HONG KONG COLLEGE OF PHYSICIANS
香港內科醫學院

SYNAPSE

Hong Kong College of Physicians **April 2001**

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RESTRICTED TO MEMBERS ONLY

Dr. Sun Yat Sen (孫中山（逸仙）先生) posing with his friends in front of the second ward of the Alice Ho Memorial Hospital（雅麗氏紀念醫院）in 1888.

From left to right are: Yeung Hok Ling（楊鶴齡）, Sun Yat Sen（孫中山）, Chan Shao Bei（陳少白）, Yao Lit（尤烈）. Standing behind is Kwan Sum Yin（關心焉）.

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

(Feature story of Dr. Sun Yat Sen at the back.)

Content

Message From the President

Dear Fellows, Members and Colleagues,

As your President and on your behalf I would like to extend our warmest congratulations to the newly elected Office Bearers of the Hong Kong Academy of Medicine. In particular to the new President Prof. CH Leong and we are quite confident that with his many years of experience as a "political animal" will transform the Academy into a leading professional institution to the benefit of all Specialists - perhaps may even restore some shine into our lately tarnished image! Both the Vice-Presidents are seasoned academicians to add weight and substance to uphold professional standards. The Honorary Secretary and Honorary Treasurer will I am sure continue to do an excellent job in maintaining the efficient functioning of the Academy and most importantly in ensuring a healthy financial situation thus avoiding an increase in fellowship subscription in years to come.

Our College will work closely and harmoniously in partnership with the new Council of the Academy in many areas that are of the common interest not only to our College but also to all other Constituent Colleges. The Academy President not only has the vision but also the ability to formulate and implement changes which in the past had been all too restrictive and that will be evident in the not too distant future. We are all working for the benefits and welfare of our Fellows.

One very important role our College plays is to work hand in hand with other constituent Colleges in specialist training. The first is with the College of Family Physicians. Having had a very successful programme in Internal Medicine for Family Physicians of monthly lectures last year the programme will continue because of overwhelming support. Secondly we are offering structural training for in-hospital acute medicine as well as outpatient specialist outpatient training for trainees in Family Physicians. It is our very strong belief that a sound knowledge and experience in internal medicine should form the backbone of good Family Physician Practice as at least 60% - 70% of the practice is General Internal Medicine based. Because of the changing spectrum of infectious diseases, conjoint training with microbiologists with the College of Pathologists is the way forward in the training of a new generation of infectious disease specialist. Microbiologists will have the necessary clinical experience while physicians will have a much better and in-depth understanding of the microbes to enable both disciplines to manage infections on an evidence based approach for the benefit of patients. Infectious disease specialists in the 21st century will have to deal with life-threatening hospital acquired infections, infection in intensive care units and infection in immunocompromised patient rather than "contagious and communicable" diseases.

The changing concept and spectrum of diseases has resulted in a joint Scientific Conference to be held on the 27 - 28th October 2001 in the Academy of Medicine. The College of Pathologists, Family Physicians and Paediatricians will join with our College to host a scientific meeting with a theme of Ambulatory Medicine 2001. I hope all trainees both basic and higher will take this opportunity to learn from the experts as their attendance will be FREE! The programme will be comprehensive and useful to all doctors being well planned by our Chairman of Scientific Committee with Dr Dominic Tsang (College of Pathologists), Prof PC Ng (College of Paediatricians) and Dr Amy Wong (College of Family Physicians) and Prof Joseph Sung who had just hosted the Advances in Medicine Conference with resounding who success.

A new challenge for both the College and basic physician trainees is expected in October this year with the introduction of a new format - PACES (Practical Assessment of Clinical Examination Skills) - to replace the long cases in the Intermediate Examination Certificate/MRCP - which will be outlined in detail in this edition of Synapse. The College will be organizing a series of Mock runs for prospective candidates.

The College is holding its 14th Annual General Meeting in the Hong Kong Academy of Medicine Building on 1st June 2001, Friday. This will be followed by Congregation for admission of new Fellows and Members. This is a very important occasion for Fellows and Members as it represents a milestone in your career as a physician. The President of the Academy will give an address which will be both philosophical and entertaining. By tradition all participating Fellows and Members will be presented a photograph of the proceedings individually. I hope you will all take a little time off for this joyous occasion. The usual Annual Diner will follow and we are greatly honoured by the presence of Professor Arthur Li, Vice-Chancellor of the Chinese University of Hong Kong as guest of honour and the sixth AJS McFadzean Orator. Professor Li is well known for his wits and humour and is a delightful speaker. I am sure you will not be disappointed by his oration titled "Reflections of a Surgeon". I do sincerely hope all of you - Fellows, Members and Trainees - will participate in this event in support of your own College.

Lastly our College has for some years established a warm and cordial relationship with the Royal Colleges in UK and Australia - a continuation of the good ground work laid down by our two previous Presidents. There will be a programme of exchange in Gastroenterology/Hepatology, Diabetes/Endocrinology and Respiratory Diseases between UK and Hong Kong arranged through the Royal College of Physicians in London in the later part of the year. The other benefit for our Fellows is in the increasing number of our Fellows being elected to the Fellowship of the Edinburgh and London Colleges through the recommendation of the Council. This is vitally important in maintaining our international link and hence standard.

I wish you all a successful year of 2001 and hope to see you all at our AGM/Annual Dinner and the Conjoint Annual Scientific Meeting.

Richard Y H Yu
April 23, 2001

Editorial

Revolution and Reforms: Then and Now

After the December 2000 issue of SYNAPSE was out, the Editorial Board received a number of positive and constructive comments from the readers, local and overseas. We received them with delight and enthusiasm and would try our best to improve further.

In this issue of SYNAPSE, the cover photo is a very precious one of Dr. Sun Yat Sen posing in the Alice Ho Memorial Hospital in 1888. The photo has a Chinese Caption on top saying "Alice Ho Memorial Hospital: Nurturing Ground for Revolution of Dr. Sun Yat Sen". I think few of our College Fellows or Members have seen "The Father of Modern China" posed in a Hospital in Hong Kong. Once again, we are very grateful to the Hong Kong Museum of Medical Sciences for allowing us to use this photo and provide us with the information. I have to express my sincere gratitude to Dr. John Mackay, my Assistant Editor, for his contribution to write the Feature Story of Dr. Sun in his early life in Hong Kong. I am sure all of you will read with the same interest as me and feel the honour of having Dr Sun, and his revolutionary ideas that bring in Modern China, so closely related to Medicine of Hong Kong which you and I are now part of.

This issue's Special Article proudly features the Sydney Watson Smith Lecture of the Royal College of Physicians of Edinburgh (RCPE) on 'Levers for Change in Medicine' by Dr. JC Petrie, the then President of the RCPE presented in our College Joint Scientific Meeting in Oct 2000. The Addendum on the same topic by Dr. NDC Finlayson, the current President of the RCPE is also included in this issue. Both speeches are really stimulating about doctors and medical practice. The problems and challenges in medicine of both UK and Hong Kong bear so many similarities that those described by Dr. Petrie look like a mirror reflection of the medical arena in Hong Kong. I am particularly impressed by the verses of "Journey of Care: Who are the Players? - Everybody, Somebody, Anybody, Nobody!" You are all urged to read the "5 levers for change", the Reforms suggested by RCPE in Dr. Petrie's speech, as it may be a crystal ball for what will happen in Hong Kong in future, and some are already happening now. Dr. Finlayson's speech reminded us the quality of doctors and sacrifice required to sustain the reputation of our profession, and to gain support from the public.

Another Special article is the College Comments on Health Care Reform Paper prepared by the Professional and Public Affairs Committee of the College addressing to the Academy President. The Health Care Reform Paper will have a profound effect on our medical system and we hope that our comments as published here will let our fellows and members know of the College standpoint.

In this issue of SYNAPSE, we will add on some quotes on medicine, which will act as food for thoughts for our readers. You are all invited to submit to us quotes or cartoons related to medicine that you find interesting to share with our Fellows and Members.

We have a Section on "Letters to Editor" in this issue and you are all encouraged to write to us. Once again, your input and feedback to us would be very important for making this a SYNAPSE for you.

The Editorial Board hopes that you continue to find the information from the Council News, Specialty Board Corner, Scientific Section and the Diary useful.

Once again, I would like to thank my Assistant Editor and Co-Editors, the College Secretariat, our President and the Council for all the support for making this issue of SYNAPSE possible.

Philip K.T. Li

Editor-in-Chief

Special Article

Sydney Watson Smith lecture: Levers for Change in Medicine

Richard Yu, Fellows, Members and distinguished guests! It is a great personal disappointment to my wife Xanthe and I that we are unable to participate in the first Federation of the UK Royal Colleges of Physicians Symposium, coupled with a Presidential visit and an important Fellowship ceremony. We are grateful for your expression of good wishes and understanding.

I am particularly grateful to the Vice President for agreeing to deliver this prestigious lecture. Please do not shoot the messenger!

A lecture can be used to provoke, stimulate and perhaps to irritate, annoy and challenge. A named lecturer is allowed the luxury to dream the impossible. I wish to address some fundamental challenges that face health services. Despite their importance the issues are seldom debated because few dare face the difficulties.

In the first part I will discuss the present status of some "journeys of care". I will then move on to describe levers which may be used in future to benefit our patients and health services.

JOURNEYS OF CARE: THE PRESENT

There are unacceptable variations in practice and in the delivery of journeys of care. The public has become increasingly well informed about misadventures and malpractice through the press, telecommunications and Internet. Soon the public will no longer tolerate "journeys of care" which are something of a lottery, that might be successful, might involve "near misses", or preventable disasters and unnecessary delays. Nor will funders in government or as insurance payers accept processes of care that are not evidence based and cost effective. Public confidence in health services has been eroded and requires to be regained.

Working practices have moved from the days of Dr Sidney Watson Smith to the present systems of partial shifts, discontinuity and fragmentation of care. Today in the UK in some hospitals an inexperienced junior doctor may be required to supervise overnight up to 200 in-patients whom they do not know. Senior doctors are extremely stressed and are retiring early. Manual case records are chaotic and disorganized. Sharing of information across the primary to secondary care divide is inefficient. Most clinical information systems are rudimentary.

Are these important Variations in practice?

In diabetes care many regions or practices do not maintain registers of diabetic patients. Local policies are variable in respect of eye, foot and cardiovascular examination. Similarly there is variation in policies for the measurement of glucose, glycosylated haemoglobin, microalbuminuria, lipids and blood pressure. Care of adolescent and pregnant diabetics is not always structured. Is this a satisfactory situation?

Stroke patients are disadvantaged in many areas that have no organised system for stroke care or for early swallowing assessment despite the high levels of evidence that show unequivocal benefits to such patients. Is this acceptable?

The care of heart failure patients is also suboptimal. The severe grades have a worse prognosis than some types of cancer yet audits show that evidence based therapies such as ACE inhibitors, diuretics, beta blockers and spironolactone are not being optimally delivered. Why?

Implementation of prophylaxis against deep venous thrombosis in patients admitted to hospitals is inconsistent despite the overwhelming evidence of beneficial effects on a reduction in preventable mortality. This is not a safe journey of care!

The rule of halves continues to operate in hypertension care. Only half of the patients are diagnosed, only half of that group is treated and only half of those adequately. Is this good for the patients or for the prevention of stroke?

Lung, colorectal and breast cancer care is variable. Long delays may occur before being seen by a specialist who may be a physician, surgeon, oncologist or radiotherapist. Delays may also occur during cross referrals. In some recent instances in the UK the delays have led to the tumour becoming inoperable. The variability in the patients' journeys lead to unacceptable variations on outcome.

Patients awaiting emergency admission to hospital wait on trolleys for hours due to bed shortages caused by delayed discharges and lack of forward planning. This is totally

unacceptable and finally awakened the UK government to the crisis in the NHS.

I will not go on.

THE JOURNEY OF CARE: WHO ARE THE PLAYERS?

Everybody, Somebody, Anybody, Nobody!

There was an important job to be done
Everybody was sure that Somebody would do it.
Anybody could have done it but Nobody did it.

Somebody got very angry because it was Everybody's job.
Everybody thought that Anybody could do it but
Nobody realized that Everybody couldn't do it.

It ended up that Everybody blamed Somebody when
Nobody did what Anybody could have done.

In the design of "quality" journeys of care clear guidance and definitions of roles of several players are required. Otherwise confusion and discontinuity will result. Who are the key players?

The patient and carer want accessible, intelligible, plain English "gold standard" information. This information should be free of advocacy and commercial overtones. By strengthening and empowering patients and informing public debate expectations of the health service are raised.

The multi-professional health professionals involved in team working, including nurses, pharmacists and professional allied workers to medicine require agreed guidance as to the objectives of care, the methods to be used and the outcomes to be measured.

Specialists require to discuss and agree "best practice" with colleagues in allied specialties who are also involved in the journey of care. Monospecialty tunnel vision that does not take into consideration the views and evidence base of others specialists, for example radiologists and the clinical chemists, will result in suboptimal journeys of care. There is a need to "work together".

Primary care physicians are the principal life time carers of patients. Agreement with secondary care practitioners on referral and discharge practices including shared care arrangements are essential, particularly with shift in the balance of care away from secondary and tertiary care as with the care of diabetes and hypertension to primary care.

Finally the key players include management. In the UK the internal market caused managers to focus on the financial "bottom line" and not on the quality of the service being delivered. Clinicians and managers became disconnected and confrontational. The connecting rods were lost.

THE JOURNEY OF CARE: THE LEVERS

The urgent problems are to regain the confidence of the public and to restore the morale of the professions. Some managers and politicians favour a "big stick" approach. This leads to resistance, opposition and tension in health care workers who in the UK already feel under major pressures without added political imperatives, sanctions and burdens. The "bottom up" approach allied to "carrots" allows changes in practice to be professionally led. Ownership is gained as valid and valued guidance is developed. Peer pressure can be applied to obtain behavioural change.

A combination of "top down" and "bottom up" approaches is required and the Royal College of Physicians of Edinburgh has attempted to suggest and cooperate with pragmatic solutions - or levers - to the pressing problems.

The first lever relates to evidence based guideline development. The College has led a process of evidence based guideline development through the Scottish Intercollegiate Guideline network (SIGN). The topics are closely aligned to national priorities for "journeys of care". The guidelines are developed using a methodology (now internationally accepted) which requires multi-professional input, a systematic review of the literature, and graded recommendations based on a hierarchy of evidence levels. Minimum data sets are suggested which increasingly form the basis of audit and information technology initiatives. 45 SIGN guidelines have now been published but alone do not change practice and other levers are required.

A second lever is the evolving process called clinical governance. Government has charged the Chief Executives of Trusts with accountability for clinical quality. The availability of professionally owned and valued SIGN guidelines facilitates the setting up of local procedures by clinicians and managers for the delivery of clinical governance (eg diabetes, stroke, coronary artery diseases etc) in the Trusts. Through the processes of

clinical governance there is an expectation that risk management procedures will identify failing services and dysfunctional doctors much earlier than in the past and nip them in the bud. Earlier correction of deficiencies should also attenuate adverse publicity.

A third lever is external quality assurance by the recently set up Clinical Standards Board for Scotland (CSBS). This statutory independent Health Authority has over 50% of its Board as non Health service members. The Board has already started to visit Trusts to review local services (eg cancer) against defined generic and specialty specific criteria that have been principally derived from the SIGN guidelines. Prior to CSBS visits the Trusts are invited to prepare a self-assessment document for scrutiny by the CSBS teams. The results of the CSBS visits will be available to the public. In England a similar quality assurance body has been set up - the Commission for Health Improvement (CHI) - again as a Special Health Authority. The methods to be used by CHI will be more those of a semi-punitive inspectorate that those of CSBS. CHI will concentrate on clinical governance issues in "red" i.e. problematic rather then "amber" or "green" i.e. non-problematic Trusts.

A fourth lever which is again under very active and controversial discussion relates to the proposed 5 yearly revalidation of doctors by the General Medical Council. Clinicians will be expected to complete a personal folder in which details of continuing personal development, personal development plans and participation in clinical functional services will be recorded. The trick will be to integrate revalidation of doctors with the external quality assurance (CSBS) and clinical governance processes. Otherwise there will be "paralysis by analysis"!

The fifth lever, referred to earlier, is the empowerment of patients. By making the guidelines, such as produced by SIGN, available to the public in accessible language, and on the internet, there will be major pressures to improve the funding of health services and the quality of the journeys of care. The involvement of patients and the public in developing SIGN guidelines, and in the work of CSBC and Trust Boards is a very powerful tool to make the problems in the delivery of services at a local level explicit.

These five levers need to be intelligently ratcheted up over a feasible timescale. And the different players need to work together. By combining the levers, safe "journeys of care" are more likely!

And finally I wish to end on a positive note. I firmly believe that the levers that are being put in place at present to deliver a "quality" journey of care for citizens will result in increasing staffing and resourcing of health services to release the time of individuals to deliver the journeys of care that all aspire to. Such an increase in funding has recently been announced in the UK, acknowledgment that the NHS was under-resourced and that health professionals were not crying wolf.

Once the levers described above are in place the public can then be more reassured of the safety of their journeys of care, and the paymasters of the cost effectiveness of the journeys. A move is essential from the gentlemen players of the past to accountable, evidence based and transparent "journeys of care".

I believe that the Royal Colleges and Academies of Medicine across the world, working with specialist groups and patients have major roles to play in setting the standards.

Fellows, Members and guests thank you for your attention!

JC Petrie

President,

Royal College of Physicians of Edinburgh

October 2000 in Hong Kong

Editors' note: Dr. Petrie, the then President of the Royal College of Physicians of Edinburgh could not attend the Joint Scientific Meeting jointly organized by the Hong Kong College of Physicians, Hong Kong College of Paediatricians, Federation of Royal College of Physicians of the United Kingdom (Edinburgh, Glasgow and London), and Singapore Academy of Medicine on 14-15 October 2000. Dr. NDC Finlayson, then President-Elect of the Royal College of Physicians of Edinburgh on behalf of Dr. Petrie, presented this Sydney Watson Smith Lecture of the Royal College of Physicians of Edinburgh on 'Levers for Change in Medicine'. At the end of the presentation, Dr. Finlayson added some personal remarks that provided a further perspective to the issues raised, as put in here as the ADDENDUM to "Levers for Change in Medicine". Both speeches are therefore included in the Synapse for the readers.

ADDENDUM to "Levers for Change in Medicine"

Professor Petrie has spoken eloquently about the various "levers" which can be used to improve medical services, and these will surely be important in bringing change for the better in future. In addition, however, we should remember the importance of the direct personal care doctors give to patients in determining the quality and humanity of medical care, the reputation of our profession, and the support we receive from the public.

We have the privilege (along with nursing) of belonging to the greatest of the professions but we must remember that medicine is a great profession because it is a serving profession and not because of any merit we as individuals may possess. The object of medicine is to cure or alleviate disease and minimise the anguish of the sick, and ultimately this comes down to the personal care an individual doctor gives to an individual patient. In other words, in the end our profession will be judged by the competence, conscientiousness and compassion of the service we give to our patients.

Conscientiousness and compassion owe much to the nature and beliefs of individual doctors, but also important are the attitudes shown by teachers in their daily practice, and this "training by example" is particularly important for senior doctors to remember. The men and women who have been "role models" in my professional life have been as notable for their character as for their competence. Competence too, however, is clearly vital for a good doctor and is the product of clinical practice (service) informed and guided by education and training. Clinical practice without education is like going to sea without a compass; education without clinical practice is not going to sea at all. Clinical practice (service) and education need to go hand in hand. Illness is no respecter of day or night, medicine cannot be constrained into socially acceptable hours, gaining and maintaining experience will always be time-consuming and as a result some degree of personal sacrifice will always be part of being a doctor.

*Niall D C Finlayson

President-Elect,

Royal College of Physicians of Edinburgh

October 2000 in Hong Kong

*Dr. Finlayson is the current President of the Royal College of Physicians of Edinburgh.

Quotes: Medicine and Magic

"Formerly, when religion was strong and science weak, men mistook magic for medicine;

Now, when science is strong and religion weak, men mistake medicine for magic."

The Second Sin (1973) 'Science and Scientism' by Thomas Szasz

College Comments on Health Care Reform

13 March 2001
Dr CH Leong
The President
Hong Kong Academy of Medicine

Dear Dr Leong

Document on Health Care Reform

The Document on Health Care Reform has been thoroughly discussed in the Council of our College. We agreed that a reform of the present health care delivery system will be to the advantage of the community and the profession. We agreed on the spirit of the Document and many of the recommendations therein. There are, however, issues that may need further deliberation and clarification. Being a professional body, our College has focused our recommendations on the professional aspects of the Document.

Vision and Policy Objectives

1. The document is biased heavily towards preventive and primary care. While this is understandable and should be supported, the role of specialists, many of which our College represent, should be given due attention.
2. There was nothing mentioned on academic research which is vital in up-keeping our standards.

Reforms to the Health Care Delivery System

3. Who should be delivering primary care?

   (a) The Skill Mix

   Family medicine trainees and even nurses and allied health professionals have been proposed (point 31 in the Document). Our College, however, had in many an occasion stressed that ambulatory care physicians should be playing a major role in primary care. The disease pattern in the primary care setting is best dealt with by physicians. With our ageing population and increasing life-expectancy, the number of patients suffering from chronic medical diseases such as diabetes mellitus and its end-organ complications (renal, neurological and cardiovascular, etc) and chronic obstructive airway disease will rise. They will require long-term care best managed by physicians, preferably in an outpatient setting.

   Our College has a structured programme and sufficient trainers for ambulatory care physician training.

   (b) The System

   The Hospital Authority, in co-operation with respective Colleges of the Academy, should be the best training ground for primary care clinicians. It may not, however, be desirable for public sector health providers to take up a major role in the actual delivery of primary care. Primary care should be left predominantly to the private sector. The HA should, instead, focus on the provision of training and protocols for public/private interface.

4. Traditional Chinese Medicine

   Should we agree on the proposal of introducing Chinese medicine into public hospitals (point 13 in the Document)?

   First and foremost in this issue will be the problem of providing professional service with different standards under the same roof. There will be difficulties in communication between carers and patients, confusions in resource utilization and professional accountability and ambiguity in medical ethics. The major impact of the above issues will be on physicians working in public hospitals.

   Our College understands the potential advantage of embracing traditional Chinese medicine. On the other hand, the in-patient service in hospitals is probably not the best starting point. We would suggest that if introduction of Chinese medicine into the public sector is destined to be the way to go, the starting point could be the outpatient departments. Their place in the health-care delivery system should be confined to primary care.

5. Public/Private Interface

   The College, comprising of Fellows from both the public and private sector, should be the best medium for any proposed public/private interface programme such as setting up of clinical protocols. The HA must address the enormous discrepancy of costing between the public/private sector before any success can be achieved.

Improvements to the System of Quality Assurance

6. As a professional and statutory organization, the Academy and its Colleges should play a major role in ensuring the quality of health delivery. This, however, has not been spelt out in the Document.

   Little has been said on the provision of specialist training in the long term.

7. A Complaint Office in the Department of Health was proposed (point 102 in Document).

   (a) The DOH will not be best suited to investigate into complaints. It does not have the appropriate expertise while on the other hand, it will still be viewed upon by the public as another government body for doctors to protect fellow doctors.

   (b) The Academy and its Colleges should be the best organization to turn to because the necessary expertise are there and being an academic and statutory body, the public may find this arrangement more acceptable.

Dr H Yuen, Chairman
Professional and General Affairs Committee
on behalf of
Dr. Richard Yu
President of The Hong Kong College of Physicians

Council News

Continuing Medical Education

Changes in Continuing Medical Education and updated information

Since the implementation of the Continuing Medical Education, the Academy Education Committee has required each Fellow to obtain minimum requirement of 10 CME Points a year and 90 CME Points in each three-year Cycle. However, in July 2000, the Academy Education Committee insisted that all Fellows must fulfill the minimum requirement of 40/60 CME Points in the second/third years before remedial programmes are approved. The Council had to agree on this principle.

Updated information from the CME Board:

1. The minimal CME points per 3-year cycle is 90
2. Fellows who fail to achieve 60 points over the 3-year cycle will neither be allowed to enter the next cycle nor to do remedial CME.
3. According to the original regulation, the minimal CME points per year is 10.
4. The previous Chairman of the Education Committee of the Academy had changed the minimal yearly CME requirement to 20. The present Chairman is examining this issue.
5. At the end of each year, the College will send all Fellow an updated record of his/her accumulative CME points. The Fellow is advised to update his/her CME activities and return to the CME board if these are already not in the College record.
6. At the end of the 3-year cycle, Fellows who have achieved the minimal CME required will be informed of their fulfillment.
7. There are overseas medical councils that require evidence of CME participation for renewal of annual practicing licenses (e.g. New South Wales Medical Board, Australia). On request by writing from individual Fellow, the CME board of the College will issue a letter certifying that Fellow is participating in the College CME program and has satisfied the mandatory yearly requirement.

Web-based CME units

The total CME units accredited through CME-online should not exceed half the CME requirements (i.e. 45 units in a three-year cycle). Furthermore, for those who achieved their CME points through such pathway, no further CME points will be awarded by journal reading. This is to ensure Fellows will attend national and international meeting with active participation.

The College website (http://www.hkcp.org) has links to a number of overseas CME websites.

Professor KN Lai

Chairman

Education and Accreditation Committee

CME-online

Where can you get CME on the Internet ?

There are many web sites on the Internet available for CME points. They include both local and oversea sites. In order to get CME points accredited by the Hong Kong College of Physicians (HKCP), the site should either be accredited by the Accreditation Council for continuing Medical Education (ACCME), American Medical Association (AMA) or HKCP.
Fellows should note that some programs could be done online while others require posting of materials. Most CME programs are free but some do charge.
The following is a sample of sites available to get CME points. For an updated list, please visit the college web site at: http://www.hkcp.org

CME (On-line) Programs provided by various Associations or Colleges:	CME (On-line) Programs available from various sites, search engines:
1. American Academy of Physical Medicine and Rehabilitation (AAPM&R) http://www.aapmr.org/cme.htm 2. American College of Cardiology (ACC) - topics in Cardiology http://www.acc.org 3. American Heart Association http://www.amhrt.org/Scientific/CME 4. American Medical Association http://www.ama-assn.org/cmeselec/cmeselec.htm 5. Baylor College http://www.hcoa.org/hcoacme/default.htm 6. Cleveland Clinic CME http://www.clevelandclinicmeded.org/online/topics.htm 7. Harvard Medical School http://134.174.17.108/conted-bin/hmscme.cgi?SECTION=HOMESTUDY 8. Mayo Clinic http://www.mayo.edu/cme/cardiology/index.html 9. Southern Medical Association http://www.sma.org 10. Temple University http://www.amscme.com/ 11. University of Texas Medical Branch http://www2.utmb.edu/oce/ 12. University of the Science in Philadelphia http://207.87.10.170/cme/CMEMedicine.html 13. University of Washington http://uwcme.org/	1. ArcMesa http://www.arcmesa.com/ 2. CME Online http://www.medicalcomputingtoday.com/0listcme.html 3. CMEsearch.com http://www.cmesearch.com/search.asp?type=INTERNET 4. CME Web http://www.cmeweb.com 5. CME Unlimited http://www.landesslezak.com/cmeu 6. Educational Symposia, Inc http://www.edusymp.com 7. Health A to Z http://www.healthatozcme-ce.com/index.html 8. imed21.com http://www.imed21.com 9. Medical Matrix http://www.medmatrix.org 10. Medscape CME http://www.medscape.com/Home/CMEcenter/CMECenter.html 11. NIH CME Online http://odp.od.nih.gov/consensus/cme/cme.htm 12. Sports Medicine CME http://www.physsportsmed.com/cme.htm 13. Theheart.org http://www.theheart.org

Visit http://www.hkcp.org for updates

S H Wan
College Webmaster

Opinion survey on the Voting Mechanism for Election of College Office-bearers and Councillors

In August 2000, the Council has conducted an opinion survey among College Fellows regarding their views on proxy versus postal ballot as the voting mechanism for the election of Office-bearers and Councillors. The following results were obtained:

Total number of replies from Fellows: 221
Number favouring proxy: 26
Number favouring postal ballot: 195

The College's Honorary Legal Advisor has recommended the issue to be decided at a future Extraordinary General Meeting.

Specialist Registrar Exchange Programme with Royal College of Physicians (London)

Currently, the specialties offering this programme are Endocrinology, Respiratory Medicine and Gastroenterology and Hepatology. Interested parties should contact the respective Specialty Board Chairman for details.

PACES Demonstration Videos

Copies are available for loan from

Ms Cailina Ng
Secretary to Professor WK Lam
Tel no : 2855 4334

Medical Masterclass

The College would like to announce again the following information from the Royal College of Physicians to the Fellows, Members and trainees about the "Medical Masterclass" which may be particularly useful for taking the Joint MRCP / HKCP Intermediate Examination :

"The Education Department of Royal College of Physicians has produced the Medical Masterclass, a modular distance learning education publication, both print and web-based, to support those intending to sit the MRCP(UK) examination.

There will be a total of 12 modules as well as a CD-ROM with additional video case-scenarios and a dedicated web site with regular updates, further case-scenarios, links to relevant reviews and papers and self-assessment questions.

Prolific illustrations and clinical pictures complement the structure and style of the modules and a variety of icon boxes will encourage integration of topics as well as provide memory aids for exam preparation."

For more information please contact
Medical Masterclass
Attn: Mr Philip Saugman
Blackwell Science
Osney Mead
Oxford OX2 0EL UK
e-mail: MedicalMasterclass@rcplondon.acuk
Web: www.medirect.com/mrcp/

"Essentials of Primary Care" Certificate Course

The Hong Kong College of Family Physicians has invited our College members to participate free of charge in the above-named course. More details of the program can be found at the College website http://www.hkcp.org/news.htm

Time :
Saturday afternoons, 2:00 p.m.- 4:00 p.m.
Venue :
* Hospital Authority Building, 147B Argyle Street, Kowloon
Accreditation: CME and /or CPD credit points may be awarded depending on nature of lecture/workshop to members of HKCFP
Enrolment: Please call Ms Alice Ting at 2528 6618 for details. Registration will be first come first served

Programme:

Date	Topic	Speaker	* Venue
28-4-2001	Common Pitfalls in Infectious Diseases Management in Primary Care	Dr. Wong Ka Wah Member, Board of Education, HKCFP	Function Room, 2/F, HA Building
19-5-2001	Rational Prescribing	Prof. Jim Dickinson Professor of Family Medicine, CUHK	Function Room, 2/F, HA Building
9-6-2001	Clinical Audit	Dr. Cindy L.K.Lam Associate Professor HKU	Function Room, 2/F, HA Building
7-7-2001	Anticipatory Care	Dr. Albert Lee Associate Professor CUHK	Function Room, 2/F, HA Building
4-8-2001	Medical Ethics & Professional Behaviour	Dr. Natalis C.L. Yuen Censor, HKCFP	Function Room, 2/F, HA Building
# 1-9-2001	Emotional Problems and Counseling Skills	Dr. Luke C.Y.Tsang Consultant, Family Medicine Department of Health	2/F, Ngau Tau Kok Polyclinic
6-10-2001	Working with Families	Dr. Daniel W.S.Chu Council Member, HKCFP	Function Room, 2/F, HA Building
3-11-2001	Quality Assurance & Continuous Professional Development	Dr. Chan Kwok Wai Council Member, HKCFP	Function Room, 2/F, HA Building
15-12-2001	Chronic Illness in Primary Care	Dr. Augustine T. Lam Council Member, HKCFP	Function Room, 2/F, HA Building

Venue: 2/F, Ngau Tau Kok Polyclinic, 60 Ting On Street, Ngau Tau Kok, Kowloon
* Dates and Venues are subject to alteration. Any changes will be announced in Board of Education News of the Hong Kong Practitioner. Further information can also be obtained from Ms. Alice Ting, secretary of the College at 2528 6618.

Infectious Diseases Courses and Postgraduate Diploma Programme

The College has agreed to grant 10 CME points per course for the above Diploma Programme organized by the Centre of Infection of the Faculty of Medicine, The University of Hong Kong.

	Topics	Date
Course 3:	Common problems in infectious diseases: to treat or not to treat?	July 14-15, 2001
Course 4:	Daily infectious diseases rounds: QMH case records, immunohaematology, radiology, and radionuclide imaging in ID. Genitourinary medicine and HIV problems	November 10-11, 2001
Course 5:	Surprises in daily medical practice: tropical diseases in the developed world and public health	April 13-14, 2002
Course 6:	Infections in immunocompromised hosts, antibiotic guidelines and optimization programme, infection control	July 13-14, 2002

For further information, please contact Ms Angela Ma (Tel: 2819 9290 e mail: akfma@hkucc.hku.hk)

Programme in Epidemiology and Biostatistics

The above programme is organized by the Department of Community and Family Medicine, Centre for Clinical trials and epidemiological research, Faculty of Medicine, The Chinese University of Hong Kong to equip participants with knowledge and skills for conducting research in clinical epidemiology and public health, and for performing critical appraisals in the practice of evidence-based medicine and healthcare.

2 Programmes:

Postgraduate Diploma	Master of Science
Part-time (evening) September 2001-June 2002	Two-year part-time (evening) September 2001-June 2003 (The MSc degree has been listed as quotable qualification by the Medical Council)

Major Areas of Study includes:
Investigation of causes and prognosis of disease
Evaluation of medical interventions
Evaluation of diagnostic tests
Critical appraisal skills for evidence-based medicine
Health surveys, health economics and health policies
Statistical methods in medical and health sciences
Writing of research protocols

(For further information please contact:
Ms Pearl Chun, Tel: 2692 8306, e mail: pearlchun@cuhk.edu.hk)

Specialty Board Corner

Organisation of rotational training programmes: Role of Specialty Programme Directors

At the 61st Education & Accreditation Committee Meeting of 4 January 2001, the Committee has requested all Specialty Programme Directors to play active roles in the planning of training programmes for the specialty trainees, starting from the time when they register for training. A rotation plan within each 3-year training period could therefore be made known in advance to both trainee and the different institutions to which he/she should be rotated as per training requirements. As far as possible, all training institutions should assist the Specialty Programme Directors to achieve one-to-one exchange of trainees in all specialties, in order to satisfy the needs of the trainees as well as the operational needs of their parent departments.

Revisions to the Annual / Exit Assessment protocol for Higher Physician Training

7.1 Item 6 : Recommendation in the Final Year Exit Assessment Form A4.4 has been revised to include "Areas of deficiency and remedial actions" whenever the candidate scores a borderline fail or clear fail. This is to ensure that the Board will feedback to the candidate his / her area of deficiency so that he/she will focus on these areas during the subsequent remedial training programmes. Similar amendments will be made to the other trainee assessment forms.

7.2 Scoring System for Exit Assessment

The amended sections are shown in bold type below.

7.2.1 Each examiner is provided with an individual marking sheet for each candidate. He/she marks independently, based on the whole performance of the candidate. The marks of the examiner are summed up. Gross discrepancy between different examiners' mark (i.e > 3 for each section or subsection) is noted and brought to the attention of the examination board. Marks can only be altered if this is justified in the light of new information not previously known to the examiner(s). Otherwise the score is simple summation of all examiners' scores. All mark sheets would be revealed to candidates who fail the Exit Assessment.

7.2.2 The scoring system is a 10-point system:

10	Outstanding
9	Excellent
8	Very good
7	Good
6	Fairly good
5	Definite pass
4	Borderline failure
3	Definite failure
2	Bad failure
1	Very bad failure
0	Exceptionally bad failure

7.2.3 In the Exit Assessment, the dissertation appraisal and dissertation viva will account for 50% of the score. In the scoring of the dissertation, the dissertation appraisal will be scored by two members of the panel, the total marks from whom will form half of the Dissertation Score. Normally, two examiners will read the dissertation. When the results of the appraisal yield one failure and one pass, a third examiner will be required to read the dissertation, and the total marks given by the three examiners will be multiplied by a factor of 2/3 to obtain the Dissertation Appraisal Score.

<table>
<tr><td colspan="7">Dissertation</td></tr>
<tr><td colspan="3">Dissertation Appraisal</td><td colspan="4">Oral Assessment</td></tr>
<tr><td>Cmax=10</td><td>Cmax=10</td><td>Cmax=(10)</td><td>Omax=10</td><td>Omax=10</td><td>Omax=10</td><td>Omax=10</td></tr>
<tr><td colspan="3">Ctotal = ∑Cn if n = 2
Or
∑Cn x 2/3 if n = 3</td><td colspan="4">Ototal =∑On/2</td></tr>
<tr><td colspan="7">Dtotal = Ctotal + Ototal</td></tr>
</table>

Dissertation Score (max) =

Dissertation Appraisal (10 x 2) + Viva on Dissertation (40/2) = 40

Clinical Viva Score (max) = 10 x 4 = 40

Total Score (max) = Dissertation score (40) + Clinical viva score = 80

Candidates awarded >75% conversion score in the Dissertation may be nominated for the "HONG KONG COLLEGE OF PHYSICIANS EXIT ASSESSMENT BEST DISSERTATION AWARDS". Normally, every year after the December/January Exit Assessment, the Advanced Internal Medicine Board can nominate 3 best candidates and all the other Specialty Boards can each nominate one best candidate in the past year to enter the competition for the Gold, Silver and Bronze Awards.

7.2.4 Compensation between sections for borderline failure

If result of one section is a borderline failure (i.e. Dissertation Score = 16 to 19 or Clinical Viva Score = 16 to 19), the final score can be a pass if it is > 40 (i.e. conversion mark > 50%). However, if result of one section is definite failure (i.e. Dissertation Score < 15, or Clinical Viva Score < 15), the final score will be a failure irrespective of its exact value.

7.2.5 The mark conversion systems for Exit Assessment

Max 80 → 100%

	%
0-3	0
4-7	5
8-11	10
12-15	15
16-19	20
20-23	25
24-27	30
28-31	35
32-35	40
36-39	45
40-43	50
44-47	55
48-51	60
52-55	65
56-59	70
60-63	75
64-67	80
68-71	85
72-75	90
76-78	95

7.2.6 Exit Assessment

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

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

7.3 Scoring System for Annual Assessment

The above scoring system can be adopted for the annual assessment, provided that the supervisor's annual evaluation score also follows the 10-point system. The annual score will account for 25% and the clinical viva 75% of the total score. Three board members will give scores independently for the clinical viva. The maximum annual evaluation score is 10 and maximum clinical viva score is 30.

The following Mark Conversion System can be used for Annual Assessment

(Max 40 → 100%)

	%
0-1	0
2-3	5
4-5	10
6-7	15
8-9	20
10-11	25
12-13	30
14-15	35
16-17	40
18-19	45
20-21	50
22-23	55
24-25	60
26-27	65
28-29	70
30-31	75
32-33	80
34-35	85
36-37	90
38-39	95

Annual Assessment

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

Eligibility for Exit Assessment

The Education & Accreditation Committee noted that, for various administrative reasons, the dates of Exit Assessment have frequently been brought forward from the originally planned half-yearly (June and December) schedules. As a consequence, some trainees who would lack < 3 months of training counting from June or December may no longer be eligible to sit on the new dates of the Exit Assessments.

The Committee has determined that the following criteria should be effective immediately.

Date of completion of training	*Eligible to sit Exit Assessment*
30 September	*May-June * of same year*
31 March	*November-December* of previous year*

* Regardless of whether the Exit Assessment has been put forward for administrative reason.

External Examiners for Exit Assessment

The College encourages all Specialty Boards to include, as far as possible, international experts or external examiners from other Boards, to participate in their Exit Assessment.

Report of Overseas Training to the Specialty Board

The Trainees are reminded to report to the Specialty Board their overseas training programme, institution attached to and the period if they want that period recognized as accredited training by the respective Board.

Scientific Section

Abstracts from Update lectures of College

X-Ray Interpretations

Interpretation of Abdominal X-ray - A systematic Approach

TKL Loke, United Christian Hospital

Interpretation of the abdominal plain film presents a formidable challenge to both radiologists and clinicians. While in many cases a specific diagnosis can be made, not infrequently the appearances are non-specific or even misleading and further investigations are required.

The abdomen is composed of soft tissue similar in density to water. The demonstration of anatomic information depends on the arrangement of soft tissue with respect to fat or gas collections that lie next to, around, or within them

Functional, metabolic and mechanical diseases of the hollow viscus can be recognized by the presence, location, extent, and contour of gas.

Enlargement of organs and masses are ascertained by the effect on organ contour, contiguous bowel loops and their displacement or obliteration of adjacent normal fat.

In many conditions, distinctive patterns of calcification provide useful and sometimes definitive diagnostic information on conventional abdominal radiograph.

Understanding the interrelationship of the four radiographic densities - gas, fat, water, and calcium is fundamental for plain film interpretation. It is also essential that adequate clinical history be provided before a final opinion is given to avoid wrong interpretation of certain signs.

The purpose of this lecture is to consider the radiographic features of each of these densities in detail with emphasis on the appearance of pathological entities.

Critical Care Medicine (I)

Acute Respiratory Failure

Loretta Yam, Pamela Youde Nethersole Eastern Hospital

Acute respiratory failure (ARF) is defined by abnormalities of gas exchange. Type I ARF describes oxygenation failure. Oxygen supplementation usually suffices as treatment but ventilatory assistance is required if high inspired oxygen (FIO2) fails to correct the abnormality or if exhaustion develops, which is usually signaled by a progressive reduction in the hyperventilation response to hypoxia, resulting in normalization of the initially low arterial carbon dioxide (PaCO2) level. Type II ARF is defined by an inability to maintain a normal PaCO2 level (raised PaCO2). Type II ARF should appropriately be treated by assisting the ventilation and removing all obstacles to breathing. Such measures include appropriate hydration, means to clear the airway of secretions, management of infection and other underlying diseases, and ensuring adequate supply of nutrition. When these measures fail or need time to work, assisted ventilation should be provided to relieve respiratory distress, improve gas exchange and revert metabolic abnormalities. Assisted ventilation can be provided non-invasively through facial or nasal masks, or invasively through endotracheal intubation or tracheostomy. Depending on patient need, ventilation can be totally or partially assisted using the "control" modes or the "spontaneous" modes. The interplay among "pressure", "volume", "flow" and "inspiratory time" will be discussed, as well as the use and problems of positive end-expiratory pressure (PEEP). Important caveats in the application of ventilatory assistance in specific lung diseases like asthma, COPD, pulmonary oedema and acute lung injury, together with the relevant newer ventilatory modes and strategies, will be discussed. The importance of respiratory and non-respiratory monitoring during assisted ventilation, in particular towards the prevention of ventilator-induced lung injury, will also be highlighted.

References & further reading

1. LYC Yam. Clinical applications of oxygen therapy in hospitals and techniques of oxygen administration - a review. Journal of the Hong Kong Medical Association 1993. 45(4): 318-325.
2. Marini JJ and Nahum A (eds). Recent advances in mechanical ventilation. Clinics in Chest Medicine 1996. 17(3): 379-590.
3. Tharratt RS (eds). Mechanical ventilation. Critical Care Clinics 1998. 14(4): 563-798.
4. Amato MBP et al. Effect of a protective-ventilation strategy on mortality in the acute respiratory distress syndrome. New Eng J Med 1998. 338(6):347-354.
5. Lee WL et al. Lung-protective mechanical ventilation strategies in ARDS. Intensive Care Med 2000. 26:1151-1155.

Ventilatory support - Decision-making in the weaning process

Jane Chan, Queen Mary Hospital

Although weaning remains a popular bedside term, it has conceptually been replaced by the term "liberation from mechanical ventilation (MV)". While "weaning" signifies a process of gradually reducing ventilatory support for the patient, "liberation" puts the focus back on the patient, emphasizing a holistic approach to optimizing the patient. To time weaning/extubation accurately is a major challenge for the clinician, as high price is paid for either liberating a patient from MV too early or not early enough. Failed extubation has been shown to increase the risk for death and ICU length of stay. Prolonged MV has been associated with increased incidence of nosocomial pneumonia.

In the decision-making process, the clinician should ask the following questions:

1. What is the cause of the acute respiratory decompensation which necessitated MV in the first place? Was it a fulminant pneumonia, septic shock, or bronchospasm? Whatever acute pathophysiologic process which necessitated MV must have been addressed and largely resolved before one can plan for weaning/extubation.
2. Is the patient alert enough for taking control of his airway and for participating in the work of breathing (WOB)? Sedatives and analgesics used during the acute phase for patient comfort needs to be backed down to allow establishment of a day/work-night/sleep cycle.
3. Are all the numbers right for challenging the patient with the WOB? The process of "liberation" involves shifting the WOB from the ventilator back to the patient. Such shift will significantly drive up patient's O2 consumption. Factors compromising O2 delivery will make this shift of WOB difficult. Such factors include shock states, severe anemia, and poor cardiac status. Hemodynamic stability and acceptable hemoglobin and PaO2 (at FIO2 <40-50%) are required for a safe transition. Other important "numbers" include fluid status (avoid fluid overload), electrolytes (esp. K+ and PO4-), acid-base status and nutritional status.
4. What is the nature of the "substrate" and what has been the time course of critical illness? "Substrate" refers to the pre-morbid physiologic condition of the patient. A patient previously healthy or well-compensated suffering from a brief critical illness, such as acute pulmonary edema, asthma, or drug overdose, can usually be extubated promptly without weaning once the critical illness resolves. Patients previously in poor health, or who have had a long-drawn critical illness requiring prolonged MV may need more gradual weaning.
5. Is the patient ready for a spontaneous breathing trial (SBT)? There are many bedside weaning parameters used to predict successful extubation, and they mostly focus on assessing respiratory muscle strength vs. load. Although these respiratory mechanical parameters are useful in delineating the ventilator-dependency state, they are less "user-friendly" and less predictive of weaning success than the index of rapid shallow breathing, the RR (breaths/min)/Vt (tidal volume in litres) ratio during a 1-min T-piece trial. If the ratio is <105, then a SBT is conducted for 30-60 minutes. A successful SBT would lead to immediate extubation.
6. What if the patient fails a SBT? If so, a holistic re-look at points 1-3 above is indicated. An action plan should also involve every effort in eliminating excessive respiratory workload and in optimizing respiratory neuromuscular performance. Regardless of the choice of weaning mode, the clinician needs to adopt a multidisciplinary approach aiming at active reconditioning/rehabilitation and at optimizing the patient's physiology. SBT should be repeated daily to assess extubation potential.

References

1. Mathous CA et al. Liberation from mechanical ventilation: A decade of progress. Chest 1998: 114:886-901.

2. Marini JJ. Weaning from mechanical ventilation. NEJM 1991; 324:1496-8.

3. Yang KL & Tobin MJ. A prospective study of indexes predicting the outcome of trials of weaning from mechanical ventilation. NEJM 1991: 324: 1445-50.

4. Esteban A et al. A comparison of four methods of weaning patients from mechanical ventilation. NEJM 1995; 332: 345-50.

5. Esteban A et al. Effect of spontaneous breathing trial duration on outcome of attempts to discontinue mechanical ventilation. Am J Respir Crit Care Med 1999; 159: 512-8.

Infections and rational use of antibiotics in the ICU

Pak Leung HO, Department of Microbiology, University of Hong Kong

Infections are increasingly common among patients in the intensive care units. The rising incidence of infections is related to a number of factors such as an increasing number of immunocompromised patients, an aging population and a growing reliance on invasive procedures in the management of the critically ill patients. Sepsis, as a complication of overwhelming infection still poses a formidable challenge to intensivists. It is only reversible when appropriate therapy is given early and this underscores the importance of early administration of effective empirical antibiotic therapy. In the critically ill patients, empirical therapy has to be initiated before

one has knowledge about the culture results. The choice should provide adequate coverage of potential pathogens at the clinically defined infection site(s). To do this in a rational manner, one has to become acquainted with the frequency of occurrence of common pathogens and their antimicrobial susceptibility. In this regard, it is important that local information and preferably the institution's own data be used.

All too often, the focus of antibiotic use is only restricted to the adequacy for an individual infection. For the sake of the individual patient, the natural inclination is to over-prescribe and be excessively broad in spectrum. Increasingly evidence has revealed that excessive use of antibiotics can be as sinister as under-usage. Notwithstanding the complexity of the antibiotic resistance problem, there are sufficient reports of the association of antimicrobial usage in hospitals with emergence of antimicrobial resistance to implicate use as a causal factor in antimicrobial resistance. Some appears to be preventable. Outbreaks of certain troublesome antibiotic resistant pathogens such as Vancomycin-Resistant Enterococcus (VRE), extended-spectrum beta-lactamase (ESBL) producing bacteria and Clostridium difficile have been controlled by improvement in the use of antibiotics. All antibiotics select for resistance but their potential in terms of ease in selecting resistance were different. With regard to antibiotic class, overuse of third generation cephalosporins has been linked to outbreaks of VRE and ESBL. Glycopeptides has been associated with VRE, and carbapenems with imipenem-resistant Pseudomonas aeruginosa and Stenotrophomonas maltophilia.

Antimicrobial resistance results in increased morbidity, mortality, and cost of healthcare. Guidelines have been published, for example by the SHEA/IDSA for the prevention of antimicrobial resistance in hospitals. Many medical centers in North America have started programs directed at the judicious use of antibiotics. Given the tremendous burden of some notorious pathogens in Hong Kong as compared to Europe and North America, it is imperative that countermeasures be implemented urgently. Of the current hospital isolates in Hong Kong, ESBLs are detected in 10 to 20% of Escherichia coli and Klebsiella species, and 40(60% of Staphylococcus aureus are resistant to methicillin. The first VRE was detected in 1997 and since then have been reported in six hospitals. In a territory-wide survey of intensive care units in Hong Kong, 10(15% of the patients were colonized with MRSA and 3rd generation resistant Gram negative rods.

In the update lecture, experience at the HKU University Medical Center will be presented and discussed. The evidence behind some current practice in patterns of antibiotic prescriptions will be reviewed.

Continuous Renal Replacement Therapy (CRRT) in Critical Care

CB Leung, Department of Medicine and Therapeutics
Prince of Wales Hospital

Acute renal failure (ARF) is known to have a high morbidity and mortality. If ARF is combined with other organ failure, or even multi-organ failure (MOF), as often seen in ICU, the mortality is even higher. Whether to start a patient with ARF on dialytic support and when to do so are the most fundamental questions for the nephrologists and intensivists in the ICU setting. Despite advances in dialysis technique and improvements in equipment, it is still unclear when dialysis should be offered and which method is the most appropriate.

There are differences between dialytic therapy in patients with end-stage renal failure and those with acute renal failure associated with MOF in the ICU. Patient in ICU with MOF usually have rapid deterioration of renal function, providing no time for adaptive process. Further, therapeutic interventions often means giving volume and solute to these patients in excess of their renal excretory capacity. In such context, dialytic intervention in ICU patient is more of renal support than renal replacement, aiming to maintain internal hemostasis, prevent further insult to kidneys, promote healing and renal recovery and to permit support measures to other organ systems without limitation.

Different techniques of CRRT, brief circuit design, complications and the use of dialysis for non-renal problem will be discussed briefly. The application of CRRT techniques is rapidly expanding. The choice depends on the understanding of the basic principles of the techniques and the underlying condition of the individual patient. Flexibility and individualized approach is required.

Suggested Readings (Journal / Book / Internet resources)

1. Mehta RL. Indications for Dialysis in the ICU: Renal Replacement vs Renal Support. Blood Purif 2001; 19: 227-232.
2. Galley H (Ed). Critical Care Focus 1: Renal failure. BM J Books 1999.
3. Ronco C et al. Effects of different doses in continuous veno-venous haemofiltration on outcomes of acute renal failure: a prospective randomized trial. Lancet 2000 1; 356: 26- 30.
4. WWW.ADQI.NET

Aim of treating ARF in ICU

1. Maintain internal homeostasis
2. Prevent further insult to kidneys
3. Promote healing and renal recovery
4. Permit other support measures without limitation

Nutritional Support for Critical Care

Wing-Wa Yan, Intensive Care Unit, Princess Margaret Hospital

Severe malnutrition is unfortunately common in critically ill patients and it is one of the most important contributory factors to mortality. Although numerous biochemical and hormonal abnormalities occur in such patients, disturbances of carbohydrate, protein and lipid metabolism are most relevant for and responsive to nutritional therapy. In all critically ill patients, appropriate nutritional support should be instituted without delay.

Objective measurements of using triceps skin fold, transferrin, albumin, prealbumin, retinol-binding protein and delayed cutaneous hypersensitivity have been used to calculate the prognostic nutritional index. However, they have not been well evaluated and validated in critically ill patients. Subjective global assessment utilizing clinical parameters such as history, physical findings and symptoms has shown to give reliable and reproducible nutritional assessment.

Optimal calorie, protein, carbohydrate and lipid should be provided. Overload may just be as harmful as not feeding at all. The usual protein requirement has been estimated to be 1.2 to 1.5g/kg/day. Protein needs to be reduced in case of renal and hepatic failure. Most of the critically ill patients are highly catabolic and have altered organ function and some glucose and fat intolerance. A nutritional formula with nonprotein calorie to nitrogen ratio of 100 to 120:1 is indicated. This kind of formulation meets the very high protein requirement of these patients and provides smaller doses of glucose and fat, which are not well tolerated. As the patients begin to improve, the ratio could be gradually switched to 150:1 which is appropriate for patients with minimal organ dysfunction and are nutritionally stable.

Enteral feeding is the preferred route of nutrient administration because it has been shown in clinical studies to reduce infection, and preserve gut integrity and barrier and immune function. Current recommendation supports initiation of enteral feeding as soon as possible after initial resuscitation. The only contraindication is a nonfunctioning gut. Standard isotonic polymeric formulations can meet most patients' nutritional needs. The use of elemental formulas should be reserved for patients with severe small bowel malabsorption. In general, the rationale for the use and clinical role of disease-specific regimens is controversial. Immune enhancing diet or immunomodulatory nutrition would be useful in post-operative or trauma patients. Despite the advantages of enteral nutrition, the targeted amount of feed can sometimes be difficult to achieve. It is also associated with complications which are mechanical (tube dislodgment, obstruction), gastrointestinal (diarrhea, aspiration, ileus, pneumatosis intestinalis or necrosis) and metabolic (electrolytes disturbances, uraemia, encephalopathy).

Nutritional goals can be achieved more often with parenteral nutrition than enteral nutrition. However, it is associated with more complications like hyperosmolality, hyperglycemia, and hypertriglyceridaemia. Complications associated with central line placement include pneumothorax, catheter malposition, catheter sepsis and central vein thrombosis.

In conclusion, the goal of nutritional support for critically ill patients is to optimize the patient's metabolic response to injury by improving their immune function, reducing inflammation, maintaining gut barrier function, and minimizing nitrogen deficit.

Key-points

* Critically ill patients require calorie intake up to 50% above normal to reduce nitrogen losses.
* During acute phase, zero nitrogen balance may not be possible, and increasing nitrogen intake beyond 14g per day has little effect.
* The goal is to provide adequate but not excessive amounts of energy. Overload may just be as harmful as not feeding at all.
* A minimum of 100g of carbohydrate per day is needed to prevent ketosis.
* Whenever feasible, enteral nutrition is preferred over parenteral nutrition.

Cardiac Support in Critical Care

Wilson Chan
Department of Medicine and Therapeutics, Prince of Wales Hospital

Cardiac Support is important in many areas of critical care. Both transthoracic (TTE) transesophageal echo (TOE) are very helpful to make diagnoses and to guide treatments. Examples include unexplained hypotension, unknown causes of heart failure, complications of trauma to chest, and pulmonary embolism. The use of TEE is frequently limited in patients in ICU e.g. post trauma or post-operation, TOE is useful not only in these situations and it also has other indications including evaluation of prosthetic valves, complications of endocarditis, intracardiac masses/thrombi.

Cardiac Support is essential in patients with suspected acute coronary syndrome/acute myocardial infarction. In patients with cardiogenic shock, intra-aortic balloon pump (IABP) combined with immediate revascularication is the treatment of choice but the mortality remains poor (50%) even with this combined strategy as shown in recent SHOCK TRIAL. The addition of Gly IIb/IIIa inhibitors may improve the outcome of these patents. The usefulness of this invasive approach in elderly patients (>75 yrs old) is however questionable. Right ventricular infarct can also result in hypotension and a small percentage will develop cardiogenic shock. Adequate volume expansion with inotropic support will be required and guided by Swan-Ganz catheter if necessary. In unresponsive cases, IABP may help especially if there is significance LV dysfunction. Pericardiectomy can be attempted in refractory cases.

Apart from direct angioplasty, percutaneous coronary intervention (PCI) should be performed in cases when thrombolysis failed. Diagnosis of failed thrombolysis, however, is difficult and and quite often too late for any intervention. At the moment, we rely on clinical symptoms, resolution of ST elevation (>50% from maximum ST elevation), absence of reperfusion arrhythmia (poor sensitivity) and early enzymes rise (too late) for the diagnosis. Failed rescue angioplasty is associated with a high mortality (25-40% vs 5-10%).

Other catheter-based interventions include IABP, pericardiocentesis, and mechanical devices for pulmonary embolism. IABP is indicated in situations including cardiogenic shock, mechanical complaints of AMI (VSD/MR), high risk CABG/PTCA. Vascular complications are getting less frequent as the size of the IABP balloons is coming down. Other complications include infection, thrombocytopenia and aortic dissection. Pericardiocentesis should be performed under ECG monitor, 2D echo guidance or fluoroscopy. Cardiac puncture should be suspected in severe hypotension or continuous profuse drainage. In acute pulmonary embolism, cardiologists can perform 2D echo to look for RV dysfunction which is one of the indications for thrombolytic treatment. In massive PE, mechanical devices can be considered. These include simple fragmentation of the clots by catheters followed by intrathrombic thrombolysis or mechanical thrombobectomy devices that could break up and aspirate the thrombi.

Other common areas that need cardiac support is cardiac arrhythmia, which is very common in ICU patients, as precipitated by myocardial ischaemia, raised catecholamines levels, electrolyes abnormalities, hypoxia, and acid-base imbalance.

Key Points

1. Prognosis of cardiogenic shock remains poor but IABP with revascularisation is the treatment of choice for patients < 75 yrs old.
2. Thrombolysis should be given in patients with PE who are haemodependly unstable or with RV dysfunction.
3. RV perforation is not uncommon with pericardiocentis. Therefore, this treatment should be performed in the presence of significant pericardial effusion. Alternative method like pericardial window by surgeon if size of effusion is only moderate.
4. TEE/TOE are useful in patients with unexplained hypotension, good example is patient with dynamic LVOT obstruction precipitated by dehydration.
5. Gly IIb/IIIa inhibitors are indicated in patents with ACS/AMI/failed thrombolysis undergoing PCI.

Diary

Update Lectures 2001

Venue : Seminar Room 1, HAHO
Time : 14:30 - 16:30 h

The Scientific Committee of our College, under the chairmanship of Prof Joseph Sung, has organised a series of update lecture every month for MRCP as well as AIM Annual and Exit Assessment candidates. The purpose of the lectures is to widen candidates' horizon and to introduce them to different aspects of the medical subspecialties, to better prepare themselves for the relevant examinations. These lectures also help the AIM candidates to prepare their Exit examination in AIM as these lectures cover the scope of clinical practice required in the training programme. Please note that CME points will be awarded for attendance. Thus, all College Fellows, Members and trainees are encouraged to attend. The schedule of the update lectures for the coming months in 2001 is as follows:

Date	Topic	Course Director
2 June 2001	Data Interpretation 1. Alex W.Y. Yu- Acid-Base Disorders 2. C.K. Chan- Cardiac Diseases 3. C.M. Chu- Interpretation of Lung Function Tests 4. Vincent T.F. Yeung- Endocrine Disorders	Vincent Yeung
7 July 2001	Interventional Radiology	KC Ho
4 August 2001	Medical Illness in Pregnancy (II)	SC Tiu
8 Sept 2001	Clinical Trials	YW Luk

14th Annual General Meeting

The College will hold its fourteenth Annual General Meeting at G/F, Pao Yue Kong Auditorium, Hong Kong Academy of Medicine Jockey Club Building, 99 Wong Chuk Hang Road, Aberdeen, Hong Kong on Friday, 1st June 2001, followed by Congregation and Annual College Dinner. Professor Arthur Kwok-Cheung Li, Vice-Chancellor, The Chinese University of Hong Kong, will deliver the Sixth AJS McFadzean Oration entitled "Reflections of a Surgeon". All Fellows and Members are welcome. Please register with the College Secretariat on or before 11 May 2001.

Joint Scientific Meeting

This year's Joint Scientific Meeting of the Hong Kong College of Physicians, Hong Kong College of Pediatricians, Hong Kong College of Family Physicians and Hong Kong College of Pathologists will be held on 27th-28th October 2001 in the Hong Kong Academy Of Medicine Jockey Club Building. This year's main theme will be Ambulatory Medicine for 2001.

Examination Results

Joint MRCP/HKCP Intermediate Examination Feb 2001 Pass List

Chan Kai Ming
Chan Ngar Yu
Chen Wai Tsan
Cheung Man Kuen
Chim Wai Ying
Choi Man Chun
Choi Wai Lap
Chow Chee Wung
Lam Siu Fung
Lau Ching Wa
Lau Kar Pui
Law Wai Lam
Ma Pui Shan

Exit Assessment for Fellowship in December 2000 Pass List

Advanced Internal Medicine
Chan Kit Yan, Selina
Chan Wing Bun
Chan Yat Sun, Joseph
Chang Kwong Kui Fa
Cheng Wing Keung
Cheung Yuk Fai
Chiu Alexander
Jim Man Hong
Ko Pat Sing
Kong Pik Shan
Lai Wai Keung, Steve
Lam Bing
Lam Chiu Wah
Lee Kang Yin
Lo Hok King, Stanley
Lui Hiu Tung, Colin
Myint Ma Wai Wai, Jennifer
So Wing Yee
Tom Kam Tim
Tong Bing Chung
Tong Mei Wai, Gensy
Tsang Kin Lun
Tse Hung Fat
Tse Lap Shing, Samuel
Wan Man Choi
Wong Wai Ming
Yip Wai Kwok, Gabriel
Yuen Man Fung

Cardiology
Lam Yui Ming
Leung Tat Chi, Godwin

Critical Care Medicine
Lam Koon Ngai
Choo Kah Lin
Poon Yat Sing
Wan Wing Lun

Endocrinology, Dabetes & Metabolism
Kam Yee Wai, Grace
Lee Ka Fai

Gastroenterology and Hepatology
Chan On On, Annie
Leung Chi Man
Wong Sau Wai, Grace
Wong Wai Hing, Cecilia
Wu Che Yuen, Justin

Geriatric Medicine
Chiu Ka Chun, Patrick
Hui Kwok Fai
Leung Ho Yin
Mok Chi Chiu
Wong Ching Yuen, Grace

Nephrology
Lee William
Tang Wing Chung, Anthony

Rehabilitation Medicine
Cheng Hing Ming
Chui Tak Yi

Respiratory Medicine
Chan Kam Keung
Ho Chung Man, James
Leung Wah Shing
So Kit Ying, Loletta

Letters to Editors

Editorial Note:

SYNAPSE serves as a bridge between College and members. It welcomes submissions that are related to articles in SYNAPSE or matters of common interests to members. There should have no personal attacks in its contents. The Editorial Board reserves the rights to edit all letters and decision for publication or not. All letters must carry writer's full name and address, though you may request to remain anonymous when it is published.

Letter:

Dear Dr Li,

Re: Journal References

Thank you for bringing to us such a wonderful Newsletter in the form of SYNAPSE. I enjoy reading the publication every time it comes out. I do have a suggestion as regards to editorial policy.

Many of the articles such as those contained in the December issue did not include references. I believe that in the absence of detailed referencing, the authority of the article drops significantly. As a matter of fact, I generally will try to avoid articles that are not referenced because with the overwhelming amount of new information that come out every month, we have no choice but to be selective in what we read. If you read a review article in the New England Journal, you will see abundant referencing. You may say the SYNAPSE is not the New England Journal but my question is: why should I read SYNAPSE if it is not of the highest standard. Will I be wasting my time reading a paper that is of a lesser quality? All of us have written papers for submission to medical journals and I am convinced that when the author starts referencing the paper, it always comes out better.

In conclusion, the SYNAPSE should require that all review articles submitted be properly referenced, and it does not matter whether the author is a senior academic or not.

Thank you for your time and kind attention.

Best Regards

Ying-Sui Archie Lo

Reply from the Editor:

Dear Dr. Lo,

Thank you for your Letter and suggestions. Some of the points are well taken as we also agree that, in general, references available in the articles of our Scientific Section would benefit our readers. However, there is a limitation on the space in SYNAPSE that can be provided for all the references that the author sometimes would like to list in a review.

From this issue onwards, our contributors to the scientific articles (mostly on Update Lectures) are suggested to list:

1. A summary of up to 5 Take Home Messages
2. Up to 5 references/further readings

The number 5 is arbitrary but takes into account the space that SYNAPSE can provide. Currently, our editorial policy is to let the authors exercise their judgment on putting up references based on our suggestions.

Once again, thank you for your interest and compliments.

Best Regards,

Editorial Board,
SYNAPSE

Events

Joint MRCP(UK) II / HKCP Intermediate Examination Examiners' Meeting Feb 2001

The Joint MRCP(UK) II / HKCP Intermediate Examination was held for the last time in the old format in Hong Kong from 19th - 23rd February 2001. From May 2001 onward, the examination will be held in the new format of PACES. With the new administrative arrangement for PACES, there will not be any Examiners' Meeting at the end of the examination to discuss and provisionally announce the results. On 23rd February, a reception was held for the last time at the Kong Siu Luey Lounge of Robert Black College for the MRCP/HKCP examiners to congratulate the successful candidates.

The President and other local and overseas examiners congratulating some of the successful candidates of the Joint MRCP(UK) II / HKCP Intermediate Examination.

The President and Dr. C. Semple, Senior Examiner, addressing the successful candidates.

PACES Demonstration Feb 2001

In the afternoon of 23rd February, a demonstration session for PACES was held at the Pamela Youde Nethersole Eastern Hospital. It was conducted with mock candidates and included all five stations of the examination. It was well attended by over fifty local examiners and trainers as well as the overseas examiners and there was useful discussion on the various aspects of the new format of examination. The College is planning to organize further mock examination including special sessions on communication skill to prepare the candidates for the new format of PACES.

Dr. JCJL Bath, Deputy Senior Examiner, discussing a point about the logistics of PACES with the participants.

Dr. Loretta Yam, host for the PACES demonstration, with the overseas examiners at Pamela Youde Nethersole Eastern Hospital.

The briefing session for PACES was well attended and participants showed keen interest in the various details of the new format of examination.

The "History Taking" station in action.

Feature Story

Dr. SUN YAT SEN (孫中山先生) and His Early life with Medicine of Hong Kong

Much has been written about Sun Yat Sen (孫中山 [逸仙]) (1866 - 1925) and his political endeavours, but less about his career as a Hong Kong qualified doctor. This article traces in more detail his early life.

He was born in November 1866 - the exact day was not recorded - into a farming family in Zhongshan (中山) County, about 30 miles north of Macau. He lived there until he was twelve, the longest period of continuous residence he was ever to have in China. He attended the village school which functioned intermittently, whenever the community had enough money to pay for a teacher.

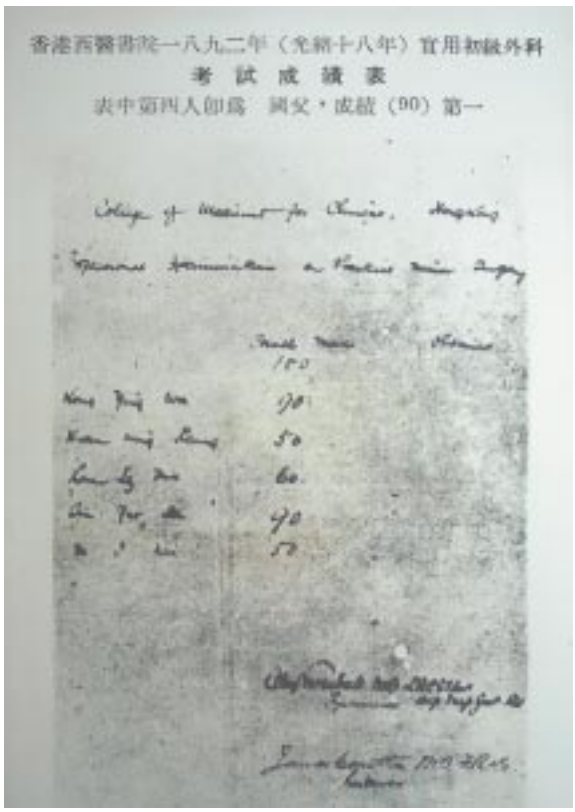
His brother, Sun Mei （孫眉), fifteen years older than himself had emigrated to Honolulu to work on a farm. In 1879 Sun Yat-Sen sailed from Macau on the ship 'Grannoch' to join him.
He entered the 'Bishop's College School' known as Iolani College, a Church of England boarding school. Having no English, he had to work hard. Here it was that he was taught about Christianity.

In 1883 he returned to China and that year was baptised by an American missionary. In November he enrolled at the Diocesan Boys School. However he only stayed there for one month, leaving, perhaps because his father had just died.
He returned to Hong Kong in April 1884, enrolling as Sun Tai Tseung (孫帝象), at Queen's College (previously named Government Central School, and Victoria College), staying there for just over two years.

Aged 18, his family arranged for him to be married to a girl from his home area. It was the 13th day of the 4th moon of 10th year of the reign of Emperor Kuang-hsu (光緒), May 7th, 1884. Being a student for the next eight years meant that he saw little of her.

His brother, hearing that Sun Yat Sen had been baptised a Christian and was spreading Christianity to his friends, insisted that he return to Hawaii and refused to pay for further schooling.

With the help of funding from the church in Honolulu Sun Yat Sen returned to Hong Kong to study to become a Christian minister. However there was no theological seminary in Hong Kong or Canton where he could get training - so with the help of a missionary friend he joined a Dr Kerr of the 'Canton Medical Missionary Society' who taught western medicine to


香港西醫書院一八九二年（光緒十八年）實用初級外科
考 試 成 績 表
表中第四人即孫 逸仙・成績（90）第一

Dr. Sun Yat Sen's Examination results on Practical Minor Surgery in The College of Medicine for Chinese, Hong Kong in 1892. Dr. Sun's result was at the 4th row with the highest score of 90.

(Photo courtesy of the Hong Kong Museum of Medical Sciences)

Chinese students at the Pak Tsai hospital in Canton.

Here it was that he is reported to have started thinking and talking of revolution, with fellow students Lu Hao-tung (陸皓東) and Cheng Shih-ling (鄭士良). He worked at the hospital to pay for his tuition, staying one year.

He left Canton to be one of the first students to enrol at the 'Hong Kong College of Medicine' when it opened in October 1887 at the newly built Alice Memorial Hospital, run by The London Missionary Society. The hospital was built with a donation from Dr. Ho Kai Ho in memory of his wife Alice who had died of typhoid two years after her arrival in Hong Kong. It was situated at the intersection of Aberdeen and Hollywood Roads. His teachers included Dr. William Hartigan, Dr. Gregory Jordan, Dr. (later Sir) Patrick Manson and Dr. (later Sir) James Cantlie.

After five years of study Sun Yat Sen graduated with the first five students, earning a Certificate of Proficiency in Medicine

and Surgery. He started his medical career in Macau, in 1892, practising surgery in a Chinese hospital, which had up till then only used Chinese medicine. Dr. Cantlie would come across from Hong Kong to assist in major surgery.

'Surgical work is not conducted in China with the privacy that attends similar work in Britain. At Sun's operations the lay committee of the hospital came and seated themselves near the operating table, and the relatives and friends of the patient stood around watching the proceedings attentively. Especially did the manipulations in cutting for stone interest the onlookers.'

When asked later why he travelled from Hong Kong to Macau to assist his former pupil, Dr. Cantlie wrote, "His is a nature that draws men's regard to him and makes them ready to serve him at the operating table or on the battlefield; an unexplained influence, a magnetism which prevaileth and finds its expression in attracting men to his side."

Another medical missionary, Dr. Nelson described him as, "A short stocky man, deliberate in his movements and very gentle in his manners."

Within months he was forced to leave Macau because of the imposition of a law that required all doctors to have a Portuguese Diploma before they could practice in that colony.
He moved to Canton to continue his practice, but in 1893, hearing about a new medical college being started by Viceroy Li Hung-chan (李鴻章) in Tientsin (天津), he travelled there with his friend Lu Hao-tung. Unfortunately, there were no jobs available.

By the following year Sun Yat Sen was firmly set on a revolutionary path. In 1895 his first attempt at rebellion in Canton was quashed before it got going, resulting in the arrest of seventy companions and the execution of three, including his close friend Lu Hao-tung.

Dr. Sun managed to escape, to begin a sixteen-year period of exile, never coming openly to Hong Kong, China or Japan.
On 11th October 1896 Sun Yat Sen was kidnapped and held prisoner in the Chinese legation in London. He was there for ten days while the legation waited for funds from Peking to charter a boat to smuggle Sun Yat Sen back to China, and probable execution.

He managed to get a letter to Dr Cantlie who, with Sir Patrick Manson, alerted the police, the Foreign Office, and the Press. Ultimately, the Prime Minister, Lord Salisbury advised the legation that what they planned was illegal, and Sun Yat Sen was released.

In 1904 he applied for, and was granted, a US passport on the strength of an affidavit that said,"....I was born in Waimanu, Ewa, Oahu, on the 24th day of November, A.D. 1870; that I am a physician, practicing at present at Kula, Island of Maui; that I make my home at said Kula;..."

At the time he was visiting his own wife and three children, who were living with his elder brother, at his brother's cattle ranch in Maui. Without an American medical registration it must be doubted if he ever practiced medicine in Hawaii. After his father's death his brother had assumed full responsibility for the family, supporting Sun Yat Sen through medical school, and Sun's first wife and their children.

Dr. Cantlie comes into Sun Yat Sen's life on one other historic occasion, and a happier one.

In 1911 the revolution had started at Wuhan. Sun Yat Sen heard about it first in Denver, Colorado, and began to make his way back to China. When he reached London and Dr Cantlie's flat he was handed a telegraph in cipher, which he hurriedly decoded. It invited him to return to China with the prospect of becoming the President of the Republic.

His last visit to Hong Kong was in 1923, when he was Generalissimo of the Southern Republic and the Northern Militarists were in power in Beijing. 'At Hong Kong he stopped off long enough to be the guest, on February 20th, of Hong Kong University, with which Queen's College is now affiliated. A crowd of cheering students met him at the university gate, and carried him on their shoulders from the automobile to the auditorium...., where he addressed a hall full of demonstrative young people.'

John Mackay

Sources:

Sun Yat Sen His Life and Meaning, by Lyon Sharman (1934)
Sun Yat Sen and the Awakening of China by James Cantlie and C. Sheridan Jones
(The Editorial Board is grateful to the Hong Kong Museum of Medical Sciences for the Chinese translation)

Erratum

In page 21 of the Dec 2000 issue of Synapse, there was an error in the caption.

The Editorial Board sincerely apologises to both Dr. Roland Chong and Dr. Benjamin Ong for any inconveniences caused as a result of this error in the caption.

"Photo here (from L-R) is Prof. JY Sung, Dr. Chew Chin Hin, Dr. NDC Finlayson, Dr. Richard Yu and Dr. Benjamin Ong"