the essentials for reform, as they are in general terms in the health sector (Wilson, J. Respirology 2022;27:786-787). They are appropriate resourcing, back-to-basics policy generation and leadership. The NHS has already made a commitment to a greener future that shows it can be done (see https://www.england.nhs.uk/greenernhs/a-net-zero-nhs/). At a personal level, we can all make a change today that will improve our chances.

Gerald Choa Memorial Lecture 15 October 2022

Primary Care in Hong Kong – Another 30 years

Prof Donald Kwok Tung LI
Chairman
Elderly Commission

I am indeed honored to be invited to deliver this prestigious lecture especially with many predecessors being my respected teachers and colleagues.

I have chosen to speak on Primary Care development in Hong Kong having waited for its evolution for 30 years and have been involved in doing a lot of research, work on primary care development in Hong Kong, mainland and globally.

We are experiencing challenges on our health systems as we face different infectious diseases such as SARs, MERS, Influenza, COVID 19 and of course anti-microbial resistance.

Rapid ageing of the population and the predominance of chronic NCDs are placing increasing pressure on our clinical practice. For countries with ageing populations, while people are living longer – which is good – they are doing so with often multiple chronic conditions which require ongoing management.

The World Health Organization WHO made a visionary declaration that primary care was the key to Health for all in Alma Ata 40 years ago. This set the scene for international efforts to promote primary care and formally acknowledged the pivotal role of a strong primary care systems. I had the privilege to be at the launch on 22nd October 2018 when every nation of the world signed up to the Astana Declaration, which offered a new commitment to making comprehensive primary care available and accessible to all.

Irrespective of WHO using newly coined phrases such as 'Universal Health Coverage' and 'Integrated Person-centered Health Services', what Astana promised was comprehensive primary care for every single person in the world.

The road to Universal Health Coverage was never going to be a straight one. If it had been easy to achieve, it would have been achieved long ago! Many countries strived to develop or strengthen their primary care systems and recognize the key role of primary care as the foundation of effective healthcare systems. Primary Healthcare (PHC) of the 21st century should include: NCDs and aged care, but is equally pertinent for maternal and child health, mental health, and injuries.

Primary Healthcare need to include population and individual interventions providing a full continuum of care - with continuity - and through a life course approach with an emphasis on patients, families, and communities, that is person-centred, supporting families, and offering a sense of care and security.

Primary Care should be a pivotal point

- between population/community and individual care
- between prevention and treatment/treatment and rehabilitation
- between health and social sector care
- between health care and individual care

There needs to be community engagement, advocates for the health of communities, and supports community actions on health.

No one could have predicted the COVID 19 pandemic. Circumstances now require us – all of us – to recalibrate, to refocus on what Universal Health Coverage or Health For All should look. Action and implementation are crucial. Even more crucial is political commitment.

There is no doubt that the pandemic has had a huge impact on all of our lives: both professional and personal. It has also had a huge impact on how we deliver primary care with challenges to providing continuous, comprehensive, coordinated, accessible care. Despite the huge challenges, primary care continued to be delivered in a different way, by adapting and being flexible about how we clinically manage patients and their conditions.

Adapting quickly, to meet the ongoing needs of patients, as part of a recalibration, we needed to reflect on the new ways of operating and sift through them to ensure that we are developing best practice for future models of primary care delivery.

'In developing or strengthening Primary Care as an impetus for improving health system performance, it is important to consider a variety of national contexts that greatly influence options for health policy development.

Careful assessment of each nation's economic, political, and social conditions, and epidemiological patterns of disease, will allow leaders to select appropriate health policy strategies, and to determine the resources necessary for Primary Care to grow and contribute to health system improvements.'

I would like to present to you the components of a good family medicine strategy – and therefore of a good primary care strategy.

You have heard these and know these, but it is worth reminding ourselves about what the important features are of a good primary care system.

- Caring
- Clinically competent
- Continuity of care
- Comprehensive care
- Cost effective care
- Coordination of care
- Common problem management expertise
- Community based care and research
- Communication and counselling skills of high standard and
- Continuing Professional development

These are part of our professional lives. We may not always meet all the standards all of the time. But we know what it is we aspire to – and we know what is globally possible to achieve, if the appropriate political levers can be exerted.

Primary Healthcare development in Hong Kong

- With longer life expectancy, we need better health. Our health system in Hong Kong is highly treatment-oriented and the public healthcare system (especially our Hospital Authority) is over-burdened. A healthcare system where the most rapid population ageing is coming in the upcoming decade, is vulnerable and its sustainability is threatened. There is a pressing need to review the health system to promote and protect people's health and well-being

So what has been achieved over the past 30 years?

The document "Your Health, Your Life" March 2008 was published and a working Group on Primary care chaired by the secretary of food and health aimed at developing basic models for primary care services, improving quality of Primary Care delivered in the public sector and establishing public Primary partnership. Eventually a Family Doctor register was also established to recognize those committed to deliver quality primary care medical services.

A Primary Care Office was also set initially under the department of Health.

During the 2017 Chief Executive policy address - a steering committee on Primary Healthcare development was established to formulate strategies and tasked to comprehensively review the existing planning of PHC services and devise service models to provide PHC services through medical-social collaboration model at the community level.

The VISION FOR THE PRIMARY HEALTHCARE SYSTEM in Hong Kong is a Shift of healthcare focus from curative treatment to the prevention of diseases and disability necessary for addressing the new challenges to our healthcare system brought about by an ageing population and increase in chronic disease prevalence.

The commitment is the establishment of district-based primary healthcare services.

Services of the District Health Centre (DHC) include the provision of prevention-centric primary healthcare with services spanning across primary, secondary and tertiary prevention level, which include health promotion and education, health risk factors assessment.

Currently there is screening for diabetes mellitus (DM) and hypertension (HT), chronic disease management and community rehabilitation through district-based medical- social collaboration and public-private partnership (PPP).

DHCs are operated by non-governmental organizations (NGOs).

DHCs in Kwai Tsing, Sham Shui Po and Tuen Mun were open in September 2019, June 2021 and May 2022 respectively, DHCs in Wong Tai Sin, Southern, Yuen Long and Tsuen Wan districts will progressively commence operation within this year. To maintain the momentum for promoting primary healthcare, DHC Expresses have been set up in 11 districts pending the establishment of full-fledged DHCs.

The Steering Committee of Primary Care has produced A Primary Care blueprint soon to be released containing five components addressing:

Firstly, to Establish a district-based, family-oriented community primary healthcare system District Health Centres will be a primary healthcare hub to support primary healthcare doctors

- More Public Private Collaboration will be encouraged
- There will be more Medical Social Collaboration
- The positioning of Public Out-patient Services will be Reviewed

The Second component is the Strengthening of primary healthcare governance;

- A Primary Healthcare Authority is proposed to be established with a function to coordinate services strategically, manage resources, and formulate service standards and quality assurance mechanism.
- The function of the Primary Care Directory is expected to be enhanced

The Third component is to utilize private healthcare services and improve the financing of primary healthcare services;

- Current government subsided primary healthcare services such as Vaccination subsidies, elderly healthcare vouchers, Public private partnership etc. will be reviewed.

The Fourth component is the Reinforcing of manpower and training of primary healthcare personnel.

- Primary Healthcare Manpower Training will be strengthened with more utilisation of Allied Health Professions.
- There will be engagement of the services of Chinese Medicine Practitioners and Community Pharmacists

The Fifth component is the Enhancing of health surveillance and sharing of health records

- The function and coverage of the Electronic Health Record Sharing System eHRSS will be enhanced and expanded.
- There will be more Big data and Artificial Intelligence research projects utilizing the Hospital Authority's Big Data Analytics Platform
- A Hong Kong population-based health database is planned

Piecemeal development will not achieve the goal, especially when it is not supported by professional development of primary care team members such as family doctors. We need a quantum shift in emphasis towards creating the platform for delivering comprehensive primary care for everyone.

Although Primary Care providers from differing professions share the same vision, we too often fail to identify and utilise the potential for synergy that our collaboration offers.

As the number of professions within Primary Care increases, there is risk of withdrawing into separate silos, replicating the fragmentation we'have observed within our Secondary Care specialties?

Such fragmentation may create competition among Primary Care professionals

There is competition for status, such as some of our Primary Care profession are hailed for providing the best care and compete for resource allocation.

The bigger and more complex the local health system becomes, the more likely professional competition and protectionism become.

Then, instead of joining forces, we risk leaving the patient in the crossfire of our professional interests.

That won't serve the well-being of our patients, of our professions, or of ourselves.

Enhanced Primary Care Services

I would like to share some thoughts on future Primary Care in Hong Kong. I think there are 3 areas we should be looking into enhancing services. 1. Digital Health 2. Elderly Health and 3. Mental Health

Digital Health

Not everything will survive a return to relative normality after the Pandemic. But some of those adaptations will resonate and will improve the service we can offer to our patients. The increase in video consultations and telephone consultations will almost certainly continue. They will not, of course, replace in-person, face to face, consultations. But for some doctors and some patients, online consultations will be welcome and will provide a more efficient way of addressing minor and ongoing health concerns. They also offer a way of **starting** a consultation, from which a face-to-face consultation may follow, if necessary, with a family doctor or an appropriate member of the primary care team.

Advances in technology can impact on the provision of online healthcare, providing solutions to present difficulties and challenge but can also create further legal, ethical, and social concerns.

Technology can provide solutions by aiding doctors in making better diagnoses at a distance and have proven valuable during the COVID19 epidemic.

The medical profession will need to consider how they can best adapt to Internet practices using technology, policy and legislation, and consumer education, to adequately protect the patient.

Any adaptation, however, should not lower the established medical standards and hence put patients at potential risk.

The need to protect consumers from the potential harmful consequences of online consultations should be a core principle, guiding the conduct of all commercial entities.

Elderly Health

The greying of nations is a common observation which will have impact on health systems.

Rising health care costs and the need for care to be more réhabilitation and care-oriented, than curative, will be the challenges for the near future.

Chronic health conditions are among the most common causes of mortality and morbidity in all countries around the world.

Developing countries are expecting to suffer increasingly from these conditions.

In aging populations, we can assume an accumulation of different chronic conditions, which lead to co-morbidity, polypharmacy, and increased health expenditures. The family physician needs to deal with this new problem.

The availability of age-friendly services and the provision of social and care giving services in the community is often scarce.

Our Vision is to see a universal gold standard of care for the elderly by primary care in collaboration with all interested disciplines and stakeholders involved. The Family Doctor should take the lead.

Reference frameworks have been developed and should be put to use by the primary care team at District Health Centres.

Mental Health

Multi-morbidity is a common phenomenon in primary care

- Providing preventive interventions in the primary care setting may improve early detection and treatment of mental health problems, especially for people with multiple chronic conditions who are at a higher risk for developing mental health problems.
- The Family Doctor can also address mental, physical and social aspects of care at the same time, addressing mental health symptoms in the context of social life stress and distress in patients using the bio-psycho-social model rather than strictly adhering to the medical model.
- Medically unexplained symptoms (MUS) are one of the common presentations in primary care
- Many of these patients also suffer from mental health problems and it makes primary care the ideal setting to treat their co-morbid mental health problems.
- Patients often have continuing relationships with their Family Doctors. Treating mental health problems in primary care may make it less stigmatising for patients and the long-term relationship with Family Doctors may make patients more willing to disclose their mental health issues to their primary care providers.

Reference frameworks have been developed and should be put to use by the primary care team at District Health Centers.

Challenges

So how should we run an effective primary health care system / district health center in Hong Kong?

QUESTIONS to have to be answered will be:

WHAT DOES THE PUBLIC WANT?

WHAT CAN BE OFFERED?

How do we alter the public's health seeking behavior?

HOW DO WE continue to KEEP THE PATIENT OUT OF THE HOSPITAL?

What are the incentives for providers as well as recipients of services?

How can we maintain Financial Sustainability?

I hope I can leave these questions to be answered by a forthcoming Primary Care Authority.

CONCLUSION

To conclude: There can be no Health for all or Universal Health Coverage without comprehensive primary care. There can be no comprehensive primary care without policies that support the development.

Many Frontline Doctors and healthcare workers have been promoting and delivering in Hong Kong.

Now, thirty years later, our Chief Executive, Health Secretaries, policy makers, politicians need to catch up.

I would like to pay tribute to my late father
Henry F K Li
a good friend of Prof Gerald Choa and
Forefather of Family Medicine

SIR DAVID TODD LECTURE
15 October 2022

Paving the Way for Disease-modifying Therapeutics with Translational Neuroscience

Dr. Ho KO
Department of Medicine & Therapeutics,
Prince of Wales Hospital
The Chinese University of Hong Kong

Devising strategies to extend healthspan is one of the Holy Grails of scientific challenges. The central nervous system (CNS) plays pivotal roles in the aging process. On the one hand, aging is the strongest risk factor for neurodegenerative diseases. On the other hand, neurons and glial cells in the brain may coordinate aging-related responses both in the CNS and in the peripheral organs. In this lecture, I intend to give an overview of a translational neuroscience approach to studying aging and neurodegeneration.

While cellular pathways related to numerous molecular targets (e.g., mTOR, NAD and sirtuin) are widely studied to guide the development of primary preventive therapeutics for a range of age-related disorders, we propose a new glucagon-like peptide-1 (GLP-1)-centered approach, with an emphasis on the extension of healthspan over lifespan extension. The foundation for targeting GLP-1 signaling to modulate aging roots from hints from prior clinical studies, as well as our recent discoveries. Specifically, we showed that systemic treatment with a glucagon-like peptide-1 receptor agonist (GLP-1RA) can remarkably reverse the transcriptomic aging signatures in many brain cell types in a genome-wide manner. Importantly, the age-related expression changes reversed by GLP-1RA treatment are functionally associated with a reduction in blood-brain barrier (BBB)

leakage and microglial priming – two functional changes that increase the susceptibility to neurodegeneration with age.

Our works provided a new mechanistic perspective for the potential applicability of GLP-1RAs in the treatment of age-related cerebrovascular and neurodegenerative conditions. The most direct clinical implication is that cerebral small vessel disease (cSVD), a devastating condition with strong neurovascular aging component and the second commonest cause of dementia, may be treatable by GLP-1RAs. It also provided the proof-of-principle that at least some components of the molecular and functional aging of the nervous system are readily reversible with a practical pharmacological approach, paving the way to primary preventive trials for other neurodegenerative conditions. With further ongoing works in the lab, we continue to investigate gliovascular dysfunction in aging and neurodegeneration, in the pursuit of identifying (or narrowing down) therapeutic approaches worth being tested in clinical trials.

RICHARD YU LECTURE
16 October 2022

Advancing Personalised Medicine in Diabetes: Old drugs to new technologies

Dr Elaine Yee-kwan CHOW
Department of Medicine & Therapeutics
Prince of Wales Hospital
The Chinese University of Hong Kong

We are entering an exciting era where rapid advances in genomics, metabolomics, novel therapies, and digital tools have the potential to transform diabetes care. Personalised medicine promises to deliver better outcomes for the individual, for targets that are personalised, and ultimately improve health at the population level. Unlike oncology, there are probably few true examples of “precision medicine” in a polygenic disorder such as diabetes, with the exception of maturity-onset diabetes of the young (MODY). Here, we recently found that a novel, dual-acting allosteric glucokinase activator (GKA) can restore glucose-sensing in a specific form of MODY characterised by inactivating glucokinase mutations. However, for the majority of patients with type 2 diabetes, they fall into a heterogenous group that exhibit variable responses to glucose lowering drugs. Some of the variation may be genetically mediated, for example, we identified CYP2C19 loss-of-function polymorphisms which are common in Chinese were associated with lower risk of sulfonylurea treatment failure. But a significant amount of variation cannot be explained by genetics. There is ongoing work to sub-phenotype and understand interactions between diet, body composition, microbiome and response to interventions.

Personalised care needs to be aligned with the priorities of the person with diabetes. As healthcare professionals, we need to account for psychosocial factors and recognise the environmental contexts influencing a patient’s lifestyle choices. With the rapid growth of rapid growth of mobile apps, wearables

such as continuous glucose monitoring (CGM), clinicians can gain more comprehensive insights into daily glucose profiles and relationships to treatments and behaviours. We will describe some opportunities and challenges in applying CGM data to tailor diabetes interventions.

There has been a major paradigm shift towards personalisation of glucose-lowering drugs based on cardiorenal risk rather than glucocentric measures. Landmark trials of sodium-glucose co-transporter 2 inhibitors (SGLT2is) showed significant reductions in of cardiorenal events and death, heart failure hospitalisations, independent of glucose lowering. Yet, in our recent territory-wide survey in Hong Kong, only 2.3% of patients with chronic kidney disease and 5.7% with heart failure were on SGLT2is. Following a decade progress, we have seen a stagnation in glycaemic outcomes in the past 5 years despite increasing use of newer drugs in Hong Kong. We will discuss future opportunities to implement personalised medicine at a structural level via integration of big data analytics and predictive tools within electronic medical records (EMR).

BEST THESIS AWARD
Gold Award Winner

Secular Trend of Treatment Uptake in Patients with Chronic Hepatitis B – a Territory-wide Study of 135,395 Patients from 2000 to 2017

Dr. Che-to LAI
Department of Medicine & Therapeutics,
Prince of Wales Hospital

Background and Objectives

The World Health Organization targets for reduction of incidence and mortality of chronic viral hepatitis by 90% and 65% respectively by 2030, and antiviral treatment is crucial to lower the mortality. Yet, antiviral treatment uptake for patients with chronic hepatitis B (CHB) has been suboptimal. We aimed to evaluate the secular trend of treatment uptake in the CHB cohort in Hong Kong from 2000 to 2017 and the factors for no antiviral treatment despite meeting treatment criteria.

Methods

This was a territory-wide registry cohort study with CHB patients under the public healthcare system identified through the Clinical Data Analysis and Reporting System of the Hospital Authority. Demographics, clinical data and laboratory parameters were retrieved. Antiviral treatment indications were defined by the Asian-Pacific guidelines published at the time of patients' CHB diagnosis in four periods: 2000-2004, 2005-2009, 2010-2013 and 2014-2017.

Results

135,395 CHB patients were included; 1493/12472 (12.0%), 7416/43426 (17.1%), 10129/46559 (21.8%), 8051/32938 (24.4%) patients

fulfilled treatment criteria in the four periods respectively. The treatment uptake rate increased from 35.1%, 43.4% and 60.2%, to 68.6% respectively. High serum liver fibrosis indices (APRI, FIB-4 and Forns indices) were the dominating factors (>90%) for treatment indication in non-cirrhotic patients, in which less than 60% received antiviral treatment. Age ≤50 years, female gender, normal platelet count and serum alanine transaminase level, negative hepatitis B e antigen and serum HBV DNA ≤2,000 IU/l were factors associated with no-treatment among those fulfilling treatment criteria.

Conclusion

Treatment uptake rates have been increasing over time, yet suboptimal. Advanced liver fibrosis is an area commonly overlooked for antiviral initiation despite apparently normal biochemical and virologic results. The importance to identify non-cirrhotic patients with advanced liver fibrosis should be stressed.

BEST THESIS AWARD
Silver Award Winner

Changes in the Epidemiological Landscape and Outcomes of Acute Promyelocytic Leukaemia over the Last Three Decades in Hong Kong

Dr. Carmen Yu-yan LEE
Department of Medicine,
Queen Mary Hospital

Background

Acute promyelocytic leukaemia (APL) arises from t(15;17)(q24;21) and PML-RARA gene fusion. We have formulated an oral preparation of arsenic trioxide (oral-ATO) and shown that it is efficacious for newly diagnosed and relapsed APL. Oral-ATO is available at significantly lower costs and offers the prospect of an economical and out-patient-based therapy. In this study, we aimed to define the epidemiological landscape of APL in Hong Kong, and to evaluate the outcome of APL treated with all-trans retinoic acid (ATRA)-chemotherapy-based regimen and oral-ATO-ATRA-based regimen.

Methods

We conducted a retrospective study of all children and adults diagnosed with APL from 1 January 1991 to 31 March 2021. Data were censored on 30 November 2021. The primary outcomes included the incidence of APL, early deaths and overall survival (OS). The secondary outcome was the incidence of second cancers. This study was approved by the Institutional Review Board (IRB) of the University of Hong Kong (HKU) and formed part of the Acute Promyelocytic Leukaemia Asian Consortium (APLAC) Project (ClinicalTrials.gov identifier: NCT04251754).

Findings

Between 1 January 1991 and 31 March 2021, 751 (364 men, 387 women) patients with a median age of 44 (range: 1-97) were diagnosed with APL in Hong Kong. The overall incidence rate of APL in Hong Kong was 0.32 per 100,000 population per year.

469 (62.5%) patients received conventional ATRA-chemotherapy-based induction, consolidation and maintenance of CR. 282 (37.5%) patients received oral-ATO-ATRA-based induction and/or maintenance of CR1 as part of clinical trials. 71 patients in the oral-ATO-ATRA group were treated with a chemotherapy-free

regimen from January 2018 to March 2021, for which the induction phase entailed a 21-day hospitalization, whereas consolidation/maintenance was entirely out-patient.

After a median follow-up of 75 (interquartile range: 14-161) months, there were 271 (36.1%) deaths. 144 (53.1%) of all deaths were early deaths within the first 30 days of admission. The 5-year and 10-year OS were 68.1% and 63.3% respectively. On multivariate analysis, men (P=0.02), age >50 years (P<0.001), leucocyte count at presentation ≥10 x 10^9/L (P<0.001), and ATRA-chemotherapy-based induction, consolidation and maintenance (P<0.001) were associated with significantly worse OS. Among the 282 patients receiving oral-ATO-ATRA-based induction and/or maintenance, the 5-year and 10-year OS were 91.5% and 84.6% respectively.

21 patients with APL developed second cancers during follow-up. There was no statistically significant difference in the incidence rate ratio of second cancers in patients exposed to oral-ATO compared with those who were never exposed to oral-ATO (incidence rate ratio: 2.14; 95% confidence interval: 0.89-5.17).

Interpretation

Frontline oral-ATO use in induction and/or maintenance of CR1 was associated with lower risk of early deaths and excellent long-term survivals. Furthermore, oral-ATO-ATRA-based therapy allowed shorter hospital stay and out-patient-based treatment, which could be particularly advantageous in the management of APL in the post-pandemic world. This study also highlighted the importance of surveillance for second cancers in a growing population of long-term survivors of APL.

BEST THESIS AWARD
Bronze Award Winner

Risk Factors and Outcomes of Metformin Associated Lactic Acidosis

Dr. Kit-ming LEE
Department of Medicine,
Queen Mary Hospital

Background and Objectives

Metformin associated lactic acidosis (MALA) is a rare (quoted 3-9/100,000 patient years) but life-threatening condition that results in significant morbidity and mortality. Patients suffering from MALA may require short-term or even long-term renal replacement therapy (RRT). There is, however, a paucity of data on the risk factors for developing MALA and the associated clinical outcomes.

Objective

We aim to investigate the risk factors for the development of MALA, and the short-term and long-term clinical outcomes after developing MALA in a Chinese population, managed in a tertiary referral center.

Research Design and Methods

Case control and case series studies were conducted. 62 MALA patients with acute kidney injury (AKI) from Queen Mary Hospital and 230 diabetic patients without history of MALA from outpatient clinics of Hong Kong West Cluster were recruited to the study. The primary outcome of the case control study was the association between MALA development and various risk factors. The association were assessed by stepwise multivariable logistic regression following cross-tabulation and univariable analysis. For the case series study, in-hospital mortality was the primary outcome. Overall mortality over different periods since MALA onset, renal recovery, progression to CKD or kidney failure, intensive care unit (ICU) and hospital length of stay, clinical presentation and triggers of MALA were the secondary outcomes for MALA in-hospital survivors. Kaplan-Meier method were employed to assess the 30-day, 90-day, and 1-year overall survival. Association between inpatient survival and prognostic markers were assessed by regression model following cross-tabulations and univariable analysis.

Results

AAdvanced age (P=0.008), low body mass index (BMI)

(P=0.005), lower baseline estimated glomerular filtration rate (eGFR) (P=0.041) and higher metformin dose (P=0.006) were associated with MALA development. In-hospital, 30-day, 90-day and 1-year overall mortality for the MALA cohort were 25.8% (n=16), 27.4% (n=17), 29% (n=18) and 33.9% (n=21) respectively. Amongst MALA in-hospital survivors (n=46), 82.6% (n=38) of them had full or partial renal recovery to chronic kidney disease (CKD) stage 3 or above. 10.5% (n=4) and 15.8% (n=6) of them progressed to CKD stage 4 and 5 respectively. The median time to reach CKD stage 4 and 5 were 1468 and 2046 days respectively. The median lengths of ICU and hospital stay were 4 and 9 days, respectively. The commonest presentations of MALA were gastrointestinal symptoms, reduced general condition and hypoglycemia. The most frequent triggers for MALA identified were hypovolemia, sepsis (predominantly from the biliary and urinary tract) and cardiogenic causes. The presence of pneumonia (P=0.017), higher oxygen requirement (P=0.016) and fewer RRT sessions (P=0.024) correlated with MALA mortality.

Conclusions

This study characterized Chinese MALA patients with AKI from a single tertiary center in Hong Kong. Age, BMI, eGFR and metformin dose correlates with the incidence of MALA. Pneumonia, oxygen requirement and RRT sessions correlates with mortality. Around one-third of MALA inhospital survivors in this cohort progressed into CKD stage 4 or 5.

Named Lectures and Awards in 2022

AJS McFadzean Oration:

The Medical Implications of Climate Change in the Asia-Pacific Region

Prof. John Wilson
Royal Australasian College of Physicians

Gerald Choa Memorial Lecture

Primary Care in Hong Kong – Another 30 Years?

Prof. Donald Kwok-tung LI
Elderly Commission, Hong Kong

Sir David Todd Lecture

Paving the Way for Disease-modifying Therapeutics with Translational Neuroscience

Dr. Ho KO
Department of Medicine & Therapeutics,
Prince of Wales Hospital
The Chinese University of Hong Kong

Richard Yu Lecture

Advancing Personalised Medicine in Diabetes - Old Drugs to New Technologies

Dr. Elaine Yee-kwan Chow
Department of Medicine & Therapeutics,
Prince of Wales Hospital
The Chinese University of Hong Kong

Highest score in AIM

Dr Tze Long LEUNG

Dr Mingyao MA

Highest score in PACES

Dr Wing Yu FUNG

Dr Tin Yan LEE

Dr Lok Yi WU

Distinguished Research Paper Award for Young Investigators 2022

Dr Rex Wan Hin HUI

Department of Medicine, Queen Mary Hospital

Magnetic resonance elastography and proton density fat fraction predict adverse outcomes in hepatocellular carcinoma

Dr Chi-Ho LEE

Department of Medicine, Queen Mary Hospital

Circulating Thrombospondin-2 as a Novel Fibrosis Biomarker of Nonalcoholic Fatty Liver Disease in Type 2 Diabetes

Dr David Tak Wai LUI

Department of Medicine, Queen Mary Hospital

Kidney outcomes associated with sodium-glucose cotransporter 2 inhibitors versus glucagon-like peptide 1 receptor agonists: A real-world population-based analysis

Dr Ting Ting CHAN

Department of Medicine and Therapeutics
Prince of Wales Hospital

Fatty pancreas is independently associated with subsequent diabetes mellitus development: A 10-year prospective cohort study

Dr Ka Shing CHEUNG

Department of Medicine, Queen Mary Hospital

Use of Antibiotics during Immune Checkpoint Inhibitor Treatment Is Associated with Lower Survival in Hepatocellular Carcinoma

Young Investigator Research Grant 2022

The following doctors received a research grant from the HKCP to complete their respective projects as named. Selection was by a scientific panel headed by Prof David Hui.

The grant was established in 2012 to encourage young Fellows aged 40 or below to conduct research in Hong Kong. Up to eight grants of up to HK$80000 each are awarded annually.

Dr Ting Ting CHAN

Department of Medicine & Therapeutics, Prince of Wales Hospital

Fatty pancreas, chronic pancreatitis and pancreatic exocrine insufficiency: A 12-year prospective follow-up study

Dr Will Yap-Hang CHAN

Department of Medicine, Queen Mary Hospital

Re-Examining strict rate control with ivabradine trial in atrial fibrillation (RE-STRICT AF)

Dr Ka Shing CHEUNG

Department of Medicine, Queen Mary Hospital

Impact of gut microbiota on the treatment effect of empagliflozin on preventing fibrosis/ cirrhosis progression in nucleos(t)ide analogue-treated chronic hepatitis B patients with advanced fibrosis/ cirrhosis in a double-blind, randomized, placebo-controlled trial

Dr Winston Wing Shing FUNG

Department of Medicine & Therapeutics, Prince of Wales Hospital

Is apixaban 2.5mg daily a more suitable dose in patients with peritoneal dialysis? A pharmacokinetics analysis

Dr Wang Chun KWOK

Department of Medicine,Queen Mary Hospital

Longitudinal lung function assessment of long COVID discharged patient using self-administrable and portable electrical impedance tomography

Dr Che To LAI

Department of Medicine & Therapeutics, Prince of Wales Hospital

Prospective evaluation of a fast-track treatment pathway for patients with chronic hepatitis B under primary care

Dr Siu Ching LI

Department of Clinical Oncology, Prince of Wales Hospital, The Chinese University of Hong Kong

Preclinical study of D3S-001 Activity in KRAS G12C mutant cancer cell lines and patient-derived xenograft models

Dr William Chun Yin LEUNG

Department of Medicine, Queen Mary Hospital

Role of gut microbiome dysbiosis in drug-resistant epilepsy

Congratulations

Prof Ng Siew-Chien, recipient of the Richard Yu Lecture award of Hong Kong College of Physicians in 2020, was recently conferred the Croucher Professorship in Medical Sciences at the Chinese University of Hong Kong, and presented the inaugural Lecture at the Shaw College on 21 March 2023

Newly elected FRCP (Edin) July 2020 - May 2023

1 Dr Au Chi Sum
2 Dr Au Hon Da Kenneth
3 Dr Au Wing Chi Lisa
4 Dr Au Yeung Yick Toa Benjamin
5 Dr Chan Yin Yan Anne
6 Dr Chan Chung On
7 Dr Chan Wai Sze Fiona
8 Dr Chan Chi Wang Gary
9 Dr Chan Man Chun Jacky
10 Dr Chan Tsz Mim Jasmine
11 Dr Chan Chun Yin Johnny
12 Dr Chan Ka Man Carmen
13 Dr Chan Lip Kiong
14 Dr Chan Wai Man
15 Dr Chan Yu Hong
16 Dr Chang Li Li
17 Dr Chang Shek Kwan Richard
18 Dr Cheng Jen Ngai
19 Dr Cheng Ka Shing
20 Dr Cheng Yik Hon Marc
21 Dr Cheng Chi-Chung Vincent
22 Dr Cheung Pik Shan Alice
23 Dr Cheung Chun Yu
24 Dr Cheung Ka Shing Michael
25 Dr Cheung Wai Yin
26 Dr Chiu Ka Chun Patrick
27 Dr Chow Chi Kai
28 Dr Chui Shing Fung
29 Dr Fan Sin Ying
30 Dr Fung Bun Hey
31 Dr Fung Yan Yue James
32 Dr Fung Chi Yan Raymond
33 Dr Ho Chun Ming
34 Dr Ho Chup Hei
35 Dr Ho Kai Tin
36 Dr Hui Wai Man
37 Dr Ip Hing Lung
38 Dr Ko Lap Yan Ryan
39 Dr Kok Ying Lung Henry
40 Dr Kwan Chi Keung
41 Dr Kwok Hau Chung Jones
42 Dr Kwok Chun Kit Kevin
43 Dr Kwong Tsz Shan
44 Dr Kwong Wai Ki Vickie
45 Dr Lai Ka Wai
46 Dr Lai Tin Lok
47 Dr Lam Chung Yan
48 Dr Lam King Yun Joanne
49 Dr Lam Kwok Wai
50 Dr Lam Koon Ngai Philip
51 Dr Lam Cheung Chi Simon
52 Dr Lam Wai Sun
53 Dr Lau Yuk-lun Alexander
54 Dr Lau Wing Yun
55 Dr Law Mei Yan
56 Dr Lee Chi Ho
57 Dr Leung Hoi Sze
58 Dr Leung Howan
59 Prof Leung wai-hong Thomas
60 Dr Leung Yuk Wah
61 Dr Li Ying-wah Andrew
62 Dr Li Hei Philip
63 Dr Liu Hor Ming Edward
64 Dr Lo Ka-yip David
65 Dr Lo Fu Hang
66 Dr Lo Wai Ting Joyce
67 Dr Lock Ka Yuen Athena
68 Dr Lui Hoi Ki
69 Dr Lui Ka Luen Thomas
70 Dr Luk Ming Chi
71 Dr Luk Ngai Hong Vincent
72 Dr Luk Yan Yan
73 Dr Lun Chung Tat
74 Dr Ma Hon Ming
75 Dr Ma Yiu-keung
76 Dr Mak Lai Yee Karen
77 Dr Mak Kwok Shing
78 Dr Mui Chun Yue
79 Dr Ng Lai Yun
80 Dr Ng Sheung Ching Jeffrey
81 Dr Ng Tit-Kei
82 Dr Ozaki Risa
83 Dr Pang Yin Yu Shirley
84 Dr Poon Ka Yan Clara
85 Dr Poon Yin
86 Dr Shan Hok Shing Edwin
87 Dr Shum Chun Keung
88 Dr Sim Pui Yin Joycelyn
89 Dr Sin Wing Yin Winnie
90 Dr Soo Oi-yan Yannie
91 Dr Sze Shun Fung
92 Dr Tam Chor Cheung Frankie
93 Dr Tam Chi Chun Terence
94 Dr Tam Ho Kee Vicki
95 Dr Tang Hing Cheung
96 Dr Tsang Chi Yan
97 Dr Tse Man Yu Mona
98 Dr Tsui Sui Na Miranda
99 Dr Wong Lai Sze Alice
100 Dr Wong Chun Kwan Bonnie
101 Dr Wong Chit-wai
102 Dr Wong Sze Man Christina
103 Dr Wong Kwok Keung
104 Dr Wong Hang Hoi Michael
105 Dr Wong Ching Han Priscilla
106 Dr Wong Pui Yan Stella
107 Dr Wong Tin Wai
108 Dr Wong Wai Sheung
109 Dr Woo Kam Wing
110 Dr Woo Wai Shan Sandy
111 Dr Yeung Chui Yan June
112 Dr Yeung Sze Wai
113 Dr Yip Lai Kuen
114 Dr Young Pui Hong Terence
115 Dr Yu Chin Wing
116 Dr Yuen Pui Kei Ivan
117 Dr Zee Sze Tsing JonPaul

Newly elected FRCP (London) in first quarter of 2023

1 Dr Chan Chi Hey Heyson
2 Dr Chan Lung Tat Andrew
3 Dr Ho Tsz Ling
4 Dr Hwang Yu Yan
5 Dr Kwok Tsz Kin
6 Dr Lee Chi Yan
7 Prof Luk On Yan Andrea
8 Dr Luk Ka Hay James
9 Dr Mak Wing Yan
10 Dr Ng Chiu Ming
11 Dr Ozaki Risa
12 Dr Shea Yat Fung
13 Dr Tam Chi Chun Terence
14 Dr Wan Man Choi

Statistics on fellows and trainees in all specialties

Specialty	Number of Fellows	Number of Trainees
Internal Medicine	**1718**	**331**
Cardiology	319	46
Clinical Pharmacology & Therapeutics	9	2
Clinical Toxicology	5	0
Critical Care Medicine	120	17
Dermatology & Venereology	122	19
Endocrinology, Diabetes & Metabolism	137	25
Gastroenterology & Hepatology	241	30
Geriatric Medicine	223	27
Haematology & Haematology Oncology	92	10
Immunology & Allergy	8	0
Infectious Disease	53	9
Medical Oncology	56	11
Nephrology	167	15
Neurology	158	26
Palliative Medicine	40	9
Rehabilitation	66	9
Respiratory Medicine	226	20
Rheumatology	104	16

Updated as of 16 May 2023

Our dedicated instructors attending instructor workshop before the official launch of AMSC. From left to right: Dr L K Tsoi, Dr Germaine Chan, Dr Candy Kwan (Co-chair, AMSC workgroup), Dr Erica Leung, Mr Tacko Tsoi (Nursing instructor), and Ms Karis To who provided administrative support to the training course.

Contemporary Physician Training – Advanced Medical Simulation Course (AMSC) 2022/23

Dr Candy Hoi Yee KWAN
Co-chair, AMSC workgroup

In this era of digitalization, accessing knowledge is simply a touch of button. If one is curious enough, hardworking enough, and possess certain degree of internet literacy, it's not difficult for him to be "knowledgeable". But being "wise" is another story. Similarly, mere acquisition of medical knowledge is only the pre-requisite of being a physician. Being able to cite all the differential diagnosis of a symptom or name every feature of a rare syndrome is admirable but not quite exemplary nowadays, because with the advancement in technology, artificial intelligent (AI) could achieve all these more precisely than human in just a second. AI could even assist physician consultation by quoting guidelines from across specialty and provide relevant information for them to answer various clinical questions in real time during the consultation session.[1] Therefore, we are not just looking for physician with "great knowledge" but a "competent" physician. Such competency does not limit to their diagnostic and therapeutic skills which often reflects their ability to apply theoretical knowledge into patient management, but also derive from their proficiency in communication skills, professional attitudes, awareness of healthcare ethics during their practice, critical thinking, clinical reasoning and problem solving, team-work, organization skills, management skills, and even information technology skills.[2] In the past, we used to rely on apprentice-style model in medical education. We used to describe the acquisition of clinical skills among physicians as "see one, do one, teach one". This is superannuated and no longer considered acceptable because of the increasing concern for the quality and standard of medical care and patient safety.

We now believe that "mentorship" and "coaching" is more appropriate for post-graduate medical education. Compared with conventional lecture-based teaching, simulation-based training is

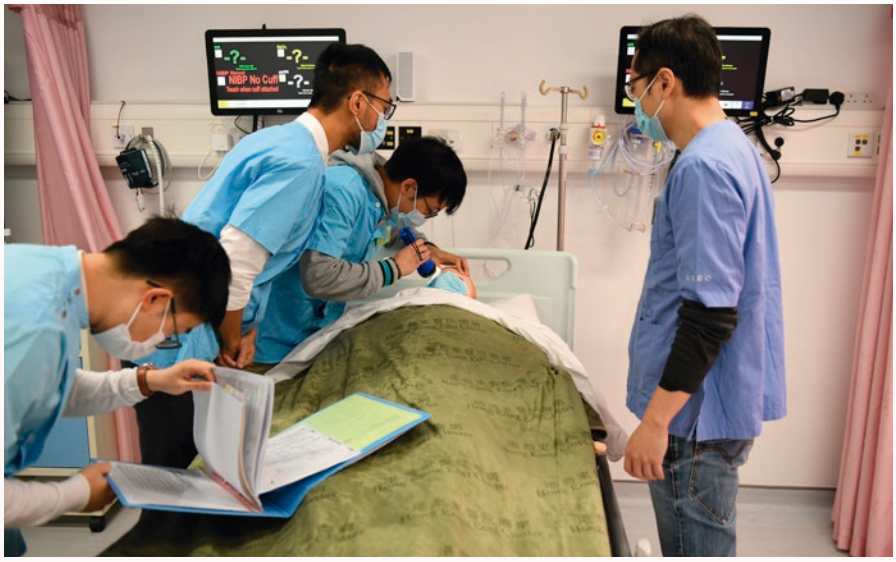
more effective in enhancing clinicians' competency, which could lead to improved patient safety and subsequently lower healthcare costs.[3] This is because medical simulation allows trainees to practise clinical skills deliberately using various high-fidelity simulation tools that mimic real patients and replicate clinical scenarios, without the fear of harming patients or any negative consequences if they erred or made mistakes. A trainee's learning experience and the degree of clinical exposure would not be limited by the availability of cases – which somehow could be quite coincidental and a stroke of luck. Debriefing by skilled simulation instructors after running a scenario helps providing constructive feedback to trainees, covering all the pre-set learning objectives ranging from recognition of a clinical problem to providing proper management, and from application of clinical guidelines to being able to response and react appropriately and professionally in a stressful situation. That forms the basis of Advanced Medical Simulation Course (AMSC) – to provide structural training to trainees to enhance their clinical competence through interactive problem-based learning and active participation in scenario-based simulation training.

Group photo taken on the last class of AMSC 2022/23 on 25 February 2023. We are honored to have Prof Daniel T M Chan, President of HKCP, to be our officiating guest and gave us a closing remark. First row, from left to right: Mr Tacko Tsoi (Nursing instructor), Dr Colin Lui (Chairman, AMSC workgroup), Dr Candy Kwan (Co-chair, AMSC workgroup), Prof Daniel T M Chan (President, HKCP), Dr Frankie Choy, and Dr L T Chan.

After the successful running of two identical pilot classes of AMSC last year, we reached another milestones of physician training development in Hong Kong in 2023 – the first time that AMSC was mandatory for all higher physician trainee (HPT) receiving Advanced Internal Medicine (AIM) and other broad-based subspecialty training. During the whole process of course development, all members of the AMSC workgroup always remind ourselves and emphasized that it should stand out from other BPT and HPT training activities by focusing on the bread-and-butter that is highly relevant to the everyday clinical duty of a HPT but yet seldom, or even not, being covered in any conventional training or fellowship examination. And we notably did. The eight identical classes held in February 2023 received very positive feedback and encouraging comments.

Inside the control room in Nethersole Clinical Simulation Training Centre, where technicians operate all kinds of high-fidelity simulation tool remotely while instructors observe participants' performance during scenario-based simulation training session. It is equipped with advanced audio-visual equipment to record the session for video-assisted debriefing immediately after the scenario. (From left to right: Dr Erica Leung and Dr Natalie Leung).

Many of them were impressed by the down-to-earth design of the course and the enthusiasm of all the instructors. One could imagine that we could never teach trainees everything in a one-day course, although it is already highly intensive and compact. In fact it is never realistic to expect every HPT to be fully competent after attending the class. Rather, we hope that they could be inspired and motivated – to endeavor life-long learning, to keep on practising and polishing their clinical skills, and most importantly, foster the mentality of striving for continuous improvement, with an ultimate aim of being a better physician in all aspects.



HPT actively participating in the scenario-based simulation training session, which provides a realistic and immersive experience in the context of different clinical settings that mirror real-life work.

An ambitious goal of AMSC is to aspire trainees to be not only a competent physician but also a capable trainer. Trainees are our future. HPT is a transition period from being a junior doctor to fellow. Very soon after they attained their fellowship, they would become trainers themselves and start supervising trainees. We therefore attempt to imbue them with the perception of being a senior staff in the medical unit, and apprehend the obligation to bear the corresponding responsibility. Through being a dependable supervisor, they could contribute in maintaining the high standard of medical care. We could not deny that a medical expert may not likewise be skillful in teaching, as the relevant skills for each are quite distinct. It would be sensible for us to begin arousing their interest and commitment in medical education early in their career life, so that they could start master the relevant skills and build the attributes that an effective supervisor should possess, as well as providing a positive learning environment to their juniors. We hope that through attending Core Medical Skill Course (CMSC) during their BPT and attending AMSC in HPT, these trainers-to-be would be influenced and willingly join our pool of instructor later in their career life. This is particularly crucial in ensuring the sustainability of our various training courses, so that they would be regularly replenished by energetic young trainers, always be bombarded with new ideas, and made physician training abreast of the times.

Yet, simulation training could never completely replace the traditional hands-on learning with real patients as well as lecture-based teaching. The sharing of experiences among physician, formally or informally, remains an important way of passing on experiences and knowledge. There is no single perfect mode of teaching for Medicine that could stand alone. Rather, we should develop a comprehensive and diversified curriculum that combines all the advantages of various format of teaching, and at the same time, nurture trainers who have the vision and the sense of responsibility in coaching trainees, and to perpetuate such enthusiasm and belief to the next generation. With that, the standard of physician could always be upheld, and that we doctors would never be replaced by AI.

References:

1. L Fernandes, M EB FitzPatrick, M Roycroft. The role of the future physician: building on shifting sands. Clinical Medicine 2020; 20(3):285-9.
2. Ledingham McA, Harden RM. Twelve tips for setting up a clinical skills training facility. Med Teach. 1998;20:503–7.
3. Abdulmohsen H. Al-Elq. Simulation-based medical teaching and learning. J Family Community Med. 2010 Jan-Apr; 17(1): 35–40.

Passing rate for the Joint HKCPIE/MRCP(UK) Part I examination:

	Sitting	Pass
September 2002	100	33 (33%)
January 2003	124	55 (44%)
May 2003 (SARS Special)	21	7 (33%)
September 2003	54	29 (54%)
January 2004	93	39 (42%)
September 2004	29	16 (55%)
January 2005	96	68 (70.8%)
September 2005	24	15 (62.5%)
January 2006	95	74 (80%)
September 2006	21	13 (62%)
January 2007	87	67 (77%)
September 2007	23	12 (52%)
January 2008	56	38 (68%)
September 2008	47	32 (68%)
January 2009	59	47 (80%)
September 2009	47	28 (60%)
January 2010	45	28 (62%)
September 2010	62	39 (63%)
January 2011	44	23 (52%)
September 2011	64	49 (77%)
January 2012	45	28 (62%)
September 2012	80	59 (74%)
January 2013	41	22 (54%)
September 2013	76	60 (79%)
January 2014	30	20 (67%)
September 2014	84	64 (76%)
January 2015	29	20 (69%)
September 2015	100	71 (71%)
January 2016	33	18 (55%)
September 2016	84	63 (75%)
January 2017	36	19 (53%)
September 2017	69	56 (81%)
January 2018	25	12 (48%)
September 2018	108	74 (69%)
January 2019	43	19 (44%)
September 2019	96	64 (67%)
January 2020	41	20 (49%)
September 2020	109	101 (93%)
January 2021	33	20 (61%)
August 2021	106	63 (59%)
May 2022	65	48 (74%)
August 2022	104	75 (72%)

Passing rate for Joint HKCPIE/MRCP(UK) Part II (Written) examination:

	Sitting	Pass
2 July 2002	53	27 (51%)
13 November 2002	50	24 (48%)
13 August 2003	110	62 (56%)
10 December 2003	54	31 (57%)
28 July 2004	65	42 (65%)
8 December 2004	46	32 (70%)
13 April 2005	32	15 (47%)
27 July 2005	76	56 (74%)
7 & 8 December 2005	26	16 (62%)
12 & 13 April 2006	29	13 (45%)
26 & 27 July 2006	91	68 (75%)
6 & 7 December 2006	33	18 (55%)
11 & 12 April 2007	34	22 (65%)
25 & 26 July 2007	80	70 (88%)
5 & 6 December 2007	19	13 (68%)
9 & 10 April 2008	21	13 (62%)
30 & 31 July 2008	47	36 (77%)
3 & 4 December 2008	17	10 (59%)
8 & 9 April 2009	32	25 (78%)
29 & 30 July 2009	50	43 (86%)
25 & 26 November 2009	12	7 (58%)
7 & 8 April 2010	41	34 (83%)
28 & 29 July 2010	25	19 (76%)
24 & 25 November 2010	8	2 (25%)
6 & 7 April 2011	45	35 (78%)
23 & 24 November 2011	32	25 (78%)
28 & 29 March 2012	55	43 (78%)
12 & 13 December 2012	57	44 (77%)
10 & 11 April 2013	60	52 (87%)
11 & 12 December 2013	48	34 (71%)
9 & 10 April 2014	54	46 (85%)
10 & 11 December 2014	26	25 (96%)
25 & 26 March 2015	53	45 (85%)
9 & 10 December 2015	68	65 (96%)
6 & 7 April 2016	29	28 (97%)
7 & 8 December 2016	62	50 (81%)
29 & 30 March 2017	25	21 (84%)
28 & 29 November 2017	58	54 (93%)
27 March 2018	21	14 (67%)
24 October 2018	20	15 (75%)
26 March 2019	79	71 (90%)
22 October 2019	17	12 (71%)
27 October 2020	87	77 (89%)
23 March 2021	107	84 (79%)
5 October 2021	44	32 (73%)
1 Jun 2022	61	49 (80%)
7 September 2022	56	40 (71%)
2 February 2023	78	60 (77%)

Passing rate of PACES over the past years:

October 2001	36/72 = 50%
February 2002	34/74 = 46%
October 2002	29/72 = 40%
February 2003	30/69 = 43%
October 2003	27/59 = 46%
March 2004	39/64 = 61%
October 2004	26/69 = 38%
March 2005	35/75 = 47%
October 2005	28/75 = 37%
March 2006	36/75 = 48%
October 2006	16/73 = 22%
March 2007	44/74 = 59%
June 2007	44/74 = 59%
October 2007	36/55 = 65%
March 2008	36/74 = 49%
October 2008	29/65 = 45%
February 2009	39/75 = 52%
October 2009	24/72 = 33%
March 2010	33/75 = 44%
October 2010	40/74 = 54%
February 2011	23/66 = 35%
October 2011	34/70 = 49%
February 2012	32/74 = 43%
October 2012	32/74 = 43%
March 2013	28/75 = 37% (for HK local candidates)
October 2013	28/74 = 38%
February 2014	29/74 = 39% (for HK local candidates)
October 2014	21/74 = 28%
March 2015	36/75 = 48%
October 2015	35/75 = 47%
March 2016	40/75 = 53%
October 2016	36/75 = 49%
March 2017	26/74 = 35%
October 2017	26/75 = 35%
March 2018	32/75 = 43%
October 2018	38/75 = 51%
March 2019	46/85 = 54%
October 2019	47/86 = 55%
No examination had been conducted in 2020	
March 2021	81/119 = 68%
October 2021	84/120 = 70%
June 2022	50/87 = 57%
October 2022	32/72 = 44%
March 2023	54/89 = 68%

Pass List (2022): Joint HKCPIE/MRCP(UK) Part II PACES Examination October 2022

Chan Chung Yuen
Chan Martin Ka-Kiu
Chan Tsz Kit
Cheng Man Wai
Cheung Tsz Long*
Cheung Wing Kit
Chu Siu Ching Dave
Fu Yin Tung
He Ziyao
Ho Yik Sau Adrian
Kong Ka Yu
Lai Wan Ying
Lam Cheuk Hang
Lee Yan Wing
Leung Hin Sing
Lo Ernest Cheuk Hei
Lo Yan Yeung Vincent
Luk Dik Wai Anderson
Ma Kwok Ming
Mahara Suprava
Mao Kevin Jia-Yu
Mui Carlo
Ng Chi Hong
Ng Chin Ting Justin
Tam Siu Chong Scarlet
Tang Hiu Chung
Tse Pui Ka
Yan Detao
Yang Xiaobo
Yee Hon Ching
Yip Pun Fung
Yu Edmond Ming Long

*Dr Cheung is currently trainee in Pathology

Pass List (2023): Joint HKCPIE/MRCP(UK) Part II PACES Examination March 2023

Au Hin Fung
Chan Hei Tung
Chan Ho Ming
Chan Shing Po
Chan Yan Chak
Chen Lauren Li
Cheng Shun Ming
Cheung Cheuk Sing
Cheung Kingsley Sze Yuen
Cheung Lok Yin Dominic
Cheung Nathan Tinwing
Cheung Wan Ning
Chiu Ivan
Chiu Kwan Yeung Edwin
Chiu Seen Hang
Chu Kim Long Matthew
Chui Edmund Anthony
Chui Yan Yee
Chun Yicttone Krissy
Chung Anthea
Chung Chi Ho
Flynn Brian Terence
Fok Ho Cheung Michael
Fung Tung Yee
Ho Wui Hang
Hsu Dany Young
Hui Kei Yan
Ip Wai Tung
Kan Chung Yan Joyce
Kwong Ho Chak
Lai Cheuk Yin
Lam Tony
Lee Chung Ho
Lee Yee Tat
Leung Hau Lam
Li Po Yi
Lor Cheuk Yin
Lum Kai Chun
Lun Yiu Kun
Ma Wai Shan
Mak Ryan Hei-Yeung
Ng Chor Ting
Ng Yat Nam
So Wai Ching
Sung Chu Lung
Tang Chi Ho Justin Chan
Tsang Yee Wai
Wan Man Ting
Wong Ting Yan Tammy
Wong Wan Hei Charmaine
Wu Tsun Wai Jeffrey
Yeo Sze Ho Jonathan
Yii Pun Kit
Yu Sheung Pok

Moving Forward: A Message from the Young Fellows' Committee Co-Chairs

Drs Thomas Sau Yan CHAN and Jacqueline SO
Co-Chairs, Young Fellows' Committee

Dr Thomas Chan:

It is with great pleasure that I write my first article in Synapse on behalf of the Young Fellows' Committee. As a newly appointed co-chair, I am humbled to work alongside Dr Jacqueline So and other brilliant members to serve the young generation of physicians in Hong Kong.

As we turn to the next page, it is important to acknowledge and appreciate the contributions of our departing members. Their hard work has laid a strong foundation for the committee's growth and success. A big note of thanks should be given to Dr. Heyson Chan, our former and the first chairman, for his leadership in transforming our committee from a mere idea to a successful platform for young physicians. Building on his previous work, we will continue to provide resources and support for our younger generations to thrive and contribute to the medical community.

At the same time, I am delighted to welcome our new members (see the new members list). They are all exceptional young people with truly inspiring attitudes and talents who will surely bring our committee to a new height. Seats are still open, and we are looking for motivated and enthusiastic individuals who would like to join us. As a member of the committee, you will have the chance to connect with like-minded individuals, which will benefit enormously in your personal and professional life. If you are interested, please do reach out to us for more information.

In the coming months, we have planned a series of events and activities that we hope will be of interest and benefit to our members. Jacqueline will elaborate more on this in the following article.

Lastly, but certainly not least, I would like to extend my heartfelt appreciation to the college council for their unwavering support and guidance. I am especially grateful to Professor TM Chan and Professor Philip Li for placing their confidence in our committee. Their leadership has been invaluable as we work to serve the physician community and contribute to the betterment of the college.

Dr Jacqueline So:

First and foremost, I would like to express my heartfelt gratitude to Dr Heyson Chan, the former chairman, who introduced me into the committee and appointed me as secretary. It has been an incredible experience to work with outstanding team members over the past 5 years. Our activities have expanded as our committee members have grown in numbers over the years. As I turned from a HPT to a young fellow during my time at Young Fellow Committee, I am honored to serve as co- chair with Dr Thomas Chan.

In this ever- changing world, we face a lot of stress and challenges at work and in life. At times, we may feel lost and helpless, especially

with regards to our career path. HKCP cares about the career development and the well -being of our physicians, especially the young members. Over the past few years, we successfully organized various events including career talks, medico-legal workshops and statistics workshop, all of which have received excellent responses.

This year, we are going to organize a career talk for fresh graduates, where we will share valuable insights on the life of physicians, tips on writing a curriculum vitae and interview skills. We will also invite young fellows from different subspecialties to share their experiences, providing graduates with a better understanding of our work. We have a new idea to organize a career talk for HBT and young fellows, where we will discuss about various career prospects, including academic opportunities and subspecialties enhancements. We understand that working on a dissertation can be challenging for our trainees. Due to the excellent feedback from our previous statistics workshop, we are planning to organize another workshop on dissertations. This workshop will focus on teaching our trainees about dissertation topic selection, preparation and writing skills, as well as the utilization of statistical tools. Additionally, we plan like to hold some fun and relaxing workshops such as art jamming, coffee tasting, yoga and meditation classes, which can help reduce stress and foster a sense of community among our members. We believe that nurturing the all-rounded development of our junior members is essential.

We are dedicated to serving our members and value all opinions. Please let us know your ideas and suggestions as your participations are of paramount importance. We look forward to seeing you at our upcoming events.

Membership of Young Fellows' Committee (*new)

Co-Chairmen	**Dr Chan Sau Yan Thomas** (Fellow, QMH)
	Dr Jacqueline So (Fellow, PWH)
Secretary	**Dr Chan Shuk Ying** (Fellow, QEH)
IT advisor	**Dr Tsoi Lap Kiu** (Fellow, TMH)
Members	**Dr Chan Hoi Kei Iki** (Fellow, UCH)
	Dr Chan Wai Hong (HPT, DH)
	Dr Chan Tin Yau (Fellow, PYNEH)*
	Dr Chu Kwok Ho Gordon (BPT, QMH)*
	Dr Ho Cheuk Ying Karen (BPT, QMH)*
	Dr Ho Chiu Leung (Fellow, PWH)*
	Dr Hooi James Kwong Yew (HPT, QMH)*
	Dr Hui Wan Hin Rex (BPT, QMH)*
	Dr Kam Ngong Pang Kenny (HPT, KWH)*
	Dr Kwok Chi Hang (Fellow, PMH)
	Dr Lau Wan Hang (Fellow, PWH)*
	Dr Muk Lam (HPT, YCH)
	Dr Ng Ka Ching (Fellow, PWH)

The College wishes to thank the following colleagues who have previously served in the Young Fellows' Committee:

- **Dr Cheung Christina Man-tung**
- **Dr Kwok Wing Tung**
- **Dr Lau Gary Kui Kai**
- **Dr Law Yee Kiu Stefanie**
- **Dr Lo Oi Shan Angeline**
- **Dr Mak Wing San**

The first physical committee meeting after COVID with our college President, Professor TM Chan

Upper row, from left to right: Dr CH Kwok, Dr Muk Lam, Dr Jacqueline So, Dr Joyce Ng, Dr Gordonn Chu, Dr James Hooi

Lower row, from left to right: Dr Chan Wai Hong, Dr Kelvin Tsoi, Dr Iki Chan, Dr Thomas Chan, Professor TM Chan

OBITUARY

Vivian Nap Yee CHAN, b. 1946, d. 2023

Professor Vivian Chan, who has died aged 78, was a pioneer in molecular medicine in Hong Kong.

After obtaining her BSc, MSc and PhD degrees in London, U.K., she joined the Chemical Pathology Department at St. Bartholomew's Hospital as a Clinical Biochemist in 1969. She was recruited by Professor A.J.S. McFadzean, Head of the Department of Medicine at The University of Hong Kong (HKU) from 1948 to 1974, shortly before his retirement, and joined the department as Lecturer in 1974. She was promoted to Senior Lecturer in 1978, Reader in 1982, and Professor of Medicine, Chair of Molecular Medicine, in 1993. She was the first appointee of the Chui Fook-Chuen Endowed Professorship in Molecular Medicine in 2008. She was Honorary Professor at the Department of Obstetrics and Gynaecology at HKU, Honorary Consultant Scientist at Wu Chung Prenatal Diagnosis Laboratory at Tsan Yuk Hospital, and Member of Senate at HKU. She became a Fellow of the American College of Biochemists in 1988, and was conferred Fellowship of the Royal College of Pathologists, U.K., in 1995. In 2001, she was elected Honorary Fellow of the Royal College of Physicians of London, and the Hong Kong College of Physicians. She retired in 2010, and was conferred the title of Emeritus Professor by HKU in 2013.

As the first scientist working in a university clinical department, she conducted research in endocrinology with Professors J. Landon and G.M. Besser in London and Professors Rosie T.T. Young and Christina Wang in Hong Kong, which contributed to improved clinical management of patients with thyroid and pituitary disorders.

She then directed her research to focus on inherited haematological disorders, in particular the different types of thalassemia and haemophilia. She was Visiting Associate at the National Institutes of Health, U.S.A., in 1979, and in 1982 she received the Wu Chung Travelling Fellowship to work with Professor Yuet-Wai Kan at University of California School of Medicine, who had discovered that thalassemia was caused by gene deletion. Back in Hong Kong, she worked with Professor David Todd and Professor T.K. Chan on thalassemia and haemophilia. Her studies on the molecular and genetic defects of these diseases resulted in better understanding of disease mechanisms and more accurate diagnosis, and earned her international recognition. Importantly, these works progenerated the establishment of the DNA Diagnostic Laboratory at the HKU Department of Medicine in 1982, and she also served as Consultant Scientist for the renowned prenatal diagnosis programme at Tsan Yuk Hospital. Her unit was the first, and the best, prenatal diagnosis service for common genetic diseases in the region. She was a member of the Asian Thalassemia Network, World Federation of Haemophilia Faculty for Haemophilia Control, and World Health Organisation/ Harvard University Global Burden of Disease Hemoglobinopathies Expert Group. In later years, her laboratory also contributed to the genetic diagnostics for the management of leukemias and lymphomas, inherited neurological disorders, viral hepatitis, and lung cancer.

In addition to being Chief of Division of Molecular Medicine at the Department of Medicine, she was Deputy Director then Acting Director of the Institute of Molecular Biology at HKU, and contributed to the planning and development of basic science research facilities at the university, including the new Medical Faculty Complex at Sassoon Road. She taught molecular medicine to medical undergraduates and trained scientists from various institutions in Hong Kong, China and South-East Asia in DNA technology. Successive generations of clinician-scientists of different specialties have benefited from her training and guidance. Throughout her career she worked closely with clinical colleagues across different disciplines to address knowledge gaps, improve diagnosis, advance patient management, and prevent adverse clinical outcomes.

A scientist known for holding herself to particularly high standards and her honest and straightforward personality, she was greatly admired and respected by colleagues and friends for her principled demeanour, fairness and integrity.

She once remarked, "I do mostly translational, rather than basic research. I enjoy seeing my efforts being applied readily to the bedside, rather than waiting for years before my findings can be linked to or used for further understanding of disease."

Daniel TM CHAN

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