



SYNAPSE

Hong Kong College of Physicians

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RESTRICTED TO MEMBERS ONLY



"Morning cock"

This was painted by Mr Leung, aged 83 years (1912-1998), who suffered from a stroke in 1995. Following rehabilitation at the Princess Margaret Hospital Geriatric Day Hospital, he managed with his weakened right hand to draw this painting to wish all staff a Happy Chinese New Year.

Courtesy of Princess Margaret Hospital

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Special Article

Message from our new President

Dear Fellows and Members,

May this communication bring you Greetings of the Season and wishes for a productive and successful 2005.

This communication is my first as your President. I have just taken up the Presidency in October 2004 from our previous President, Professor Richard Yu. I anticipate the challenge and hard work ahead of me following the footsteps of our previous presidents.



During the last six years serving the Council as the vice-president, I have observed the progress of our College in setting a leading standard in training and the implement of practice-related skill assurance within the Academy. Perhaps in the next three years, my first objective is to consolidate these novel developments that our College has achieved in the last few years. The second important objective is to ensure training programs and physician manpower are updated periodically and this information are available to trainees and Fellows regularly through Synapse and from our College website. The third objective of the College is to introduce a new information technology system such that CME/CPD activities and training records can be accessed electronically in the near twelve months. Lastly, the College is actively restructuring the annual and exit examinations for all subspecialties. Our target is to ensure all questions are planned, selected, tailored, and well-orientated to daily common medical problems hence formulating an objective structural examination as in PACES. This will serve as a comprehensive and fair examination for higher physician trainees.

The College was established as the sole institution to set standards, accredit standards, and monitor the standards of training and practice of physicians in Hong Kong. In many aspects, the novelty and initiatives of our approach in training have spearheaded the development in the Academy of Medicine and other sister colleges. Furthermore, our close relationship with other Physician Colleges worldwide enables our College to adopt a cosmopolitan attitude in practicing the art of healing and the science of medicine. A universal and holistic approach to medicine must be the guiding principles for us to achieve our objectives irrespective of and in spite of political challenges. We will work closely with the Academy of Medicine, the Medical Council and the Hospital Authority as partners to gain the profession's support and the community's respect. The College continues to advocate good doctor-patient rapport and we will be stringent in maintaining the highest professional standard. Yet we do not encourage the proliferation of medico-legal litigation, often initiated due to inadequate communication, misunderstanding, or unreasonable expectation. Thus, the College is seeking to do more through involvement in different government statutory and advisory bodies, and specialty societies to ensure that the community will be given the knowledge of development as well as limitation of modern medicine.

Looking back at the last four years, I am proud to say that despite the unexpected emergence of SARS, avian flu, dengue fever and other diseases, Hong Kong through her solid foundation in medical education, has remained one of the few regions providing excellent and advanced medical care with maximal cost-effectiveness.

It has always been our belief that the College must not only be internationally recognised but also produce international impact. The College is a leading member of the IACAP (International Association of College and Academy Presidents). Our Council members sit in the Policy and Examination Boards of the MRCP(UK) examination. Our College has recently provided external examiners for the specialist qualification examination in Macau. I believe this is only the beginning of our new course in international medicine.

On behalf of the new College Council, I look forward to all Fellows and Members to give their utmost to support your College.

Professor K.N. Lai
January 1, 2005

President's Address to the congregation at the 17th Annual General Meeting

Richard YH Yu
President, HKCP

This evening I am bidding you all farewell as the President of the College, having held the helm for the past six years. I am relinquishing my Presidency to a very able and capable successor Prof KN Lai. I would like to thank you all for having given me the opportunity, privilege and honour to serve the College. It has been an enormous challenge and I have had the pleasure and satisfaction to see our College grow from strength to strength. No doubt credit has to be given to our very devoted, supportive and dedicated Council and I would like to offer our Council Members past and present my sincere thanks, gratitude and appreciation.

You all remember the very devastating and calamitous SARS outbreak in the year 2003 and I am proud of our Fellows, Members and trainees for their enormous personal sacrifice, devotion to duty and selfless dedication in fighting and overcome this initially unknown epidemic. Had it not been for the brilliant hard work of one of our Fellows Prof Yuen Kwok Yung and his team in identifying the coronavirus in such a short span of time the consequences would be unimaginable! It is most unfortunate that we have a Judas in our midst who was not satisfied with the deliberation by an international panel consisting of experts of repute but called on a Select Committee with one and only one aim – witch hunting! To quote Professor Sian Griffith, Co-Chairman of the Panel, President and Professor of the Faculty of Public Health "Whilst the Select Committee process is still ongoing, our view remains that no individual was to blame, that Hong Kong responded well to SARS overall, and that the most important thing is to get on with establishing the Centre for Health Protection and other recommendations". I personally think this Select Committee has done more harm than good to our profession. Wasting resources is but a small price to pay. Subjecting all the frontline health workers particularly our Fellows, Members and Trainees to all the indignity and torment behind the skirt of "Privilege" by people with a warped sense of justice is totally unnecessary, unjustified and counter productive in improving our healthcare system. Its report is now history. What has it achieved? The unfortunate and untimely resignation of two leading professionals who have devoted their entire lives and careers to improve the healthcare of the community. You would agree with me that what we have today is more than 100% better than 20 to 30 years ago. Their resignation is indeed a very honourable and noble act, an act to protect the medical profession and the Hospital Authority from further abuse by the public who had been provoked into a state of emotional frenzy – what our founding President Professor Sir David Todd called "Mob rule not unlike the French Revolution!!" This evening we will honour them by conferring the highest accolade that can be bestowed by our College – our Honorary Fellowship.

We are most fortunate that the SARS didn't return to haunt us and hopefully never will. It is time now for us to reflect. To all the healthcare personnel, to all Fellows and Members of the College, to all Faculty members of the two medical schools, to all the leaders of the profession, let us not squabble, let us not quarrel, let us not point an accusing finger at one another, let us not stab one another's back, let us join hands to work for a common cause – to build a caring profession, to build a clean society – fully prepared to face any new challenge of emerging or re-emerging infection this coming winter. I am confident our profession with selfless dedication and sacrifice will once again overcome these adversities provided that there is no political interference.

To the newly elected Fellow Graduates and Members I offer my warm and sincere congratulations. This is a very important milestone in your professional career as a physician. Having witnessed the darkest chapter in the history of the profession, the one important message I offer to you all – don't mix politics with medicine. As I have said before, Medicine is a noble profession whilst politics is but a dirty game! I hope you will all endeavour to rekindle and uphold the dignity of our profession with professionalism and conviction in your future career.

President's Annual Report 2004

Richard YH Yu
President, HKCP

In the year of the Monkey 2004, Hong Kong SAR and in particular the College of Physicians witnessed one of the darkest Chapters in our history. Having weathered the devastating onslaught of the deadly coronavirus so bravely and successfully by our Fellows, Members and Trainees we so unexpectedly and unwittingly witnessed the injudicious and unfortunate resignation of Dr EK Yeoh, a Founding Fellow, first Chairman of the Education and Accreditation Committee and formerly Vice-President External Affairs and Secretary for Health, Welfare and Food. This was followed by an equally dedicated and capable Chairman of the Hospital Authority Dr CH Leong. Their noble act had one common aim – to protect the Hospital Authority and the medical profession from further abuse by the public. To them we owe our gratitude and appreciation.

Having held the helm of the College for the past six years I am relinquishing my Presidency to a very able and capable successor Professor KN Lai. I would like to thank all the Fellows and Members for having given me the opportunity and honour to serve you. It is without a shadow of doubt that I had the devoted support from the Council throughout and I would like to thank both past and present Council Members for their dedication above and beyond their call of duty to serve the College. My gratitude and appreciation goes to all Chairmen, Members of the Committee, the Boards and the Secretariat for having done such a magnificent job.

The Annual Report outlines the various events and achievements of all the College Committees and hence, requires no further elaboration. However I would like to highlight some of the important changes.

Education and Accreditation Committee

Collaboration and Cooperation with our sister Academy Colleges: to bring the training and standard of practising medicine into the new Millennium.

College of Emergency Medicine under Dr David Wong Tai Wai
Exposure of our Basic Physicians Trainees to Emergency Medicine in Accident and Emergency Departments and vice versa is beneficial to both.

College of Pathology under their former President Dr Robert Collins and Chairman of their respective Boards

Exposure of laboratory training in Microbiology, Haematology, Chemical Pathology, Immunology for our trainees in Infectious Disease, Haematology and Haematological Oncology, Endocrinology, Diabetes and Metabolism and Rheumatology/Immunology is fundamental to becoming a specialist in these specialties.

Centre for Health Protection under Dr Leung Pak Yin

For training in core competence, career structure and epidemiology in infectious disease.

College of Family Physicians under Dr Donald Li

Because of changing pattern of diseases Family Practice now largely involved in general medical diseases. Our College has proposed a state of the art training programme with more emphasis on General Internal Medicine to equip them to handle the changing practice. This has yet to be implemented.

With the implementation of Contract Appointment in Hospital Authority the College has finalized plans for trainees to complete their training either full-time or part-time locally or aboard.

Examination Committee

Congratulations to our Basic Physician Trainees for their success in the Intermediate Examination/MRCP(UK) examination. We achieved a 65% pass rate in Part II and 61% in Part II PACES – the highest percentage from all centres world-wide.

Administration and Finance Committee

We are grateful to our Hon Treasurer Dr TF Tse for his very shrewd investment that has enriched our coffers by more than \$2.0 million.

The very close cooperation and cordial collaboration between the College and the Academy under the Presidency of Dr CH Leong had entered into a symbiotic relationship and I would like to thank him and his Council for all the support and encouragement given.

Finally no word of appreciation or thanks can express my gratitude to Prof KN Lai, Vice President – Chairman of Education and Accreditation Committee, Prof Joseph Sung Vice-President (External Affairs), Prof WK Lam, Chairman of Examination Committee and National and International Liaison Committee, Prof TK Chan, Chairman of Membership Committee, Prof CS Lau, Chairman of Scientific Committee, Dr Matthew Ng, Chairman of Professional and General Affairs Committee, Prof Raymond Liang, Chairman of Research Committee, Dr TF Tse, Chairman of Administration and Finance Committee, Dr Philip Li, Editor of Synapse and the pillar and the "woman" behind the College Dr Loretta Yam, our ever dedicated Hon. Secretary who has kept the ever enlarging and complex Secretariat functioning without a hitch and to all the very hardworking secretaries my sincere thanks and appreciation.

Introduction to the AJS McFadzean Oration 2004

Richard YH Yu
President, HKCP

Alexander James Smith McFadzean – Professor of Medicine 1946-1974. He was a man of vision and integrity. When he took up the Chair of Medicine he set himself a goal – the Department of Medicine must be chaired by one of his students and a graduate of the University of Hong Kong. In fact when he retired in 1974 not only was he succeeded by Professor Sir David Todd, a graduate of Class 1952 but the whole Department was staffed by his students. It is therefore appropriate that Dr CH Leong one of his former students and house officer is given the privilege to deliver his oration tonight.

C.H. needs no formal introduction amongst this audience. Be that as it may he has an incredible and impeccable C.V. A product of the old school of the Faculty of Medicine, Hong Kong University he chose a career of flamboyance as a prima donna – that is to be a surgeon. He soon established himself as a master craftsman par excellence and rapidly rose to the rank of Reader delivering the Hunterian Oration in the Royal College of Surgeons England on his way – the youngest Hunterian Orator in the history of the College. In 1978 he left academia for a greener pasture as a urologist and transplant surgeon of distinction and soon earned the illustrious title of "Golden Knife"!

Being a man in constant pursuit of challenge and having amassed a fortune, he turned his enormous energy to politics, becoming a political animal as some would say. After an initial setback he successfully became our representative in the medical constituency in the Legislative Council - a stint which lasted for 12 years. This must be the lowest point of his otherwise illustrious career!!

Finally he came to his senses and took up the Presidency of the Academy of Medicine which had degenerated into a bit of joke and later became Chairman of the Hospital Authority to continue his contribution to his profession and society. The Academy today is internationally recognized as a creditable and respectable institution.

In spite of the fact that he is a doyen amongst surgeons, lurking in his heart of hearts he very much would like to be a physician of respect. Because of his exposure to medicine when he worked in Queen Mary Hospital during the time when the Departments of Medicine and Surgery were in close collaboration, his knowledge of internal medicine is outstanding and sound, better than some of us physicians. Today he can proudly and unashamedly assume the mantle of a physician who heals with a knife.

He has given numerous distinguished named lectures – Hunterian, Diby Memorial, GB Ong Lectures to name a few but to deliver this prestigious McFadzean Oration to physicians must be the pinnacle of his achievements. May I now invite C.H. to deliver the Oration title – A Tribute to a great Teacher – Infectious Disease: A public health challenge? A social dilemma? Or a political melodrama?

Address to New Fellows

C.H. Leong

President, Hong Kong Academy of Medicine

I would like to begin by thanking you, Mr. President and your wise Council for conferring on me the honour of the Honorary Fellowship of your esteemed College. I am humbled by this honour for deep in my inner self I do not think I deserve this distinction. Furthermore, to be standing in the same rank with Prof. T.K. Chan, a true physician par excellence, Dr. E.K. Yeoh and Prof. Zhong Nan Shan who have contributed so much for improvement of health care services on both sides of the Shengzhen river makes me feel like David amongst the many Goliaths. Yet I am proud, proud to realise that the honour so conferred on me is not just a recognition of myself but all in the profession working in partnership with me, debating and enacting laws for the profession and service when I was with the LegCo; formulating specialist standards with me in the Academy; and bettering the health care services both in the public and in the private sectors when I was at the helm of the Hospital Authority. I thank them all.

A week ago, I was addressing the First Fellows of the Hong Kong College of Orthopaedic Surgeons on the subspecialty of Rehabilitation. On that note of Rehabilitation, I made the remark that the society and people of Hong Kong should also be rehabilitated. This insatiable bickering over Article 23; the pace of constitutional reform; the harbourfest; most recently SARS and the invariable weekend marches on the street and many others have left people in Hong Kong in complete disarray.

No one would deny that in a democratic and open society, it is every citizen's responsibility and duty to monitor government, steer the government to what is best for the public, and express our discontent on areas that the government has not done right. Yet it would also be destabilizing to confront for the sake of confrontation and to consider "consensus" as a dirty word.

This "blame culture" is grossly affecting the work of ourselves, the medical professional and worse, upsetting the time-honoured doctor-patient relation. We have seen the increase in medical litigation and thus the exponential increase in medical malpractice indemnity premium. In the public health care services, complaints are ever on the increase. After all, for the complainants, why not? There is apparently nothing to lose by complaining. Regrettably all these have demoralized staff morale. Worse in the days to come many of us would be pushed to practise "defensive medicine" resulting in further jacking up the health care cost with excessive, perhaps unnecessary, investigations and delays in treatment – nobody wins.



The medical profession has to be rehabilitated too. For the last few years there has been too much internal bickering tarnishing our leadership role in the society. The arguments on mandatory continuing medical education (CME) have made a laughing stock of the profession. It should be remembered that CME whilst a tool for us in the profession to regularly update our knowledge, mandatory CME is for the public to realise that we are providing the best for them. The Academy of course stands firm by compulsory CME/CPD. Our 98% compliance in the last two cycles reflects that compulsory CME not only is possible but works.

Colleagues and new graduates, as Fellows of the Hong Kong College of Physicians and as leaders of the profession, may I urge you to take a lead to uphold the prestige of the profession, the high moral ground that is expected of us and all our pledges in the Hippocratic Oath.

Mr. President, I am given to understand that in two days' time you will be demitting office after so successfully having led your College for six years. In line with the spirit and principles of your forefathers, you have raised your College to new heights. Your College is now the biggest College, in size of the Fellowship, in the Academy. You have greatly enhanced the image of your College in the international world of medicine. In the local scene through your diplomacy you have enhanced working relationship with many other Colleges and your many clinical guidelines for specialist training and accreditation are role models for other Colleges to follow. The Academy will no doubt miss the wisdom of your wise counsel.

Finally, Mr. President, ladies and gentlemen, for years I yearned to become a physician, I realise that I still cannot become a physician, but at least now I can become an Honorary Physician.

Thank you.

AJS McFadzean Oration**A Tribute to a Great Teacher - Infectious Disease : A public health challenge ? A social dilemma? Or a political melodrama ?**

C.H. Leong

President, Hong Kong Academy of Medicine

Mr. President, Ladies & Gentlemen

It is indeed a singular honour to be invited to deliver the McFadzean oration. It is an honour to me in particular as my early medical related days were spent in the McFadzean era, both as a student of medicine and as his house staff. In many aspects, he was thus my mentor. No, Alexander James Smith McFadzean did not teach me surgery. In fact, surgeons were a breed of doctors he disliked, but he taught me much more, as this oration will unveil.

My very initial impression of Professor McFadzean was memorable, to say the least. As a student I was asked by him to close the door of the lecture hall, "from the outside". As a young doctor burning with desire to be a surgeon, I was baffled by why during every single Christmas, there were bound to be drawings on the wall of Queen Mary Hospital of the Professor of Medicine crossing swords with the then Professor of Surgery.

Yet as I came to understand this fiery Professor from Scotland more, I started to appreciate the way he dwells into details of patients' illnesses, the environment surrounding the sickness, the societal impact the illness will bring about before exhibiting his evidence based treatment. I started to respect the way that he would stand by the profession, using all his ability to stand up to the integrity of the profession and the institute he served. Yet he would never give in to any nonsense.

It is on these two aspirations of Alec McFadzean that I am using tonight's oration to pay tribute to.

Professor McFadzean came to benefit Hong Kong as a young man at the age of 34. Prior to this he had served in the Middle East and Africa in an era of infectious disease – malaria, plague, tuberculosis and small pox. Between then and now many of these deadly infections have either been proclaimed to be eradicated or at least, very much controlled. Small pox for example was declared eradicated in December 1979. Plague was at least temporary declared controlled when the last officially certified human case appeared in Kanataka state, India in 1966. T.B. was considered a treatable condition since Koch discovered the cause, and Malaria should NOT be fatal any more since quinine was discovered. So convinced that infectious diseases were on the way out that a Harvard Public Health Group headed by Christopher Murray forecasted in late 1960 that more than 85% of all deaths in U.S. by the close of the 20th century would be due to chronic diseases such as cancer and heart problems. Rightly so, in 1900 nearly 800 Americans out of 100,000 every year died of infectious diseases and by 1980, only 36.



Take another issue. Of some 1240 new drugs licensed in the 20 years after 1975, only 13 (1%) were for infectious diseases primarily affecting the tropics and poor countries.

It comes as no surprise that for some 5 decades priorities for infectious diseases, thus public health, were dwindling. In Hong Kong before SARS struck there were only 60 infectious disease beds for a population of some 7 millions. In the Hong Kong Medical Council's specialist registry, there were only 6 registered as infectious disease specialists. Even amongst our community medicine experts, the majority are specialists in administrative medicine, not in public health.

It therefore came as no surprise that the world, and for that matter Hong Kong, was not ready to face any public health outbreak with efficiency.

Yet there had been warning signs. Plague returned to India in August 1994, and resistant T.B. became an epidemic in Russia in 2000. In 1998, W.H.O. launched the Roll Back Malaria campaign to fund incentive for development of the anti-malarial drugs while chloroquine began to lose its effectiveness. Of course, there is the Avian Flu of 1997.

We did not take the hint, we lived in comfortable ignorance oblivious to the fact that new human pathogens can emerge and old infections once thought conquered could resurface.

In short, in the history of mankind, where there are victims, there will be infectious diseases. It becomes obvious therefore, that we can look at infectious disease from 3 angles :

- As a public health issue where properly organised public health means could prevent or control an epidemic, and where its failure could produce a catastrophe.

- As a social issue, where the disease is known, the causative agent is identified, its prevention is well mapped, yet difficulties abound in convincing the society to adapt to it – from the Government to the man on the street, and even the world as a community to work together.
- As a melodrama where the injection of politics, the struggle for power, could have blurred proper scientific investigations of the disease and hamper the precious lessons learned from any infectious outbreak that is to no ones' benefit. As Milton in his "Paradise Lost" said "And out of good still to find means of evil".

Let me elaborate.

Whilst it may sound disheartening and perhaps even pitiful, it was a decrease in infectious diseases which brought about the increase in life expectancy of the world, not the discovery of curative medicine.

To wit, data from England, Wales and Sweden have shown that in 1700, the average male lived just 27 to 30 years. By 1971, male life expectancy was 75 years. More than half of that improvement occurred before 1900. In all 86 percent of that improvement occurred before 1900. In all 86 percent of the increased life expectancy was due to a decrease in infectious diseases that occurred prior to the age of antibiotics. In U.K, T.B. death dropped from nearly 4000 per million people to 500 per million between 1838 and 1949 (the year when antibiotics treatment was introduced). Since then, with the advent of anti T.B. treatment in the next 20 years, the death rate only fell to 460 per million.

What prompted the decrease in infectious disease is of course a matter of considerable academic debate. Yet one cannot ignore nor neglect that the following could well be key issues :- Nutrition, housing, sewage disposal, safe drinking water, epidemics control, swamp drainage, public education, literacy, access to prenatal and maternity care. One and all are public health issues.

A study of the story of plague will give the whole issue away. As known to us now, plague is caused by *Yersinia pestis*, a gram negative bacillus that lives on fleas that are parasites on black rats "*Ratus ratus*". Transmission to human is either through flea bites producing bubonic plague or in the case of pneumonic plague, from droplets – bacilli coughing out with blood from those infected. We know now too that the bacilli respond favourably to tetracycline.

Plague in HK began in the early summer of 1894 before the antibiotic era. Many speculations surrounded the cause of the disease – from the supernatural belief of offending the ancestors to obnoxious gas from the earth. By July of the same year the causative organism was discovered by Kitasato and Yersin, yet what could be done. Hygiene or better public health were perhaps the only actions which were ultimately found to be effective. The infection was highest in areas of Hong Kong where sanitation appeared to be the worst. The Sanitation Board ordered cleaning the streets in Taipingshan area, house to house search for sick and suspected patients, isolating these victims in 3 hospitals – Kennedy Town Police

Hospital, the Glass Work Hospital controlled by the Tung Wah Board and a naval ship in the harbour – the Hygia. This was not without opposition and antagonism of the local population. People took to the streets – not uncommon by standards of today – chanting unfounded rumours that house search was an excuse for rape and pillage, and immediate removal of body for burial is for the westerner to remove body organs to grind up for medicine. The actions, though unpleasant, took effect and the epidemic was finally controlled by 22 August. All in all, there were 2679 cases notified, 2552 died. Public health took centre page.

Nor was the story different in recent days. In the summer of 1994 following an earthquake in Maharashtra, India, plague broke out in a nearby town of Surat, a place suddenly overpopulated by migrant workers for the diamond industry where sanitation was the exception rather than the rule.

Modern medical treatment did little to help to curb the epidemic. In fact there was a general rush for tetracycline which was soon depleted and the Indian FDA was compelled to warehouse caches of the medicine.

What brought the containment was the declaration of Surat being "plague list" by the then prime minister - the army was dispatched to maintain order and quarantine, to stop exodus to other parts of the country, to burn up all waste, improve sanitation, kill all the rats. Again, a public health triumph.

Like the public medical service in HK during SARS, the Indian Public Medical Services all kept their ground and worked closely with private physicians. But unlike the dedication in Hong Kong, 80% of the private physicians in India went into panic and fled the city.

But public health is not the be all and end all for infectious diseases. In some of the worst infectious disease pandemics, social and societal issue takes the front page. Such is the case with HIV/AIDS.

Since the first case of HIV/AIDS was identified in 1981, and since the discovery of the retrovirus, most countries were aware of the mode of spread – through unprotected sex, sharing needles, mother to foetus transmission, accidental transfusion of infected blood. Similarly, most in the developed world would know the best way to prevent getting infected. The discovery of the "cocktail" treatment using protease inhibitors also brought new hopes to the HIV positive in that the treatment protocol taken life long could delay the onset of eruption of the disease – HIV positive but not AIDS affected.

Yet up to now, some 20 years later, the number of HIV/AIDS cases around the world is in no way curbed. Instead the trend is increasing, in particular in Subsahara Africa, in the Indian subcontinent, in S.E. Asia and in China. Why did all these happen when the message is not about being discrete, but about using condoms and not sharing needles and syringes. Today as the figure looms at 45 million, AIDS becomes not just a public health issue, not just a medical issue but a societal and community issue. There are at least 5 contributory factors.

Firstly, there is the issue of denial. In the Mainland, for example, HIV/AIDS was not taken on board as a national problem until as late as the early 1990's. Hitherto, HIV/AIDS was a foreigners' disease. Much change in attitude has since taken place for the better, hopefully it is never too late.

Secondly, there is the issue of stigmatization and discrimination. For whilst most people are conscious of the fact that HIV/AIDS cannot and will not be caught under the usually social style of contact, many still frown on having an HIV/AIDS infected person sharing the same building, walking the same road. It is a matter of proper education on a wide ranging base. This could be extremely difficult considering the size of some countries and the remoteness of some isolated villages.

Thirdly, there is the discrimination between the rich and the poor. Yes protease inhibitors are now available to delay the development of full blown AIDS, yet it has a price tag of over HK\$1,000 a month. It became obvious that the treatment is for the very rich.

The state of affairs in the Sub Sahara African Continent is a shining example. In South Africa for example where the total infection rate is around 5 million, less than a few percentage can afford the treatment. Data shows that some 290 million Africans have an average income of less than US \$1 per day. Whilst it is well known that the "cocktail treatment" if given at early pregnancy could decrease the incident if not eliminate the chance of mother to foetal spread, such treatment was denied in favour of cost. Whilst it may be understandable that many developing or less developed countries could not afford to provide free "cocktail treatment" for all HIV positive victims, pharmaceutical industries are NOT willing to cut the cost, under the disguise of the need to recover the cost of research and development. It comes as no surprise that whilst the whole world in the issue of AIDS is ONE WORLD, with ONE HOPE, in many countries it is obvious that we are all in one world, but many have no hopes. Ironically it is in the poor countries that AIDS are most extensive.

The fourth issue is lack of trust, lack of trust in the personal who are supposed to look after them, perhaps through lack of communication skills and ultimately reflecting to lack of confidence of the Government.

The tragedy in 河南 is a vivid example of poverty, ignorance, lack of trust and discrimination. 河南上蔡縣 is a very poor village. Farmers reap barely enough from their crops for daily living. Extra spending, even schooling for children, requires other ways of acquiring cash. Selling blood became the natural and easy source of income as blood is a 無本生利的工具. Much of the collected blood were pooled together and after the plasma proteins and other necessary blood elements were removed for other purposes, the left behind was transfused back to the donors – sparking a chain of infection transfer. Yes, through international agencies and the Central Government, drugs are available for most inflicted. Regrettably the issuing of these "good will", were never properly explained. Like all medications, some may experience certain side effects albeit minor, such as vomiting at the initial

phase. Cynicism prevailed, many refused to take the medication. A philanthropic act had thus turned sour. Worse, many look to hiding for fear of discrimination.

The fifth issue is that of societal priorities. As mentioned early, the initial phase of AIDS in the Mainland was that of denial – it is a foreigner disease – it was so sad. The leadership was never seen then to support the necessity to raise concern to AIDS. Yes, in January 1997, the late minister of Health, the 陳敏章 and myself visited the 地壇 hospital and shook hands with a HIV/AIDS patient. There were minimal and only local publicity. The visit of Bill Clinton speaking to 清華 university on AIDS and afterwards shook the hands of an HIV patient and advocate raised the profile. Premiere Wan saw the need to visit AIDS inmates and place Wu Yee to take charge of AIDS policy and movement in China. For AIDS, both workers and victims, such was a triumph in politics.

But not all political moves, albeit calculated could end up in triumph as the story of SARS and its aftermath unfolds.

SARS like a whirlwind swept Hong Kong off its feet. Everything came almost to a standstill. The health care profession and health care services were hard hit most. Incidentally we were completely ignorant of the cause, the way the illness spread, how we could protect ourselves and our patients, nor did we know the right form of treatment. It was a fear and frustration seeing a continuous stream of patients being admitted, one by one your working partners fall as victims of the disease, not knowing when it is your own turn. But our health care workers braved on. Within weeks the causative Corona Virus was discovered and isolated. Every health care personnel stood firm, there was not a single deserter. Instead some even volunteered to serve the infected wards to substitute or replace their colleagues who were either sick or because of higher risk. We lived with our masks, assumed a faceless status, gave up social life but with one aim in mind – get rid of that despicable infectious disease – regrettable, even as of today, there was no vaccine and no recognizable recommended treatment. It was a story of pure and profound bravery.

SARS raged on, and as more data and statistics accumulated, Hong Kong's health care workers took the centrefold. Our detailed and transparent records, our rapid breakthrough in discovering the virus and the detailed scientific studies on this new atypical pneumonia which could well be another pandemic, became the envy of the world. Our e-SAR for contact tracing, our direction to carry on long term studies of the patients for possible complications either of the disease itself or the treatment has put Hong Kong on the map to lead studies on infectious diseases. So far over 50 papers have been published on SARS from Hong Kong for us to take the grid position.

Like other epidemics SARS brought Hong Kong back to realize that infectious diseases are still very important and that we have been inadequately prepared. It gave us the direction to rebuild the health care service and system, and to define our priorities in service and in training personnel. It also gave Hong Kong public medical services a chance to wrangle more

money from Government for health care to top up the needs for those priorities, and we have succeeded. A total of HK\$1165 million has so far been pumped into or approved for the public medical service to enrich health care in infection control and more could be forthcoming.

The final chapter of SARS could therefore be that of "they live happily ever after" or like the typical Chinese movie – 大團完大結局.

But this is not to be the case, instead the closing chapters of the "activities that the whole world praised" were that of Tears, of Frustration, of Rolling of Heads and of Unnecessary Financial Loss.

Tears, were uncontrollable to mourn the 299 who lost their lives, some eight of them from the health care team. Frustration, were from health care workers who in spite of selfless devotion fighting the unknown were critically interrogated by the LegCo select Committee and criticized by its reports. At least three in the hierarchy of health care resigned and one left Hong Kong seeking greener pastures. Millions of dollars were spent, perhaps unnecessarily by LegCo to stage the inquisition and by HA to prepare the data and legal grounds for the response. All these as one would realize are money from the public. But this is not all, legal battles are expected between the victims of SARS and the public health care service and possible compensation claims could be enormous.

Why did all this happen? Dare I say it all backfired from a presumably calculated political motive?

The Government was criticized for initially playing down the severity of the infectious spread suggesting that there might be some "covering up" in favour of possible effects on Hong Kong's economy. But then what could the relevant Bureau do when even on the 22 April 2003 the then China's Minister of Health at a press briefing in this very building to the Hong Kong media said that there were only "a few cases of atypical pneumonia in China".

It is obvious that a saga such as SARS where some 299 died and some 1,755 were infected and where Hong Kong was almost brought to a stand-still deserved some form of a high power independent investigation especially in this political climate of "blame culture" and "accountability and responsibility". There were calls therefore, from many, that an Independent Judicial Commission be set up by the Hong Kong Government to look at the whole picture – from health care to close of schools, quarantine to border control, and to suggest recommendations for the future.

This was regrettably not to be. In the interim, an expert committee was set up within the Health Welfare and Food Bureau and an independent internal investigatory committee within the Hospital Authority, both to look at lessons to be learnt.

It is evident from the start that these two bodies and their expected reports other than an independent commission will not satisfy our "Peoples' Representatives" – paving the

way for them to set up a Select Committee with "power and privilege" to call and "question witness". The aim of this Select Committee, since LegCo was not satisfied with the other 2 reports that no blame was apportioned, was to "witchhunt for person or persons responsible".

Regrettably this "Select Committee" was open to criticism.

As a start, the efficiency in this body stood to question. It was expected to investigate a completely unknown saga from medical causes and yet it did not have expertise of that speciality within its membership or even as advisors.

Secondly much questioning was done of the front-line health workers with a motivation of criticism when it was obvious that whilst these front-liners were sacrificing their lives to fight the war of SARS, many of the members of the Select Committee were in the safe environment of their offices, oblivious to the danger that their voters and constituents were facing. It was no surprise that at least one front line executive wrote to the Select Committee.

"Where were you when we needed you most".

Thirdly, perhaps in an attempt to lobby for votes for the then forthcoming LegCo election, conclusions of the Select Committee were leaked well before the investigation was completed, not just once but at least twice. An investigation was staged in LegCo for the so call "McDonald" incidences, but as expected, produced no results. The second leak was from an obvious source but was side stepped by putting the blame on the "efficiency" of the Hong Kong Post Office.

What then was the subsequent score.

As mentioned earlier, three from the health care hierarchy have resigned and one left Hong Kong. Of course, they could be replaced.

Of the eleven members of the Select Committee, only four were returned to LegCo, of the remaining seven, two elected to step down and five were defeated. They were all replaced.

In the whole exercise, nobody won, both the hunters and the hunted succumbed. In many cases the hunters became the hunted.

The final closing chapter of SARS was thus a modern day Hamlet. Is it a comedy or a tragedy? Nay, it is neither, it is a pure melodrama of miscalculated politics.

But is the profession more united? Has the image of the profession improved? Is the integrity of the health care institutions maintained?

Alec McFadzean, I am confident, would NOT have approved.

Thank you!

Gerald Choa Memorial Lecture - Back to Basics

Rosie Young

The late Professor Gerald Hugh Choa joined the University of Hong Kong to study medicine in 1939 and was in the 3rd year of his studies when the Pacific war broke out. Like many of his classmates he left Hong Kong during the Japanese occupation to continue his studies at Cheeloo University in Chong Qing. He returned to Hong Kong in 1946 and graduated as MBBS. He provided leadership to the medical profession and distinguished service to Hong Kong for a total of 55 years. He was also well known internationally and received a number of prestigious accolades from the international community. Until his death in December 2001 he led a very active professional career as a physician, teacher, researcher and administrator.

This gives me an excuse very briefly to review the changes in these areas, i.e. clinical practice, medical education, medical research and the healthcare system from 1946 to 2001. While most of what I am going to say is general and applicable worldwide, the focus is naturally on what happened in Hong Kong.

The Practice of Medicine

In developed countries the practice of medicine has undergone a tremendous change in the 20th century. The average expectancy of life at birth has increased resulting in a growing proportion of the elderly in the population; from 1973 to 2000, Hong Kong life expectancy at birth increased from 68.5 to 78.0 years for males and 75.9 to 83.9 years for females. Infectious diseases such as tuberculosis have given way to degenerative diseases and malignancies as the leading causes of death. The major factors which brought about these changes were improvements in public health and advances in medical and basic scientific research.

Medicine is often regarded as both an art and a science. In those days diagnosis of a patient's condition was based almost entirely on his complaints and the doctor's astute observation of any physical signs present. This was aided by simple blood tests or radiographs. The final diagnosis was sometimes not revealed until an operation or autopsy was performed after the patient's death. Thus the diagnosis might be delayed and the patient might die of a potentially treatable condition. Even when a diagnosis was correctly made the range of effective drugs available or operations that could be safely performed was limited.

In the 1940s, infections (parasitic, bacterial and viral) were common. Public health measures including vaccination were mainly responsible for eradicating communicable diseases such as smallpox or preventing epidemics such as poliomyelitis, plague, cholera etc. The time-honoured saying that prevention is always better than cure should always be remembered. The discovery of penicillin by Fleming, Chain and Florey must be



Prof Rosie Young presented with the medal for the Gerald Choa Memorial Lecture

hailed as a breakthrough in the treatment of bacterial infections. This discovery also laid the foundation for the development of new generations of antibiotics. In the meantime as the population demography changed malignancies and degenerative diseases became more common. Chemotherapy and immunomodifying agents were added to our therapeutic armamentarium. The completion of the human genome project in 2001 gave an impetus to research in gene therapy. Gene therapy may be considered the ultimate goal in the treatment of genetic diseases. The possibility of reversing genetic defects by replacing defective genes instead of merely treating symptoms is very appealing. Great progress has also been made in other modalities of treatment such as surgery, radiotherapy and nuclear medicine.

Research

In the latter part of the 20th century the two areas of discovery, which had the greatest impact on the diagnosis, and treatment of diseases were:

a) Human genetics

In the 1950s methods were devised for the accurate study of chromosome numbers. For the first time it became clear that the normal human chromosome count is 46. This was soon followed in 1953 when Watson and Crick published the double helix model of the DNA molecule. This exciting discovery was the beginning of the Genome era and paved the way for the development of genetic engineering and gene therapy.

b) Immunology

Immunity, in the broadest sense of the term depends on two kinds of processes which we can characterise as specific and non-specific. Each is as important as the other in ridding the body of infections. Specific immunity involved recognition of a mechanism whereby antigens bind to specific

lymphocyte receptors and lead to the production of antibodies. The body generates a strong and specific antibody and cellular immune response against foreign materials which cause infections. The same immune response however also explains the occurrence of graft rejection in organ transplantation. In 1960 Burnet and Medawar were awarded a Nobel Prize for the discovery of acquired immunological tolerance, the theory of self and non-self, which paved the way for solving the immunological problems of graft rejection. It also marked the dawn of modern immunology.

Technological advances played a vital role in medical research as well as diagnosis and treatment. These are :

- 1) Molecular biology technology. The tools of recombinant DNA technology and other advances have been used to study the molecular basis of single gene and polygenic disorders, congenital malformation, malignancies and autoimmune diseases. It has therefore become possible to produce monoclonal antibodies for diagnosis and treatment, and to synthesise unlimited amounts of hormones e.g. insulin, growth hormone, blood products and vaccines such as hepatitis vaccine.
- 2) Sensitive and specific methods have evolved to measure very small amounts of substances in blood and tissues, e.g. hormones. In 1955 Berson and Yalow developed a radioimmunoassay for the measurement of insulin in tissue and plasma. These techniques have provided a tremendous impetus to endocrinology and given rise to a wealth of basic and clinical investigative tools.
- 3) Imaging techniques. The introduction of radiography, computerised tomography and magnetic resonance imaging opened our eyes to very fine details within organs and tissues and helps us to visualise their function at any moment in time. They were so revealing sometimes that they threatened to put the surgeon and pathologist out of business.
- 4) Nuclear physics, I put last but not least. Nuclear physics and nuclear medicine underpin many of the above mentioned advances made in molecular biology, radioimmunoassay and imaging. Nuclear medicine itself is also a distinct field for the investigation and treatment of human diseases.

Medical Education

Until 1981 there was only one medical school in Hong Kong. In 1952 the intake of medical students into the Medical Faculty of the University of Hong Kong was only 58. Medical graduates from the Commonwealth countries were automatically allowed to register in Hong Kong. Medical

graduates from elsewhere, mainly from China were also allowed to do so after passing a qualifying examination. Today the University of Hong Kong and the Chinese University of Hong Kong each have a medical students annual intake of 150.

The undergraduate curricula were initially modifications of a British one. It has undergone many modifications over the years. Spurred by the rapid expansion of medical and scientific knowledge both medical schools felt an urgent need to revise the curriculum. An overcrowded curriculum is one of the major problems facing medical schools worldwide. In the University of Hong Kong the new curriculum involving problem-based learning was introduced in 1997 and the Chinese University of Hong Kong introduced an integrated system-organ based curriculum in 2001. Didactic teaching in the form of lectures is reduced in favour of more innovative and stimulating small group tutorials. Focus is on learning rather than teaching and there is much more guided self-learning than direct transfer of knowledge face to face. The emphasis in both curricula is cross disciplinary integration removing the previously compartmentalised teaching in preclinical and clinical subjects. This also allows the early introduction of clinical experience and increases the understanding of basic medical sciences. Teaching of communication skills, medical ethics, professional attitudes, information technology, research and life long learning which might previously have been ignored or underprovided are emphasised. The goal is to produce doctors with demonstrated competence in the understanding and delivery of effective, humane and ethical medical care, who are committed to life-long learning and ready to proceed to postgraduate training.

Postgraduate training

The concept and structure for postgraduate training was non-existent when Gerald graduated in 1946. By law any medical graduate could practise medicine, surgery and obstetrics and gynecology if he/or she felt competent to do so. Because of rapid progress in medical science, diagnosis and treatment it became imperative that doctors keep up to date through continuing study. Those working in the two medical schools had the opportunity of undertaking systematic higher training, including a period of overseas study. This enabled the medical schools to develop different specialties. However, for others who comprised the majority of those working in public hospitals and in private practice systematic and structured post-graduate training was not available. Training took place during off-duty hours and relied on the commitment and goodwill of the trainers. Little allowance for postgraduate education was made in the calculation of staffing levels in Hong Kong public hospitals. Facilities and the resources required to fund them were largely inadequate. The shortage of properly structured and supervised postgraduate training programs in the territory compelled many doctors to upgrade their skills and qualifications by seeking further education opportunities overseas, especially in the United Kingdom, Australia and North America. Over the ensuing years the

prospects for postgraduate training slowly improved, largely through the effort and commitment of the entire medical profession and especially the two medical schools.

The history of the founding of the Academy of Medicine is well documented in the "The Pursuit of Excellence" book which was published by the Academy in 1993 to commemorate its 10th anniversary. Without elaborating further on the achievements of the Academy, I hope you would agree with me that post-graduate training has taken a great stride forward in the last 10 years and that the quality of our medical specialists today compares well with that in any other country. In retrospect, it is evident that inclusion of the College of Family Medicine as a founding member also reflected the wisdom and foresight of the Halnan report (Working Party on Postgraduate Medical Education and Training).

Continuing education is now an integral part of our postgraduate training for both specialists and non-specialists.

Healthcare

Time does not permit me to describe in any detail the changes in the healthcare organization in Hong Kong since the end of the second world war. Arguments are rife as to whether we have got the right formula or right mix to provide healthcare for the community. As you are aware there is no perfect solution to all the problems in healthcare and no magic answer which will satisfy the criteria for providing an equitable, accessible, affordable and at the same time effective and efficient healthcare delivery to all, even if resources were unlimited. The difficulty is greater when resources are dwindling, our public demand is heightened by the rising costs of advanced technology and sophisticated treatment.

In Hong Kong various attempts have been made to improve healthcare delivery. In 1974 a government white paper on 'the further development of medical and health services' mapped out an ambitious plan for expansion of the medical and health services. This brought about the completion of three major government hospitals and 16 new government clinics. The hospital building program boosted the number of hospital beds from 17,000 in 1974 to 24,000 in 1984 and an expected 16,000 more beds in 1994. Despite this expansion and the availability of low cost, heavily subsidized in-patient and outpatient service to everyone in Hong Kong, there was growing public discontent over overcrowding and the poor physical environment in the government hospitals. The long queues and unsatisfactory quality of care in the general outpatient clinics as well as the high cost and variable standard of care in the private sector was another cause of public disquiet. In 1985 the government commissioned WD Scott to review the management of the public hospital system. This culminated in the establishment of the Hospital Authority in 1990. The development in primary care lags far behind attempts to improve the public hospital system. A working party on Primary Healthcare made its report to the government in 1991. This included among other issues the

recommendation to integrate primary health care and hospital services. Regrettably not all its recommendations were adopted. The over-reliance on hospital and the underdevelopment of primary care are recognized by the Academy of Medicine and the medical profession. In the recent report to the Medical Council on the accreditation of the two medical schools (2003), members of the panel recommended that much more was needed to strengthen the teaching of family medicine and the training of family physicians.

Until the onslaught of SARS in March 2003, the surveillance and control of infectious diseases by the Department of Health was regarded as adequate as evidenced by the declining number of infectious disease notifications over the years. SARS, as a new disease of unknown source and aetiology at the beginning was a warning that emerging infectious diseases are always lurking around the corner. Hence, we must always be on high alert for known as well as unknown infectious diseases not only in our midst but also in our neighbouring countries and further afield. The recommendations of the expert panel on SARS led to the recent establishment of the Centre for Health Protection.

Where do we go from here?

Here I wish to make an appeal to return to the basics. There is much that we can do and should do to strengthen the training of family physicians and to improve public health in Hong Kong.

Medicine is an art as well as a science.

I wish to quote from Harrison's Textbook of Medicine 'The practice of medicine combines both science and art. The role of science in medicine is clear. Science based technology is the foundation of the solution to many clinical problems. Yet skill in the most sophisticated application of technology and in the use of the latest therapeutic modality does not make a good physician. The combination of medical knowledge, intuition and judgment defines the art of science'

'Tact, sympathy and understanding are expected of the physician, for the patient is no mere collection of symptoms, signs, disordered functions, damaged organs, and disturbed emotions. He is human, fearful and hopeful, seeking relief, help and reassurance. The true physician has a Shakespearean breadth of interest in the wise and the foolish, the proud and the humble, the stoic hero and the whining rogue. He cares for people'

In essence besides possessing sound medical knowledge and skill a good doctor needs empathy and sympathy based on a good understanding of human nature and behaviour.

Ladies and gentlemen I hope you will agree with me that in the late Professor Gerald Choa we have found the typical example of an ideal physician.

Council News

Joint Scientific Meeting 2004

The College held its annual Joint Scientific meeting with the Hong Kong College of Paediatricians on the 23-24 October 2004 at the Hong Kong Academy of Medicine Jockey Club Building. The theme this year was "Novel Treatment of Common Medical Disorders" featuring symposiums on neurological, cardiovascular and metabolic diseases. The attendance for the two days exceeded 700 delegates. Highlights included presentations of the best local scientific papers and the Gerald Choa Memorial Lecture delivered this year by Professor Rosie Young. Included in the programme for the first time were two presentations by winners of the best medical student essay awards.

Sir David Todd Lecture

Molecular Genetics in GI Cancers – Pathogenesis and Clinical Application
Dr Annie On On CHAN

Distinguished Research Paper Award for Young Investigators 2004

The following doctors together with their research teams received the awards at the College Annual Dinner.

- (1) Dr Chi Chiu MOK
Predictors and Outcome of Renal Flares after Successful Cyclophosphamide Treatment for Diffuse Proliferative Lupus Glomerulonephritis.
Arthritis and Rheumatism 2004;50(8):2559-2568
- (2) Dr Eric Wai Choi TSE
Null Mutation of the Lmo4 Gene or a Combined Null Mutation of the Lmo1/Lmo3 Genes Causes Perinatal Lethality, and Lmo4 Controls Neural Tube Development in Mice
Molecular & Cellular Biology 2004; 24(5):2063-73
- (3) Dr Angela Yee Moon WANG
Is a Single Time-Point C-reactive Protein Predictive of Outcome in Peritoneal Dialysis Patients?
J Am Soc Nephrol 2003;14:1871-1879
- (4) Dr Man Fung YUEN
HBsAg Seroclearance in Chronic Hepatitis B in The Chinese: Virological, Histological and Clinical Aspects
Hepatology 2004; 39(6):1694-701



CC Mok



AYM Wang



MF Yuen

17th Annual General Meeting

At the Annual General Meeting, Professor Richard Yu reported on the activities of the College in the final year of his presidency. He then introduced Professor KN Lai as the new President of the College and welcomed the new council for 2004-2005.

For their exceptional contributions to health care services in Hong Kong, the College conferred the Honorary Fellowships to Prof Tai Kwong Chan, Dr CH Leong, Dr EK Yeoh and Prof Nan Shan Zhong. The ceremony proceeded with conferral of Fellowships and Memberships to 69 and 56 doctors respectively.

During the College Dinner, the AJS McFadzean Oration, titled "A Tribute to a Great Teacher – Infectious Disease : A Public Health Challenge ? A Social Dilemma? Or a Political Melodrama ?" was delivered by Dr CH Leong.



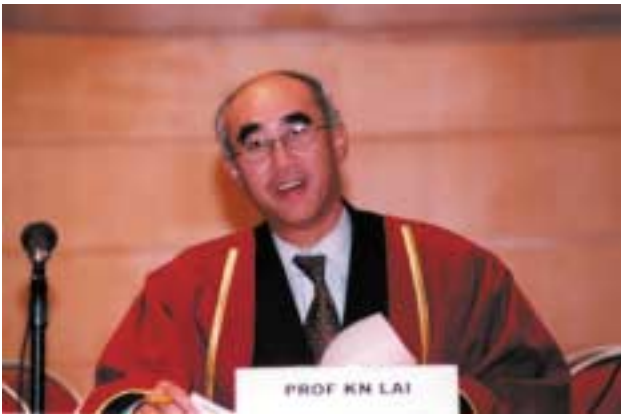
*Distinguished guests at the College Dinner.
Prof Yu is flanked by Honorary Fellows.*

Fellows at the College Dinner



The HKCP Council 2004-2005

- | | |
|--------------------------|---|
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Prof KN Lai, President, HKCP



HKCP Council

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 Administration and Finance Committee – Dr TF Tse
 Working Group in Traditional Chinese Medicine - Dr TF Tse
 Research Committee – Prof Lawrence Wong
 Synapse – Dr Matthew Ng

Continued Medical Education Information Management Portal

In order to increase overall operational efficiency, the College is setting up a tailor-made Information Technology initiative called the "Continued Medical Education Information Management Portal" (Portal) to replace the existing application software, which is developed in Microsoft Access. The new Portal is designed and maintained by the Richvast (Hong Kong) Limited. It can be accessed by authorized users through the Internet. Authorized users can access the Portal through the Internet at any time in any place.

The Portal provides major functions including maintenance of postgraduate training profile, personal profile, Continued Medical Education (CME) attendance or participation records and payment history. Fellows, members and trainees of the College can update their personal and training records, view their payment history and CME records via the internet. Specialty Board members can obtain the information of trainers and trainees in the specialties. The College hopes that the implementation of the new Portal can bring convenience to our College's Fellows, members and trainees. The Portal is scheduled to be launched this year.

New premises of the College

The College Secretariat has moved to new premises at room 603, Hong Kong Academy of Medicine Jockey Club Building, 99 Wong Chuk Hang Road, Hong Kong, on 17 September 2004. The area of the new premises is 200m². Apart from the staff working area, there are three meeting rooms and one President's room. The meeting rooms are designed for Specialty Boards to hold their Annual and Exit Assessments.

Royal College of Edinburgh website

Edinburgh College is advertising its website www.behindthemedicalheadlines.com, which provides independent, specialist, medical commentaries on current health issues reported in our daily media.

RCP (London) - International Sponsorship Scheme

The International Sponsorship Scheme (ISS) is designed for overseas doctors who wish to undertake part of their specialist training in the UK. Sponsorship may be for variable periods depending on the training requirements of the individual. It is intended for those who have a firm commitment to return to their home country to practice at the end of the sponsored period.

The College is able to sponsor well-qualified doctors for limited registration with exemption from the Professional and Linguistic Assessments Board (PLAB) test. However, the College will only consider sponsoring overseas doctors who have already been offered a salaried post in the UK at Senior House Officer (SHO) grade or higher, or who have been awarded a scholarship or official funding. Eligible candidates must be holders of the MRCP(UK) part 1 or a recognised higher medical qualification or degree from their home country.

For further details, please click on website as below.
<http://www.rcplondon.ac.uk/college/international/iss.htm>

Alternatively you can write to:

ISS Coordinator
 International Office
 Royal College of Physicians
 11 St Andrew's Place
 Regent's Park
 London NW1 4LE

Scientific Section

Sir David Todd Lecture

Molecular Genetics in GI Cancers – Pathogenesis and Clinical Application

Annie On On Chan

Department of Medicine, Queen Mary Hospital

Molecular Genetics in GI Cancers – Pathogenesis and Clinical Application

Cancer evolves through several histological stages: adenoma-carcinoma sequence in colorectal cancer (CRC), the gastritis-intestinal metaplasia-dysplasia-adenocarcinoma sequence in gastric cancer (GC). The morphological progression is associated with the accumulation of multiple genetic and epigenetic events, including CpG island methylation at the promoter region of tumor suppressor gene(1-4).

Molecular alterations in the morphological progression of CRC and GC

Hyperplastic polyps and Aberrant crypt foci (ACF) in CRC

We analyzed the molecular changes in patients with hyperplastic polyposis. We found that the hypermethylator phenotype could be related to patient-specific factors, such as carcinogenic exposure or genetic predisposition (5). We then compared the molecular changes in ACF from patients with familial adenomatous polyposis (FAP) or sporadic CRC. We observed that methylation in ACF is an early event in a subset of CRC, and that FAP ACF and sporadic CRC ACF have distinct epigenetic changes that reflect differences in molecular pathogenesis (6).



Gastritis and intestinal metaplasia in gastric cancer

We investigated the change of E-cadherin expression along the Correa's cascade. We showed that the expression of E-cadherin was decreased early in intestinal metaplasia and followed by a progressive decrease along the cascade (7) and that the decrease was due to methylation at the E-cadherin gene (8).

Interaction between methylation, environment and other molecular changes

Colorectal cancer in middle-east countries

CRC in Egypt showed unusual pathologic features: few K-ras mutations, high frequency of rectal tumors, poorly differentiated histology and high levels of MSI-H (9). Extension of this molecular epidemiology study to the other middle-eastern countries revealed molecular differences between countries, which may result from different environmental exposures (10).

Methylation and Helicobacter pylori in gastric cancer

To confirm the etiology role of H. pylori in causing methylation at E-cadherin gene, we randomized patients with dyspepsia and H. pylori positive to receive eradication therapy or no treatment. Methylation at E-cadherin was found to be much reduced in patients received eradication therapy but not in the group without (11). We postulate that patients with interleukin 1 β polymorphism and infected with H. pylori will have up-regulation of interleukin 1 β , which will lead to the production of nitric oxide and the subsequent activation of DNA methyltransferase, hence induce gene methylation (12).

Genetic alterations in other gastrointestinal tumors

Duodenal and biliary tumors, Carcinoid and pancreatic endocrine tumors

Our studies indicate that the methylation profile and genetic alterations of duodenal carcinomas are distinct from biliary and ampullary carcinomas (13), and that methylation profile of carcinoid tumors differs from PETs, reflecting different molecular pathogenesis (14).

Clinical application of molecular genetics

Soluble E-cadherin in gastric cancer

We found that soluble E-cadherin concentrations were significantly elevated in patients with gastric cancer than normal, and in

palliative/inoperable cancers than operable cancers (15). Soluble E-cadherin is also an independent factor predicting long-term survival (16). The optimal cut-off level of E-cadherin at 10,000ng/ml could predict 64% of recurrence at months 6 post-operation in patients received curative resection of gastric cancer (17).

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Best Thesis Award – Gold Award Winner

Liver Graft-Versus-Host Disease (GVHD) after Haematopoietic Stem Cell Transplantation (HSCT): Diagnosis, Pattern and Prognosis

Lawrence Shing Yan Ma

Department of Medicine, Queen Mary Hospital

Derangement of liver function test (LFT) following haematopoietic stem cell transplantation (HSCT) is a very common clinical problem. Liver graft-versus-host disease (GVHD), being the commonest cause, can often be diagnosed clinically when accompanied by cutaneous and/or gut GVHD. Problems emerge when (1) there is only isolated liver GVHD (2) the patient is a hepatitis B virus (HBV) carrier and (3) there is concurrent sepsis. Liver biopsy is an important but risky procedure in the diagnosis, prognostication and disease monitoring in liver GVHD but its role in our high HBV prevalent area is not defined.



Dr SY Ma received Gold Award with his supervisor, Prof R Liang.

After reviewing the indications and results of 75 liver biopsies, we concluded that a satisfactory diagnosis of LFT derangement post-SCT might often be reached on clinical grounds and a liver biopsy is most informative and necessary when underlying infective causes, particularly reactivation of HBV and HCV, are suspected.

In contrast to the classical liver GVHD with cholestatic LFT derangement, a new entity called hepatic-variant liver GVHD has recently been reported. It is clinically manifest as increased serum transaminase levels to 10-20 times normal post-HSCT or shortly after donor lymphocyte infusion (DLI), with viral or drug etiologies having been excluded. However, its clinical features and prognostic implications have not been well defined. We showed that hepatic-variant GVHD might not be uncommon, as 38/106 (36%) of all our liver GVHD cases were hepatic-variant, but its clinical course and treatment outcome did not appear to be different from classical liver GVHD. Moreover, the prognosis of hepatic-variant GVHD post-HSCT and post-DLI were similar in our cohort. In HBV prevalent areas, differentiation between HBV reactivation and hepatic-variant GVHD is very important, in view of the different treatment that should be given. Finally, because only few cases of hepatic-variant GVHD have been reported, the prognostic impact of a predominant hepatic LFT derangement should be further clarified.

Best Thesis Award – Silver Award Winner**Thromboembolism in Southern Chinese Patients with Systemic Lupus Erythematosus: a Prospective Study**

Sandy Shuk Kuen Tang

Department of Medicine & Geriatrics, Princess Margaret Hospital

Objectives: To study the risk of thromboembolism and its predictive factors in a cohort of southern Chinese patients with systemic lupus erythematosus (SLE).

Study Design: Longitudinal observation study of an inception cohort of SLE patients.

Patients and method: Patients with newly onset SLE between January 1995 and January 2003 were prospectively followed for the occurrence of thromboembolic events. All patients fulfilled at least 4 of the ACR criteria for SLE. Conventional risk factors and the antiphospholipid (aPL) antibodies (anti-cardiolipin antibodies and lupus anticoagulant) were surveyed. Cumulative risk for thromboembolism was studied using Kaplan-Meier analysis and predictive factors were identified using the Cox proportional hazard model.



Results: Two hundred and twenty-three SLE patients were recruited (197 women and 26 men). The mean age at diagnosis was 34.6 ± 13.4 years (range 15-84 years) and the median follow-up time was 42.0 months (range 3 – 102 months). Twenty-six percent of our patients were positive for aPL antibodies. None of the patients received primary prophylaxis with aspirin or anticoagulation. At the time of analysis, 34 patients (15.2%) developed a total of 38 thromboembolic events. Arterial events occurred in 29 patients (cortical or lacunar stroke in 19, transient ischemic attacks in 5, ischemic heart disease in 3, retinal artery thrombosis in 1 and digital gangrene in 1) and venous events occurred in 8 patients (deep vein thrombosis in 5, pulmonary embolism in 1, portal vein thrombosis in 1 and branch retinal vein thrombosis in 1). Three patients developed both arterial and venous thrombotic events and 1 patient had recurrent stroke. Two patients had active lupus at the time of thromboembolism. One patient died of acute myocardial infarction at the age of 45. Thirteen patients (5.8%) had thromboembolic events at the onset of SLE. For the remaining patients, the median time to develop a thromboembolic event was 38.5 months (range 2 – 102 months). The cumulative risks of thromboembolism were 1.9%, 4.2%, 7.0%, 9.6% and 12.2% at 12, 24, 36, 48 and 60 months respectively. By multivariate Cox regression analysis, male sex (HR 6.45 [1.80-23.09]; $p=0.004$), older age at diagnosis (HR 1.05 [1.01-1.08] per year; $p=0.012$) and positive family history of thromboembolism (HR 4.95 [1.28-19.23]; $p=0.021$) were independent risk factors for vascular thrombosis. The lipid profile and the presence of aPL antibodies did not predict thromboembolic events.

Conclusions: Thromboembolism is not an uncommon event in our Chinese SLE patients and is not predicted by status of the antiphospholipid antibodies. Conventional risk factors cannot fully explain the increased risk.

Best Thesis Award – Bronze Award Winner**Aphasia Recovery A Study of Post-Stroke Aphasia**

Sonny Fong Kwong Hon

Department of Medicine, Pamela Youde Nethersole Eastern Hospital

Aphasia is a common and debilitating problem resulting in significant frustration for both patient and family. With the advance of technology, especially of functional imaging, and improved understanding of the neurocognitive functions, the concept of aphasia as a disorder is evolving. Remarkable neuronal adaptation, reorganization and even neurogenesis had been found to occur after brain injury. Ongoing investigations continue to submit exciting insights into the phenomenon of brain plasticity. Evidences shows that speech therapy is beneficial, especially with newer technique like the MIT and the Constraint Induction approaches. Data on pharmacological intervention is exciting and promising, but there is not equal evidence to support routine clinical use of any drug for language recovery at the moment.



However, data on aphasia in the Chinese population remains limited; the distribution of aphasia subtypes is poorly characterized. In order to evaluate the character of aphasia affecting the Chinese, we conducted a prospective longitudinal observational study in a cohort of stroke-induced aphasic Chinese in Hong Kong. We screened Cantonese-speaking patients who presented with acute stroke (infarction or hemorrhage) in our hospital and had aphasia as described by the National Institutes of Health stroke scale (NIHSS) from Dec 2002 to May 2003. Patients with preexisting language or cognitive impairment, poor Glasgow Coma Scale (GCS), significant co-morbidity were excluded. Language was assessed with the Chinese Aphasia Battery (CAB), during the acute stage, at 1 week and 3 months after stroke. Computer tomography (CT) brain scan was done in all patients within 24 hours of acute stroke. There were 484 acute strokes in the study period, 73 patients had aphasia; 27 patients were recruited in the study. There were 15 global aphasia (55.6%), 6 transcortical aphasia (22.2%), 4 anomic aphasia (14.8%), 1 Broca's aphasia (3.7%) and 1 conduction aphasia. Twelve (44.4%) patients showed improvement in language function in 3 months time. Among them, 4 (14.8%) showed dramatic improvement from global aphasic to normal or anomic aphasic. Global aphasia was the most important factor for poor outcome. 66.7% of global aphasic patients had poor outcome. All the 3 mortalities in our cohort were globally aphasic. Overall, good prognostic factors for language recovery included anomic aphasia at presentation, higher education level, less severe stroke, lesion restricted to subcortical structure, and possibly hemorrhagic stroke.

Abstracts of Medical Student Essay Award

Atrial Remodeling: "Remodeling" the Treatment of Atrial Fibrillation

Mr WC Wong

Recent understanding of the pathogenesis of atrial fibrillation (AF) is captured by the concept of "atrial remodeling", which comprises the structural and electrical changes in the atria underlying the initiation and maintenance of AF. Current evidence generally suggests a role for stretch in the initiation of AF, possibly leading to neurohormonal activation and atrial fibrosis. Intracellular calcium overload is commonly considered as a key signal for the alterations in the expression of ion channels and other proteins.

The atrial remodeling process presents scientists with an increasing variety of novel therapeutic targets, with the potential of slowing or reversing the progression of AF. Existing agents may acquire a new place in AF treatment. ACE inhibitors, AT1-receptor blockers, aldosterone antagonists and β -blockers may prevent the signalling for atrial fibrosis, while vitamin C and statins may counteract the oxidative stress for remodeling. Examples of experimental agents that possibly prevent remodeling include calpain inhibitors, $\text{Na}^+/\text{Ca}^{2+}$ or Na^+/H^+ exchange inhibitors, stretch – activated channel inhibitors, metalloproteinase inhibitors, connexin modulators and 5-HT₄ antagonists. Not much potential, however, is currently seen with gene-based approaches against atrial remodeling. More efforts are therefore needed to identify the core processes to target, and to evaluate the clinical utility of these novel approaches.



Novel Treatment of Gastrointestinal Disorders – The Potential Therapeutic Uses of Oral Bacterial Therapy

Mr Tongny Lam

Purpose of review: This essay summarizes the clinical efficacy of oral bacterial therapy (probiotics) in gastrointestinal disorders and examines the mechanisms of actions related to their therapeutic effects.

Recent findings: The demonstration that immune and epithelial cells can discriminate between different microbial species has extended the known mechanism(s) of actions of probiotics beyond simple barrier and antimicrobial effects. It has also confirmed that probiotic bacteria modulate mucosal and systemic immune activity and epithelial function. The progressive unraveling of these mechanisms of actions has led to new credence for the use of probiotics in clinical medicine. Level I evidence now exists for the therapeutic use

of probiotics in infectious diarrhoea in children, recurrent *Clostridium difficile*-induced infections and postoperative pouchitis. Level II evidence is emerging for the use of probiotics in other gastrointestinal infections, prevention of postoperative bacterial translocation, irritable bowel syndrome, and in both ulcerative colitis and Crohn's disease. Nevertheless, one consistent feature has emerged over the past year: not all probiotic bacteria have similar therapeutic effects. Future clinical trials will need to incorporate this fact into trial planning and design.

Summary: The use of probiotics as therapeutic agents for gastrointestinal disorders shows great potential. More randomized controlled trials are needed to provide the necessary evidence for their incorporation into the therapeutic armamentarium.



Examinations and Results

New Seating Arrangements for Joint HKCPIE/MRCP(UK) Part II (Written)

The MRCP(UK) Central Office has new seating rules stipulating a minimum distance between desks for candidates taking the abovenamed examination. In order to comply with these regulations, the examination was held on 8 December 2004 at the Run Run Shaw Hall of the Academy Building.



Timetable for MRCP(UK) Part II Clinical PACES

7-11 March 2005

24-28 October 2005 (to be confirmed)

Pass rates (2002 – 2004) for Joint HKCPIE/MRCP(UK) Part 1

	<u>Sitting</u>	<u>Pass</u>
Sep 02	100	33 (33%)
Jan 03	124	55 (44%)
May 03 (SARS Special)	21	7 (33%)
Sep 03	54	29 (54%)
Jan 04	93	39 (42%)
Sep 04	29	16 (55%)

Pass rates (2001 – 2004) for Joint HKCPIE/MRCP(UK) PACES

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%

Pass list of the Joint HKCPIE/MRCP(UK) October PACES 2004

Congratulations to members who will receive the Intermediate Examination Certificates at our Annual General Meeting in 2005.

CHAN Gavin Jehim	HO Tsz Ling	ONG Ho Yun Liza	WONG Chun Man
CHAN Hiu Yan	HONG Yeuk Fai	SIN Wai Ching	WONG Fung Kwan Gida
CHAN Ka Man	KO Yiu Kwan	TANG Wai Ming	WONG Kin Chung Martin
CHAN Pierre	KWAN Hoi Yee	TO Cho Ting	YIU Kwai Ping
CHAN Shuk Fan	LAW Tse Sam Grace	TSANG Chi Yan	YU Man Ching Kelvin
CHEUNG Pik Shan	LEUNG Yuk Yan Rock	TSE Hoi Nam	
HO Sze Ki Sandy	LO Fu Hang	WANG Kin Fong Teresa	

Training

Requirement for Dissertation before Fellowship application

All higher physician trainees are reminded that obtaining a pass in a dissertation is a pre-requisite for College Fellowship, as clearly stipulated on Page 140 of Guidelines on Postgraduate Training in Internal Medicine, third edition, July 2002, Section "Exit Assessment: The Final Year's Assessment Process". All trainees must submit a dissertation in the first specialty examined if they wish to acquire College and Academy Fellowship after their first Exit Assessment, whether this specialty is in AIM or any other specialty. Without a pass in a dissertation, the College will not process any applications for Fellowship.

Statistics of Number of Fellows (HKCP) in Specialties

Updated 16 December 2004

SPECIALTY	FELLOWS TOTAL (PP/DH/HA/OTHERS)	FELLOWS								HONG KONG EAST + WEST CLUSTER
		HONG KONG EAST CLUSTER			HONG KONG WEST CLUSTER					
		PYNEH	RH	TWEH	FYKH	GH	QMH	TWH		
CARDIOLOGY	161	7	2	0	0	4	11	0	24	
CRITICAL CARE MEDICINE	45	4	0	0	0	0	7	0	11	
DERMATOLOGY & VENEREOLOGY	69	0	0	0	0	0	1	0	1	
ENDOCRINOLOGY, DIABETES & METABOLISM	56	2	2	3	0	0	9	0	16	
GASTROENTEROLOGY & HEPATOLOGY	100	6	2	0	0	0	10	1	19	
GERIATRIC MEDICINE	128	5	13	2	3	0	4	0	27	
HAEM/HAEM ONCOLOGY	34	3	0	0	0	0	9	0	12	
IMMUNOLOGY & ALLERGY	6	0	0	0	0	0	1	0	1	
INFECTIOUS DISEASE	16	0	0	0	0	0	0	0	0	
MEDICAL ONCOLOGY	30	0	0	0	0	0	6	0	6	
NEPHROLOGY	90	4	0	0	0	0	8	2	14	
NEUROLOGY	57	5	3	0	0	0	4	1	13	
PALLIATIVE MEDICINE	13	0	1	0	0	1	0	0	2	
REHABILITATION	36	0	3	3	1	0	1	4	12	
RESPIRATORY MEDICINE	119	5	6	0	0	9	9	1	30	
RHEUMATOLOGY	34	2	1	0	0	0	3	2	8	

SPECIALTY	FELLOWS TOTAL (PP/DH/HA/OTHERS)	FELLOWS									
		KOWLOON CENTRAL CLUSTER		KOWLOON EAST CLUSTER			KOWLOON WEST CLUSTER				KOWLOON CENTRAL + EAST + WEST CLUSTER
		KH	QEH	HOHH	TKOH	UCH	CMC	KWH	PMH	YCH	
CARDIOLOGY	161	0	11	0	2	5	1	5	8	3	35
CRITICAL CARE MEDICINE	45	0	5	0	1	4	4	2	1	2	19
DERMATOLOGY & VENEREOLOGY	69	0	0	0	0	0	0	0	0	0	0
ENDOCRINOLOGY, DIABETES & METABOLISM	56	0	5	0	1	3	2	1	3	1	16
GASTROENTEROLOGY & HEPATOLOGY	100	0	8	0	3	2	5	5	12	4	39
GERIATRIC MEDICINE	128	5	3	6	2	10	7	8	10	3	54
HAEM/HAEM ONCOLOGY	34	0	5	0	1	1	0	0	1	0	8
IMMUNOLOGY & ALLERGY	6	0	0	0	0	0	0	0	0	0	0
INFECTIOUS DISEASE	16	0	1	0	0	0	0	0	6	1	8
MEDICAL ONCOLOGY	30	0	1	0	0	0	0	0	0	0	1
NEPHROLOGY	90	0	8	2	1	3	3	5	7	2	31
NEUROLOGY	57	0	6	0	1	2	0	4	2	0	15
PALLIATIVE MEDICINE	13	0	0	3	0	2	3	0	0	0	8
REHABILITATION	36	5	0	1	0	3	0	1	1	0	11
RESPIRATORY MEDICINE	119	7	5	5	3	4	3	3	5	1	36
RHEUMATOLOGY	34	1	1	0	0	2	2	1	3	0	10

SPECIALTY	FELLOWS TOTAL (PP/DH/HA/OTHERS)	FELLOWS							
		NEW TERRITORIES EAST CLUSTER					NEW TERRITORIES WEST CLUSTER	NEW TERRITORIES EAST + WEST CLUSTER	
		AHNH	NDH	PWH	SH	TPH	TMH		
CARDIOLOGY	161	2	2	7	0	0	8		19
CRITICAL CARE MEDICINE	45	1	2	1	0	0	1		5
DERMATOLOGY & VENEREOLOGY	69	0	0	0	0	0	0		0
ENDOCRINOLOGY, DIABETES & METABOLISM	56	2	1	10	0	0	1		14
GASTROENTEROLOGY & HEPATOLOGY	100	1	2	9	0	0	8		20
GERIATRIC MEDICINE	128	1	0	3	7	3	11		25
HAEM/HAEM ONCOLOGY	34	0	0	3	0	0	2		5
IMMUNOLOGY & ALLERGY	6	0	0	0	0	0	0		0
INFECTIOUS DISEASE	16	1	0	1	0	0	3		5
MEDICAL ONCOLOGY	30	0	0	11	0	0	0		11
NEPHROLOGY	90	2	0	6	0	1	7		16
NEUROLOGY	57	2	2	4	0	0	1		9
PALLIATIVE MEDICINE	13	0	0	0	2	0	0		2
REHABILITATION	36	0	0	2	1	2	3		8
RESPIRATORY MEDICINE	119	4	3	4	0	1	6		18
RHEUMATOLOGY	34	1	1	4	0	2	1		9

Statistics on Number of Trainees (HKCP) in all Specialties

Updated 16 December 2004

SPECIALTY	TRAINEES TOTAL (PP/DH/HA/ OTHERS)	TRAINEES							
		HONG KONG EAST CLUSTER			HONG KONG WEST CLUSTER				
		PYNEH	RH	TWEH	FYKH	GH	QMH	TWH	
		YEAR			YEAR				
CARDIOLOGY	17	1 2 3-1 4	1 2 3-2 4	1 2 3 4	1 2 3 4	1 2 3 4	1-1 2 3 4-1	1 2 3 4	
CRITICAL CARE MEDICINE	10	1-1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4-1	1 2 3 4	
DERMATOLOGY & VENEREOLOGY	9	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4-1	1 2 3 4	
ENDOCRINOLOGY, DIABETES & METABOLISM	17	1 2 3 4-1	1 2 3 4-1	1 2-1 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	
GASTROENTEROLOGY & HEPATOLOGY	12	1 2-1 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	
GERIATRIC MEDICINE	26	1-1 2-1 3 4-1	1 2 3 4	1 2 3-1 4-1	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4-1	
HAEM/HAEM ONCOLOGY	6	1-1 2 3-1 4-1	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3-1 4	1 2 3 4	
IMMUNOLOGY & ALLERGY	0	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	
INFECTIOUS DISEASE	9	1-1 2 3 4	1 2-1 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4-1	1 2 3 4	
MEDICAL ONCOLOGY	4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2-1 3-1 4	1 2 3 4	
NEPHROLOGY	15	1 2 3-1 4-1	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	
NEUROLOGY	12	1-1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4-1	1 2 3 4	
PALLIATIVE MEDICINE	3	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	
REHABILITATION	3	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	
RESPIRATORY MEDICINE	25	1-1 2 3 4-1	1 2 3 4-2	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4-1	1 2 3 4	
RHEUMATOLOGY	9	1 2 3 4-1	1 2 3 4-1	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	

* No. of trainers is shown in italics in right low hand corner of each hospital

SPECIALTY	TRAINEES TOTAL (PP/DH/HA/ OTHERS)	TRAINEES											
		KOWLOON CENTRAL CLUSTER		KOWLOON EAST CLUSTER			KOWLOON WEST CLUSTER						
		KH	QEH	HOHH	TKOH	UCH	CMC	KWH	PMH	YCH			
YEAR		YEAR			YEAR								
CARDIOLOGY	17	1 2 3 4	1 2 3-1 4	11	1 2 3 4	0	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3-1 4	3	
CRITICAL CARE MEDICINE	10	1 2 3 4	1 2 3 4	4	1 2 3 4	0	1 2 3 4	1 2 3-1 4	1-2 2 3-1 4	1-1 2 3 4	1 2 3 4	1 2 3 4	3
DERMATOLOGY & VENEREOLOGY	9	1 2 3 4	1 2 3 4	0	1 2 3 4	0	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	0	0
ENDOCRINOLOGY, DIABETES & METABOLISM	17	1 2 3 4	1 2 3 4	4	1 2 3 4	0	1 2 3 4	1 2 3-1 4	1 2-1 3-1 4	1 2 3 4	1 2 3 4	1 2 3-1 4	1
GASTROENTEROLOGY & HEPATOLOGY	12	1 2 3 4	1 2 3 4-1	8	1 2 3 4	0	1 2 3 4	1-1 2 3 4-2	1 2 3 4	1 2 3 4	1 2 3 4-1	11	2
GERIATRIC MEDICINE	26	1 2-1 3 4	1 2 3-1 4	3	1 2 3 4	4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3-1 4-1	1 2 3 4	9	3
HAEM/HAEM ONCOLOGY	6	1 2 3 4	1 2-1 3 4	3	1 2 3 4	0	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2-1 3 4	1 2 3 4	0
IMMUNOLOGY & ALLERGY	0	1 2 3 4	1 2 3 4	0	1 2 3 4	0	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	0	0
INFECTIOUS DISEASE	9	1 2 3 4	1-1 2 3-1 4	0	1 2 3 4	0	1 2 3 4	1 2 3 4	1 2 3 4	1 2-1 3 4	1 2 3 4	3	1
MEDICAL ONCOLOGY	4	1 2 3 4	1 2 3 4	0	1 2 3 4	0	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	0	0
NEPHROLOGY	15	1 2 3 4	1-1 2 3-1 4	6	1 2 3 4	0	1 2 3 4	1 2 3 4	1 2 3 4	1 2-1 3-1 4	1 2 3 4	7	1
NEUROLOGY	12	1-1 2 3 4	1 2 3 4-1	5	1 2 3 4	0	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1	0
PALLIATIVE MEDICINE	3	1 2 3 4	1 2 3 4	0	1 2 3 4	1	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	0	0
REHABILITATION	3	1 2-1 3 4	1 2 3 4	0	1 2 3 4	1	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1	0
RESPIRATORY MEDICINE	25	1 2 3-1 4	1 2-1 3 4-1	3	1 2 3 4	4	1 2 3 4	1 2 3-1 4	1 2 3-1 4	1 2 3 4	1 2 3 4	3	1
RHEUMATOLOGY	9	1 2 3 4	1 2-1 3 4-1	1	1 2 3 4	0	1 2 3 4	1 2 3 4	1 2 3 4	1 2-1 3 4	1 2 3 4	1	0

* No. of trainers is shown in italics in right low hand corner of each hospital

SPECIALTY	TRAINEES TOTAL (PP/DH/HA/ OTHERS)	TRAINEES NEW TERRITORIES EAST CLUSTER						NEW TERRITORIES WEST CLUSTER	
		AHNH	NDH	PWH	SH	TPH	TMH		
		YEAR						YEAR	
CARDIOLOGY	17	1 2 3 4	1 2 3-2 4	1-1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	7
CRITICAL CARE MEDICINE	10	1 2 3 4-1	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1
DERMATOLOGY & VENEREOLOGY	9	1 2 3 4	1 2 3 4	1-1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	0
ENDOCRINOLOGY, DIABETES & METABOLISM	17	1 2 3 4	1 2 3-1 4	1 2-1 3 4	1-1 2 3-1 4	1 2 3 4	1 2 3 4	1 2-1 3 4-1	1
GASTROENTEROLOGY & HEPATOLOGY	12	1 2 3 4-1	1 2 3-1 4	1 2-1 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2-1 3 4	6
GERIATRIC MEDICINE	26	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3-1 4-3	1 2 3 4-2	9
HAEM/HAEM ONCOLOGY	6	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	2
IMMUNOLOGY & ALLERGY	0	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	0
INFECTIOUS DISEASE	9	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3-1 4	2
MEDICAL ONCOLOGY	4	1 2 3 4	1 2 3 4	1-1 2 3-1 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	0
NEPHROLOGY	15	1 2 3-2 4-2	1 2 3 4	1 2-1 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	5
NEUROLOGY	12	1 2 3 4	1 2 3 4	1-1 2 3 4-1	1-1 2-1 3 4-1	1 2 3 4	1 2 3 4	1-1 2 3 4	1
PALLIATIVE MEDICINE	3	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	0
REHABILITATION	3	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1
RESPIRATORY MEDICINE	25	1 2 3 4-1	1 2 3 4-1	1 2-1 3-1 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3-2 4	4
RHEUMATOLOGY	9	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2-1 3 4	1 2 3 4-1	1 2 3-1 4-1	1

* No. of trainers is shown in italics in right low hand corner of each hospital

SPECIALTY	TRAINEES TOTAL (PP/DH/HA/ OTHERS)	TRAINEES DH
DERMATOLOGY & VENEREOLOGY	9	1-2 2 3-2 4-3
GASTROENTEROLOGY & HEPATOLOGY	12	1 2 3 4
IMMUNOLOGY & ALLERGY	0	1 2 3 4
RESPIRATORY MEDICINE	25	1 2 3 4-1

Updated Training Guidelines

INFECTIOUS DISEASE

(I) OBJECTIVES

1. To provide a broad training and in-depth experience at a level sufficient for the trainee to acquire the competence of a specialist in Infectious Disease
2. To develop clinical skills, knowledge and competence in the management of Infectious Disease
3. To acquire the fundamental concepts of epidemiology of Infectious Diseases, hospital antimicrobial policies, administrative decisions on infection control and prevention
4. To inculcate in trainees a commitment to continuing medical education and scientific research in Infectious Disease

(II) STRUCTURE

A period of three years of supervised and accredited training in Infectious Disease is required, of which two years are devoted to core training.

1. The 2-year core programme in Infectious Disease consists of
 - 1.1 A period of 12 months of modular training in specialised areas of Infectious Disease in College-recognised institutions and units. The modules include:
 - 1.1.1 Six months of training in notifiable infectious diseases such as cholera, typhoid fever, malaria, etc.
 - 1.1.2 Three months of training in HIV infection and acquired immunodeficiency syndrome (AIDS) medicine
 - 1.1.3 Three months of training in the inpatient and outpatient management of tuberculous disease
 - 1.2 A period of 12 months of training in General Infectious Disease is required. The trainee should have full-time duties in the Internal Medicine service in order to get experience in a wide range of infectious diseases. A 3-month period in these 12 months should be dedicated to the management of infection in immunocompromised patients who are recipients of chemotherapy or transplants. Another 3-month period should be dedicated to the management of infections in critical care patients. The trainee should also act as liaison officer on infection with the microbiologists by maintaining a close link with them, consulting for advice when necessary
 - 1.3 Throughout the two years of core training, there should be ample interaction with the microbiologists and time set aside for training in a College-recognised microbiology laboratory:
 - 1.3.1 The trainee should spend three months in the microbiology laboratory to learn about relevant methods and techniques. He/She should also acquire knowledge in infection control and antimicrobial policy in this attachment
 - 1.3.2 During these three months of laboratory training, he/she is required to attend the combined Infectious Disease/Microbiology ward rounds
 - 1.3.3 He/she should maintain clinical involvement in these three months by taking emergency calls in his/her parent medical unit after office hours
2. There should be training in the management of sexually transmitted disease during a minimum of 20 clinic sessions. This can be undertaken throughout the training period in College-recognised units
3. Trainees are required to attend at least one College-approved course in Infectious Disease/Infection Control/Epidemiology during the period of training.
4. The 12 months' training outside the core-training programme should be spent in acute general medicine. There should be rotations to specialties closely related to Infectious Disease, including Gastroenterology & Hepatology, Nephrology and Respiratory Medicine.
5. Trainees enrolled in concurrent training with AIM should also undergo training in specialties closely related to Infectious Disease specified under Item 4, in addition to other AIM specialties of their choice.

(III) CONTENTS

During the course of training, the trainee is expected to acquire experience, knowledge and skills related to the field of Infectious Disease. Familiarity with inter-related subjects is also expected

(A) Knowledge

1. Aetiology, pathophysiology, pathogenesis, natural history, clinical manifestations, investigations, and management of various global and endemic infectious diseases, including clinical tropical medicine

2. Knowledge in epidemiology of common or important infections in the territory as well as epidemiology of nosocomial infections. The trainee is required to design, execute and analyse at least one epidemiological study during the training period
3. The mechanisms and pathobiology of infection
4. Hospital antimicrobial policies, clinical pharmacology of antimicrobials and their use in different clinical settings
5. Hospital infection control and territory-wide infection control
6. Diagnostic techniques and other laboratory experience in clinical microbiology, virology and parasitology
7. Immunological investigations, concepts in immunopathogenesis and clinical management of immunocompromised patients
8. Vaccinology
9. Travel medicine
10. Knowledge of nuclear medicine and radiological methods pertaining to the diagnosis of infections
11. Basic knowledge of clinical research methods and statistics
12. Concepts of quality assurance and cost-effectiveness in the practice of Infectious Disease

(B) Skills

1. Acute management and routine care of patients suffering from severe infection and its sequelae
2. Management of severe infection in a critical care setting
3. Management of patients with communicable and tropical infections, e.g. cholera, malaria, etc.
4. Care of immunocompromised patients, including neutropenic and those with HIV infection / AIDS
5. Management of nosocomial infections through knowledge in infection control and appropriate liaison with laboratory services
6. Practical knowledge of common clinical procedures, e.g. sigmoidoscopy, lumbar puncture, central line insertion, etc.
7. Essential staining and culture techniques for common micro-organisms in different specimens
8. Microscopic examination of important infectious agents, e.g. malaria parasites, meningococci, etc.

(IV) INSTITUTIONAL REQUIREMENTS

1. The training programme may involve more than one recognised training hospital / institution. A training institution for Infectious Disease should be an acute care hospital with the following features:
 - 1.1 Twenty-four-hour emergency admission
 - 1.2 General medical and surgical beds, for which Infectious Disease consultations are called upon on a regular basis
 - 1.3 Isolation facilities
 - 1.4 Outpatient referral clinics for Infectious Disease, including travel medicine
 - 1.5 A designated team composed of infectious disease physicians and microbiologists responsible for the management of a wide spectrum of infectious diseases
 - 1.6 Laboratory support including microbiology, virology, parasitology, histopathology, biochemistry and haematology
 - 1.7 Radiology support
 - 1.8 Bronchoscopy and gastrointestinal endoscopy facilities
2. In all training institutes for Infectious Disease, the following features should be available:
 - 2.1 Staffed by at least 2 Fellows of the College who have been accredited in Infectious Disease. Regular ward rounds, supervised emergency calls and outpatient services should be provided. The minimum trainer to trainee ratio should not be less than 1:2
 - 2.2 Laboratory and diagnostic facilities including radiology, histopathology, microbiology, clinical chemistry and haematology
 - 2.3 Adequate educational facilities such as access to medical library, computerised literature search systems, educational equipment, etc.
 - 2.4 Regular education programmes and audit meetings
 - 2.5 Opportunities for research throughout the training period

Principles & Guidelines on Continuing Medical Education

Prof KN Lai

Chairman

Board of CME/CPD

May 2004 (updated in August 2004 with amendments shown in bold italics)

1 Objective

The purpose of CME/CPD is to enable Fellows to remain informed and up-to-date on current medical advances, and to maintain a high standard of practice in Internal Medicine through continuous professional development.

2 Supervision

- 2.1 The CME/CPD programme will seek and receive formal approval from the Education Committee of the Hong Kong Academy of Medicine (HKAM) before implementation.
- 2.2 Any changes to the CME/CPD programme will also be approved by the Academy Education Committee before implementation.
- 2.3 All Fellows of the College who are also Fellows of the HKAM must satisfy the full requirements of the CME/CPD programme by the end of each Cycle.
- 2.4 The College will ensure compliance with CME/CPD requirements. Non-compliance will be recorded and reported to the Academy Education Committee. This Committee has been empowered to recommend to HKAM Council the suspension of delinquent Fellows, unless it is satisfied that there are mitigating circumstances, and that deficiencies can be remedied within an acceptable time.
- 2.5 All operations related to CME/CPD issues will be undertaken by a Board of Continuing Medical Education.

3 The Cycle

- 3.1 A Cycle of CME/CPD assessment shall span three years.
- 3.2 ***The first Cycle commences immediately upon HKAM admission for new Fellows after the implementation of CME/CPD.*** The date of commencement will be recorded for each Fellow.

4 Measurement of activities

One Point of CME/CPD activity is normally equivalent to one hour of audience participation in a ***Formal College-Approved Activity (FCAA)*** as specified under Section 5.2a.

5 Accreditable CME activities

- 5.1 Self-study
 - a) Self-study is accepted as a form of CME/CPD.
 - b) Self-study is only accredited subject to prior approval from the College, with evidence that it has been carried out diligently.
 - c) Certain self-assessment programmes designed for physicians are endorsed by HKCP for Self-study. A list of accredited programmes are maintained by the Board of CME/CPD, and will be updated from time to time (Appendix I). CME/CPD Points equivalent to the credits/credit-hours defined by the organising institution will be awarded on completion of each programme.
Fellows may subscribe to such programmes on an individual basis, and submit to the Board of CME/CPD documentary evidence of participation. Instructions relating to subscription will be provided by the College. Subscription to College-approved self-assessment programmes via Internet may also be accredited upon submission of evidence of participation.
Programmes from organisations not on the College-approved list should be individually submitted to the Board of CME/CPD for approval.
 - d) Journal reading from a College-approved list is an acceptable form of Self-study. Documentation of journal reading is required. A maximum of 45 CME/CPD Points in each three-year cycle may be accredited.
 - e) Self-study may be accredited a maximum of 75 CME/CPD Points per three-year.
- 5.2 Passive Participation
 - a) One CME/CPD Point is awarded for each hour of audience participation in a FCAPM, up to a maximum of eight CME/CPD Points per day.
 - b) Participation in international postgraduate meetings may be retrospectively accredited upon submission of proof of attendance.

- c) Local subspecialty societies/associations must seek from the Board of CME/CPD prior accreditation for each meeting, and supply a summary of contents and speaker (with brief curriculum vitae). Criteria to accredit such meetings will be determined by the Board of CME/CPD. Public and private hospitals organizing Grand Rounds and Journal Clubs, must obtain prior approval from the Board of CME/CPD for accreditation.
- d) CME/CPD activities organised by other Academy Colleges and their subspecialty societies/association may also be accredited by the College, if prior approval is sought and received in writing. CME/CPD Points equivalent to physician-organised activities may be awarded to Physician Fellows for attendance at such meetings.
- e) Proof of attendance must be provided.
- f) Passive Participation as defined above may be accredited a maximum of 75 Points per three-year cycle.

5.3 Active Participation

- a) Active Participation includes chairing or presenting in a **FCAA**
- b) Active participation as speaker may be awarded a maximum of two CME/CPD Points per presentation. Active participation as Chairman may be awarded a maximum of two CME/CPD Points per session.
- c) Active Participation may be accredited a maximum of 75 Points per three-year Cycle.

5.4 Publications

- a) A maximum of four CME/CPD Points may be awarded to the chief author, and two Points for secondary authorship of each Publication in non-indexed international journals, journals published by constituent Colleges of HKAM, or other College-approved local journals.
- b) A maximum of six CME/CPD Points may be awarded to the chief author, and three Points for secondary authorship of each Publication in journals published by HKAM and indexed international journals.
- c) A maximum of 10 CME/CPD Points may be awarded to the chief author and 5 Points for secondary authorship of each chapter or section of a medical textbook.
- d) A maximum of 10 CME/CPD Points may be awarded to the author of a thesis or treatise.
- e) Publications may be accredited a maximum of 45 CME/CPD Points per three-year Cycle.

5.5 Quality Assurance

- a) Quality Assurance activity in itself will not be awarded.
- b) A maximum of five CME/CPD Points may be awarded to each author for the production of each College-approved Quality Assurance Report.
- c) Quality Assurance Reports may be accredited a maximum of 30 Points per three-year cycle.

6 Exclusions

Participation in the following activities will not be awarded CME Points.

Acting as Examiner in College Examinations

Research

Research Grant Application

Development of New Technologies

Undergraduate Teaching

Postgraduate Teaching other than those listed under Sections 5.2 and 5.3.

Attending seminars or lectures in the enrollment of a postgraduate diploma or degree course.

7 Minimum CME/CPD Requirement

7.1 The minimum CME/CPD requirement is 90 Points in each three-year Cycle.

7.2 The minimum annual CME/CPD requirement is 10 Points.

8 Certification

The Board of CME/CPD will certify completion of CME/CPD requirements for Physician Fellows at the end of each Cycle.

9 CME/CPD Registry

The Board of CME/CPD will maintain a Register of Physician Fellows who has been awarded certification under Section 8.

Profile Doctor

Professor Chan Tai Kwong

John MacKay

Derek Chan has a tough act to follow. Derek is fifteen, studying at the prestigious Winchester College in England, and may well be going into medicine like his father before him.

Derek's advantage is that both his parents are eminent members of the medical world, whereas his father was the first in the family to be a doctor: his paternal grandfather had been a trained pharmacist who developed a successful pharmaceutical trading company.

Chan Tai Kwong was born in 1938 in Hong Kong to a Hong Kong family. His early education was disrupted by the Japanese occupation during which time the family moved to Macau where he attended the Pui Ching school.

On return to Hong Kong in 1946 he attended the St. Stephen's Girls School which, for a short time immediately after the war, also admitted boys to make up numbers. He then went on to Wah Yan College where he was given an excellent education by the Jesuit fathers, won several academic prizes and enjoyed playing football.

The choice of Medicine as a career followed from his interest in science, and the encouragement of his father.

He entered Hong Kong University Medical School in 1956 with a scholarship from the Hong Kong Government. His first three years at University he lived in St John's Hostel, where he continued his interest in football and was introduced to billiards. He was captain of Sports for one year.

Academic awards marked his progress through medical school; the Ng Li Hing Prize in Anatomy, C.P.Fong Gold Medal in Medicine, the Ho Fok & Chan Kai Ming Prize in the Final Examination, and the Anderson Gold Medal for highest aggregate of marks in all MB examinations.

On qualification T.K. joined the Department of Medicine of Hong Kong University at the Queen Mary Hospital, at a time when it was headed by Professor Alec McFadzean. He remembers Professor McFadzean as being a stern taskmaster, but fair, and always helpful and kind to him. Professor David Todd he also remembers as being kind, and very organized. He was appointed an Assistant Lecturer in 1964 and a Lecturer a year later. For the next two years he was awarded a Commonwealth Scholarship during which he spent one year in



Prof TK Chan was conferred the Honorary Fellowship of the HKCP in October 2004

Glasgow as an Honorary Registrar passing both Edinburgh and London MRCP examinations in 1966, and a second year in London doing haematological research at University College Hospital.

Back at Hong Kong University, T.K. continued his interest in haematology, enhancing further the standing of a department that had already achieved a world-wide reputation for original research.

Publications from 1964 onwards reflected his interests in glucose-6-phosphate dehydrogenase (G6PD) deficiency, the subject in which he was awarded an M.D. from Hong Kong University in 1983, and with it won the Sir Patrick Manson Gold Medal. The award of a China Medical Board Fellowship allowed him to spend a year as Visiting Assistant Professor at the University of Rochester School of Medicine in New York. He was happy to return from abroad to Hong Kong for the rest of his academic life, unlike about half the graduates of his medical year who chose to establish their careers overseas.

Professor T.K.Chan continued to climb the academic ladder at Hong Kong University becoming a professor in 1980 and Head of the Department of Medicine from 1989 till his retirement from the University in 1995.

Professor Todd, the head of the Department of Medicine preceding T.K., paid tribute to him on his retirement from the University for his ability as a clinician, and for his contribution to haematological research in areas of red cell physiology, G6PD deficiency, hypersplenism, molecular genetics of

thalassaemia, haemophilia, Christmas disease, and haematological malignancies. Flowing from this work there is an impressive body of 150 publications in international journals and books.

Reflecting his primary interests as a clinician and researcher Professor Chan revealed that his moments of greatest satisfaction came from the diagnosis of a patient's obscure but treatable condition, and the achievement of success of a research project.

His ability as an administrator and organizer led to his appointment to many advisory bodies in Hong Kong and overseas. A particularly challenging time was the reorganization consequent on the setting-up of the Hospital Authority in 1991.

He was a Foundation Fellow of the Hong Kong College of Physicians, the Hong Kong College of Haematologists and the Hong Kong Academy of Medicine.

Since leaving the university T.K. has enjoyed the slightly more leisurely life in private practice as a specialist in haematology, giving him time to enjoy his interests in collecting Chinese ceramics, visiting art galleries, and reading. However, he still allows himself just two weeks holiday a year, and is still involved in many advisory bodies. Plans for the future include the writing of a book of haematological case studies.

Asked to comment on his views regarding medical education he reiterated the philosophy held by Professor McFadzean that physicians should have a thorough grounding in general medicine before specializing, and to maintain that interest.

Since coming out into Private Practice he had been gratified to discover how up-to-date his new colleagues were. Having been involved in post-graduate education for many years it was not surprising to hear that he firmly believes in the necessity of Continuing Medical Education, and that he felt that before long a satisfactory achievement of a reasonable target would be required before a doctor could be re-registered.

Regarding the Hospital Authority he was concerned about the major problem regarding finance, the work pressure on staff,(aggravated by the recent influx of non-Hong Kong-residents coming for expensive treatments); and the lack of resources sufficient to keep junior doctors in training posts until they were fully qualified should they have a wish to specialize.

In another ten years who can predict what the medical scene will be like in Hong Kong? By then (Dr) Derek Chan will be in a position to find out for himself.