

HONG KONG COLLEGE OF PHYSICIANS

SYNAPSE



JULY 2006

RESTRICTED TO MEMBERS ONLY



Dance in Snow

Photographer: Dr. Jeffrey Shiu-chung TSANG

This photo is the first of the series "Photography by Physicians."

Contents

SYNAPSE

3

President's Column

Accreditation – The Cornerstone of Our Professional Allegiance

Prof KN Lai

5

Special Articles

Mah-jong parlours, karaoke bars and bathhouses

Dr Judith Longstaff Mackay

10

Council News

12

Scientific Section

Specialty Update – Cardiology
Cardiac Resynchronization Therapy:
The Unique Role of Research in Hong Kong

Prof Cheuk-Man YU

Medicine in the News
Hyponatraemia in Marathon Runners

*Dr Kai-Ming CHOW
Prof Philip Kam-Tao LI*

16

Examinations and Results

17

Training

*Statistics on No. of Fellows in all Specialties
Statistics on No. of Trainees in all Specialties*

23

Trainees' Column

Voluntary Medical Work in Heqing, China
Taking the PACES examination in the United Kingdom

Dr Grace Wong

Dr Yannie Soo

24

Events

25

Announcements

27

Profile Doctor

Professor TSO Shiu Chiu

Dr John Mackay



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Accreditation – The Cornerstone of Our Professional Allegiance

Prof KN Lai

President, HKCP

In the first edition of the "Guidelines on Postgraduate Training in Internal Medicine" published in 1993, the Hong Kong College of Physicians had clearly outlined the training program of 15 subspecialties within the realm of internal medicine. In the following two editions, the Educational and Accreditation Committee has since added two other subspecialties as well as Advanced Internal Medicine and Ambulatory Care Medicine to complete a comprehensive program. The set-up of these training guidelines is a proactive approach despite some subspecialties only having a few or no trainees over the past several years. The College has updated the number of trainees and the nature of training positions in all local accredited training centers in recent issues of our newsletter, "Synapse". Some subspecialties have few or even no trainee. One may ask why training guidelines are established in these subspecialties that apparently no trainee is enrolling. In most circumstance, these subspecialties are relatively specialized areas of Internal Medicine and these specialists are clustered in a few major medical centers. Nonetheless, the College is committed to maintain such training programs irrespective of the job prospect because of their recognized importance. The training programs are revised regularly and the fourth edition of the College Training Guidelines is now under preparation. The College also recognizes the job opportunity of individual subspecialty is not static but rather in a constantly changing status. Both the College and most training centers believe specialist training should be conducted under the principle of market-driven instead of "planned economy". This is best exemplified by the dramatic change in attitude of the Hospital Authority (HA) and the trainees towards training for Infectious Diseases physicians following the SARS crisis in 2003. The College is proud of her foresight of structuring a solid training guideline for Infectious Diseases even though the number of trainees was very small before 2003. With the emergence of new infectious diseases, the College also demonstrates the versatility by introducing new programs into the training guideline.

Now let me turn to a separate issue that also hinges on the principle of proper accreditation. This scenario illustrates the viewpoint and determination of our College to maintain the standard of accreditation in our profession. Recently, an associate consultant position was established in a HA hospital when a new program was introduced. The position requires a qualified physician trained in the subspecialty "X" of the Hong Kong College of Physicians. The successful candidate will provide consultative, administrative and supervisory role to the HA in the area of "X"

that handles important medically litigating issues. Several resident specialists or higher physician trainees contacted me in my capacity as the President of the College. They realized that there is no qualified specialist in HA for the subspecialty "X". They expressed further concern that appointing specialist from other subspecialties as an Associate Consultant in "X" is deemed as unfair and substandard. I checked the College record and confirmed that there has not been a single trainee registered in the subspecialty "X", probably due to the uncertain job opportunity within the HA in the past. This issue was thoroughly debated in the Educational and Accreditation Committee and Council of the College. The consensus opinion was the HA must appoint a fully qualified physician as dictated by the job specification. On behalf of the College, I wrote a letter reminding the Hospital Authority that there is never a trainee in the subspecialty "X" in the College. If a qualified specialist was to be recruited from overseas, the candidate's qualification must be vetted by the Medical Council. The College also indirectly heard that the administration of the concerned hospital considered the College's stand as one of many opinions but not a professional dictum. An interview was conducted as scheduled. This matter was then brought to the attention of the Chairman and Chief Executive of the Hospital Authority. Both concurred and supported the College's insistency that a specialist in subspecialty "X" must be employed and substitution with a specialist in other subspecialties for this appointment was not allowed.

There are several issues emerged from this saga. Why is the College not sympathetic to the hospital's plea of ignoring the accreditation requirement? With a long established training program in subspecialty "X" for more than a decade, the College opines that there is no excuse to ignore the accreditation requirement. As the training preference is frequently market-driven or job opportunity-related, the College sees no reason to bend the rules when an *ad hoc* position becomes available. In modern management, planning is mandatory for any launching of a new endeavor. Experienced personnel are the key to success. The College is not prepared to waive the accreditation requirement because a position has been created and deemed to be filled. The period for additional subspecialty training for our Fellow is only 24 months. The hospital should plan specialist training in the subspecialty "X" if it is going to receive funding and accept the undertaking of providing a special clinical service in the HA. The ultimate obligation the College has to observe is the assurance to the public and our peers that professional allegiance

will never be compromised. The accreditation of our profession is an all-or-none business, and there is nothing in between. Our College and the profession will lose their credibility if we do not adopt such a didactic approach in this issue. I am sure the Chairman and the Chief Executive of the HA, both of whom are not medically qualified; also fully understand this principle from their moral grounds.

Next, one would ask why the resident specialists complained to the College. Why some worried about the selection process? This may partly be due to the partisan or sectarian impression within the hospital clusters of the HA. This impression has been the subject of discussion after the SARS crisis. Do we have the justification for such an impression especially in selection of senior positions such as consultants or associate consultants? My personal impression is not necessarily true yet the composition of the selection committee may allow the individual hospital board to command the maximal influence. The external members from the HA headquarter, the Central Coordinating Committee (Medicine) or the College are often outnumbered by the representatives of the individual hospital board. This critical number unduly generates the mistrust or even a sense of partisan from the frontline medical staff. I have heard arguments for preference for recruitment from within the cluster that loyalty and team spirit can be maintained. This is really a double-edge sword as complacency, unawareness of danger, lack of tolerance, and little breadth of view often germinate from this inbreeding system. These shortcomings are often magnified during crisis such as SARS. As a board member of the HA, I have the opportunity to work with members from other professions. The present system of selecting senior medical staff is often not viewed as cosmopolitan or with broad outlook by the business world. In modern management, gradual but regular influx and exchange of personnel with novel ideas is the only means to progress and to break down any barrier while maintaining a healthy stability.

How can the HA achieve the above-mentioned goal in the selection of senior clinical staff? If we go back to the history, this had been accomplished by the Medical and Health Department in the pre-HA era. Before the HA decentralization in the staff employment, senior clinical staff were employed by the central administration. They were selected by a panel of senior consultants from various regional hospitals with the input of a professional body such as the College. The successful candidates were then seconded to the hospitals with appropriate vacancy and they could be transferred to other centers if new service was developed. What are the advantages of this system? First, the best and most able person in the field will be selected. Second, new knowledge and technology will be disseminated from specialized centers. In turn, the hospital that employed this new staff is able to develop a new clinical service with the "imported" technology. Lastly, a healthy traffic between different clusters will accelerate the breakdown of any artificial barrier, increase mutual understanding amongst doctors from different cluster, and create a seamless working environment within the HA. This may appear to represent a great leap in the administrative bureaucracy, yet technically is a small step to improve the professional standard. The value of a seamless medical team within the HA will no doubt be a major asset in any future crisis. If such selection policy is to be implemented, a panel consisting of HA board members, senior consultants from various regional hospitals, and the College representative should be formed to ensure total transparency, adequate representation, maximal diversity and widespread input.

Beginning with the scenario of an associate consultant appointment, I engage in an unintended discussion of staff selection in our public hospital system. Perhaps, I conclude by reiterating the stand of the College that proper accreditation is the cornerstone of our professional allegiance. The College's assurance to the public of high medical standard will never be compromised.

Mah-jong parlours, karaoke bars and bathhouses

Dr Judith Longstaff Mackay

Asian Consultancy on Tobacco Control, Hong Kong

Tobacco has again become a hot topic in Hong Kong for two reasons: China, including Hong Kong and Macau, has just ratified the WHO Framework Convention for Tobacco Control (FCTC) which now mandates Hong Kong to implement a broad platform of tobacco control measures. Secondly and coincidentally, Hong Kong stands poised for another round of legislation that is currently before the Legislative Council. The latter is being fought to the death, literally, if one considers the impact of passive smoking on workers in the workplace, including restaurants, bars, mah-jong parlours, karaoke bars and bathhouses.

An unlikely array of people have been paraded in front of Legco by the opposition: An insurance agent who said half her clients were in the food and beverage industry and she would not be able to earn a livelihood if the law went through, as restaurants would have to close down. A real estate executive, who said the value of real estate would collapse in Hong Kong, and he would be out of business. Even a collector of refuse for recycling said that if restaurants closed, there would be nothing to recycle and she would have no job. Financial destitution was the theme and, pulling at the heart strings, even ageing and dependent parents were mentioned.



Legco building, HK

Yet country after country is passing such legislation, and economic surveys show that the hospitality industry does not suffer financially when a ban goes through – in fact, the opposite – more people go out to eat in smoke-free environments. Even the sales value of restaurants benefit: a nationally representative sample of nearly 12,000 US restaurants and bars over a 10 year period reported in *Contemporary Economic Policy* in 2004 showed a median increase of 16% in the sale price of a restaurant in a jurisdiction with a smoke-free law compared with a comparable restaurant in a community without such a law. Smoke-free ordinances add value to these establishments.¹

History

This is not a new war – the first skirmishes in Hong Kong occurred more than one quarter of a century ago, with the first health education on tobacco; China started even earlier when, in the 1600s, Chinese philosopher, Fang Yizhi, discussed the dangers of smoking, pointing out that long years of smoking “scorches one’s lung.”² Health education on tobacco then picked up again in China in the 1970s, on a parallel course with Hong Kong.

Over the last 30 years, Hong Kong has published much research on the health impact of active and passive smoking and conducted public opinion surveys; introduced health warnings; banned most forms of advertising and promotion, including a rather novel law banning placing a tobacco ad on internet; increased tobacco tax to deter youth from smoking; created smoke-free areas in government buildings, transport, shopping malls, cinemas and theatres; banned all forms of smokeless tobacco; established the HK Council on Smoking and Health (COSH) in 1987; and more. In the 1980s, Hong Kong and Singapore became exemplars for the Asia Pacific region, showing that tobacco control action is not a prerogative of western countries, and that Asia can implement measures swiftly and effectively. Smoking prevalence in Hong Kong and Singapore dropped to the lowest in the world.

Is this enough? No. Global experience shows that tobacco control legislation must be regularly updated, expanded and tightened, at minimum every 5 years, or it become dated, and clever circumvention of the law occurs. One example of this is from the early days of Hong Kong when a law was passed banning smoking in lifts. Many smokers holding burning cigarettes claimed that they were “not smoking,” so the legislation had to be amended to include ‘smoking or holding a lighted cigarette...’ Circumvention of bans on promotion – at least circumvention of the spirit of the law – are notorious.

The last comprehensive round of tobacco control legislation was passed the week of the handover in 1997, so Hong Kong is seriously overdue a revision of the legislation, and this assumes even greater necessity with the FCTC now in effect.

The tobacco companies have continuously challenged the Hong Kong government on legally binding measures, and even threatened legal action. Hong Kong has faltered and, unlike Singapore, has taken few recent measures, noticeably failing to ban all tobacco advertising and promotion, or to create smoke-free workplaces, in spite of strong public support for these measures, as shown by several Public Opinion Surveys conducted by the Community Medicine Department of the University of Hong Kong.

Health and epidemiology

The health statistics are only too well known and hardly need repeating. Half the world's tobacco deaths occur in Asia. Half of all smokers die from tobacco and, of these, half die in middle age. Many tobacco-related diseases, such as lung cancer, cardiovascular disease, and chronic bronchitis and emphysema are incurable at the time of diagnosis. Thus, the key to reducing the epidemic lies in prevention, and here health professionals have a crucial role to play.

In spite of all efforts in the past 50 years, the numbers of smokers in the world is increasing. Unless there are new and robust initiatives that both reduce the level of youth starting to smoke, and also are effective in getting smokers to quit in their millions, then global annual tobacco related deaths will rise from the present 5 million to 10 million by 2030; seven million of these deaths will be in developing countries; two million will be in China alone.

FCTC

The FCTC places Hong Kong under international legally binding obligation to implement tobacco control measures. All told, 168 nations have signed the convention, including every country in the Western Pacific Region. At the time of writing, more than 120 have ratified, making it one of the fastest track UN conventions of all time.



FCTC negotiations in Geneva

The FCTC arose from the realization that the medical model alone had not been enough to reduce the global tobacco epidemic.

Not surprisingly, the tobacco industry is not in favour of a strong, legally binding FCTC and has instead sought to promote self-regulating marketing mechanisms and voluntary agreements. But FCTC has widespread support from civil society around the world. In 2001 a public opinion survey of five major countries (Argentina, Japan, India, Nigeria and Russia) showed 87% of people supported the international efforts of WHO to help create a set of rules and regulations to curb tobacco use. Only 9% were opposed.³

The main provisions of the FCTC

Regulation of:

- contents, packaging and labelling of tobacco products
- prohibition of sales to and by minors
- illicit trade in tobacco products
- smoking in work and public places

Reduction in consumer demand by:

- price and tax measures
- comprehensive ban on tobacco advertising, promotion and sponsorship
- education, training, raising public awareness and assistance with quitting

Protection of the environment and the health of tobacco workers

Support for economically viable alternative activities

Research, surveillance and exchange of information

Support for legislative action to deal with liability

Health evidence: During the lengthy negotiations at WHO in Geneva, there was no disagreement between member states on the health evidence that led to the treaty. For example, Article 8 states: "Parties recognize that scientific evidence has unequivocally established that exposure to tobacco smoke causes death, disease and disability." This has direct relevance to the legislation currently proposed in Hong Kong.

Economic concerns: The main concern of countries was economic – whether the FCTC would have an effect on their tobacco farmers and other tobacco workers or even reduce tobacco tax revenues. Reassuringly, analysis of economics and trade by the World Bank, FAO and other health economists concludes that neither the FCTC nor any tobacco control measures will harm economies, even of major tobacco-growing countries such as China or Brazil. With the number of smokers in the world predicted to rise from the current 1.3 billion to 1.6 billion by 2030 (principally due to increases in global population), no tobacco farmers will be out of work for decades to come.

These economists have pointed out that many tobacco control measures cost nothing – for example, legislation requiring warnings labels on cigarette packets or the creation of smoke-free areas, or simple advice on quitting from a health professional.

Other actions may have some cost, but are cost-effective, such as bans on advertising and promotion, and the provision of quitting services, including nicotine replacement treatment. Price measures, such as increased tobacco tax and a crackdown on smuggling, will actually increase government tax revenue, while reducing the numbers of young smokers and encouraging adults to quit.

The FCTC will make it much more difficult for the tobacco industry to suggest to any nation that their proposed tobacco control measure are extreme and inappropriate, as now most other nations are doing it too. The FCTC indicates that the tide of tobacco control action is international, unstoppable and a necessary public health measure, accepted as good for the wealth and health of nations.

The role of health professional organisations

The FCTC and the proposed legislation has considerable implications for health professionals around the world. WHO has therefore drawn up a Code of practice for health professionals, which was adopted in 2004:

WHO Code of practice on tobacco control for health professional organizations

Preamble: In order to contribute actively to the reduction of tobacco consumption and include tobacco control in the public health agenda at national, regional and global levels, it is hereby agreed that health professional organizations will:

1. Encourage and support their members to be role models by not using tobacco and by promoting a tobacco-free culture.
2. Assess and address the tobacco consumption patterns and tobacco-control attitudes of their members through surveys and introduction of appropriate policies.
3. Make their own organizations' premises and events tobacco-free and encourage their members to do the same.
4. Include tobacco control in the agenda of all relevant health-related congresses and conferences.
5. Advise their members to routinely ask patients and clients about tobacco consumption and exposure to tobacco smoke – using existing evidence-based approaches and best practices --, give advice on how to quit smoking and ensure appropriate follow-up of their cessation goals.
6. Influence health institutions and educational centres to include tobacco control in their health professionals' curricula, through continued education and other training programmes.
7. Actively participate in World No Tobacco Day every 31 May.
8. Refrain from accepting any kind of tobacco industry support – financial or otherwise --, and from investing in the tobacco industry, and encourage their members to do the same.
9. Ensure that their organization has a stated policy on any commercial or other kind of relationship with partners who interact or with interests in the tobacco industry through a declaration of interest.
10. Prohibit the sale or promotion of tobacco products on their premises, and encourage their members to do the same.
11. Actively support governments in the process leading to the signature, ratification and implementation of the WHO Framework Convention on Tobacco Control.
12. Dedicate financial and/or other resources to tobacco control – including dedicating resources to the implementation of this code of practice.
13. Participate in the tobacco-control activities of health professional networks.
14. Support campaigns for tobacco-free public places.

World medical, nursing, heart, cancer, dentistry, pharmacist and many other societies have all taken a firm stand against tobacco, yet this has not filtered down to country or individual level in many places. The health profession still focuses on curative medicine. There is no proportionate response to, or funding for, tobacco control commensurate with the size of the problem, in contrast to communicable diseases such as SARS, avian flu, or natural disasters, which account for far fewer deaths.

The role of individual health professionals

"The role and image of the health professional are essential in promoting tobacco-free lifestyles and cultures." World Health Organization, 2005.⁴

The individual health professional is uniquely placed to reduce the tobacco pandemic in many ways.⁵

Act by personal example

Health professionals should be non-smokers, create 'smoke-free' offices and clinics, and display health promotion posters and pamphlets. They should not support the tobacco industry, for example, by investing in tobacco shares, attending tobacco-sponsored events as have taken place recently in Hong Kong, accepting research, conference or other funding from the tobacco companies.

Advise the young

Health professionals can ask young patients if they have tried cigarettes (especially if they have a cough) and counsel them accordingly, as the long-term key to reducing the tobacco epidemic lies in prevention.

Give quitting advice

Helping patients quit smoking while still healthy is arguably more worthwhile than giving another course of antibiotics to chronic bronchitis patients.

Smokers can be referred to quitting clinics in Hong Kong. There is a list of these on the website of the HK Council on Smoking and Health at www.smokefree.hk, or in English at <http://www.smokefree.hk/cosh/ccs/index.xml?lang=en>. Click on Smoking Cessation. This site gives Cessation hotline telephone numbers, a Youth Quitline for smokers aged 12-25 years, and contact information for all Quitting services in Hong Kong.



Prof Sophia Chan at Quit clinic

Smoking patients can be identified by a chop on the outside of their file, so that their smoking status can be questioned at subsequent visits.

It is important to get the patient to choose a 'Quit Day' and to emphasize the positive benefits of quitting, e.g., the patient will:

1. feel healthier and fitter
2. gain freedom from a dangerous and addictive habit
3. know that their children will be healthier AND less likely to smoke themselves
4. take less time off work because of illness (smokers are 6% less productive than non-smokers)⁶
5. save money (adding up the yearly cost of 20 cigarettes a day comes as a surprise to many smokers – over HK\$10,000 annually for a pack-a-day smoker)

Information should include the facts that smokers need to quit completely rather than cut down; that many smokers require several attempts before they quit permanently; that physically addicted smokers (those who light up a short time after waking) will more than double their success rates by temporary nicotine replacement and newer drug therapy; and that quitting does not lead to weight gain if simple diet and exercise replaces the smoking habit.

Many health professionals are frustrated by low quitting rates. This may in part be because many doctors give the same advice to all smokers, whereas in reality they are at three different stages, and success will be improved by different approaches:⁷

- **Stage 1, the 'Red Group':**

This group is not ready to stop, and may be quite hostile to the suggestion. This group needs preliminary advice, a pamphlet, and a welcome to return if they change their mind, but not (yet) an all-out attempt to get them to quit.

- **Stage 2, the 'Orange Group':**

These patients are unsure about stopping, and need more information about smoking and quitting, with a definite offer of support if they decide to try to quit.

- **Stage 3, the 'Green Group':**

These are ready to stop now. This group requires the most active intervention, with specific advice and follow up.

Several follow-up visits should be planned to support the smoker's decision.

Care for the sick

Management, treatment and terminal care for patients with tobacco-related illnesses is one component of the responsibilities of health professionals.

Research

While there are ample data from about 60,000 studies on the harmfulness of tobacco, there is still a need for on-going research

on prevalence, consumption, health effects, public opinion, the economic impact of tobacco, the tobacco industry, and the effectiveness of tobacco control measures. New research has recently demonstrated the connection between smoking and tuberculosis, for example, as well as other cancers.

Medical curricula

Health professionals working in medical, nursing and allied health schools can ensure that smoking is systematically included in the curricula. The most recent study showed only 60% of smoking medical students in nine Asian countries thought that smoking was harmful to health, and there was a 'gross underestimation of tobacco's causal role in a number of important diseases ...' Only 44% of final year students (26% of smokers) thought increased taxation on tobacco products an important preventive measure.⁸

The curriculum should include not only information on the harmfulness of smoking and how to give advice on quitting, but also information on legislation, taxation, and countering the tactics of the tobacco companies.

Advocacy

Reduction in tobacco use requires national, political and media action. Decisions regarding nation wide containment of tobacco, for example legislation and price increases, lie with governments, not within hospitals or clinics.

Health professionals can support these:

- Write letters to the press; go on TV
- Lobby government and politicians, such as Legislative Council members
- Testify before legislative bodies
- Involve their local medical organizations in tobacco issues
- Support litigation (personal injury, public interest, law enforcement, etc)
- Demonstrate!

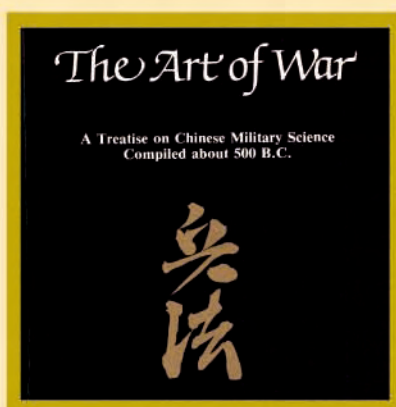
It is crucial that individual health professionals and organizations support the FCTC and the tobacco control legislation currently under consideration in Hong Kong. The two hot topics before Legco at the moment are:

- a) the ban on smoking in the workplace, especially restaurants, bars, nightclubs, mahjong parlours, karaoke bars and bathhouses; and
- b) whether Hong Kong should follow 32 countries that have already banned misleading descriptor terms such as "light" and "mild", a recommendation that is also enshrined in the FCTC. This is being strongly opposed by the Japanese manufacturers of "Mild Seven."

It may seem a leap from clinical practice to briefing politicians on economic surveys, or challenging industry trademarks, but this is where the battle lines are drawn. The objectives of the tobacco war are similar to those of most wars:

Principles of warfare	... in relation to the tobacco epidemic
To protect countries from being invaded and overpowered	..by the transnational tobacco companies
To save people from being killed	.. by tobacco
To return land to growing food	.. instead of tobacco
To improve the economy	.. by reducing tobacco-attributable health care costs, lost productivity, costs of fires caused by careless smoking, clearing up litter, damage to property, etc
To protect the environment	.. by reducing deforestation caused by the use of wood to cure tobacco, fires, litter

The principles are similar to the model described in Sun Tzu's "Art of War,"⁹ but the tobacco war will be the longest in history. The key message is that the medical model is not enough, and health professionals who work only in curative medicine will never reduce the tobacco epidemic.



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Continuing Medical Education

At its 176th Meeting of 25 May 2006, the Council discussed the relevant enquiries from Fellows and decided that CME/CPD Points will not be awarded to online video-taped seminars. In addition, CME/CPD Points will not be awarded to Fellows who claim self-study by reading books.

Overseas Fellows please note that formal CME reports from national accreditation bodies should be submitted to the College on an annual basis on request by the College, since the CME Points obtained can also be accredited by the College. Overseas Fellows do not therefore have to complete the CME/CPD registry which should be only completed by local Fellows.

New Fellows Admission Ceremony, Royal College of Physicians (Edinburgh)

Professor Neil Douglas, PRCP(Edinburgh) and Professor KN Lai officiated at the Signing of the Roll ceremony for forty-one new Fellows from Hong Kong held on the 13 May 2006. The event was held at the Hong Kong Club.

The RCPE has over 10000 Fellows, Members and Associates in 87 countries, of which 52% are in the United Kingdom. Hong Kong has 487 Fellows which is the largest number in any country outside the UK.



The Officiating Party for the Roll Signing Ceremony: Prof. Philip Li as MC, Dr. Loretta Yam, Prof. WK Lam, Prof. Richard Yu, Prof. KN Lai with Prof. Neil Douglas (from Left to Right)



Prof. Neil Douglas addressing the Fellows of the Edinburgh College in the Edinburgh Room of the Hong Kong Club, the venue for the Roll Signing Ceremony.

Visits by the Presidents of the Royal College of Physicians (London)

In keeping with the tradition of strong friendly ties between the London College and our College, both the President-elect and current President of the RCP (London) visited Hong Kong in the recent two months.

Professor Ian Gilmore was elected President of the Royal College of Physicians on 10 April 2006. During his visit to Hong Kong, our Council hosted a dinner in his honour on 17 May, 2006. He has visited Hong Kong several times in the past as specialty board examiner and as an invited lecturer. Professor Ian Gilmore, who is currently a Professor of Medicine at Liverpool University, will take over from current President Professor Dame Carol Black at a New Fellows Ceremony on 25 July 2006.



Professor Ian Gilmore with the HKCP Council.

Professor Dame Carol Black has served as President since 2002. Recently, she was invited to speak at the Hong Kong Medical Forum on systemic sclerosis. We look forward to her return in October when she will deliver the Gerald Choa Memorial Lecture at the HKCP 20th Anniversary Annual Scientific Meeting.



Professor Dame Carol Black with Professor Richard Yu

Specialty Update

Cardiology

Cardiac Resynchronization Therapy: The Unique Role of Research in Hong Kong

Prof Cheuk-Man YU

Division of Cardiology
The Chinese University of Hong Kong

INTRODUCTION

Device therapy for heart failure is a rapidly evolving area in cardiovascular medicine. Among the established device therapies, biventricular pacemaker therapy, or cardiac resynchronization therapy (CRT), is a clinically important and rapidly developing area. This therapy is characterized by implanting a left ventricular (LV) lead, typically through the coronary sinus, into the lateral or postero-lateral cardiac vein to pace the LV free wall region. Resynchronization is achieved by pacing the LV simultaneously by the LV and right ventricular leads, with the liaison of atrial contraction by the right atrial lead.

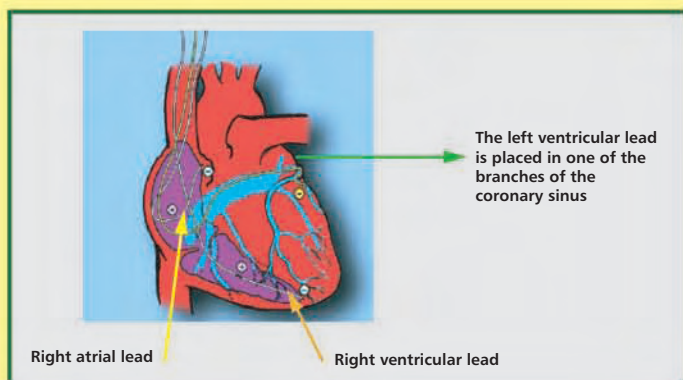


Figure 1 Biventricular pacemaker therapy

Indications of CRT include patients with advanced New York Heart Association class III or IV heart failure symptoms despite optimal medical therapy, enlarged LV with ejection fraction <35%, and prolonged QRS duration of >120ms. Nowadays this device can be implanted as standalone pacemaker or in combination with defibrillator therapy. CRT has its uniqueness in which cardiologists from at least 3 major subspecialties are involved in the management of patients, namely heart failure physicians, electrophysiologists and echocardiographic experts. In fact, echocardiography serves a vital role throughout the management from pre-implant assessment, device optimization, evaluation of treatment efficacy and finally the prediction of favorable response.

The evidence of benefits of CRT has been compelling, which include improvement of heart failure symptoms, functional capacity as well as long-term prognosis such as heart failure re-hospitalization, sudden cardiac death and all-cause mortality.^{1,2}

Furthermore, it benefits the heart by improving contractile (systolic) function as well as regressing LV enlargement process, the so called "reverse remodeling" effect.³

Despite the convincing benefits of CRT which is now recommended as one of the standard therapies for heart failure by the American Heart Association / American College of Cardiology as well as European Society of Cardiology, about one-third of patients do not respond favorably to CRT.^{1,4} This is explained by the fact that ECG is not a sensitive marker to predict the presence of electrical activation delay in the LV or electromechanical coupling delay.⁵ This finding has also ignited a series of studies world-wide to examine further the potential predictors of "non-responders" to CRT.

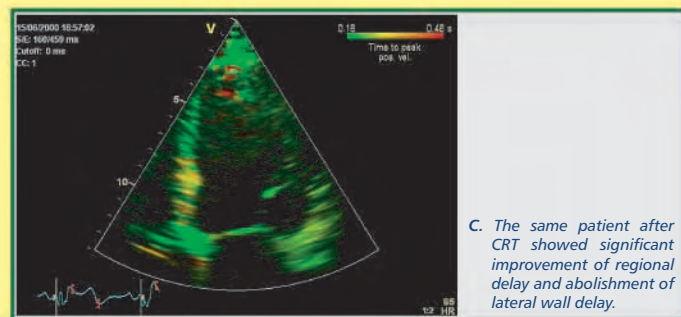
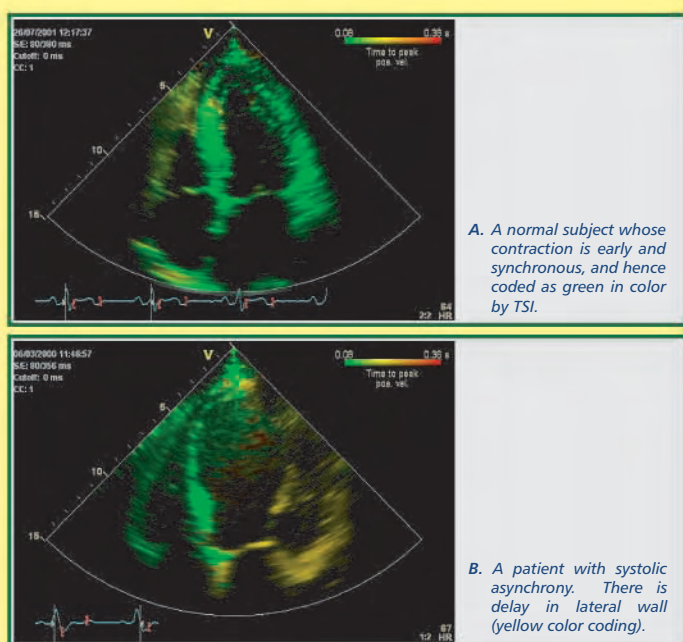
As a matter of fact, investigators in Hong Kong have been at the forefront of CRT research in a number of key areas. The following are some of the illustrations.

1. Hong Kong is the first city in the world that applied tissue Doppler imaging (TDI) to assess systolic asynchrony (uncoordinated contraction) in heart failure patients who received CRT. TDI is a special form of echocardiographic imaging modality that examined regional myocardial contraction and relaxation, and is able to measure the regional timing of myocardial events. A landmark study was conducted in Hong Kong which provided insight into the understanding of the mechanism how systolic synchronicity was achieved after CRT.³ The study illustrated that regional wall motion was homogenously delayed so that myocardial segments contracted in a belated but simultaneous manner.
2. Hong Kong was also the first in the world that applied TDI to develop the systolic Asynchrony Index, from which a cutoff value was defined which was useful to predict responders of CRT.⁶ When the Asynchrony Index was compared with other echocardiographic indices of systolic asynchrony, such as those parameters that examined a smaller number of segments or those derived by other echocardiographic technologies, it appeared that the Asynchrony Index has a highest sensitivity and specificity to predict LV reverse remodeling response.⁴ Currently multi-centre trials are on-going to determine what is the best echocardiographic predictor of CRT, in particular the PROSPECT study.⁷

- The application of real-time 3-dimensional echocardiography to assess systolic asynchrony is a potentially powerful tool. In fact, the first report was published by investigators in Hong Kong which incorporate this new tool to evaluate systolic asynchrony, and suggested a comprehensive method of assessing the condition.⁸ Interestingly, the indices derived from 3-dimensional echocardiography correlated closely with Asynchrony Index that was derived by TDI.
- The clinical importance of LV reverse remodeling in CRT was illustrated for the first time by our study that patients who had a 10% LV reverse remodeling after receiving CRT for 3 to 6 months were associated with a significantly better long-term prognosis. This include all-cause mortality, cardiovascular mortality, heart failure hospitalization and the composite end-point of mortality and cardiovascular hospitalizations.⁹
- One of the future directions in the CRT era is to consider extending the therapy to other heart failure groups, in particular those with normal QRS duration. This group belongs to about three-quarter of the total heart failure population. Pioneer research in Hong Kong has demonstrated for the first time by TDI technology that systolic asynchrony occurred in 43% of heart failure patients with normal QRS duration.¹⁰ Subsequently, this finding was confirmed by other studies with various echocardiographic techniques. Currently, pilot studies are ongoing to explore the potentially beneficial role of CRT in heart failure patients with narrow QRS duration who have coexisting systolic asynchrony by echocardiography.

There are other echocardiographic tools that are under development that are targeted to assess systolic asynchrony. Based on our concept that measures “the time to peak systolic velocity of myocardial contraction by TDI”, the regional delay in contraction resulting in asynchrony can be visualized as color coding on the echocardiographic images, a technique called “tissue synchronization imaging”.¹¹ This information allows a quick qualitative appreciation of regional delay, which is useful when employed in conjunction with Asynchrony Index (Figure 2).¹¹

Figure 2 Tissue synchronization imaging (TSI) to visualize regional delay in myocardial contraction. The measured parameter of “time to peak systolic contraction” was transformed into color codes: early as green color, and progressive delay as yellow, orange and red.



There is a continuous quest for more accurate identification of responders of CRT so as to reduce the number of non-responders and improve the cost-effectiveness of the therapy.^{12,13} Echocardiography holds the future as it is non-invasive, readily available, and serial assessment is harmless for patients implanted with devices. With the continuous development of various device therapies for heart failure, patients who are classified as “no option” group previously are now subjected to new opportunities and new lives.

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Medicine in the News

Hyponatraemia in Marathon Runners

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After the first report of two ultramarathon runners with symptomatic hyponatraemia in 1981, the past two decades in clinical sports medicine have been witness to increasing case reports, followed by more thorough understanding of exercise-induced hyponatraemia. The issues to consider include: what is exercise-induced hyponatraemia; how is hyponatraemia among marathon runners diagnosed; what causes exercise-induced hyponatraemia; can hyponatraemia in marathon runners be prevented, and if so, how; and are there guidelines for the runners to follow?

Exercise-induced hyponatraemia refers to the occurrence of hyponatraemia in individuals engaged in prolonged physical activity, and is defined by a serum or plasma sodium concentration below the normal reference range of the laboratory (less than 135 mmol/L in most laboratories).^{1,2} Marathon has been commonly implicated because exercise-induced hyponatraemia classically occurs in events lasting longer than four hours. Hyponatraemia among marathon runners, nevertheless, could be asymptomatic or manifests in non-specific manners and with marked variability with respect to individual susceptibility. Any athlete who exhibits possible signs and symptoms of hyponatraemia should be screened accordingly with rapid point-of-care testing in the field, or transferred to emergency room for laboratory test if the medical facilities at endurance events do not have onsite analysis of serum or plasma sodium concentration.

To understand the symptomatology of hyponatraemia, one should realize that a narrow physiologic range of sodium concentration is important in order to protect our brain. Symptoms of hyponatraemia are primarily neurological because the human brain is confined within the rigid cranial vault and thereby vulnerable to water movement or volume expansion. When serum sodium concentration falls, water movement from the extracellular space in cells (including the brain) causes cerebral swelling and thus the potential hazard of brain injury or hyponatraemic encephalopathy.³ In other words, hyponatraemic athletes might exhibit symptoms and signs of headache, nausea and vomiting, disorientation, confusion, obtundation, focal neurologic deficits or seizures. The osmotic water shift into the brain, if of sufficient magnitude or rapid enough, causes significant alteration of the central nervous system function due to cerebral oedema. One of its fatal sequelae reported among hyponatraemic marathon runners⁴, non-cardiogenic pulmonary oedema, refers to an increased flux of fluid and protein into the lung interstitium and air spaces, in the context of normal ventricular systolic function, diastolic function and normal valvular function. Conversely, respiratory insufficiency or hypoxia is recently thought to impair the ability of the brain to volume regulate by virtue of appropriate outward movement of intracellular solutes and organic solutes. Although it remains unclear whether hypoxia is a cause or result of severe hyponatraemia, the weight of the literature supports that hypoxia in athletes with hyponatraemia is an ominous sign.^{4,5}



Putative mechanisms for exercise-induced hyponatraemia can be derived from a mathematician's perspective. In simple terms, serum sodium concentration refers to the quotient of "quantity of sodium" divided by a "volume of fluid". This begs the question of whether exercise-induced hyponatraemia is primarily due to loss of sodium (decreasing the numerator) or to an increase in total body water (increasing the denominator). The Nguyen-Kurtz equation is a recent development in the mathematics of predicting sodium concentration⁶, showing how the sodium concentration changes as a function of total body water, change in total body water, and change in the sum of exchangeable sodium and potassium. It is beyond the scope of this article to review these detailed calculations; the interested reader is directed to an excellent mathematical analysis by Weschler.⁷ Briefly, it has been shown that for a person with total body water of 50 litres, a net increase of 1-litre water lowers the sodium concentration by 3.2 mmol/L, whereas a loss of 159 mmol of sodium plus potassium (roughly equivalent to 1.5 teaspoons of table salt) would be required to produce the same effect.⁷ Stated alternatively, a low sodium concentration among marathon runners should better be conceptualized as "hyponatremia" or water excess, rather than as a deficit of sodium. In fact, current evidence ascribes exercise-induced hyponatraemia to a form of dilutional hyponatraemia or water retention, which is by far the most common form of hyponatraemia disorder.

In fact, excessive (hypotonic) fluid intake appears to be the most important risk factor of hyponatraemia among the major published series of exercise-induced hyponatraemia after marathon, ultramarathon and/or triathlon participation.⁸ To evaluate exercise-induced hyponatraemia using the design of observational field studies, all the participating athletes should preferably be recruited during a marathon race. This is because not all symptoms after marathon are caused by hyponatraemia, and not all hyponatraemic athletes are symptomatic. The best example comes from a recent prospective study¹ involving 488 Boston Marathon participants, among whom 13% and 0.6% had hyponatraemia (serum sodium concentration \leq 135 mmol/L) and critical hyponatraemia (sodium concentration \leq 120 mmol/L) respectively at the finish line. Multivariate analysis identified two most significant factors underlying hyponatraemia, namely, weight gain and longer racing time. This study focused on a large cohort of marathon runners as opposed to elite or ultraendurance runners. Perhaps the most important lesson from this article is the clinical evidence to support the pathophysiological link between excessive fluid consumption and hyponatraemia among athletes. Firstly, those who drink more would be expected to gain more weight. Secondly, the hypothesis that a slower pace during a marathon run means a longer period when water can be consumed every mile also makes sense in the context of water excess. Thus, the slow-paced athletes simply take more frequent "advantage" of water availability and consume larger volumes when they drink than do fast-paced runners.

In response to increased recognition about over-consumption of fluids by hyponatraemic athletes, the current guidelines by and large concern the principle of fluid drinking during exercise. To this

end, an international consensus conference on exercise-induced hyponatraemia has been convened in 2005², with particular emphasis on new guidelines for fluid replacement during exercise. According to the Exercise-Associated Hyponatremia Consensus Panel, the primary objective of preventing exercise-induced hyponatraemia is to avoid excessive fluid retention, as manifested by weight gain, during or after exercise. Two important general recommendations are endorsed to prevent hyponatraemia during prolonged exercise:

1. Athletes should drink only according to thirst (*ad libitum*), instead of following the conventional advice to "stay ahead of your thirst";
2. Athletes should use the USA Track and Field Federation (USATF) (the national governing body for track-and-field sports in the United States) guidelines⁹, or analogous methods, to estimate hourly sweat losses during exercise and avoid consuming amounts greater than this during endurance exercise events.

Concerning the second recommendation, marathon athletes are recommended to weigh themselves before and after training and adjust their fluid intake accordingly. If the runners gain significant weight, they should cut back on water intake until they find the right balance - long before the marathon race day. Actions to protect athletes from the tragic course of hyponatraemia should therefore focus on the education that gaining weight during exercise is a warning sign of excessive fluid intake. This statement has now been given grade A evidence according to another international panel of experts from the American College of Sports Medicine (ACSM) who convened a comprehensive evidence-based analysis in 2005.¹⁰ While we await further evidence for any role of electrolyte-containing sports drinks, there is no substitute for the advice to avoid over-drinking among marathon runners.

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MRCP Examination Dates

Joint HKCPIE/MRCP(UK) Part I

12 September 2006

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

26 & 27 July 2006

6 & 7 December 2006

PACES

23-27 October 2006

MRCP Pass Rates

Joint HKCPIE/MRCP(UK) Part I examinations from 2002 to 2006

	Attempt	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%)
Sep 05	24	15 (62.5%)
Jan 06	95	74 (80%)

Joint HKCPIE/MRCP(UK) Part II (Written) examination from 2002 to 2006

	Attempt	Pass
2 Jul 02	53	27 (51%)
13 Nov 02	50	24 (48%)
13 Aug 03	110	62 (56%)
10 Dec 03	54	31 (57%)
28 Jul 04	65	42 (65%)
8 Dec 04	46	32 (70%)
13 April 05	32	15 (47%)
27 July 05	76	56 (74%)
7 & 8 Dec 05	26	16 (62%)
12 & 13 April 06	29	13 (45%)

PACES examinations from 2001 to 2006

October 2001	36/72 = 50%
February 2002	34/74 = 46%
October 2002	29/72 = 40%
February 2003	30/69 = 43%
October 2003	27/59 = 46%

March 2004	39/64 = 61%
October 2004	26/69 = 38%
March 2005	35/75 = 47%
October 2005	28/75 = 37%
March 2006	36/75 = 48%

PACES Pass List

Congratulations to our doctors who will receive the Intermediate Examination Certificate at the coming AGM on 14 October 2006

October 2005

CHAN Chun Kong	CHAN Hiu Fai
CHAN Yuen Sze	CHENG Hon Wai
CHEUNG Chun Yu	CHEUNG Ling Ling
FOK Man Chun, Juliana	HO Kwok Yip
HO Ling Yin	HSU Shing Jih, Axel
KAN Yee Man	KO Kwok Chun, Jason
KWOK Chi Lok, Stephen	LEUNG Kwok Chuen, Dennis
LOO King Fan, Steven	LI Richard
MAK Wai Han, Maria	NG So Shan
SIN Wing Yin, Winnie	TANG Kai Yan, Gloria
TSE Choi Ting	TSUI Zen Ying, Phillippa
WONG Lai Sze, Alice	WONG Pui Yan, Stella
WONG Shiao Yi	WONG Tai Chiu
WONG Yuet Lin, Elaine	YEUNG Hon Cheung

March 2006

CHAN Chi Yuen	CHAN Ka Hing, Jacky
CHAN Pak Hei	CHAN Siu Kim
CHAN Yin Yan, Anne	CHANG Mee
CHAU Ka Yee	CHEN Pak Lam, Sammy
CHENG Ka Shing	CHEUNG Shing Him
CHU Pui Shan, Jenny	CHUI Ka Lung
CHUI Shing Fung	HAI Siu Han, JoJo
HAU Kai Ching	HO Kwok Tung
HWANG Yu Yan	KWOK Lai Wa
LAM Ching Yu	LAM Ho
LEE Wei Sze, Eleanor	LO Chi Hung
LO Ka Yip	LO Kwok Chi
LOONG Ho Fung, Herbert	MOK Ka Wai, Alice
NG Man Yuk	SHUM Rocky
SIU Ka Fai, Danny	SZE Shun Fung
TSANG Ho Kai, Patrick	Wan Chi Kin
WONG Hung Fan	WONG Wai Kwan
YU Ka Lung, Carrel	YUEN Pui Kei

Statistics on No. of Fellows in all Specialties

Updated in March 2006

		FELLOWS										
		HONG KONG EAST CLUSTER				HONG KONG WEST CLUSTER					HONG KONG EAST + WEST CLUSTER	
SPECIALTY	FELLOWS TOTAL (PP/DH/HA/OTHERS)	PYNEH	RH	TWEH	Subtotal	FYKH	GH	QMH	TWH	Subtotal		
CARDIOLOGY	167	6	2	0	8	0	5	9	0	14	22	
CRITICAL CARE MEDICINE	48	5	0	0	5	0	0	8	0	8	13	
DERMATOLOGY & VENEREOLOGY	73	0	0	0	0	0	0	1	0	1	1	
ENDOCRINOLOGY, DIABETES & METABOLISM	60	2	2	2	6	0	0	9	0	9	15	
GASTROENTEROLOGY & HEPATOLOGY	107	6	2	0	8	0	0	9	1	10	18	
GERIATRIC MEDICINE	140	6	12	4	22	3	0	5	0	8	30	
HAEM/HAEM ONCOLOGY	38	2	0	0	2	0	0	9	0	9	11	
IMMUNOLOGY & ALLERGY	6	0	0	0	0	0	0	1	0	1	1	
INFECTIOUS DISEASE	20	1	0	0	1	0	0	1	1	2	3	
INTERNAL MEDICINE	823	37	24	7	68	1	6	69	9	85	153	
MEDICAL ONCOLOGY	32	0	0	0	0	0	0	7	0	7	7	
NEPHROLOGY	95	6	0	0	6	0	0	8	2	10	16	
NEUROLOGY	64	4	3	0	7	0	0	5	1	6	13	
PALLIATIVE MEDICINE	13	0	1	0	1	0	2	0	0	2	3	
REHABILITATION	39	0	3	3	6	1	0	1	4	6	12	
RESPIRATORY MEDICINE	130	7	8	0	15	0	10	9	1	20	35	
RHEUMATOLOGY	39	3	2	1	6	0	0	3	2	5	11	

		FELLOWS														
		KOWLOON CENTRAL CLUSTER			KOWLOON EAST CLUSTER				KOWLOON WEST CLUSTER					KOWLOON CENTRAL + EAST + WEST CLUSTER		
SPECIALTY	FELLOWS TOTAL (PP/DH/HA/OTHERS)	KH	QEH	Subtotal	HOHH	TKOH	UCH	Subtotal	CMC	KWH	OLMH	PMH	WTSH		YCH	Subtotal
CARDIOLOGY	167	0	11	11	0	1	5	6	1	6	1	6	0	3	17	34
CRITICAL CARE MEDICINE	48	0	5	5	0	1	4	5	4	2	0	1	0	2	9	19
DERMATOLOGY & VENEREOLOGY	73	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
ENDOCRINOLOGY, DIABETES & METABOLISM	60	0	5	5	0	1	3	4	2	2	1	4	0	1	10	19
GASTROENTEROLOGY & HEPATOLOGY	107	0	6	6	0	3	2	5	5	6	1	12	0	6	30	41
GERIATRIC MEDICINE	140	5	3	8	6	2	11	19	8	8	1	10	4	5	36	63
HAEM/HAEM ONCOLOGY	38	0	5	5	0	1	1	2	0	0	0	2	0	0	2	9
IMMUNOLOGY & ALLERGY	6	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
INFECTIOUS DISEASE	20	0	1	1	0	0	0	0	0	0	0	5	0	1	6	7
INTERNAL MEDICINE	823	6	56	62	7	14	35	56	25	32	5	54	3	22	141	259
MEDICAL ONCOLOGY	32	0	1	1	0	0	0	0	0	0	0	1	0	0	1	2
NEPHROLOGY	95	0	7	7	2	2	4	8	2	5	0	7	0	2	16	31
NEUROLOGY	64	0	8	8	0	1	3	4	0	4	1	3	1	0	9	21
PALLIATIVE MEDICINE	13	0	0	0	3	0	1	4	4	0	0	0	0	0	4	8
REHABILITATION	39	6	0	6	1	0	3	4	1	1	0	2	4	0	8	18
RESPIRATORY MEDICINE	130	7	7	14	5	3	3	11	3	3	0	4	6	1	17	42
RHEUMATOLOGY	39	1	2	3	0	0	2	2	1	1	0	3	0	1	6	11

		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	Subtotal	POH	TMH	Subtotal	
CARDIOLOGY	167	3	2	8	0	0	13	0	9	9	22
CRITICAL CARE MEDICINE	48	2	2	1	0	0	5	0	3	3	8
DERMATOLOGY & VENEREOLOGY	73	0	0	1	0	0	1	0	0	0	1
ENDOCRINOLOGY, DIABETES & METABOLISM	60	2	1	10	0	0	13	0	1	1	14
GASTROENTEROLOGY & HEPATOLOGY	107	2	2	6	0	0	10	0	8	8	18
GERIATRIC MEDICINE	140	2	1	4	4	5	16	1	11	12	28
HAEM/HAEM ONCOLOGY	38	0	0	3	0	0	3	0	5	5	8
IMMUNOLOGY & ALLERGY	6	0	0	0	0	0	0	0	0	0	0
INFECTIOUS DISEASE	20	1	0	1	0	0	2	0	3	3	5
INTERNAL MEDICINE	823	18	13	51	4	6	92	2	57	59	151
MEDICAL ONCOLOGY	32	0	0	11	0	0	11	0	0	0	11
NEPHROLOGY	95	3	0	5	0	1	9	0	7	7	16
NEUROLOGY	64	1	2	5	0	0	8	0	3	3	11
PALLIATIVE MEDICINE	13	0	0	0	1	0	1	0	0	0	1
REHABILITATION	39	0	0	2	1	2	5	1	3	4	9
RESPIRATORY MEDICINE	130	3	3	6	0	1	13	0	7	7	20
RHEUMATOLOGY	39	1	0	3	0	2	6	0	1	1	7



Statistics on No. of Trainees in all Specialties

Updated in March 2006

SPECIALTY	TRAINEES TOTAL (PP/DH/HA/ OTHERS)	TRAINEES												
		HONG KONG EAST CLUSTER						HONG KONG WEST CLUSTER						
		PYNEH		RH		TWEH		FYKH		GH		QMH		TWH
YEAR														
CARDIOLOGY	22	1 2 3 4-I	1 2 3 4-II	1-I 2 3 4	3 2 2 0	1 2 3 4	0 0 0 0	1 2 3 4	0 2 3 4	1 2 3 4	0 1 3 6	1 2 3 4	0 2 3 4	
CRITICAL CARE MEDICINE	14	1-II 2-I 3 4-I	4 2 3 4	1 2 3 4	0 2 3 0	1 2 3 4	0 0 0 0	1 2 3 4	0 2 3 0	1 2 3 4	0 1 3 0	1 2 3 4	0 2 3 0	
DERMATOLOGY & VENEREOLOGY	7	1 2 3 4	0 2 3 4	1 2 3 4	0 2 3 0	1 2 3 4	0 0 0 0	1 2 3 4	0 2 3 0	1 2 3 4	0 0 0 0	1 2 3 4	0 2 3 0	
ENDOCRINOLOGY, DIABETES & METABOLISM	18	1 2 3 4	0 2 3 4	1 2 3 4	0 2 3 1	1 2 3-I 4	1 2 3 2	0 0 4 4	1 2 3 0	1 2 3 0	0 1 3 0	1 2 3 6	1 2 3 4	
GASTROENTEROLOGY & HEPATOLOGY	16	1 2 3-I 4	1 2 3 5	1 2 3 4	0 2 3 2	1 2 3 4	0 0 0 0	1 2 3 4	0 2 3 0	1 2 3 4	0 1 3 0	1 2 3 7	1 2 3 4	
GERIATRIC MEDICINE	12	1 2-I 3-I 4	2 2 3 5	1 2 3 4	0 2 3 II	1 2 3 4	0 0 3 3	1 2 3 4	0 2 3 0	1 2 3 4	0 1 3 0	1 2 3 2	1 2 3 4	
HAEM/HAEM ONCOLOGY	7	1 2-I 3 4	1 2 3 4	1 2 3 4	0 2 3 0	1 2 3 4	0 0 0 0	1 2 3 4	0 2 3 0	1 2 3 4	0 1 3 0	1 2 3 8	1 2 3 4	
IMMUNOLOGY & ALLERGY	0	1 2 3 4	0 2 3 4	1 2 3 4	0 2 3 0	1 2 3 4	0 0 0 0	1 2 3 4	0 2 3 0	1 2 3 4	0 1 3 0	1 2 3 1	0 2 3 4	
INFECTIOUS DISEASE	8	1 2-I 3 4	1 2 3-I 4	1 2 3-I 4	1 2 3 0	1 2 3 4	0 0 0 0	1 2 3 4	0 2 3 0	1 2 3 4	0 1 3 0	1 2 3 0	1 2 3 4	
INTERNAL MEDICINE	163	1-I 2-V 3-III 4-III	12 2 3 26	1-II 2 3-I 4-II	5 2 3-I 18	1 2 3-I 4-III	4 1 5 5	1 2-I 3 4	1 2 3 1	1 2 3 4	0 0 4 4	1-VI 2-III 3-II 4-II	13 2 3 43	1 2 3 4
MEDICAL ONCOLOGY	6	1 2 3 4	0 2 3 4	1 2 3 4	0 2 3 0	1 2 3 4	0 0 0 0	1 2 3 4	0 2 3 0	1 2 3 4	0 1 3 0	1 2 3 6	1 2 3 4	
NEPHROLOGY	10	1 2 3 4	0 2 3 4	1 2 3 4	0 2 3 0	1 2 3 4	0 0 0 0	1 2 3 4	0 2 3 0	1 2 3 4	0 1 3 0	1 2 3 5	1 2 3 4	
NEUROLOGY	13	1 2-I 3 4	1 2 3 4	1 2 3 4	0 2 3 3	1 2 3 4	0 0 0 0	1 2 3 4	0 2 3 0	1 2 3 4	0 1 3 0	1 2 3 4	1 2 3 4	
PALLIATIVE MEDICINE	2	1 2 3 4	0 2 3 4	1 2 3 4	0 2 3 1	1 2 3 4	0 0 0 0	1 2 3 4	0 2 3 2	1 2 3 4	0 1 3 0	1 2 3 0	1 2 3 4	
REHABILITATION	4	1 2 3 4	0 2 3 4	1 2 3 4	0 2 3 3	1 2 3 4	0 0 2 0	1 2 3 4	0 2 3 0	1 2 3 4	0 1 3 0	1 2 3 0	1 2 3 4	
RESPIRATORY MEDICINE	22	1-I 2-I 3 4	2 2 3 4	1-I 2 3 4	1 2 3 5	1 2 3 4	0 0 0 0	1 2 3 4	0 2 3 4	1 2 3 4	1 1 3 7	1 2 3 4	0 2 3 5	
RHEUMATOLOGY	8	1 2-I 3 4	1 2 3 4	1 2 3 4	0 2 3 1	1 2 3 4	0 0 0 0	1 2 3 4	0 2 3 0	1 2 3 4	0 1 3 0	1 2 3 2	1 2 3 4	

SPECIALTY	TRAINEES TOTAL (PP/DH/HA/ OTHERS)	TRAINEES																					
		KOWLOON CENTRAL CLUSTR		KOWLOON EAST CLUSTER					KOWLOON WEST CLUSTER														
		KH	QEH	HOHH	TKOH	UCH	CMC	KWH	OLMH	PMH	WTSH	YCH											
		YEAR		YEAR					YEAR														
CARDIOLOGY	22	1 2 3 4	0 1-1 3 4	3 2-1 3 9	1 2 3 4	0 2 3 0	1 2 3 1	0 2 3 4	1 2 3 4	2 2-1 3 4	1 2 3-1 4	1 2 3 4	0 2-1 3 4	1 2 3 4	1 2 3 4	0 2 3 4	1 2 3 4	1 2 3 4	0 2 3 4	1 2 3 4	1 2 3 4		
CRITICAL CARE MEDICINE	14	1 2 3 4	0 1-1 3 5	1 2 3 4	0 2 3 0	1 2 3 1	0 2 3 4	1 2 3 4	3 2-II 3 4	1 2-1 3 4	1 2-1 3 4	2 3 3-1 4	1 2 3 0	0 2-1 3 4	1 2 3 1	2 3 3-1 4	1 2 3 4	0 2 3 4	1 2 3 4	0 2 3 4	1 2 3 4	0 2 3 2	
DERMATOLOGY & VENEREOLOGY	7	1 2 3 4	0 1 3 0	1 2 3 0	0 2 3 4	1 2 3 0	0 2 3 4	1 2 3 0	0 2 3 4	0 2 3 4	0 2 3 4	1 2 3 4	0 2 3 4	0 2 3 4	1 2 3 4	0 2 3 4	0 2 3 4	1 2 3 4	0 2 3 4	0 2 3 4	1 2 3 4	0 2 3 0	
ENDOCRINOLOGY, DIABETES & METABOLISM	18	1 2 3 4	0 1-II 3 5	1 2 3 4	0 2 3 0	1 2 3 4	0 2 3 4	1 2 3 1	2 2 3 4	1 2 3 4	1 2 3-1 4	1 2 3 4	0 2 3 1	1 2 3 4	0 2 3 4	1 2 3 3	0 2 3 4	1 2 3 4	0 2 3 4	1 2 3 4	0 2 3 4	1 2 3 1	
GASTROENTEROLOGY & HEPATOLOGY	16	1 2 3 4	0 1-1 3 4	1 2 3 6	1 2 3 4	0 2 3 0	1 2 3 4	1 2-1 3 2	1 2 3 4	1 2 3 2	1 2 3 4	1 2 3 5	0 2 3 4	1 2-1 3 10	1 2 3 4	1 2 3 4	0 2 3 4	1 2 3 4	0 2 3 4	1 2 3 4	1 2-1 3 4	1 2 3 2	
GERIATRIC MEDICINE	12	1 2-1 3-1 4	2 1 3 4	1 2 3 3	0 2 3 4	1 2 3-1 6	1 2 3 4	0 2 3 1	1 2 3 4	1 2-1 3 9	1 2 3 4	1 2-1 3 6	1 2 3 6	0 2 3 4	1 2 3-1 9	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	0 2 3 4	1 2 3 4	1 2 3 3	0 2 3 3
HAEM/HAEM ONCOLOGY	7	1 2 3 4	0 1-1 3-1 4	1 2 3 3	2 1 3 0	1 2 3 4	0 2 3 1	1 2 3 4	0 2 3 1	0 2 3 4	1 2 3 1	0 2 3 4	1 2 3 0	1-1 2 3-1 4	2 2 3 1	1 2 3 4	0 2 3 4	1 2 3 4	0 2 3 4	1 2 3 4	0 2 3 4	1 2 3 0	
IMMUNOLOGY & ALLERGY	0	1 2 3 4	0 1 3 0	1 2 3 0	0 2 3 0	1 2 3 4	0 2 3 0	1 2 3 4	0 2 3 0	1 2 3 4	0 2 3 0	1 2 3 4	0 2 3 0	1 2 3 0	0 2 3 0	1 2 3 4	0 2 3 4	1 2 3 4	0 2 3 4	0 2 3 4	1 2 3 0	0 2 3 0	
INFECTIOUS DISEASE	8	1 2 3 4	0 1-1 3 0	1 2 3 0	1 2 3 0	0 2 3 4	1 2 3 4	0 2 3 0	1 2 3 4	0 2 3-1 4	2 2 3 0	1 2 3 4	0 2 3 4	1 2 3 0	1 2 3 5	0 2 3 4	1 2 3 4	0 2 3 4	1 2 3 4	0 2 3 4	1 2 3 4	0 2 3 1	
INTERNAL MEDICINE	163	1 2 3 4	0 1-VI 2-III 3-IV 4	17 2 3 45	1 2-1 3 4	1 2 3-1 5	1 2-1 3-1 4-II 13	6 2-1 3-1 4-V 26	1 2-1 3-1 4-V 26	17 2-1 3-1 4-V 26	1 2-1 3-1 4-V 26	1 2-1 3-1 4-V 26	8 2-1 3-1 4-V 19	1 2-1 3-1 4 24	12 2-1 3-1 4 3	1 2-1 3-1 4 43	9 2-1 3-1 4 43	1 2 3 4-1 2	1 2 3 4-1 2	1 2 3 4-1 2	1 2-1 3 4-1 17	4 2-1 3 4-1 17	
MEDICAL ONCOLOGY	6	1 2 3 4	0 1-1 3 0	1 2 3 0	1 2 3 4	0 2 3 0	1 2 3 4	0 2 3 0	1 2 3 4	0 2 3 0	1 2 3 4	0 2 3 4	1 2 3 0	1 2 3 4	0 2 3 4	1 2 3 4	0 2 3 4	1 2 3 4	0 2 3 4	1 2 3 4	0 2 3 4	1 2 3 0	
NEPHROLOGY	10	1 2 3 4	0 1-1 3 5	1 2 3 4	1 2 3 0	0 2 3 4	1 2 3 1	0 2 3 4	1 2 3-1 4	1 2 3-1 3	2 2 3-1 4	1 2 3 4	1 2 3 5	1 2 3-1 4	1 2 3 6	1 2 3 4	1 2 3 4	0 2 3 4	1 2 3 4	0 2 3 4	1 2 3 4	0 2 3 1	
NEUROLOGY	13	1 2 3 4	0 1 3 5	1 2 3 4	0 2 3 0	1 2 3 4	0 2-1 3 1	1 2 3 4	1 2-1 3 4	1 2 3 2	1 2 3 4	1 2 3-1 4	0 2 3 4	1 2 3 4	0 2 3 4	1 2 3 4	0 2 3 4	1 2 3 4	0 2 3 4	1 2 3 4	0 2-1 3 4	1 2 3 0	
PALLIATIVE MEDICINE	2	1 2 3 4	0 1 3 0	1 2 3 0	0 2-1 3 4	1 2 3 4	0 2 3 4	1 2 3 4	0 2 3 4	0 2-1 3 4	1 2 3 4	0 2 3 4	1 2 3 4	0 2 3 4	1 2 3 4	0 2 3 4	1 2 3 4	0 2 3 4	1 2 3 4	0 2 3 4	1 2 3 4	0 2 3 0	
REHABILITATION	4	1 2-1 3-1 4	2 1 3 3	1 2 3 0	0 2 3 4	1 2 3 4	0 2 3 4	1 2 3 4	0 2 3 4	1 2 3 4	0 2 3 4	1 2 3 4	0 2 3 4	1 2 3 4	0 2 3 4	1 2 3 4	0 2 3 4	1 2 3 4	0 2 3 4	1 2 3 4	0 2 3 4	1 2 3 0	
RESPIRATORY MEDICINE	22	1 2 3 4	0 1 3-1 6	1 2 3 4	1 2 3-1 4	1 2 3 4	1 2-1 3 4	1 2 3 4	2 2-1 3 4	2 2 3 4	1 2 3 4	1 2 3 4	0 2-1 3 4	1 2 3 4	0 2 3 4	1 2 3 4	0 2 3 4	1 2 3 4	0 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 1
RHEUMATOLOGY	8	1 2 3 4	0 1-1 2 1	2 2 3 4	1 2 3 0	0 2 3 4	1 2 3 4	0 2 3 4	1 2 3 4	1 2 3-1 4	1 2 3 4	1 2 3 4	0 2 3 4	1 2 3 4	0 2 3 4	1 2 3 4	0 2 3 4	1 2 3 4	0 2 3 4	1 2 3 4	0 2 3 4	1 2 3 0	

		TRAINEES										
		NEW TERRITORIES EAST CLUSTER					NEW TERRITORIES WEST CLUSTER					
SPECIALTY	TRAINEES TOTAL (PP/DH/HA/ OTHERS)	AHNSH	NDH	PWH	SH	TPH	POH	TMH				
		YEAR					YEAR					
CARDIOLOGY	22	1 0 2 2 3 3 4 2	1-I 2 2 2 3 3 4-I 2	1-I 3 2-I 3 3-I 3 4 5	1 0 2 0 3 0 4 0	1 0 2 0 3 0 4 0	1 0 2 0 3 0 4 0	1 0 2 0 3 0 4 0	1 0 2 0 3 0 4 0	1 0 2 0 3 0 4 0	1 0 2-I 1 3 3 4 6	1 0 2 0 3 0 4 0
CRITICAL CARE MEDICINE	14	1 0 2 2 3 3 4 1	1 0 2 0 3 2 4 2	1 0 2 0 3 1 4 1	1 0 2 0 3 0 4 0	1 0 2 0 3 0 4 0	1 0 2 0 3 0 4 0	1 0 2 0 3 0 4 0	1 0 2 0 3 0 4 0	1 0 2 0 3 0 4 0	1 0 2 0 3 0 4 0	1 0 2 0 3 0 4 0
DERMATOLOGY & VENEREOLOGY	7	1 0 2 2 3 3 4 0	1 0 2 2 3 3 4 0	1 1 2-I 2 3 3 4 0	1 0 2 0 3 0 4 0	1 0 2 0 3 0 4 0	1 0 2 0 3 0 4 0	1 0 2 0 3 0 4 0	1 0 2 0 3 0 4 0	1 0 2 0 3 0 4 0	1 0 2 0 3 0 4 0	1 0 2 0 3 0 4 0
ENDOCRINOLOGY, DIABETES & METABOLISM	18	1 0 2 2 3 3 4 1	1 1 2 2 3 3 4-I 1	1-I 3 2-I 2 3-I 3 4 9	1 2 2-I 2 3-I 3 4 0	1 0 2 0 3 0 4 0	1 0 2 0 3 0 4 0	1 0 2 0 3 0 4 0	1 0 2 0 3 0 4 0	1 0 2 0 3 0 4 0	1 1 2 2 3 3-I 4 1	1 1 2 2 3 3-I 4 1
GASTROENTEROLOGY & HEPATOLOGY	16	1 0 2 2 3 3 4 0	1 2 2-I 2 3-I 3 4 2	1-III 4 2 2 3-I 3 4 6	1 0 2 0 3 0 4 0	1 0 2 0 3 0 4 0	1 0 2 0 3 0 4 0	1 0 2 0 3 0 4 0	1 0 2 0 3 0 4 0	1 0 2 0 3 0 4 0	1-I 2 2 2 3-I 3 4 5	1-I 2 2 2 3-I 3 4 5
GERIATRIC MEDICINE	12	1 0 2 2 3 3 4 1	1 0 2 2 3 3 4 1	1 0 2 0 3 3 4 2	1 1 2-I 2 3 3 4 6	1 1 2 0 3 0 4 0	1 1 2 0 3 0 4 0	1 1 2 0 3 0 4 0	1 1 2 0 3 0 4 0	1 1 2 0 3 0 4 0	1 0 2 2 3 3 4 8	1 0 2 2 3 3 4 8
HAEM/HAEM ONCOLOGY	7	1 0 2 2 3 3 4 0	1 0 2 2 3 3 4 0	1 0 2 0 3 3 4 3	1 0 2 0 3 0 4 0	1 0 2 0 3 0 4 0	1 0 2 0 3 0 4 0	1 0 2 0 3 0 4 0	1 0 2 0 3 0 4 0	1 0 2 0 3 0 4 0	1-I 1 2 2 3 3 4 2	1-I 1 2 2 3 3 4 2
IMMUNOLOGY & ALLERGY	0	1 0 2 2 3 3 4 0	1 0 2 2 3 3 4 0	1 0 2 0 3 0 4 0	1 0 2 0 3 0 4 0	1 0 2 0 3 0 4 0	1 0 2 0 3 0 4 0	1 0 2 0 3 0 4 0	1 0 2 0 3 0 4 0	1 0 2 0 3 0 4 0	1 0 2 0 3 0 4 0	1 0 2 0 3 0 4 0
INFECTIOUS DISEASE	8	1 0 2 2 3 3 4 1	1 0 2 2 3 3 4 0	1-I 1 2 2 3 3 4 1	1 0 2 0 3 0 4 0	1 0 2 0 3 0 4 0	1 0 2 0 3 0 4 0	1 0 2 0 3 0 4 0	1 0 2 0 3 0 4 0	1 0 2 0 3 0 4 0	1 0 2 2 3 3 4-I 2	1 0 2 2 3 3 4-I 2
INTERNAL MEDICINE	163	1 3 2 2 3-I 3 4-II 12	1-IV 10 2-II 2 3-I 3 4-III 10	1-VII 16 2-III 2 3-V 3 4-I 38	1-I 7 2-III 2 3-II 3 4-I 5	1 2 2 2 3 3 4-II 5	1 0 2 0 3 0 4 2	1 0 2 0 3 0 4 2	1 0 2 0 3 0 4 2	1 0 2 0 3 0 4 2	1-II 9 2-III 2 3-II 3 4-II 39	1-II 9 2-III 2 3-II 3 4-II 39
MEDICAL ONCOLOGY	6	1 0 2 2 3 3 4 0	1 0 2 2 3 3 4 0	1 3 2-II 2 3 3 4-I 6	1 0 2 0 3 0 4 0	1 0 2 0 3 0 4 0	1 0 2 0 3 0 4 0	1 0 2 0 3 0 4 0	1 0 2 0 3 0 4 0	1 0 2 0 3 0 4 0	1 0 2 2 3 3 4 0	1 0 2 2 3 3 4 0
NEPHROLOGY	10	1 1 2 2 3 3 4-I 2	1 0 2 2 3 3 4 0	1 1 2 2 3-I 3 4 5	1 0 2 0 3 0 4 0	1 0 2 0 3 0 4 0	1 0 2 0 3 0 4 0	1 0 2 0 3 0 4 0	1 0 2 0 3 0 4 0	1 0 2 0 3 0 4 0	1 0 2 2 3 3 4 5	1 0 2 2 3 3 4 5
NEUROLOGY	13	1 1 2 2 3-I 3 4 1	1-I 1 2 2 3 3 4 1	1 1 2-I 2 3 3 4 4	1 2 2 0 3-I 3 4 0	1 0 2 0 3 0 4 0	1 0 2 0 3 0 4 0	1 0 2 0 3 0 4 0	1 0 2 0 3 0 4 0	1 0 2 0 3 0 4 0	1 0 2 2-I 3 3 4 1	1 0 2 2-I 3 3 4 1
PALLIATIVE MEDICINE	2	1 0 2 2 3 3 4 0	1 0 2 2 3 3 4 0	1 1 2 2 3 3 4 0	1 0 2 0 3 0 4 0	1 0 2 0 3 0 4 0	1 0 2 0 3 0 4 0	1 0 2 0 3 0 4 0	1 0 2 0 3 0 4 0	1 0 2 0 3 0 4 0	1 0 2 2 3 3 4 0	1 0 2 2 3 3 4 0
REHABILITATION	4	1 0 2 2 3 3 4 0	1 0 2 2 3 3 4 0	1 0 2 2 3 3 4 2	1 0 2 0 3 0 4 0	1 0 2 0 3 0 4 0	1 0 2 0 3 0 4 0	1 0 2 0 3 0 4 0	1 0 2 0 3 0 4 0	1 0 2 0 3 0 4 0	1 2 2 2-I 3 3-I 4 1	1 2 2 2-I 3 3-I 4 1
RESPIRATORY MEDICINE	22	1 0 2 2 3 3 4 3	1-II 3 2-I 2 3 3 4 3	1 1 2 2 3-I 3 4 4	1 1 2 0 3 0 4 0	1 1 2 0 3 0 4 0	1 0 2 0 3 0 4 1	1 0 2 0 3 0 4 1	1 0 2 0 3 0 4 1	1 0 2 0 3 0 4 1	1 2 2 2 3 3 4-II 5	1 2 2 2 3 3 4-II 5
RHEUMATOLOGY	8	1 0 2 2 3 3 4 0	1 0 2 2 3 3 4 0	1 0 2 2 3 3 4 3	1 0 2 0 3 0 4 0	1 0 2 0 3 0 4 0	1 1 2 0 3-I 3 4 1	1 1 2 0 3-I 3 4 1	1 0 2 0 3 0 4 0	1 0 2 0 3 0 4 0	1 0 2 2 3 3 4 1	1 0 2 2 3 3 4 1

* Total No. of trainees is shown in upper right corner of each hospital

** No. of trainees is shown in italics & bold in lower right corner of each hospital

SPECIALTY	TRAINEES TOTAL (PP/DH/HA/OTHERS)	TRAINEES	
		DH	
DERMATOLOGY & VENEREOLOGY	7	1 2—IV 3 4—II	6 13
INTERNAL MEDICINE	163	1 2 3—I 4	1 <i>0</i>
IMMUNOLOGY & ALLERGY	0	1 2 3 4	0 2
RESPIRATORY MEDICINE	22	1 2 3 4	0 5

* Total No. of trainees is shown in upper right corner of each hospital

** No. of trainees is shown in italics & bold in lower right corner of each hospital



Voluntary Medical Work in Heqing, China

Dr Grace Wong Resident, Department of Medicine and Therapeutics, Prince of Wales Hospital

A small team of Christian doctors from our department traveled to the Heqing County (鹤庆县) hospital to offer medical training. Heqing was a small but pretty county in rural part of Yunnan, China. The county hospital served a population of 260,000 people.

Our first trip was in 2004, after the SARS outbreak. Medical Services International (MSI), a Christian professional service organization, invited us to conduct an Infectious Disease course. In January 2005, we were invited to offer a certificate course on common medical problems.

Our initial challenge was to overcome the 'language barrier'. We had to prepare the presentations in simplified Chinese and deliver the talks in Mandarin! Some of us took Mandarin lessons but others relied on our accompanying spouses as voluntary translators.

It was a cold night when we arrived at Heqing. We received a warm welcome by the Scharfschwerdt family from Germany. The couple, Eckehard and Silke, a family physician and paediatrician, have lived in Heqing since 2001. Both are Christians sent by the MSI to serve for the poor. We were amazed that their Mandarin was more fluent than ours.

Early next morning, we delivered six one-hour lectures. The audience included doctors, nurses and medical students. The attendants were enthusiastic to know the updated practice in Hong Kong, despite being limited by their resources. An example was treating all stroke patients as haemorrhagic strokes due to the lack of a CT scanner. Only a minority receive a CT brain scan a few days later in Kunming. During group tutorials, we discussed case scenarios. Despite being rather shy in presenting their management plans, their answers were appropriate. They valued our lectures and appreciated our efforts to communicate in Mandarin.

We visited the wards during meal breaks. It was interesting that family members of patients were able to stay in the wards and cook for them during their hospitalisation. Patients provided for their own necessities, including using their own blankets.

In the evening, the Chinese Medicine Hospital invited us to deliver talks on managing gastrointestinal bleeding and myocardial infarction. Even though our management approach was different, it was good to have an exchange of views.

This trip had provided us with a wonderful opportunity to show our support towards medical training in this small county hospital.

Taking the PACES examination in the United Kingdom

Dr Yannie Soo Department of Medicine, Prince of Wales Hospital

For those making that long journey to the United Kingdom for the PACES examination, here is some information that may help you plan your trip.

Arrange annual leave early

It is wise to reserve adequate annual leave before you take your Part II written. You will need at least 2 weeks if you intend to join the MRCP preparation courses.

Choosing the examination centre

The next decision I faced was the choice of the examination centre. While I have heard that it is more difficult to pass the examination in London, I found the prospects of encountering a thick Scottish accent in Glasgow or Edinburgh too daunting for me. After balancing the risks and benefits, I took my PACES in London and found the examiners there to be fair.

Examination date and documents

I found it useful to telephone the UK college secretaries to politely request for the examination date to fall within a defined period (e.g. over 3-5 days) so as to facilitate planning the flight and accommodation.

If you leave for the UK 1-2 weeks ahead of your examination date, you may not receive the examination details and *admission document* before your departure. I requested the college secretaries in UK to send these documents to me early. Alternatively, arrange for your colleagues or family in HK to fax it to you. As a last resort, you should be able to obtain them from the Royal College of Physicians office.

MRCP Courses in UK are expensive options

These are usually held a few weeks before PACES in various UK hospitals. They are intensive courses offering a wide exposure to many patients with classical as well as rare physical signs. However, they are very costly: a 2-day course costs around HK\$25,000; while a 4- or 5-day course costs around HK\$45,000. You may find the advertisements from the British Medical Journal or internet. If you take more than one course, because you will be seeing the same types of patients!

Hospital attachment

Alternatively, I arranged an attachment to a UK tertiary/teaching hospital and joined their bedside teaching sessions for 1-2 weeks before the examination. I found this experience tremendously useful, because I had many chances to practice and refine my examination and presentation skills with the local candidates (you will not have many opportunities to present in the above courses!). Through observation and discussion with them, you will learn a lot and become more confident in front of your patients and examiners (this is the key to success in your exam!).

To arrange this attachment, seek the help of doctors in your department who have links with UK physicians. This may prove more fruitful than sending out application letters on your own.

If you are registered with GMC, you will have a higher chance of success.

Other things to note

Be familiar with:

- 1) Giving instructions in English, particularly for the neurological exam.
- 2) Diseases that are common in Caucasians but rare in Asians. (e.g. Crohn's disease, Wilson's disease, Cystic Fibrosis, Porphyria etc.)
- 3) UK law concerning epilepsy and driving. (<http://www.dvla.gov.uk>)
- 4) Name of UK supporting groups for alcohol abstinence, epilepsy, HIV etc

Journey planning

Arrive early to allow time for jet lag. Be familiar with the local accent and transportation. If your examination centre is located in a remote area in London, stay close to the underground station for easy access to food/ restaurants or arrange accommodation close to the examination centre.

If the examination centre involves a long train journey from Central London, do check the train schedule and purchase your tickets early. The costs of train ticket may be 50% less if you buy your tickets early. Arrive at your examination venue 1 to 2 days earlier and it is helpful to make a pre-exam visit to your examination centre.

Wishing you success in your examination and good luck!

Hong Kong College of Physicians: 20th Anniversary Celebrations

Annual Scientific Meeting and 20th Anniversary Dinner (14-15 October, 2006)

You are invited to join our 20th anniversary celebrations at the Annual Scientific Meeting to be held at the Hong Kong Academy of Medicine.

The theme "Twenty Years of Excellence in Medicine" guarantees an exciting program packed with many distinguished speakers including Professor Dame Carol Black and Honorary Fellows of our College - Professor Lawrence KF Chan, Professor Lei-Shi Li, Dr CH Leong, Professor Lap-Chee Tsui and Professor NS Zhong. For an overview of advances in medicine, each sub-specialty board of the College has nominated a representative to deliver update lectures. The outstanding research work by our Fellows will be presented at the Sir David Todd Lecture and the Distinguished Young Investigator Award sessions.

The highlight event will be our 20th Anniversary dinner. The AJS McFadzean Oration will be presented during the dinner by The Honourable Mr. Wong Yan-lung, Secretary for Justice, HKSAR. In addition, Professor Richard Yu will share his memoirs of the past twenty years of the College with unforgettable photos. As a revolutionary step into the future, College portal on the web will be launched that evening. This will enable Members and Fellows to have online access to their membership, CME and training records. For lighter entertainment, the program will feature a 'Face Change' performance as well as prize presentation of the winner of the logo contest.

HONG KONG COLLEGE OF PHYSICIANS

TWENTY YEARS OF EXCELLENCE IN MEDICINE

14 October (Saturday)

10:00 – 18:00	Registration	
10:00 – 11:00	Distinguished Research Paper Award for Young Investigators 2006	
11:00 – 12:30	Advances in Medicine Lectures	
	1. Update in Cardiology	– Title and Speaker to be announced
	2. Practical Dermatological Procedures: An Update of a Craftsman's Work	– Dr. YM TANG
	3. Update in Endocrinology	– Dr. IT LAU
	4. Colorectal Cancer Screening in Hong Kong	– Professor WK LEUNG
12:30 – 13:30	Sponsored Lunch and Invited Lecture	
13:30 – 13:50	Opening Ceremony and Keynote Address	
	Professor KN LAI	– President, Hong Kong College of Physicians
13:50 – 14:20	Lecture by Honorary Fellow	
	Genetic Research and Health	– Professor Lap-Chee Tsui (Vice-Chancellor, The University of Hong Kong, HKSAR)
14:20 – 14:50	Lecture by Honorary Fellow	
		– Professor Lawrence KF Chan (Director, Transplant Nephrology, Division of Renal Diseases and Hypertension, USA)
14:50 – 15:05	Coffee Break	
15:05 – 16:15	Advances in Medicine Lectures	
	1. Implementation of Extubation Protocol	– Dr. PK CHAN
	2. The Developments of Geriatric Medicine in an Ageing Population	– Dr. MF Leung
	3. Two Decades of Haematology	– Professor YL KWONG
16:15 – 17:00	Sir David Todd Lecture	
17:00 – 18:30	AGM & Fellowship Conferment	
18:30 – 19:00	Cocktail Reception	
19:00 – 22:00	20th Anniversary Dinner & Celebration	
	Welcome Speech	– Professor KN Lai
	AJS McFadzean Oration	– The Honourable Mr. Wong Yan-lung, SC, JP, Secretary for Justice, HKSAR.
	20 years of Hong Kong College of Physicians	– Professor Richard Yu

** Please be reminded that all trainees must attend the College's Annual Scientific Meeting at least once every two years.

15 October (Sunday)

9:00 – 16:00	Registration	
9:00 – 9:45	Best Thesis Award	
10:00 – 10:55	Advances in Medicine Lectures	
	1. HIV / AIDS – Crossing the Barriers of Specialisation	– Dr. LS LEE
	2. Advances in Therapeutics and Supportive Approaches in Cancer Treatment	– Dr. W YEO
	3. Renal Medicine: Areas we have put Hong Kong on the Map of the World	– Dr. CWS TANG
10:55 – 11:25	Lecture by Honorary Fellow	– Professor Lei-Shi Li (Professor and Director, Research Institute of Nephrology, Jinling Hospital, China)
11:25 – 11:45	Coffee Break	
11:45 – 12:15	Sponsored Lecture	
12:15 – 12:45	Lecture by Honorary Fellow	– Dr. CH Leong
12:45 – 13:45	Sponsored Lunch and Invited Lecture	
13:45 – 14:15	Lecture by Honorary Fellow	– Professor NS Zhong (Professor of Medicine, and Director, Guangzhou Institute of Respiratory Disease, China)
14:15 – 14:45	Gerald Choa Memorial Lecture	– Professor Dame Carol Black (Professor, Centre for Rheumatology, Royal Free and University College London Medical School, UK, Past President of the RCP(London) and Chairman of the Nuffield Trust)
14:45 – 15:30	Advances in Medicine Lectures	
	1. Update in Neurology	– Title and Speaker to be announced
	2. Recent Advances in Palliative Medicine	– Dr. MKM SHAM
15:15 – 15:35	Coffee Break	
15:35 – 16:45	Advances in Medicine Lectures	
	1. Rehabilitation for Improving Function – Recent Developments	– Dr. LSW LI
	2. The Development of Respiratory Medicine in Hong Kong	– Dr. JCM HO
	3. Rheumatology in Hong Kong: Back to the Future	– Dr. CC MOK
16:45 – 16:50	Closing Ceremony	

** Please be reminded that all trainees must attend the College's Annual Scientific Meeting at least once every two years.

Announcements



Winners of the Synapse Photography Competition

Readers will be able to enjoy these photographs on the front cover of Synapse in a new series entitled "Photography by Physicians". The cover photo for this issue features the winning photograph taken by Dr. Jeffrey Shiu-chung TSANG. We would also like to thank the other winners Dr. Yuk-lung KWOK and Dr. Wa LI for submitting their interesting and outstanding photographs. We would like to thank all participants for their entries and to our expert judges for taking time to select the winning photographs.

Hong Kong College of Physicians

20th Anniversary Logo Competition



In order to celebrate the 20th anniversary of the College, the College has organised a logo competition. The details are as follows:

Deadline

15 July 2006

Selection

A panel consisting of Prof KN Lai, President, Prof Richard Yu, Immediate Past President, Prof Philip Li, Hon Secretary, Prof CS Lau, Chairman of the Scientific Committee, will select the best design of the logo.

Prizes

- 1 The winner of the logo competition will be awarded a prize of HK\$3,000.00
- 2 The winner will be invited to attend our Annual College dinner and receive the prize during the dinner.
- 3 The logo selected will be used for letterheads (1-2 months before our Annual General Meeting and Annual Scientific Meeting to be held on 14-15 October 2006), special issue of Synapse, Annual Scientific Meeting programme booklet and other College related functions.

Rules

- 1 All Fellows, members and trainees who have registered with the College are invited to submit one logo to compete for the logo competition.
- 2 Members of the HKCP Council and are not eligible to join this contest.
- 3 The logo should be the original work of the participant.
- 4 The logo submitted should be in colour.
- 5 Each logo must be printed with dimensions 8 x 10 inches (8R). Slides and video frame grabs are not accepted.
- 6 Each logo must be accompanied with the entry form provided or the entry will be disqualified.
- 7 Please send the logo together with the entry form and a soft electronic copy in a sealed envelope to the following address:
Hong Kong College of Physicians
Room 603, Hong Kong Academy of Medicine Jockey Club Building
99 Wong Chuk Hang Road
Hong Kong
- 8 All prints will not be returned and will remain the property of Hong Kong College of Physicians.
- 9 Hong Kong College of Physicians reserves the right to reproduce the logo in the College's documents including Synapse, letterheads, programme booklet and other College related functions.
- 10 The decision of the selection panel will be final and irrevocable.

Queries

Contact College Secretariat for clarification at 2871 8836.

Entry Form

Name (English):

Name (Chinese):

Title:

Mr. / Mrs. / Ms. / Dr. / Prof. / other _____

Address:

e-mail address:

Contact phone no.:

Membership status:

Member / Fellow / Basic Physician Trainee

Hospital

Department:

I hereby certify that the logo I submit is my original work and has never been copyrighted. I understand and allow the College to use my logo in letterheads, Synapse, Annual Scientific Meeting programme booklet and other College related functions.

Signed _____

Date _____



1997 Professor Tso at the opening of the Nethersole Centenary Exhibition at the Hong Kong Museum of Medical Sciences

Professor TSO Shiu Chiu

Dr John Mackay

Success in life can be measured in different ways. In academic terms it can be measured by the position held at an institution, the number of papers published, the number of addresses given to learned bodies, the honours bestowed by prestigious organisations; and on a more human level by the gratitude of patients, by the esteem of colleagues, and by the pleasure given and received in passing on wisdom and skills to students. In personal terms it can be measured in a happy family, a fond circle of friends, and a satisfaction of a life well lived.

For Dr. Tso life is a success judged by many of these measures.

His early childhood was spent in Hong Kong, son of a Civil Servant, with a grand-father who was a Chinese herbalist – his only connection with the medical profession. The Japanese war led to his family moving to 'free China', staying in a number of places including Guilin, where there were a number of friends also refugees from Hong Kong, and later Chongqing where he continued his schooling.

These were hard times for his family. Dr. Tso recalls; "As we travelled through the southern provinces, my family had to support ourselves with whatever savings we had and by selling old clothing. I am not sure, but perhaps the British Foreign Office in China did give some support to former Hong Kong civil servants taking refuge in China during the Japanese occupation of Hong Kong. After we reached Chongqing, my father found work with an American film distributor and then the American Consulate".

At the end of the war his father was welcomed back to Hong Kong to help get the administration going again. He and the family were flown back to Hong Kong, a big adventure for them all. There were two other children apart from S.C., a brother, an electrical engineer who went on to become a professor at Hong Kong University, and then at City University; and a sister who became a teacher.

His education prospered at Queen's College enabling him to win by examination a scholarship to Hong Kong University to study Medicine. Professor McFadzean was Professor of Medicine at that time. Dr Tso remembers him as a great teacher and demanding clinician who emphasised that treating the disease was not enough, the whole person should be cared-for.

Academic success continued with the winning of the Ho Fook Prize for best Second M.B. examination, and the C.P. Fong Gold Medal for Medicine in the final examinations. (The C.P. Fong Prize was instituted by Professor McFadzean in memory of a brilliant doctor who was killed at an early age in a tragic accident).

He was President of the Students Union for one year, a responsibility which included efforts to raise money for needy students, at a time before Hong Kong became the prosperous place it is today. Despite the pressure of work he enjoyed time off to play basketball for the Eliot Hall and, after Eliot was closed, badminton for the University Hall.

After completing his first houseman year at the Queen Mary Hospital he was appointed Clinical Assistant in the Department of Medicine, and a year later became an Assistant Lecturer. During this time he developed an interest in Haematology, stimulated by his seniors, Prof McFadzean and, at that time, Dr. David Todd.

In 1962 he won one of the two prestigious Sino-British Fellowships for postgraduate study for two years in the United Kingdom. The first nine months were spent in Edinburgh, working with Professor Ronald Girdwood, and studying for and passing the Edinburgh Membership examination.

Two short spells of study followed, on pathology in Aberdeen, and on radioisotope techniques at the United Kingdom Atomic Research Establishment. The final period of nearly a year was spent as a research officer with Professor Lazlo Lajtha, a pioneer in stem cell research at the Paterson Laboratories, Christie Hospital and Holt Radium Institute in Manchester.

Returning to Hong Kong in 1964 he was appointed Lecturer at the Department of Medicine. He was to spend the next twenty years in the department, the last five years as a Professor in the Department of Medicine. During these years he authored or co-authored a succession of papers on original research on haematological subjects. As his reputation grew he was an invited speaker to many international conferences, and was honoured with the Fellowship of the Royal College of Physicians of Edinburgh, and Fellowship of the Royal Australasian College of Physicians.



1985 Members of the Organising Committee of the Scientific Meeting of the Royal College of Physicians of Edinburgh held in Hong Kong. Shown in the photograph are Sister Mary Gabriel, Dr CW Tsang, the late Sister Mary Aquinas, Dr CY Wong, Professor Tso and Professor CY Yeung

In 1985 Dr. Tso stepped down from his academic position to enter private medical practice, though he still kept in touch with the University as an Honorary Clinical Lecturer.

When asked why he retired early from a successful academic career Dr Tso replied, "I have never considered my own success to be the most important thing in life. My consideration then was that since throughout my working life, I have served the community in the capacity of a university teacher and academic and a clinician in an institutional setting, I thought that I might change my career by serving the public in a different, perhaps more direct, manner. There is of course the personal consideration of a freer style of work and perhaps a financially better chance of preparing for my retirement (the remuneration of a university clinical teacher being what it was in the days before the Hospital Authority).

Teaching had been one of Dr. Tso's greatest pleasures, as it afforded him the chance of meeting fresh, young minds. He still feels it particularly important that doctors look past the immediate

needs of investigation and treatment of a patient's illness, to take in a whole patient view and create an empathy with the patient. This is something the importance of which he grew to recognise and practise; and is happy that this aspect of care is given more weight in current undergraduate teaching.

In 1998 he and his wife of 33 years, Priscilla, moved to Vancouver, Canada, to enjoy well-deserved retirement.

About this choice he said, "Having lived here for nearly my entire life, I would like to retire to some place different. As I did not feel that I could survive in a purely rural setting, I chose a city that did not have the minus qualities that Hong Kong possessed, such as atmospheric pollution, noise, crowdedness and confinement.

Vancouver fitted the bill and had the appeal of scenic surroundings and being within easy reach of Hong Kong where my children and many friends and relatives are."

Travel is now a consuming interest, something that his wife, Priscilla, had been involved in as an educator for 24 years with the Department of Extramural Studies (forerunner of 'SPACE', the School of Professional and Continuing Education) of the University of Hong Kong.

It is informed travel. Before each trip they study carefully the country they are about to visit, still leaving two months in the year when they return to Hong Kong to enjoy time with their daughters Grace and Annette, son-in-law Godfrey and other relatives and friends.

There is no doubt that Dr. Tso is fulfilling the criteria of 'a successful life'. It is a life of academic accomplishment, yet a balanced life, happily without the passion for achievement that drives some people towards ever greater goals, at the expense of personal health and family relationships.



1978 Members of the University Department of Medicine at Queen Mary Hospital. From right to left, Professor Tso, Professor David Todd, Professor TK Chan and Professor Donald Yu