HONG KONG COLLEGE OF PHYSICIANS

SYNAPSE

SEPTEMBER 2005 RESTRICTED TO MEMBERS ONLY

This painting of a peony is by **Mr Lee Siu Man**, aged 76 years old, who attends the Ruttonjee Hospital Diabetic Clinic. The peony (牡丹) is often considered the "King of Flowers" and is a favorite subject for artists and poets. First cultivated more than two thousand years ago, it has a long history in Chinese culture, with records of its use as a medicinal plant dating back to the 東漢 dynasty.

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SYNAPSE

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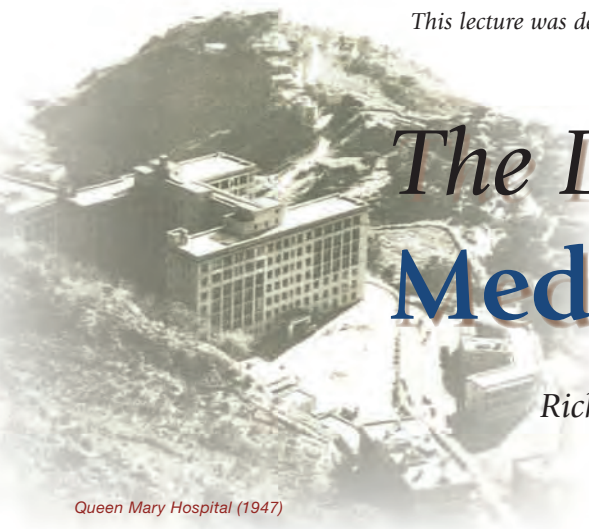
Change has become an integral part of our daily working life as our health care system continually seeks the best model to face challenges of a rising budget, the demands of the public and the expansion of technology in medicine. Likewise, our College has evolved by leaps and bounds since it was founded in 1986. During these past years, a prodigious amount of work by many unsung individuals has led to the development of an excellent training and examination structure that is now in place. It is perhaps appropriate to stand back and recapture the visions of those who lay the foundations in those early years, as Professor Richard Yu's article on the development of medicine in Hong Kong will surely remind us. The College's tireless quest for perfection is evidenced by the constant refinement of training guidelines. In this issue, the updated versions for higher physician training and continuous medical education merit your attention.

In this same spirit of change, Synapse, too has taken a few bold steps forward. First, our editorial board has expanded to include a broad spectrum of specialists from a wide range of hospitals. This move endeavors to make Synapse more representative of you, Fellows and Members of this College. Secondly, we have introduced new columns likely to be of interest to our readers. The specialty column will feature guest authors who are international experts in their own field and aims to highlight findings of relevance to our local practitioners. This series kicks off with a contribution from Professor Frances Chan whose research has practical implications for our practice. The newly introduced infection column is an accurate reflection of how emerging infections has moved from small print in the textbooks to medical practice and the media. Professor PL Ho has summarized for us the infections that you have encountered in the news. Last but not least, our third change is certainly the most visible of all. The format and presentation of Synapse has been enhanced to make it lively and attractive for readers. We hope you like it and will be happy to hear your views and suggestions.

Happy reading.

Editor

This lecture was delivered by Professor Richard YH Yu at the 10th Hong Kong Medical Forum on 16th July 2005



Queen Mary Hospital (1947)

The Development of Medicine in Hong Kong

Richard YH Yu

Past President, Hong Kong College of Physicians

The development of medicine in Hong Kong is the outcome of vision, dedication, commitment and ability on the part of many individuals, but especially the giants who stood on each other's shoulders. Central to the saga is the Department of Medicine in the University of Hong Kong and Queen Mary Hospital. After suffering so much from the ravages of war, Hong Kong was blessed with a man who began to shape the course of events immediately upon his appointment to the University's Chair in Medicine in 1948 at the young age of 34 years. Even today, A.J.S. McFadzean's philosophy and vision continue to influence and guide the thinking of doctors in Hong Kong.

In 1948, A J S McFadzean, a Glasgow University graduate was appointed to the Chair and headship of the Department of Medicine

Prof Alexander James Smith McFadzean
1948 - 1974

During McFadzean's twenty-six year tenure as Professor and Head, the Department of Medicine took the lead in determining the scope and direction of medical teaching and practice in Hong Kong. The Missions and Objectives so eloquently promulgated by the Department in 1995 embody in essence the philosophy and vision of Alex McFadzean.

"To produce doctors equipped to practise medicine of the highest standard and in the best interests of their patients and the community, and to inspire them to strive for and achieve academic excellence."

McFadzean's first mission objective was to develop medical subspecialties, both to supply clinical services in line with international standards and to train future leaders of the profession. Juniors were posted to the medical world's centres of excellence for post-graduate education – Glasgow, Edinburgh, London and later the US and Australia. There they gained valuable experience in the art and science of the different fields. Equally importantly, these individuals were exposed to different professional cultures and established personal relationships which were to proved vital to future intellectual, academic and practical exchange. Under his guidance the subspecialties of cardiology, respiratory medicine, haematology, gastroenterology, endocrinology and nephrology were born. In the mission objective of academic research, one of McFadzean's most far-reaching decisions was to recruit a scientist - a non-clinical lecturer - to organize and initiate research. Dr (now Professor) Vivian Chan was interviewed by him and joined the Department in 1974. The Division of Molecular Medicine was thus born, laying a timely and solid foundation for the development of medical research and science in Hong Kong.

Battle of the Titans : McFadzean takes on Francis Stock, surgeon at QMH (Christmas 1972)

Sir David Todd

Sir David Todd
1974 - 1989

One of Alex McFadzean's star pupils – now Sir David Todd – succeeded to the Headship of the Department of Medicine in 1974, thereby fulfilling the great man's wish to pass the torch to a local graduate. Under Professor Todd's wise and able leadership the Department enjoyed a period of rapid expansion, with new subspecialties – neurology, haematological oncology, immunology/rheumatology, hepatology and clinical pharmacology - being introduced as existing ones became established in strength and achievements. A large increase in the junior establishment, coupled with the recruitment of doctors from other centers to undertake subspecialty training, produced a great and lasting impact on the development of medicine in Hong Kong. Sir David's influence was all-pervasive. In the private sector, it was the golden age in which subspecialty practice became firmly established.

It was the result of Sir David's international standing and personal relationships with the UK's Royal Colleges that from 1985, the MRCP (UK) examination began to be held entirely in Hong Kong. This was a milestone in the development of medicine in the territory, which set the direction for postgraduate education and training up to the present time. Another of his great – perhaps the most enduring – achievements was his chairmanship of a working group, which led (in 1986) to the formation of the Hong Kong College of Physicians. With Sir David as Founding President, the HKCP has been instrumental in ensuring the continued development of medical training and practice to the highest international standards. A sibling organization, The Hong Kong Academy of Medicine, was inaugurated by statutory ordinance 1993, once again with Sir David as Founding President.


Prof TK Chan

Prof T. K. Chan
1989 – 1995

Another McFadzean protégé succeeded Sir David. In 1989, Professor T.K. Chan took over the mantle, both as Head of the Department of Medicine and President of the Hong Kong College of Physicians. In close collaboration with the Hospital Authority or HA (which was founded in 1991), T.K. established the Joint Committee on Internal Medicine Training (JCIMT) and formed the Subspecialty Advisory Group to map out the scope and content of future subspecialty training under the auspices of the HKCP. This committee gave birth to 12 Specialty Boards, and it was under T.K. Chan's authorship that the first edition of Guidelines in Postgraduate Training in Internal Medicine was published in July 1993. A monumental document.

The development of medicine took a new direction. Today, I am proud to witness a standard of training and practice in medicine and its subspecialties in Hong Kong which bears comparison with anywhere in the world. This achievement is due in no small part to Dr E.K. Yeoh (another of McFadzean's and Todd's star pupils), who was the first Chief Executive of the HA from 1991 to 1999 and who was fortunately also Vice-President of the HKCP with responsibility for education and accreditation. After many years of working hand-in-glove with colleagues from the College, Dr Yeoh left the HA to become Hong Kong's first Secretary for Health, Welfare and Food happy in the knowledge that his grand design to restructure and enhance community healthcare was an unqualified success.

Academically, the Department of Medicine went from strength to strength during this time, for example with the establishment of the Bone-marrow Transplant Centre (a first in Hong Kong) and the Diabetes Centre of Excellence. Seminal research in genetics at molecular/cellular level and a legion of world-class publications from the Molecular Medicine Division placed Hong Kong firmly on the field's international map, for example research in Thalassaemia. Most of what happened is due to a formidable marriage, intellectually and in fact, between T.K. and Vivian. They produced academic excellence and also one Derek Chan, who is shaping up to be a scientist of great promise even at the tender age of 16 years.

Under the leadership of Alex McFadzean, David Todd and T.K. Chan, we in Hong Kong have enjoyed a standard of medical teaching, practice and research to be proud of. Let us now pause and contemplate what lies ahead.

The Changing Pattern of Diseases

Latest (2004) statistics show a sharp increase in medical diseases, especially as measured by A&E admissions into HA hospitals (up 54% year-on-year). At the same time, life expectancy in Hong Kong has steadily increased, from 67.8 years for males and 75.3 years for females in the 1970s to 78.6 years for males and 84.6 years for females at the beginning of the millennium.

The changing pattern of diseases reflected and implied by the above figures requires a far-reaching reappraisal of healthcare delivery in Hong Kong. It is the HKCP's aim to take up as large a share as possible of the responsibility to re-orientate the development of medical training and practice in line with shifts in the community's needs and expectations. The areas where attention is especially required are Geriatric/Rehabilitation Medicine, Infectious Diseases, and Oncology.

Geriatric and Rehabilitation Medicine

This area was targeted as long ago as 1991, when Dr E.K. Yeoh became Chief Executive of the Hospital Authority. I was offered the challenge of amalgamating Department of Geriatrics and Medicine throughout Hong Kong, with the immediate objective of enhancing co-ordination in patient management among Hong Kong's aging population and to develop the subspecialty of Rehabilitation Medicine. I am happy to report that beginning with the one handful when the Specialty Board was founded in 1993, we now possess 128 accredited fellows in Geriatrics who are capable and proficient in dealing with acute medical problems together with 30 trainees while in Rehabilitation there are 37 fellows with 14 trainees.

Infectious Diseases

Here, credit is due in the first place to Professor SK Lam. In 1998, when I assumed the HKCP Presidency, he proposed that the College should evaluate and restructure training in infectious diseases and seek more recruits into this specialty. I must say I was both astounded and dismayed to discover that practice in this field was still entrenched in the ancient regime in many areas, with little knowledge on the importance of microbiology, infection in the immunocompromised host, infection in intensive care units and hospital/community acquired infections. The absence of modernity was even more conspicuous in epidemiology and infection control.

Thanks to the wise counsel and guidance of Professor Yuen Kwok Yung, Dr Raymond Yung, members of the Specialty Board of Microbiology and Dr Robert Collins (then President of the College of Pathologists), training guidelines were thoroughly revised and a comprehensive training programme implemented. When Hong Kong was devastated by SARS in 2003, a small number of Fellows and trainees were ready to join the battle. We now have 17 fellows proficient in microbiology; epidemiology and infection control and 10 trainees, and I am very grateful to the College of Pathologists and Dr Leung Pak Yin of the Government's Centre for Health Protection for their part in bringing about this less-uncomfortable state of affairs. I am confident that we will soon achieve the projected equilibrium requirement of 1 consultant, 2 associate consultants and 2-3 specialists with trainees for each HA cluster.

Medical Oncology

With higher life-expectancy and an aging population, we can expect an accelerated increase in the incidence of malignancy and multiple malignancies. Traditionally, problems of this nature are managed by surgery or radiotherapy. Over the last decade, the rapid development of chemotherapy and cytotoxic agents and monoclonal antibodies has led to new opportunities for treatment and an increase in the demand for medical oncologists. This has completely redefined the management approach, especially as regards the promise of better survival and quality of life. Because of toxicity which can cause serious morbidity and mortality, cytotoxic and monoclonal antibodies represent much more than the mere dispensing of drugs. A basic training in general medicine is therefore essential for safe administration and monitoring of chemo and a monoclonal therapy, the more so because the majority of patients are increasingly likely to be elderly with frequent co-morbidity and underlying general medical problems. Effective management of cancer in the future will require a multi-disciplinary approach involving internal physicians, surgical oncologists, radiotherapists and palliative physicians to cater for the holistic needs of patients.

Conclusion

It is clear that the changing pattern of disease requires a radical re-appraisal of healthcare delivery in Hong Kong. For its part, the College of Physicians must plan to increase the supply of physicians in the various specialties, in particular in Infectious Disease and Medical Oncology, both to cater for expanding demands on the teaching and practice of internal medicine and to meet the following challenges and problems:

1. Increase intake for basic physician training towards MRCP(UK)/intermediate exam certificate.

2. Restructure existing infrastructure in HA hospitals
   - Substantial increase in general/specialist medical beds.
   - Reduction in the number of beds for specialties facing decreasing demand.

3. Develop the cluster concept and approach
   - Medical Oncology – Multi-Disciplinary Team.
   - Infectious Diseases – Cluster Team to group and co-ordinate expertise in particular from specialists in Infection Control, Epidermiology, Clinical Microbiology, Clinical Infectious Disease.

Professionalism

Recently and especially after SARS, public perception of the medical profession in Hong Kong has turned negative with loss credibility and respect. This is a situation which demands an immediate and effective response. To restore and enhance our social status, image and patient trust, let us not wash dirty linen in public, engage in unnecessary litigation, not tarry in disciplinary action against professional misconduct which should be severely and justly reprimanded and not waste time and energy on petty and trivial issues (such as "canvassing") which have no bearing on the standard of healthcare. I also propose the resumption of overseas training of at least six to twelve months, both for exposure to international professional and academic cultures and to establish contacts so vital to the career development of aspiring fellows.

On the practice of medicine itself, I submit that the good physician must posses five qualities:

Competence

Compassion

Caring Attitude

Empathy

Humility

The human element in these desiderata was highlighted by Dr EK Yeoh, in his 1st EK Yeoh Oration delivered to the College of Community Medicine in April 2005:

As a physician in the 21st century, we are most fortunate to have massive infusion of technology to enhance our diagnostic and therapeutic aptitude. The art of medicine remains a vital component in the process of healing the sick and should not be dictated by technology. The development of medicine in the last three or four decades has been characterized by the growth of specialization. However, the commitment to general medicine remains mandatory. The College has therefore introduced one year of mandatory general medicine training in the Higher Physician Training Programme.

May I end by quoting Professor Lim Pin, Professor of Medicine and former Vice-chancellor of the National University of Singapore, in his 16th Gordon Ransom Oration delivered during the Singapore/Malaysia Congress of Medicine in August 2002.

"Most importantly however we should never lose sight of the fact that these advances in the science of medicine are but aids and tools to assist us in the work of healing the sick. Our clinical sense and judgment, human understanding and patient's trust and confidence, lie at the heart of the practice of medicine, even as we embrace the many blessings and challenges from the rising tide of opportunities in the sea of science and technology".

"House-warming" party for new HKCP office premises

The new office of the HKCP at Room 603, HKAM Jockey Club Building was officially declared open at a recent house-warming party.

New Fellows of the RCP (London) and RCP (Edinburgh)

The Council would like to congratulate HKCP Fellows who were recently elected as Fellows of the respective UK Colleges.

In particular, we wish to congratulate two of our previous AJS McFadzean Orators, Professor Tsui Lap Chee and Professor Arthur Li who were awarded the prestigious Honorary Fellowship and the Fellowship by Distinction of the RCP (London) respectively. At the recent conferment ceremony in London, their citations were read by Professor Richard Yu of the HKCP and Professor Ian Gilmore of the RCP (London), who have both kindly allowed Synapse to print the citations in this edition.

FRCP (London)

Elected 9 March 2005

Honorary Fellow

Prof Tsui, Lap Chee

Fellowship by Distinction

Prof Li, Arthur Kwok Cheung

Members of the College

Dr Au, Kok Ki
Dr Dai, David Lok Kwan
Dr Kwan, Min Chung
Dr Lee, Shui Shan
Dr Tsui, Hing Sum
Dr Chau, Ka Foon
Dr Ko, Kwai Fu
Dr Law, Alexander Chun Bon
Dr Leung, Sum Kin
Prof Wong, Chun Yu

Fellows of other College of Physicians

Dr Yip, Shing Yiu

FRCP (Edinburgh)

Elected 30 July 2004

MRCP Holders

Dr Lai, Cham Fai
Dr Lau, George K K
Dr Chan, Wai Ming
Dr Tong, Bing Chung
Dr Lo, Dennis Yuk Ming
Dr Chow, Charles Wai Ho
Dr Ching, Chi Keung
Dr Yue, Sunny Chiu Sun
Dr Ko, Tony Pat Sing

Elected 13 October 2004

MRCP Holders

Dr Lee, Ka Fai
Dr Yee, Wilson Kwok Sang
Dr Wong, Ping Nam

Citation for Lap-chee TSUI

Richard Yu
Hong Kong College of Physicians

Professor Lap-chee Tsui was the AJS McFadzean Orator in 2003

Professor Lap-chee TSUI has made major contributions to the mapping, cloning and characterization of the gene mutated in cystic fibrosis as well as the molecular genetics of this common genetic disorder. He has also made significant contributions to the mapping and annotation of human chromosome 7, and, identification of additional disease genes.

In 1985 Tsui found the first DNA marker linked to the disease locus for cystic fibrosis, a common autosomal recessive disorder, in the Caucasian population. In 1989, working with Collins and Riordan, Tsui identified the gene and the major mutation localized to the long arm of Chromosome 7 through the mapping of the DNA marker causing this disorder. This is the first disease gene identified through pure "positional cloning" strategies. While continuing to contribute to the understanding of genotype – phenotype correlation on cystic fibrosis, Tsui demonstrated that the varied severity of cystic fibrosis disease could be due to the effects of modifier genes using a mouse model and showed the existence of at least one of the modifier genes in cystic fibrosis patients. In addition, Tsui has made significant contributions to the physical mapping and annotation of human chromosome 7 and identification of additional disease genes in this chromosome. He served as President of the Human Genome Organization.

Tsui has received numerous awards and honours over the years. The most notable are Fellow of the Royal Society of Canada, Fellow of the Royal Society of London and Fellow Academica Sinica. In addition to many national and international prizes he received honorary doctorates from renowned universities. He was also awarded the Order of Canada (official rank) and the Order of Ontario.

Tsui became the fourteenth Vice-Chancellor of the University of Hong Kong in September 2002. He established the University's Genome Research Centre of which he is the Director. This is the home for many genome research projects and provides a suite of genomics and proteomics facilities in Hong Kong. In addition Tsui leads a team of Hong Kong scientist part of the Chinese Consortium in the International HapMap Project in collaboration with scientists in the United States, the United Kingdom, Japan, Canada, China (including Hong Kong and Taiwan) and Nigeria, and has just completed the genotyping work for 2.5% of the human genome. The goals of the International HapMap Project is to develop a haplotype map of the human genome, the (HapMap) which will describe the common patterns of human DNA sequence variants as to make this information freely available in the public domain. The HapMap is expected to be a key resource for researchers to use in finding genes that affect health, disease, responses to drugs and environmental factors. Discovering the DNA sequence variants that contribute to common diseases risks offer one of the best opportunities for u nderstanding the complex cause of disease in human. In fact Tsui and his colleagues have already initiated a number of projects on diseases, such as diabetes, that are common in Hong Kong and nearby region.

Citation for Arthur LI

Ian Gilmore
Royal College of Physicians, London

Professor Arthur Li was the AJS McFadzean Orator in 2001

President – It is a pleasure to present to you Professor Arthur Li for election to the Fellowship of this College by distinction. He is currently Secretary for Education and Manpower and also a Member of the Executive Council of the Government of the Hong Kong Special Administrative Region (equivalent in the UK to being a senior Government Minister and in the cabinet). He has been elected to numerous honorary Fellowships around the world and I will undoubtedly struggle to startle him with anything original in this citation. However I think that this may be the first time that he has become a proper physician. I suspect that FRCP was beyond his horizon when he completed his last 'physicianly' post – as house physician to Professor Ivor Mills at Addenbrookes in 1970. For, madam President, in his professional life Arthur Li has been first a surgeon, second an academic and third and most recently a politician.

Our paths first crossed in 1965 at King's College Cambridge where neither of us graced its famous choir but Arthur was an enthusiastic member of the rowing club. In more academic pursuits he was encouraged by the outstanding Director of Studies there, Kendal Dixon (who would now be called a coach or mentor). Kendall nudged his young charges into the course most suiting their talents and countered any flagging enthusiasm by the judicious application of samples from the College wine cellar of which he was steward. Arthur's part II in pathology laid a scientific foundation which would later pay rich dividends. After clinical training at the Middlesex he went straight into surgery and was nearly lost to the UK when he went to Harvard to spend 3 years. He was appointed to a staff position at Harvard but was tempted back to a Senior Lecturer and consultant post at the Royal Free in 1980. But the inevitable finally happened when he was lured back to Hong Kong in 1982 to take up the Foundation Chair of Surgery in the Chinese University. There he built up an internationally recognised department, published over 300 papers and established an enviable clinical practice in hepatobiliary surgery. He managed to combine this with pushing forward modern educational reforms in the Medical School and he was made Dean of the Faculty of Medicine in 1992 and then in 1996 Vice-Chancellor of the whole Chinese University of Hong Kong. It was his skills that steered the University into the new era of the special administrative region of Hong Kong within the Republic of China, the so-called one country –

two systems – and maintain the University's independence. His major contributions to Hong Kong were recognised by the award of the Gold Bahinia Star, the bahinia being the wonderful Lilly that is the floral emblem of that country.

As secretary of education in Hong Kong, equivalent to our Secretary of State, he has been able to implement his vision for the future, and has been particularly successful in fostering innovative links with community Colleges, local businesses and major industry. As the face of South east Asia is transformed by the burgeoning Chinese economy, we as a College wish to build on the excellent relations we have with Hong Kong. We could have no better ally and friend in that aim than Professor Arthur Li who, while rejoining the ranks of Physicians after an absence of 35 years, will continue to be a major force and influence in Education in China. I present him to you, Madam President, for election to Fellowship by virtue of his outstanding distinction as a clinician, academic and educationalist.

Advice from the Royal College of Physicians, London for doctors who want to work in the United Kingdom

At the end of 2003, the General Medical Council (GMC) changed its regulations governing direct entry onto the Medical Register in the UK for overseas medical graduates. There is no longer a direct route to full registration. To obtain limited registration, most overseas doctors need to pass the Professional and Linguistic Assessment Boards (PLAB) tests.

The International Office at the Royal College of Physicians (London) is able to assist some of these doctors by providing two alternative routes to limited registration with the GMC:

1. **Recognition of completion of basic specialist training for entry into higher medical training in the UK**
2. **The International Sponsorship Scheme (ISS)**

For more information on the criteria for recognition of completion of Basic Specialist Training and how to apply, please see www.rcplondon.ac.uk/college/international/recogBMT.htm

For a full list of the criteria see the ISS Handbook at: www.rcplondon.ac.uk/college/international/iss.htm

A very useful handbook of advice can be found on the website link below :
http://www.rcplondon.ac.uk/college/international/OverseasDoctorsHandbookAustralasia.pdf

Specialty Column – Gastroenterology

Is the use of clopidogrel justified in patients with aspirin intolerance?

Francis KL Chan

Institute of Digestive Disease, The Chinese University of Hong Kong

For many years, clopidogrel (Plavix) has been widely prescribed as an alternative to aspirin in patients with coronary syndromes or cerebrovascular insufficiency who cannot tolerate the gastrointestinal (GI) side effects of aspirin. Such practice is based on the belief that clopidogrel does not damage the gastrointestinal tract. The current American College of Cardiology-American Heart Association Guidelines recommend that clopidogrel should be administered to hospitalized patients who cannot take aspirin because of major GI intolerance (a class IA recommendation).[1] Surprisingly, this high-level recommendation was solely based on a post hoc subgroup analysis of the CAPRIE trial that was not designed to compare the GI safety of clopidogrel and aspirin.[2] The first study that evaluated the GI safety of clopidogrel was a retrospective analysis of 70 patients with a history of peptic ulcer.[3] More than 12 % of the patients had recurrent ulcer complications within one year. This alarming observation was confirmed by a recently published, double-blind, randomized trial that compared clopidogrel (75 mg daily) and aspirin (80 mg daily) plus esomeprazole (20 mg twice daily) in patients with previous ulcer bleeding.[4] All the patients were confirmed to have healed ulcers and a negative test for Helicobacter pylori before randomization. A total of 320 patients were enrolled. The cumulative incidence of recurrent bleeding during the 12-month period was 8.6% (95% C.I., 4.1 to 13.1%) among patients who received clopidogrel and 0.7% (95%, 0 to 2.0%) among those who received aspirin plus esomeprazole. The results of these two studies do not support the current recommendation that patients with major GI intolerance of aspirin be given clopidogrel. For patients who can benefit from aspirin alone, switching to clopidogrel because of aspirin intolerance is expensive and counterproductive. They should continue to take aspirin and receive a proton-pump inhibitor.[5]

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Emerging infections in the News

PL Ho

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Despite improvement in sanitation, advancement in medical technology and the increasing availability of antimicrobial agents and vaccines, new infectious threats continue to appear and some infections thought to be under control increase in incidence. The reasons for the changes in infectious diseases are complex and not fully understood. Population growth, changes in human behaviours, modern travel, trade, microbial adaptation and evolution, climatic changes, inadequacy of public health infrastructures have all contributed. In Hong Kong, there has been a renewed focus on emerging infections since severe acute respiratory disease (SARS) broke out three years ago. Emerging infections can be defined as "infections that have newly appeared in a population or have existed but are rapidly increasing in incidence or geographic range[1]." Many of these are zoonosis such as avian influenza, SARS, Crimean-Congo hemorrhagic fever; or vector-borne diseases like Dengue and Japanese encephalitis[2,3]. Most of the remaining emerging infections may be categorized under drug-resistant microbes, foodborne diseases, travel-related infections and opportunistic infections. This manuscript discusses three examples with a recent interest in our locality.

Staphylococcus aureus susceptibility testing by disc diffusion method showing resistance to oxacillin and susceptibility to tetracycline, cotrimoxazole, erythromycin, clindamycin and fusidic acid.

COMMUNITY-ASSOCIATED METHICILLIN-RESISTANT STAPHYLOCOCCUS AUREUS
社區性的「抗藥性金黃葡萄球菌」

In the August 2005 issue of the Communicable Diseases WATCH, the Centre for Health Protection reported the investigation of a familial cluster of community-associated methicillin-resistant Staphylococcus aureus (CA-MRSA)[4]. This follows the first report in 2004 of a confirmed infection by this new pathogen in an adult. Among the seven members in this Nepalese family, two had microbiological confirmation and another three had previous symptoms consistent with infections by CA-MRSA. The strains of MRSA from this family were resistant to methicillin (oxacillin), amoxycillin-clavulanate but were unique in remaining susceptible to erythromycin, clindamycin, gentamicin, levofloxacin, cotrimoxazole, chloramphenicol and tetracycline. Molecular analysis of the strains confirmed that they possess markers typical of CA-MRSA and that they form a clonal cluster with the strain reported in 2004.

Since the first appearance of methicillin resistance among *S. aureus* in 1961, MRSA has become widespread in hospitals around the world. Locally, MRSA accounts for 30-50% of the *S. aureus* nosocomial infections and the proportion increases to 70% in the intensive care units. In the past, MRSA is generally considered to colonize or infect persons with exposure to the healthcare environments such as recent hospitalization (in the preceding 12 months), recent surgery, regular ambulatory care (e.g. dialysis), residence in old age homes and close contact with persons with these risk factors. These MRSA are commonly referred to as healthcare-associated MRSA (HA-MRSA). However, in the past decade, new strains of MRSA have emerged in the community in many countries and were found to cause infections in healthy

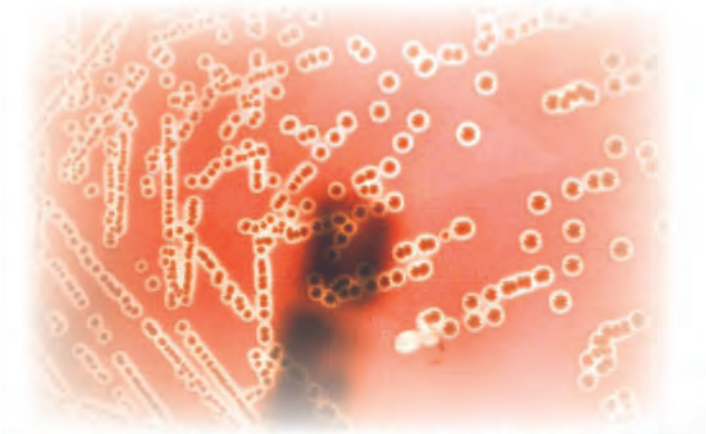
children and adults without the aforementioned healthcare-associated risk factors. At present, a consensus definition on what constitute community-associated (or -acquired) MRSA has not been reached. In the literature, clinicians should aware that tremendous heterogeneity exists in the case definition used by different authors. This stems in part from the fact that nosocomial colonization with MRSA may go undetected and may lead to infection many months after hospital discharge (i.e. community-onset), thus making it difficult to establish the origin of strains causing MRSA infection. In an attempt to limit the confusion, the term community-onset MRSA (CO-MRSA) has been recently suggested to replace community-acquired MRSA for all strains that is found in the out-patient settings or within 2 days of admission. CO-MRSA, therefore, could be divided into those with and without healthcare associated risk factors. The latter group represents "true" CA-MRSA that is emerging in many countries. Nonetheless, some investigators disagree with the "community-onset" and "risk factor" approach.

Given that CA-MRSA strains could also spread in hospital settings, there will be situations in which the patient history proves insufficient for differentiating between what is a typical nosocomial strain versus an emerging CA-MRSA strain. Under such circumstances, the application of molecular typing techniques in the epidemiological investigation would be invaluable. Studies so far indicated that the CA-MRSA strains tend to restrict to a limited number of clones, but which were genotypically distinct from the major types of MRSA in the healthcare settings in the same geographic areas[5]. In addition, CA-MRSA is more likely than the HA-MRSA to encode novel types of methicillin-resistance cassette elements (type IV and V) and the virulence factor, Panton-Valentine leukocidin (PVL), and to remain susceptible to the non-beta-lactam antibiotics such as macrolides, clindamycin, fluoroquinolones, cotrimoxazole and aminoglycosides.

CA-MRSA most frequently present as skin infections. The most common manifestation is furunculosis (skin abscesses), which initially may be mistaken as an insect or spider bite. Other manifestations, including infected chickenpox lesions, impetigo, bullous impetigo, and scald skin syndrome have also been described[6]. The ability of CA-MRSA to cause outbreaks of infections is particularly noteworthy. In overseas countries, outbreaks of CA-MRSA furunculosis and other skin infections have been described among children with chronic skin conditions, prisoners, military personnel, aboriginals, injection drug users, the homeless and contact sports athletes. According to Kazakova et al[7], five factors were associated with outbreaks of the infection – crowding, skin contact, abrasions, sharing contaminated towel or equipment and a lack of hygiene. Necrotizing pneumonia is the other main, but less frequent clinical manifestation of CA-MRSA infection. This disease is characterized by high fever, haemoptysis, leucopenia, and multi-lobar involvement which could progress rapidly to acute respiratory distress syndrome and septic shock[8,9]. Despite aggressive management, necrotizing pneumonia is associated with high mortality.

What are the clinical implications now that we know CA-MRSA exists in Hong Kong? For people with severe and life-threatening infections such as necrotizing pneumonia, vancomycin should be considered as empirical therapy while cultures are pending[10]. At this stage, the local incidence is too low to justify a major change in the clinical approach for mild and minor skin infections. The majority of infections that belong to this group are treated in the community empirically without obtaining cultures. The possibility of CA-MRSA will need to be considered and assessed by appropriate cultures when the patient comes from a foreign country with a high prevalence of CA-MRSA (e.g. Japan and some cities in the United States), and also when a skin infection fails to respond to an anti-staphylococcal beta-lactam antibiotic or is recurrent. It is important to remember that appropriate drainage is the mainstay of treatment for most furunculosis. Cases of CA-MRSA furunculosis have been reported to respond to drainage alone and sometimes to treatment with antibiotics without in vitro activities[11]. Since CA-MRSA strains are often susceptible to the non-beta-lactam antibiotics, erythromycin, clindamycin, fluoroquinolones with enhanced anti-staphylococcal activity (e.g. moxifloxacin), minocycline and cotrimoxazole could be considered as adjunct treatments to surgical intervention when this organism is suspected or documented. Finally, since household transmission of CA-MRSA may occur, family members should be instructed to observe good personal hygiene.

STREPTOCOCCUS SUIS (豬鏈球菌) *INFECTION*



Streptococcus suis in Columbia sheep blood agar showing the characteristic narrow zone beta-hemolysis

On 25 July 2005, the Department of Health was updated by the Ministry of Health (MOH) about the reports of deaths among agricultural workers in Sichuan linking to Streptococcus suis infection, a zoonosis. This followed media reports of an outbreak of a mysterious pig-borne disease in two Sichuan cities Ziyang and Neijiang. According

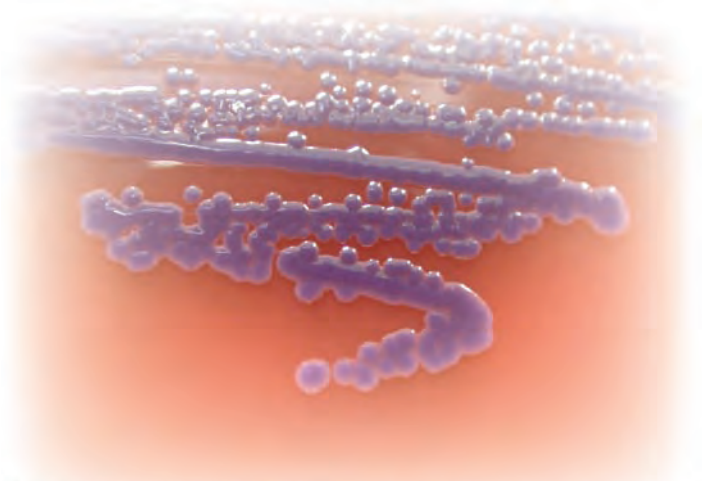
to an interim MOH report investigating the disease, the index case was a resident in Ziyang and was reported to become sick on 22 June 2002. The investigation analyzed 55 human cases and found that the main symptoms were fever, chills, vomiting, and headache and generalized aches. A virulent strain of S. suis (serotype 2, MRP-positive; see below) was isolated from clinical specimens of three patients and five pigs. After implementation of control measures, the disease was brought under-controlled. No further cases were reported to the MOH since 4 Aug 2005. As of 21 Aug 2005, a total of 204 presumed or confirmed infections in human were found from 12 cities in Sichuan. The death toll was 38. Since 2 Aug 2005, notification of S. suis becomes mandatory, increasing the number of notifiable disease to 31 in Hong Kong.

S. suis is often carried in the noses or on the tonsils of adult pigs. Gilts and sows may also carry S. suis in the uterus and vagina. From these adult carrier pigs, the bacterium is transmitted to young piglets. In swine, the bacterium is known to cause a variety of syndromes including arthritis, meningitis, pneumonia, bacteremia, endocarditis, abortions and abscesses. Higher rates of infections have been associated with closed herds, intensive farming, crowding, and poor hygiene. Outbreaks in swine herds are recognized worldwide and are often attributed to mixing at weaning and introduction of a carrier into the herd[12]. In pig herds, the relationship between carriage rates and disease occurrence is in complex. Carrier rates of up to 100% have been described but were only associated with only a low disease attack rate. The discrepant relation between carriage prevalence and disease rate has been suggested to correlate with the capsular type and other virulence factors. Historically, *S. suis* was classified as group S and group R streptococci according to their reactivity with Lancefield group anti-serum. The former group was then named S. suis type 1 and the latter as S. suis type 2. By 1995, 35 capsular serotypes of *S. suis* are recognized[13]. Type 1, 2, 7, 9, 14 and 1/2 are the serotypes most commonly associated with disease in swine. Additionally, virulence in strains had a strong correlation to the expression of two proteins, muramidase-release protein (MRP) and extracellular factor (EF).

Human infection by *S. suis* was first described in Denmark in 1968. Since then, sporadic cases were reported in the literature with the majority of cases coming from European and South East Asian countries. In human, pyogenic meningitis is the most frequently seen clinical syndrome. Bilateral deafness is a unique characteristic of *S. suis* meningitis and has been reported to occur in 50% to 80% of the survivors. In Hong Kong, it is noteworthy that studies in 1981-1993 found *S. suis* to be a more common cause of community-acquired meningitis than were *S. pneumoniae* and Neisseria meningitidis[14,15]. In a recent review of a local hospital's experience, *S. suis* was the third most common cause of meningitis, *after Mycobacterium tuberculosis* and *S. pneumoniae*[16]. With appropriate treatment, the mortality of *S. suis* infection is about 10%[15]. Other reported syndromes in human include bacteremia, arthritis, endocarditis, toxic shock syndrome and endophthalmitis[14,17]. Another unique feature of human *S. suis* infections is that it tends to occur in mini-epidemics in the summer[14]. The reason for this observation is unclear, but a higher disease attack rates in pig herds and changes in the level of meat contamination may be contributory. *S. suis* strains in the great majority of human infections belong to type 2 and are often MRP- and EF-positive. Several cases of infections by type 4 strains have also been reported. The people at greatest risk of infection are those in close contact with pigs and pork such as pig farmers, abattoirs, meat processing and transport workers, butchers and cooks. In Hong Kong, infections have also been recognized in housewives[14,15]. Presumably, small cuts, unrecognized abrasions or infected wounds provide the portal of entry for infections in most cases.

Physicians should note that *S. suis* may be misidentified as other streptococci (e.g. *S. salivarus, S. viridans, S. milleri, S. acidominimus*) by the microbiology laboratory[18]. This relates to the inability of some commercial microbial identification systems to differentiate between *S. suis* and other streptococci. In our experience, the API systems are most likely to yield a correct *S. suis* identification. In case of doubt the reference laboratories should be consulted and if necessary confirmation could be achieved by 16S rRNA analysis. In terms of treatment, penicillin remains the treatment of choice for *S. suis* infection. Cefotaxime or ceftriaxone are potential alternatives. In vitro, strains of *S. suis* from human is almost uniformly susceptible to penicillin, ampicillin, amoxicillin and the 3rd generation cephalosporins while susceptibility to the macrolides, clindamycin, tetracyclines and cotrimoxazole are often variable and unpredictable[19].

CHROMOBACTERIUM VIOLACEUM
(紫色色桿菌)



Chromobacterium violaceum on blood agar showing the typical purple-colored colonies

On 31 May 2005, the public was informed of a fatal case of infection in a 40-year-old man by a rare bacterium, C. violaceum. The deceased served as a trainer in a camp in Tuen Mun on 21 and 22 May. He was hospitalized in PWH on May 25 and found to have an abscess on his

right arm. The patient died one day after admission. Subsequent investigation revealed that some water samples collected at the campsite were culture positive for the bacterium.

Chromobacterium violaceum in a bottle of water with the production of a purple diffusible pigment

C. violaceum is a Gram-negative saprophytic bacillus found commonly in soil and water in tropical and subtropical areas. The name of the bacterium is derived from its ability to produce a purple pigment in agar plates. The geographic distribution of the organism may be explained by its preference to grow at temperatures of 20-37 °C, with growth occurring up to 44 °C but the bacterium cannot survive at 4 °C[20]. The organism is known to cause infections both in human and in animals. In people, *C. violaceum* infections are rare, and were predominantly opportunistic infections. In a review of the literature in 2002[21], the total number of reported cases was 62, from Australia, Argentina, Brazil, India, Singapore, Taiwan, Thailand, Vietnam and the United States (the southeastern states). The infection usually begins with the exposure of non-intact skin or mucous membrane to contaminated soil or water during outdoor activities such as wading in a pool, playing in a muddy ditch, scuba diving and swimming in a freshwater pond. The reported interval between exposure and clinical infection ranges from one day to 2 months. Patients with chronic granulomatous disease are highly vulnerable to *C. violaceum* infection. Diabetes mellitus and alcoholism have also been associated with infection in adults. Diseases in young and apparently healthy individuals are well-recognized and may be related to strain virulence or an undiagnosed immune defect[22,23]. When infection develops, cellulitis and lymphadenitis are the most common clinical manifestations. Abscesses formation in internal organs, especially liver, spleen and lung is a unique feature of *C. violaceum* infection and these often necessitate surgical drainage and prolonged antimicrobial therapy. In tropical areas, the disease may sometimes be confused with melioidosis, both clinically and microbiologically[24,25]. *C. violaceum* infection has been reported to cause gastroenteritis, sinusitis, necrotizing conjunctivitis, nasopharyngeal abscess and meningitis following mucosal exposure, aspiration or swallowing of contaminated water[21,26,27]. When systemic infection occurs, the disease can progress rapidly to septic shock and fatal outcome. In bacteremic infection, two studies found fatality rates of 75% and 48%[21,28]. The prognosis is worst in patients who did not promptly received effective antimicrobial treatment. In this regard, *C. violaceum* is unique in having intrinsic resistance to a broad range of antibiotics. In vitro, *C. violaceum* is uniformly resistant to the penicillin, ampicillin, cloxacillin and the first generation cephalosporins and that the resistance cannot be reversed by addition of beta-lactamase inhibitor[29]. Drugs that are often found to be most active against *C. violaceum* include imipenem, cefepime, ciprofloxacin and cotrimoxazole. Other drugs with good in-vitro activities include piperacillin and tetracyclines. The susceptibilities to third generation cephalosporins and aminoglycosides are variable[21,30,31]. When the infection is suspected or confirmed, combination therapy with two drugs likely to be active should be given pending the susceptibility result. The advice of an infection specialist should also be sought.

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Examinations

Joint HKCPIE / MRCP(UK) Part II (Written)

The MRCP(UK) Central Office has informed the College that with effect from December 2005, the Part II (Written) examination will be held on two days. The December examination has been scheduled on 7 & 8 December 2005.

Joint HKCPIE/MRCP(UK) Examinations – Hong Kong Calendar 2006

MRCP(UK) Part 1 Examination - 2006

Closing Date	Fri 4 November 2005
Examination	Tues 24 January 2006
Closing Date	Fri 30 June 2006
Examination	Tues 12 September 2006

MRCP(UK) Part 2 Examination - 2006

Closing Date	Fri 3 February 2006	*2006/1*
Examination	Wed 12 April – Thurs 13 April 2006	*2006/1*
Closing Date	Fri 26 May 2006	*2006/2*
Examination	Wed 26 July – Thurs 27 July 2006	*2006/2*
Closing Date	Fri 29 September 2006	*2006/3*
Examination	Wed 6 December – Thurs 7 December 2006	*2006/3*

MRCP(UK) Part 2 Clinical Examination PACES - 2006

Closing Date	Friday 6 January 2006
Main assessment period	(Exact dates to be confirmed)
Closing Date	Friday 25 August 2006
Main assessment period	(Exact dates to be confirmed)

Results

Joint MRCP(UK) / HKCPIE Part I examinations for the year 2002-2005:

	Sitting	Pass
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%)
Jan 05	96	68 (70.8%)

Joint HKCPIE / MRCP(UK) Part II (Written) examinations for the year 2002-2005 :

	Sitting	Pass
First 2 x 2 ½ hour papers		
2 Jul 02	53	27 (51%)
13 Nov 02	50	24 (48%)
13 Aug 03	110	62 (56%)
10 Dec 03	54	31 (57%)
First 2 x 3 hour papers		
28 Jul 04	65	42 (65%)
8 Dec 04	46	32 (70%)
13 April 05	32	15 (47%)

Pass rate of PACES for the year 2001-2005 :

October 2001	36/72 = 50%
February 2002	34/74 = 46%
October 2002	29/72 = 40%
February 2003	30/69 = 43%
October 2003	27/59 = 46%
March 2004	39/64 = 61%
October 2004	26/69 = 38%
March 2005	35/75 = 47%

Pass list of the March 2005 PACES examination

Congratulations to our doctors who will receive the Intermediate Examination Certificate at the next AGM on 5 November 2005:

But Yiu Kuen, David
Chan Ka Chun, Alan
Chan Pui Shan, Julia
Chan Tsz Mim, Jasmine
Cheng Hon Kuen
Cheung Wing I
Chung Ho Yin
Fong Ching Han
Ho Ping Cheong
Ip Fong Cheng
Kwan Wai Mei, May
Lam Ka Man
Liu Kin Wah
Ng Chi Ho
Ng Pui Yung
Sze Yuen Chun
Wong Chun Kwan, Bonnie
Wu Ho Yan
Chan Hay Nun
Chan Leung Kwai
Chan Tung Ching
Chang Shek Kwan
Cheng Yuen Shan, Angela
Cheung Wing Lin, Kent
Fok Wai Ming, Joshua
Hau Hong
Hui Ka, Eugenie
Khemlani Mansha Hari
Lam Chun Wai
Lam Yim Kwan
Ma Tin Wei, Ada
Ng Ka Yan, Calvin
Ngai Chun Li
Wat Yee Mun, Mildred
Wong Lai Ping

Specialty Training Pass Lists for Intermediate Examination and Exit Assessment

At its 162nd Meeting of 4 March 2005, the Council decided to regularly inform the Chiefs of Service, Programme Directors and the Training Subcommittee of the COC (Internal Medicine) of the Hospital Authority the pass list of the Intermediate Examination and Exit Assessments in all the specialties under the College. Consent for release of examination results will be sought from trainees in advance at the time of application to sit the examination/assessment.

CME Update

Principles & Guidelines on Continuing Medical Education

Loretta Yam

Chairman
Board of Continuing Medical Education/Continuous Professional Development
17th June 2005

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 (Active CME/CPD)

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 Attendance at Formal College-Approved Activity (FCAA)

5.2.1 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, and a maximum of 35 CME/CPD Points per conference/meeting.

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 60 Points per three-year cycle.

5.2.2 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.

5.3 Publications (Active CME/CPD)

a) A maximum of four CME/CPD Points may be awarded to the first author, and two Points for co-authors 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 first author, and three Points for co-authors 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 first author and 5 Points for co-authors of each chapter or section of a medical textbook.

d) Publications may be accredited a maximum of 45 CME/CPD Points per three-year Cycle.

5.4 Quality Assurance Report (Active CME/CPD)

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.

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

Thesis or treatise

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.

CME Update

Appendix 1 :

Self-Assessment Programmes

Updated on 20 June 2005

1 Royal Australasian College of Physicians – Maintenance of Professional Standards Program (MOPS)

RACP – Australia
Associate Professor Neil Paget
Director of Education
RACP
145 Macquarie Street
Sydney NSW 2000
Phone 02 9256 5490
Fax 02 9252 3310
Email paget@medeserv.vom.au

RACP – New Zealand
Dr Peter Holst
Director of Continuing Education
5th Floor, St John House
99 The Terrace
Wellington NZ
04 472 6713
04 472 6718
Email p.hoist@racp.org.nz

2 American College of Physicians

R0980
MKSAP
American College of Physicians
PO Box 7777
Philadelphia, PA 19106-0980
Tel 800-523-2546 ext 2600

American College of Physicians
Annals of Internal Medicine
6th Street at Race, Independence Mall West
Philadelphia, PA 19106
Customer Service Telephone 800-523-1546 ext 2600
Internet: http:www.acponline.org/index.html

American College of Chest Physicians
Chest
300 Dundee Road, Northbrook IL 60062
Tel 847-498-1400 Fax 947-498-5460
Internet: http://www.chestnet.org

American College of Gastroenterology
American Journal of Gastroenterology
4900 B South 31st Street
Arlington, Virginia 22206-1656
Tel 703-820-7400 Fax 703-931-4520
Internet: http://www.acg.gi.org

American College of Cardiology
Journal of the American College of Cardiology
9111 Old Georgetown Road, Maryland 20814
Tel 301-897-5400 Fax 301-897-9745
Internet: http://www.acc.org

American College of Rheumatology
Arthritis & Rheumatism
60 Executive Park South
Atlana, GA 30329
Tel 404-633-3777 Fax 404-633-1870
Internet: http://www.rheumatology.org

American Society of Nephrology
Journal of the American Society of Nephrology
American Society of Nephrology National Office
1200 19th Street, N.W.
Suite 300
Washington DC 20036-2422
Tel 202-857-1190 Fax 202-223-4579
Internet: http://www.asn-online.org/

American Society of Clinical Oncology
Journal of Clinical Oncology
435 North Michigan Ave, Suite 1717
Chicago, IL 60611-4067
Tel 312-644-0828 Fax 312-644-8557
Internet: http://www.asco.org

American Society of Hematology
Blood
1200, 19th Street, N.W., Suite 300
Washington, DC 20036-2422
Tel 202-857-1118 Fax 612-623-3504
Internet: http://www.hematology.org

American Academy of Neurology
Neurology
2221 University Avenue SE
Suite 335 Minneapolis MN 55414
Tel 612-623-8115 Fax 612-623-3504
Internet: http://www.aan.com/professionals/

Scientific American Medicine
415 Madison Avenue
New York, NY 10017
Tel 212-754-0550
Internet: http://www.sciam.com/

American Academy of Allergy Asthma and Immunology
Journal of Allergy and Clinical Immunology
611 East Wells Street
Milwaukee, WI 53202
Tel 414-272-6071 Fax 414-276-3344
Internet: http://www.aaaai.org/

The Endocrine Society
The Journal of Clinical Endocrinology and Metabolism
4350 East West Highway, Ste 500
Bethesda Maryland 20814—4410
Tel 301-941-0246 Fax 301-941-0259
Internet: http://www.endo-society.org/

American Academy of Dermatology
Journal of the Academy of Dermatology
P.O. Box 4014
Schaumburg, IL 60168-4014
Tel (847) 330-0230 Fax (847) 330-0050
Internet: http://www.aad.org/professionals/educationcme/

3 Royal College of Physicians

The Royal College of Physicians of Edinburgh
CME website
http://www.rcpe.ac.uk/education/CME/cme.html

Royal College of Physicians and Surgeons of Glasgow
CPD website
http://www.rcpsglasg.ac.uk/education /physicianscpd.asp

Royal College of Physicians London
CPD website
http://www.rcplondon.ac.uk/index.asp

4 Internet

4.1 All CME programmes which are accredited by the Accreditation Council of Continuing Medical Education (ACCME) and/or American Medical Association (AMA) will be recognized. One CME Point will be awarded for every accredited hour of participation.

Evidence of participation to be submitted to the Board of CME, when required should include the name of the College/University/Organisation offering the programmme and its website, a CME certification or print-out proof of completion of the programme in question.

4.2 **Internet CME sites**

The MedConnect
Site: http://www.medconnect.com

Medscape
Site: http:www.medscape.com

American Heart Association
Site: http://my.americanheart.org/portal/professional

CME Web
Site: http://www/cmeweb.com

* Please refers to the CME On-line session of HKCP web site for updated CME activities on the Internet (http://www.hkcp.org)

CME Update

CME/CPD Operational Guidelines

Summary and Logistics

Summary

1. The minimum requirement is 90 Points in each 3-year cycle.
2. The minimum annual requirement is 10 Points.
3. Due to the introduction of the Continuous Professional Development (CPD) concept by the Academy, all Fellows must fulfill both active and passive components of CME at a minimum ratio of **30:60 or 1:2**.
4. CME Points awarded by Physician Colleges in Australasia, Singapore, United Kingdom and United States are recognised for CME accreditation by the Hong Kong College of Physicians. Formal CME reports from national accreditation bodies should be submitted to the College for award of CME Points.
5. CME for trainees

   The same CME/CPD requirement of 90 Points in every CME/CPD cycle also applies to all Trainees. Trainees will be assessed by supervisors and Programme Directors on log books and submissions of CME/CPD forms.

   Minimum attendance: 2 out of the first 3 meetings every year as listed below.

   a. ***Advances in Medicine organized by the Chinese University of Hong Kong***
   b. ***Medical Forum organized by the University of Hong Kong***
   c. ***Annual Scientific Meeting organized by Hong Kong College of Physicians (Every Trainee must attend at least once every 2 years)***
   d. ***Annual and other Scientific Meetings of respective Specialties under the auspices of the College***

Logistics of accrediting Formal College Approved Activities (FCAA), Overseas Conferences and Certificate Courses

1 Formal College Approved Activities (FCAA): Local meetings/ conferences

1.1 Application for CME accreditation of local educational activities should be sent to the address listed below, or fax to 2556 9047 **at least one month before the meeting. Only prospective accreditation will be awarded. Late applications will not be entertained**.

1.2 Doctors who have attended local meetings and conferences and signed on Attendance Sheets do not have to return Certificates of Attendance to the College after the meeting.

2 Overseas Meetings

2.1 Retrospective accreditation will be awarded for attendance at overseas meeting **up to two months after the meeting**.

2.2 Applications must be supported by the following documents, which should be forwarded to the Secretariat by mail (copies) or fax (2556 9047): Details of the programme and Certificate of Attendance.

3 Certificate Courses

3.1 Application for CME accreditation of Certificate Course should be sent to the address below at least one month **before commencement** of the course. **Only prospective accreditation will be awarded. Late applications will not be entertained**.

3.2 Award of CME Points for pre-approved Certificate Courses will be effected on submission of Certificate of Attendance after completion of the course, and will be distributed over the years covered by the course on a pro-rata basis.

3.3 Certificate Courses straddling two CME cycles will have all awarded CME Points assigned to the cycle in which the Attendance Certificates are received. This will be effected on submission of Certificate of Attendance after completion of the course.

4 Apart from the minimum of 10 CME Points in each year, **the CME Board will not record further CME Points into the College CME Registry for Fellows who have fulfilled 90 CME Points in each cycle**.

	Activities	Category [Active (CPD)/Passive]	CME/CPD accreditation	Maximum CME/CPD Points accredited		Remarks
				Per year	Per 3-year cycle	
A	Formal College Approved Activities (FCAA)					
A1	FCAA organised by hospitals: Grand Round, Journal Club in Internal Medicine or its subspecialties	Active (Chairman & Speaker) OR Passive	1. Maximum of 2 Points per session of active participation for Chairman. 2. Maximum of 2 Points per presentation of active participation for speaker. 3. 1 Point per hour of passive participation.	25 Points for active participation. 20 Points for passive participation.	75 Points for active participation. 60 Points for passive participation.	1. Prior approval from the CME/CPD Board is required.
A2	FCAA organised by professional societies/ associations	Active (Chairman & Speaker) OR Passive	1. Maximum 2 Points per session of active participation for Chairman. 2. Maximum of 2 Points per presentation of active participation for speaker. 3. Maximum 1 Point per hour of passive participation.	25 Points for active participation. 20 Points for passive participation.	75 Points for active participation. 60 Points for passive participation.	1. Prior approval from the CME/CPD Board is required. 2. Activities organized by pharmaceutical / equipment industry will not be approved for CME. 3. Time spent on lunch/tea break will not be accredited as CME activity. 4. Meetings on topics in Internal Medicine or its Specialties will be accredited the maximum CME/ CPD Points. 5. Meetings on Internal Medicine-related subjects may be accredited at up to 50% of the maximum CME/ CPD Points.

	Activities	Category [Active (CPD)/Passive]	CME/CPD accreditation	Maximum CME/CPD Points accredited		Remarks
				Per year	Per 3-year cycle	
A3	Local or overseas Conference	Active (Chairman & Speaker) OR Passive	1. Maximum 2 Points per session of active participation for Chairman. 2. Maximum of 2 Points per presentation of active participation for speaker. 3. 1 Point per hour of passive participation for maximum of 8 Points/day AND maximum of 35 Points per conference/meeting.	25 Points for active participation. 60 Points for passive participation.	75 Points for active participation. 60 Points for passive participation.	Approval mechanism 1. Time spent on lunch/tea break will not be accredited as CME/CPD activity. 2. Meetings on topics in Internal Medicine or its Specialties will be accredited the maximum CME/CPD Points. 3. Meetings on Internal Medicine-related subjects may be accredited at up to 50% of the maximum CME/CPD Points.
A4	Certificate course	Passive	Approved for defined number of CME/CPD Points, up to a maximum of 10 Points per course.	10 Points for passive participation.	30 Points for passive participation.	1. Prior approval from the CME/CPD Board is required. 2. Courses organised by hospitals for hospital doctors (in-house training for hospital) will not be accredited as Certificate Courses. 3. Courses on topics in Internal Medicine or its Specialties will be accredited the maximum CME/CPD Points. 4. Courses on Internal Medicine-related subjects may be accredited at up to 50% of the maximum CME/CPD Points.
B	Self study			25 Points (Total)	75 Points (Total)	
B1	Journal Reading	Active	Not more than 1 Point per article.	15 Points	45 Points	Submit list of authors, name of article, journal, year, page numbers.
B2	Self-study programmes of accredited Colleges and Academies	Active	Approved for defined number of CME/CPD Points per programme, up to a maximum of 20 Points.	25 Points	75 Points	Approved programmes (including approved programmes from Internet) are attached in Appendix.
C	Publications					
C1	Non-indexed international journals, journals published by constituent Colleges of HKAM, or other College-approved local journals.	Active	Maximum 4 Points and 2 Points for first and co-authors respectively.	15 Points	45 Points	1. Submit name of publication, journal, textbook and thesis with year, volume and page numbers for journal articles, and chapter/section, and page numbers for textbook. 2. Publications on topics in Internal Medicine or its Specialties will be accredited the maximum CME/CPD Points. 3. Publications on Internal Medicine-related subjects may be accredited at up to 50% of the maximum CME/CPD Points.
C2	Indexed international journals and journals published by HKAM.	Active	Maximum 6 Points and 3 Points for first and co-authors respectively.	15 Points	45 Points	
C3	Medical textbook	Active	Maximum 10 Points and 5 Points for first author and co-authors respectively of each chapter or section.	15 Points	45 Points	
D	College-approved Quality Assurance report	Active	Maximum 5 CME Points for each author depending on venue of publication	10 CME Points	30 CME Points	1. Prior approval from the CME Board is required. 2. Full QA report and venue of publication should be submitted for approval.
E	Exclusion	Not applicable	Not approved for CME/CPD accreditation	Not applicable	Not applicable	Not applicable
E1	Examiner in College examinations					
E2	Research & research grant application					
E3	Development of new technologies					
E4	Undergraduate teaching					
E5	Postgraduate teaching other than those listed above					
E6	Postgraduate diploma or degree course					
E7	Thesis or Treatise					

CME Update *CME for Trainees*

Please note that trainees are required to attend the following mandatory meetings towards fulfillment of CME.

(1) Annual Scientific Meeting of the College (to be held on 5-6 November 2005).

(2) Advances in Medicine of the Chinese University of Hong Kong (to be held on 4 & 5 June 2005).

(3) The Medical Forum of the University of Hong Kong (to be held on 16 & 17 July 2005).

In addition, all trainees must attend the College's Annual Scientific Meeting at least once every two years.

Update on the Annual and Exit Assessments in Advanced Internal Medicine

Thomas ST Lai
Chairman, Specialty Board in Advanced Internal Medicine

The Specialty Board in Advanced Internal Medicine has had the largest number of trainees all along. There are constantly over 50 candidates for the Annual Assessment and over 30 candidates for the Exit Assessment in each diet. The conduct of the Assessments has been an area of concern with regard to both the complexity of execution and the fairness to candidates. Following the recent restructuring of the Examination Committee, the Higher Physician Board has been formed. The Board Chairman, Prof Richard YH Yu, and Secretary, Dr CS Li, will be responsible for setting policies and guidelines for the Annual and Exit Assessments. Upon the advice from and in co-operation with the Higher Physician Board, the Specialty Board in Advanced Internal Medicine is the first one to introduce changes in the Assessments as shown below:

1. Annual Assessment

1.1. Starting from June 2006, each AIM trainee is required to submit TWO case reports with literature review per year, coinciding with the Annual Assessment. The logistics and guidelines will be announced in due course. Concerning the case reports:

1.1.1. Marks are given for each report ranging from 0-10

1.1.2. Emphasis on common medical problems rather than rare clinical cases

1.1.3. Reference format — Case report as submitted to Hong Kong Medical Journal

- Text not to exceed 1000 words
- Number of tables or figures used should not be more than 2
- References should not be more than 15

1.2. The time for assessment of each candidate will be extended from 15 min to 20 min

1.3. Scores in AIM Annual Assessment:

1.3.1. Two parts of scoring:

- Assessment based on viva examination:
  - Individual examiner's score ranges from 0-10
  - Three Annual Assessment Examiners' scores (E1, E2 and E3) are added up
  - Total score ranges from 0-30
- Assessment apart from viva examination:
  - Supervisor's score (S)
  - Two case reports' scores (CR1 and CR2)
  - Each of the above score ranges from 0-10
  - Average of total score, i.e. (CR1+CR2+S)/3, ranging from 0-10, is used in the calculation of final marks

1.3.2. Final marks are calculated as follows:

- Sum of {E1 + E2 + E3 + (CR1+CR2+S)/3}
- Marks range from 0-40 with the passing mark of 20

2. Exit Assessment

2.1. The new format of Exit Assessment was adopted in June 2005. For the sake of uniformity, a set of six standard questions with suggested answers were prepared for the examiners. All candidates were asked the same questions:

2.1.1. Two on acute medicine.

2.1.2. Two on management of chronic conditions.

2.1.3. Two on ethics / communication / evidence-based medicine / issues of local or regional relevance

2.2. To prevent the leak of questions during the assessment, candidates of Cycles One and Three were quarantined temporarily as a security measure.

3. Examiners

3.1. The examiners have mainly been a restricted group of consultants of the Hospital Authority in the past. For future Annual and Exit Assessments, more senior academic staff of the universities and consultants of the HA will be invited to be examiners.

3.2. Other academic staff and senior SMOs/Associate Consultants will be invited to act as observers in the Annual Assessment. They will then become examiners in the next Annual Assessment, and also in the Exit Assessment later on, after going through this priming process.

For the benefit of both trainees and trainers, a report on the Annual and Exit Assessments in June 2005 has been made. An analysis of the results revealed the following findings:

1. Annual Assessment

1.1. There were 54 candidates and 53 passed while one failed. If the supervisor's score had been excluded, 5 would have failed basing on the clinical viva. The highest score was 80 and the lowest score was 45. The median was 65 and the mean was 63.

1.2. The relative weight of the supervisor's score will be reduced in the future with the introduction of score for case reports.

2. Exit Assessment

2.1. The total number of candidates was 34, among whom 33 passed and one failed. The highest score was 75 and the lowest score was 48. The median was 62 and the mean was 61.5.

2.2. The average scores for the 6 questions were between 6.1 and 6.3. All candidates passed the questions on acute medicine, while three failed in questions on chronic disease management and three failed in questions on ethics / communication.

2.3. Though the numbers are too small to show a real difference, some candidates seemed to have weaker performance in chronic disease management and ethics / communication. This should serve as a good reminder for trainees who will undertake the coming Exit Assessments.

It is hoped that the changes, which have been or will be brought in with regard to the Annual and Exit Assessments, are the right steps towards transforming them into an open, impartial and workable means of evaluation of our trainees. At the same time, our Specialty Board welcomes opinions and suggestions for further improvement on the existing practice.

Acknowledgement

Dr Lai Moon Sing and Dr Chan Kin Sang have contributed to the compilation of this update.

Higher Physician Training

Summary of Possible Results towards Obtaining a Pass at Exit Assessment

Updated 27 April 2005

Dissertation	Clinical Viva	Total	Pull Up	Overall	Recommendation
⩾ 20	⩾ 30	⩾ 50	---	Pass	Eligible for admission as College Fellow
> 90% of pass mark					
19	⩾ 31	⩾ 50	Yes	Pass	Eligible for admission as College Fellow
18	⩾ 32	⩾ 50	Yes	Pass	
	> 90% of pass mark				
⩾ 21	29	⩾ 50	Yes	Pass	Eligible for admission as College Fellow
⩾ 22	28	⩾ 50	Yes	Pass	
⩾ 23	27	⩾ 50	Yes	Pass	

Summary of Possible Results for Failure at Exit Assessment

Updated 27 April 2005

Score	Failure Category	Total Score	1 section of Exit Assessment	2 sections of Exit Assessment
90-99% of section pass mark	Borderline fail	<50	Remedial action and repeat Exit Assessment in the failed section after an additional 6-month training in the relevant specialty.	Remedial action and repeat full Exit Assessment after an additional 12-month training in the relevant specialty.
80-89% of section pass mark	Fail	Any	Remedial action and repeat full Exit Assessment after an additional 12-month training in the relevant specialty.	Remedial action and repeat full Exit Assessment after an additional 12-month training in the relevant specialty. Trainees should be exposed to trainers in other institution(s) for six months.

Score	Failure Category	Total Score	1 section of Exit Assessment	2 sections of Exit Assessment
<80% of section pass mark	Bad fail	Any	Remedial action and repeat full Exit Assessment after an additional 12-month training in the relevant specialty.	Remedial action and repeat full Exit Assessment after an additional 12-month training in the relevant specialty, of which 6 months should be undertaken in programmes and/or training centres specified by the Specialty Board.

Notes

1 (i) Section pass mark for Dissertation = 20
90% of pass mark = 18
80% of pass mark = 16

(ii) Section pass mark for Clinical Viva = 30
90% of pass mark = 27
80% of pass mark = 24

2 Candidates who have failed the written part of their dissertations can be allowed to take the Exit Assessment. Those who failed the dissertation do not have to write a new dissertation on a different topic at the following Exit Assessment. They are only required to re-write or revise their previous dissertation to improve their knowledge and presentations on the same topic.

3 Candidates who failed either part of the Exit Assessment will only be required to repeat the failed section at the following Exit Assessment. Candidates failing both sections with different levels of failure in the two sections will be required to undergo remedial training in accordance with the recommendation for the worse level of failure.

Statistics on No. of Fellows in all Specialties
Updated in July 2005

		FELLOWS							
		HONG KONG EAST CLUSTER			HONG KONG WEST CLUSTER				HONG KONG EAST + WEST CLUSTER
SPECIALTY	FELLOWS TOTAL (PP/DH/HA/ OTHERS)	PYNEH	RH	TWEH	FYKH	GH	QMH	TWH	
CARDIOLOGY	166	6	2	0	0	4	11	0	23
CRITICAL CARE MEDICINE	46	4	0	0	0	0	7	0	11
DERMATOLOGY & VENEREOLOGY	73	0	0	0	0	0	1	0	1
ENDOCRINOLOGY, DIABETES & METABOLISM	60	2	3	3	0	0	9	0	17
GASTROENTEROLOGY & HEPATOLOGY	104	6	2	0	0	0	9	1	18
GERIATRIC MEDICINE	132	5	13	2	3	0	4	1	28
HAEM/HAEM ONCOLOGY	36	4	0	0	0	0	9	0	13
IMMUNOLOGY & ALLERGY	6	0	0	0	0	0	1	0	1
INFECTIOUS DISEASE	18	0	0	0	0	0	0	0	0
MEDICAL ONCOLOGY	31	0	0	0	0	0	6	0	6
NEPHROLOGY	92	4	0	0	0	0	8	2	14
NEUROLOGY	60	5	3	0	0	0	4	1	13
PALLIATIVE MEDICINE	13	0	1	0	0	2	0	0	3
REHABILITATION	38	0	3	3	1	0	2	3	12
RESPIRATORY MEDICINE	124	7	7	0	0	10	10	1	35
RHEUMATOLOGY	37	3	1	0	0	0	4	1	9

		FELLOWS									
		KOWLOON CENTRAL CLUSTER		KOWLOON EAST CLUSTER			KOWLOON WEST CLUSTER				KOWLOON CENTRAL + EAST + WEST CLUSTER
SPECIALTY	FELLOWS TOTAL (PP/DH/HA/ OTHERS)	KH	QEH	HOHH	TKOH	UCH	CMC	KWH	PMH	YCH	
CARDIOLOGY	166	0	13	0	1	5	1	6	8	3	37
CRITICAL CARE MEDICINE	46	0	5	0	1	4	4	2	1	2	19
DERMATOLOGY & VENEREOLOGY	73	0	0	0	0	0	0	0	0	0	0
ENDOCRINOLOGY, DIABETES & METABOLISM	60	0	5	0	1	3	2	2	4	1	18
GASTROENTEROLOGY & HEPATOLOGY	104	0	8	0	3	3	5	6	11	5	41
GERIATRIC MEDICINE	132	5	3	6	2	11	7	8	10	5	57
HAEM/HAEM ONCOLOGY	36	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	18	0	1	0	0	0	0	0	5	1	7
MEDICAL ONCOLOGY	31	0	1	0	0	0	0	0	1	0	2
NEPHROLOGY	92	0	7	2	1	3	3	5	8	2	31
NEUROLOGY	60	0	8	0	1	2	0	4	2	0	17
PALLIATIVE MEDICINE	13	0	0	3	0	2	3	0	0	0	8
REHABILITATION	38	6	0	1	0	3	1	1	1	0	13
RESPIRATORY MEDICINE	124	7	6	5	3	4	3	1	6	1	36
RHEUMATOLOGY	37	1	2	0	0	2	2	1	3	1	12

		FELLOWS						
		NEW TERRITORIES EAST CLUSTER					NEW TERRITORIES WEST CLUSTER	NEW TERRITORIES EAST + WEST CLUSTER
SPECIALTY	FELLOWS TOTAL (PP/DH/HA/ OTHERS)	AHNH	NDH	PWH	SH	TPH	TMH	
CARDIOLOGY	166	3	2	9	0	0	8	22
CRITICAL CARE MEDICINE	46	1	2	1	0	0	2	6
DERMATOLOGY & VENEREOLOGY	73	0	0	1	0	0	0	1
ENDOCRINOLOGY, DIABETES & METABOLISM	60	2	2	10	0	0	1	15
GASTROENTEROLOGY & HEPATOLOGY	104	1	2	9	0	0	9	21
GERIATRIC MEDICINE	132	2	0	3	6	4	10	25
HAEM/HAEM ONCOLOGY	36	0	0	3	0	0	3	6
IMMUNOLOGY & ALLERGY	6	0	0	0	0	0	0	0
INFECTIOUS DISEASE	18	1	0	2	0	0	3	6
MEDICAL ONCOLOGY	31	0	0	11	0	0	0	11
NEPHROLOGY	92	3	0	6	0	1	7	17
NEUROLOGY	60	2	2	4	0	0	1	9
PALLIATIVE MEDICINE	13	0	0	0	1	0	0	1
REHABILITATION	38	0	0	2	1	2	2	7
RESPIRATORY MEDICINE	124	3	3	5	0	1	6	18
RHEUMATOLOGY	37	1	1	3	0	2	1	8

Statistics on No. of Trainees in all Specialties

Updated in August 2005

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	16	1 2 3 4 *4*	1—1 2 3 4—2 *2*	1 2 3 4 *0*	1 2 3 4 *0*	1 2 3 4 *3*	1 2—2 3 4 *9*	1 2 3 4 *0*
CRITICAL CARE MEDICINE	8	1 2—1 3 4 *3*	1 2 3 4 *0*	1 2 3 4 *0*	1 2 3 4 *0*	1 2 3 4 *0*	1 2 3 4 *6*	1 2 3 4 *0*
DERMATOLOGY & VENEREOLOGY	6	1 2 3 4 0	1 2 3 4 0	1 2 3 4 0	1 2 3 4 0	1 2 3 4 0	1 2 3 4 0	1 2 3 4 0
ENDOCRINOLOGY, DIABETES & METABOLISM	17	1 2 3 4 *0*	1 2 3 4 *1*	1 2 3—1 4—1 2	1 2 3 4 *0*	1 2 3 4 *0*	1 2 3 4 *6*	1 2 3 4 *0*
GASTROENTEROLOGY & HEPATOLOGY	11	1 2 3—1 4 *5*	1 2 3 4 *2*	1 2 3 4 *0*	1 2 3 4 0	1 2 3 4 *0*	1 2—1 3 4 *8*	1 2 3 4 *1*
GERIATRIC MEDICINE	13	1 2—1 3—1 4 *5*	1 2 3 4 *12*	1 2 3 4—1 *2*	1 2 3 4 *3*	1 2 3 4 *0*	1 2 3 4 *2*	1 2 3 4 *0*
HAEM/HAEM ONCOLOGY	7	1 2—1 3 4—1 *3*	1 2 3 4 *0*	1 2 3 4 *0*	1 2 3 4 *0*	1 2 3 4 *0*	1 2—1 3 4 *7*	1 2 3 4 *0*
IMMUNOLOGY & ALLERGY	0	1 2 3 4 *0*	1 2 3 4 *0*	1 2 3 4 *0*	1 2 3 4 *0*	1 2 3 4 *0*	1 2 3 4 *1*	1 2 3 4 *0*
INFECTIOUS DISEASE	8	1 2—1 3 4 *0*	1 2 3—1 4 *0*	1 2 3 4 *0*	1 2 3 4 *0*	1 2 3 4 *0*	1 2 3 4 *0*	1 2 3 4 *0*
MEDICAL ONCOLOGY	4	1 2 3 4 *0*	1 2 3 4 *0*	1 2 3 4 *0*	1 2 3 4 *0*	1 2 3 4 *0*	1 2 3—1 4 *6*	1 2 3 4 *0*
NEPHROLOGY	11	1 2 3 4 *4*	1 2 3 4 *0*	1 2 3 4 *0*	1 2 3 4 *0*	1 2 3 4 *0*	1 2 3 4 *4*	1 2 3 4 *2*
NEUROLOGY	8	1 2—1 3 4 *3*	1 2 3 4 *3*	1 2 3 4 *0*	1 2 3 4 *0*	1 2 3 4 *0*	1 2 3 4 *4*	1 2 3 4 *0*
PALLIATIVE MEDICINE	1	1 2 3 4 *0*	1 2 3 4 *1*	1 2 3 4 *0*	1 2 3 4 *0*	1 2 3 4 *2*	1 2 3 4 *0*	1 2 3 4 *0*
REHABILITATION	4	1 2 3 4 *0*	1 2 3 4 *3*	1 2 3 4 *3*	1 2 3 4 *1*	1 2 3 4 *0*	1 2 3 4 *1*	1 2 3 4 *2*
RESPIRATORY MEDICINE	16	1 2—1 3 4 *3*	1—1 2 3 4 *6*	1 2 3 4 *0*	1 2 3 4 *0*	1 2 3 4—1 *10*	1 2 3 4 *7*	1 2 3 4 *0*
RHEUMATOLOGY	5	1 2 3 4 *1*	1 2 **3** 4 *1*	1 2 **3** 4 *0*	1 2 **3** 4 *0*	1 2 **3** 4 *0*	1 2 **3** 4 *3*	1 2 **3** 4 *1*

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 CLUSTR		KOWLOON EAST CLUSTER			KOWLOON WEST CLUSTER			
		KH	QEH	HOHH	TKOH	UCH	CMC	KWH	PMH	YCH
		YEAR		YEAR			YEAR			
CARDIOLOGY	16	1 2 3 4 *0*	1—1 2 3 4—1 *11*	2 3 4 *0*	2 3 4 *1*	2 3 4—1 *4*	2 3—1 4 *1*	2—1 3 4 *5*	3—1 4—1 *7*	4—1 *3*
CRITICAL CARE MEDICINE	8	1 2 3 4 *0*	1 2 3 4 *4*	1 2 3 4 *0*	1 2 3 4 *1*	1 2—2 3 4—1 *4*	1 2—1 3 4 *3*	1 2—1 3 4—1 *2*	1 2 3—1 4 *1*	1 2 3 4 *2*
DERMATOLOGY & VENEREOLOGY	6	1 2 3 4 *0*	1 2 3 4 *0*	1 2 3 4 *0*	1 2 3 4 *0*	1 2 3 4 *0*	1 2 3 4 *0*	1 2 3 4 *0*	1 2 3 4 *0*	1 2 3 4 *0*
ENDOCRINOLOGY, DIABETES & METABOLISM	17	1 2 3 4 *0*	1—1 2 3 4 *5*	1 2 3 4 *0*	1 2 3—1 4—1 *1*	1 2 3 4—1 *2*	1 2 3—1 4 *2*	1 2 3 4—1 *1*	1 2 3 4 *3*	1 2 3 4—1 1
GASTROENTEROLOGY & HEPATOLOGY	11	1 2 3 4 *0*	1 2 3 4—1 *8*	1 2 3 4 *0*	1 2—1 3 4 *2*	1—1 2 3 4 *3*	1 2 3 4 *4*	1 2 3 4 *5*	1 2—1 3 4 *11*	1 2—1 3 4 *3*
GERIATRIC MEDICINE	13	1 2—1 3—1 4 *3*	1 2 3 4—1 *3*	1 2 3—1 4 *5*	1 2 3 4 *1*	1 2—1 3 4 *9*	1 2 3 4—1 *6*	1 2 3 4—1 *6*	1 2 3—1 4 *9*	1 2 3 4 *3*
HAEM/HAEM ONCOLOGY	7	1 2 3 4 *0*	1 2—1 3—1 4 *3*	1 2 3 4 *0*	1 2 3 4 *1*	1 2 3 4 *1*	1 2 3 4 *0*	1 2 3 4 *0*	1—1 2 3—1 4 *1*	1 2 3 4 *0*
IMMUNOLOGY & ALLERGY	0	1 2 3 4 *0*	1 2 3 4 *0*	1 2 3 4 *0*	1 2 3 4 *0*	1 2 3 4 *0*	1 2 3 4 *0*	1 2 3 4 *0*	1 2 3 4 *0*	1 2 3 4 *0*
INFECTIOUS DISEASE	8	1 2 3 4 *0*	1 2—1 3 4—1 *0*	1 2 3 4 *0*	1 2 3 4 *0*	1 2 3—1 4—1 *0*	1 2 3 4 *0*	1 2 3—1 4 *0*	1 2 3 4 *5*	1 2 3 4 *1*
MEDICAL ONCOLOGY	4	1 2 3 4 *0*	1 2 3 4 *0*	1 2 3 4 *0*	1 2 3 4 *0*	1 2 3 4 *0*	1 2 3 4 *0*	1 2 3 4 *0*	1 2 3 4 *1*	1 2 3 4 *0*
NEPHROLOGY	11	1 2 3 4 *0*	1 2—1 3 4—1 *5*	1 2 3 4 *0*	1 2 3 4 *1*	1 2 3—1 4—1 *3*	1 2 3—1 4 *3*	1 2 3 4—1 *5*	1 2—1 3 4 *6*	1 2 3 4 *1*
NEUROLOGY	8	1 2—1 3 4 *0*	1 2 3 4 *5*	1 2 3 4 *0*	1 2 3 4 *1*	1 2 3 4 *2*	1 2 3 4 *0*	1 2 3—1 4 *3*	1 2 3 4 *1*	1 2 3 4 *0*
PALLIATIVE MEDICINE	1	1 2 3 4 *0*	1 2 3 4 *0*	1 2—1 3 4 *1*	1 2 3 4 *0*	1 2 3 4 *0*	1 2 3 4 *2*	1 2 3 4 *0*	1 2 3 4 *0*	1 2 3 4 *0*
REHABILITATION	4	1 2—1 3—1 4 *4*	1 2 3 4 *0*	1 2 3 4 *1*	1 2 3 4 *0*	1 2 3 4 *3*	1 2 3 4 *1*	1 2 3 4 *1*	1 2 3 4 *0*	1 2 3 4 *0*
RESPIRATORY MEDICINE	16	1 2 3 4 *5*	1 2 3—1 4 *4*	1 2 3—1 4 *4*	1 2 3 4—1 *3*	1 2—1 3 4—1 *3*	1 2 3 4 *3*	1—1 2 3 4—1 *1*	1 2 3 4 *4*	1 2 3 4—1 *1*
RHEUMATOLOGY	5	1 2 3 4 *1*	1 2 3—1 4 *1*	1 2 3 4 0	1 2 3 4 *0*	1 2 3—1 4 *1*	1 2 3 4 *2*	1 2 3—1 4 *0*	1 2 3 4 *1*	1 2 3 4 0

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

		TRAINEES					
		NEW TERRITORIES EAST CLUSTER					NEW TERRITORIES WEST CLUSTER
SPECIALTY	TRAINEES TOTAL (PP/DH/HA/ OTHERS)	AHNH	NDH	PWH	SH	TPH	TMH
		YEAR					YEAR
CARDIOLOGY	16	1 2 3 4 *2*	1 2 3 4—2 *2*	1 2—1 3—1 4 *6*	1 2 3 4 *0*	1 2 3 4 *0*	1 2 3 4 *8*
CRITICAL CARE MEDICINE	8	1 2 3 4 *1*	1 2 3 4 *2*	1 2 3 4 *1*	1 2 3 4 *0*	1 2 3 4 *0*	1 2 3 4 *2*
DERMATOLOGY & VENEREOLOGY	6	1 2 3 4 *0*	1 2 3 4 *0*	1 2—1 3 4 *0*	1 2 3 4 *0*	1 2 3 4 *0*	1 2 3 4 *0*
ENDOCRINOLOGY, DIABETES & METABOLISM	17	1 2 3 4 *1*	1 2 3 4—1 *1*	1 2—1 3—2 4 *9*	1 2—1 3 4—1 *0*	1 2 3 4 *0*	1 2 3—1 4 *1*
GASTROENTEROLOGY & HEPATOLOGY	11	1 2 3 4 *1*	1 2 3 4—1 *2*	1—1 2 3—1 4 *7*	1 2 3 4 *0*	1 2 3 4 *0*	1 2 3—1 4 *6*
GERIATRIC MEDICINE	13	1 2 3 4 *1*	1 2 3 4 *0*	1 2 3 4 *2*	1 2 3 4 *6*	1 2 3 4—1 *3*	1 2 3 4 *9*
HAEM/HAEM ONCOLOGY	7	1 2 3 4 *0*	1 2 3 4 *0*	1 2 3 4 *3*	1 2 3 4 *0*	1 2 3 4 *0*	1 2 3 4 *2*
IMMUNOLOGY & ALLERGY	0	1 2 3 4 *0*	1 2 3 4 *0*	1 2 3 4 *0*	1 2 3 4 *0*	1 2 3 4 *0*	1 2 3 4 *0*
INFECTIOUS DISEASE	8	1 2 3 4 *1*	1 2 3 4 *0*	1 2 3 4 *0*	1 2 3 4 *0*	1 2 3 4 *0*	1 2 3 4—1 *2*
MEDICAL ONCOLOGY	4	1 2 3 4 *0*	1 2 3 4 *0*	1 2—2 3 4—1 *7*	1 2 3 4 *0*	1 2 3 4 *0*	1 2 3 4 *0*
NEPHROLOGY	11	1 2 3 4—2 *2*	1 2 3 4 *0*	1 2 3—1 4 *6*	1 2 3 4 *0*	1 2 3 4 *0*	1 2 3 4 *5*
NEUROLOGY	8	1 2 3—1 4 *1*	1 2 3 4 *1*	1 2—1 3 4 *4*	1 2—1 3—1 4 *0*	1 2 3 4 *0*	1 2—1 3 4 *1*
PALLIATIVE MEDICINE	1	1 2 3 4 *0*	1 2 3 4 *0*	1 2 3 4 *0*	1 2 3 4 *1*	1 2 3 4 *0*	1 2 3 4 *0*
REHABILITATION	4	1 2 3 4 *0*	1 2 3 4 *0*	1 2 3 4 *2*	1 2 3 4 *1*	1 2 3 4 *2*	1 2—1 3—1 4 *2*
RESPIRATORY MEDICINE	16	1 2 3 4 *3*	1—1 2—1 3 4 *3*	1 2 3—1 4 *4*	1 2 3 4 *0*	1 2 3 4 *1*	1 2 3 4—2 *4*
RHEUMATOLOGY	5	1 2 3 4 *0*	1 2 3 4 *0*	1 2 3 4 *3*	1 2 3 4 *0*	1 2 3—1 4 *1*	1 2 3 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	6	1 2—3 3 4—2 *16*
GASTROENTEROLOGY & HEPATOLOGY	11	1 2 3 4 *0*
IMMUNOLOGY & ALLERGY	0	1 2 3 4 *1*
RESPIRATORY MEDICINE	16	1 2 3 4 *5*

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

Please note in your diaries the dates of two major forthcoming events.

Firstly, the Annual Scientific Meeting of the Hong Kong College of Physicians will be held on the 5-6 November, 2005. The theme of this meeting is "Moving points in Medicine" and the provisional programme is printed below.

Secondly, the Hong Kong Academy of Medicine Intercollegiate Scientific Meeting will be held on 26 February, 2006 and the theme is "Disaster management".

Annual Scientific Meeting 5 – 6 November, 2005

MOVING POINTS IN MEDICINE

5 November (Saturday)

12:00 – 6:00 pm	*Registration*
12:30 – 1:30 pm	*Lunch [sponsored by Pfizer Corporation (HK) Ltd]*
1:30 –1:45 pm	*Opening Ceremony*
1:45 – 2:15 pm	Aggressive lipid lowering Dr. Peter Nicol Koping Hospital, Sweden
2:15 – 3:30 pm	*Symposium on Unsuspected Medical Syndromes I* Chairman: Dr SZETO Ming-Leung (TMH) & Dr CHONG Lai-Yin (DH) 1. A child with recurrent infections – Professor LAU Yu-Lung (QMH) 2. Atypical influenza – Dr LAI Jak-Yiu (PMH) 3. Skin diseases – skin-depth? – Dr. HO King-Man (DH)
3:30 – 4:00 pm	*Tea / Coffee Break*
4:00 - 5:15 pm	*Symposium on Unsuspected Medical Syndromes II* Chairman: Dr TSUI Hing-Sum (CMC) & Dr CHIANG Chung-Seung (QEH) 1. Shortness of breath and COPD – Professor TSANG Wah-Tak (QMH) 2. Cardiac syncope – Dr. MOK Ngai-Shing (PMH) 3. Recurrent aches and pains – Dr. LEUNG Moon-Ho (QEH)
5:15 – 6:27 pm	*Distinguished Research Papers Award for Young Investigators 2005 & Medical Student Essays* Chairmen: Prof SUNG Jao-Yiu, Joseph and Dr WONG Chun-Por 1. Dr HUI Chee- Kin – A long-term follow-up study on hepatitis B surface antigen positive patients undergoing allogeneic hematopoietic stem cell transplantation 2. Dr HUNG Cheung-Tsui – Long-term outcome of H. pylori-negative bleeding ulcers: A prospective cohort study 3. Dr WANG Yee-Moon Angela – Resting energy expenditure and subsequent mortality risk in peritoneal dialysis patients 4. Dr TAM Lai-Shan – Higher prevalence of squamous intraepithelial lesion in Systemic Lupus Erythematosus-association with human papilloma virus infection
6:45 – 8:15 pm	*AGM & Fellowship Conferment*
8:15 – 8:45 pm	*Cocktail Reception*
8:45 – 9:45pm	*Annual Dinner, AJS McFadzean Oration & Award Presentation* AJS McFadzean Orator: Mr Andrew SHENG, Chief Executive, Securities and Future Commission Title of the Oration: Medicine and Capital Markets Introduction: Prof LAI Kar-Neng, President, HKCP

6 November (Sunday)

8:30 am – 1:00 pm	*Registration*
9:00 – 10:00 am	*Best Thesis Award* Chairman: Prof LAU Chak-Sing
10:00 – 11: 15 am	*Symposium on Unsuspected Medical Syndromes III* Chairman: Dr NG Mar-Tai, Matthew (TWH) & Prof CHAN Yan- Keung, Thomas (PWH) 1. Toxic liver disease – Dr. CHAN Lik-Yuen, Henry (PWH) 2. Toxic nephropathies – Dr. CHOW Kai-Ming (PWH) 3. Diarrhoea and per rectal bleeding – Dr. LAI Kam-Chuen (QMH)
11:15 – 11:30 am	*Tea / Coffee break*
11:30 – 12:00 pm	*Gerald Choa Memorial Lecture* Speaker: Dr LEONG Che-Hung Introduction: Prof LAI Kar-Neng, President, HKCP
12:00 – 12:45 pm	*Sir David Todd Lecture* Speaker: Pending Introduction: Prof LAM Wah-Kit, Vice-President, HKCP

Laurence Chan (centre), with Professor Sir David Todd and Professor Rosie Young

Professor Chan Kwong Fai, Laurence

Carolyn PL Kng

Professor Laurence Chan graduated from the University of Hong Kong in 1972. He recalls the momentous car journey to the graduation ceremony at the City Hall as one of the highlights of his career. It was a thrill and a privilege to share the same car as his mentor, Richard Yu, who he admired for his "scholarly approach to medicine". Also in the same car were David Todd, AJS MacFadzean and Rosie Young. Indeed, this day marked the beginning of an exemplary career in medicine.

After graduation, Prof. Chan worked at the University Department of Medicine at Queen Mary Hospital for over three years. He considers this period as pivotal in shaping his career in academic medicine. In 1976, he left Hong Kong for further training in the United Kingdom, initially at Newcastle and then Edinburgh. In 1977, he became a Fellow under the tutorship of Sir David Weatherall and Sir Peter Morris at the John Radcliffe Hospital, Oxford University. He was promoted to Clinical Lecturer in Medicine at the same hospital in 1981. His memories of this period were mostly of days spent labouring in the research laboratories and frequent sleep deprivations lasting over 72 hours were frequently experienced.

In Oxford, he completed his PhD studies in 1982 under the direction of Sir Hans Krebs and Brian Ross MD, PhD. Prof. Chan was also grateful for the supports that he received from the late Sir Richard Doll, the first Warden of Green College, Oxford. In the days where magnetic resonance imaging was only a research tool, Laurence pioneered the application of magnetic resonance spectroscopy/imaging to study the biochemical aspects of kidney failure and the metabolic regulation of the kidney. He describes the use of magnetic resonance as a means of studying 'chemistry in vivo'. When asked what triggered his interest in this field of research, he recalled assisting in a cadaveric organ donation operation as a medical student during a surgical clerkship in 1969. He was intrigued by the process of harvesting the organs and was keen to find the optimal metabolic conditions for keeping the donor organs viable and healthy.

He left for the United States in 1983 to join the University of Colorado, School of Medicine as Assistant Professor of Medicine, Director of the Dialysis Unit and the Director of the Nuclear Magnetic Resonance Laboratory. When the University of Colorado restarted the kidney transplant program, Prof Chan led the team as the Medical Director of the program. In 1997, he became Professor of Medicine and continues as Director of Transplant Nephrology, and Program Director of Renal Transplant Fellowship at the same University. He speaks proudly of the high success rate of the transplant program, over 95 per cent graft survival, as being one of the highest in the world. He still looks after the world's longest surviving kidney transplant recipient, who is now 79 years old. Prof Chan's described the key reason for his success as a transplant nephrologist as being a 'good team-player'.

Among the many honours and awards received by Prof Chan are the prestigious National Kidney Research Scholar (1981), William Gibson J.R. Fellow of the Green College, Oxford University (1981), Service Award from the Colorado Kidney Support Group, Award from the American Association Kidney patients (1996) and Best Doctors in America (1999). He was elected Honorary Fellow of the Hong Kong College of Physicians in 2002 in recognition of his many achievements.

Internationally, he is widely acknowledged as a most distinguished nephrologist and has been invited frequently as visiting professor in many universities and institutes. He has served on many international and national committees for the American Society of Transplantation. He sits on the renal accreditation committee of the American Societies of Nephrology and Transplantation. He was founding member and past President (1995) of the Chinese American Society of Nephrology. He is most proud of his outreaching initiatives over the past 15 years with the International Society of Nephrology's Commission on Global Advancement of Nephrology in providing supports and educational program of personnel in developing countries. He continues to keep close links with nephrologists in Hong Kong, China, Taiwan and in the

Asian Pacific region. Recently, he has worked with a group of community leaders in Colorado to create the Transplant Foundation, which he hopes will increase awareness of organ donation, fund medical science and research, and influence public policy related to transplantation.

Prof Chan is devoted to teaching. He deems himself fortunate to have met many great teachers in his career and believes strongly in contributing to improving health care by teaching and "inspiring his trainees to help patients". He has mentored over sixty fellows and trainees from different parts of the world, including several of our local nephrologists.

Although he is most passionate and animated when we were discussing his research and teaching commitments. Prof Chan spoke warmly of his wife and son. His son, a White House Presidential Scholar in 2003, is presently studying bioengineer and bioinformatics at Stanford University but he has not written off the possibility that he may well develop a career in medicine later on. Despite a busy schedule, he reserves time for sports. He played badminton and squash competitively and represented the University of Hong Kong as a medical student. He continues to enjoy playing a game of squash to keep fit and to relax.

Prof Chan is a great example of the high standards of achievement that Hong Kong physicians have made overseas. He has made a mark internationally and done us proud.

Receiving the Honorary Fellowship of the Hong Kong College of Physicians from Prof Richard Yu in 2002