HONG KONG COLLEGE OF PHYSICIANS

SYNAPSE

FEBRUARY 2007

RESTRICTED TO MEMBERS ONLY

Photographer: Dr. Yuk-lung KWOK *(2nd prize winner of the Synapse photo competition)*

Contents

SYNAPSE

Room 603
Hong Kong Academy of Medicine Jockey Club Building
99 Wong Chuk Hang Road
Aberdeen
Hong Kong

Tel 2871 8766
Fax 2556 9047
email hkcp@netvigator.com
College Website http://www.hkcp.org

The President's Annual Report 2006

KN Lai President, HKCP

In the year of the Dog 2006, Hong Kong SAR has consolidated the recovery of the local economy. Despite constant threat of Avian flu in Asia and local food safety issues, our medical community has demonstrated its usual vitality in providing excellent medical care to Hong Kong. Perhaps, the other unsettled issue that involved some of our Fellows, Members and Trainees is the working hours and compensation settlement with the Hospital Authority. Hopefully, a mutually acceptable solution will arise in the near future.

This is my second annual report since elected to the Presidency in 2004. I appreciate greatly of the support from the Council and I would like to thank all Fellows and Members for having given me the opportunity and honor to serve you. With the rapid and visionary development of the College initiated by the immediate Past President, Professor Yu, my task is to consolidate our achievement and to uphold the present College direction of global networking with other major physician colleges. The College had moved into a new premise in late 2004 with a floor area of 200 square meters. This has provided additional space to conduct many annual and exit examinations in higher physician training. The College has maintained her full complement of supporting secretarial staff due to the increasing demand on examination and continuous professional development program. Most importantly in early 2007, the College is working to launch our computerization system in training and examination matters aiming that paper documentation can ultimately be conducted from the desktop computer using the Web.

From the Annual Report it outlines the various events and achievement of all the College Committees that require no further elaboration. My heartiest gratitude and appreciation goes to all Chairmen, Members of the Committee, the Boards and the Secretariat for having done such a magnificent job. Briefly, I would like to highlight some of the important changes.

Education and Accreditation Committee

Under the very capable Chairmanship of Dr Loretta Yam the committee had improved the examination format, scoring system, remedial training program, and written guideline of the dissertation thesis. The Committee is planning to publish the fourth edition of the Guidelines on Postgraduate Training in Internal Medicine in early 2007. Several new developments in training are established in the last 12 months.

1. With effect from July 2007, the College will also rename the present "SMO Assistant to Programme Directors" as "Assistant Programme Directors". Their contributions to the training and accreditation function of the College are highly appreciated.
2. To enhance the monitoring of training progress, the Specialty Board in AIM has introduced the writing of case reports at its Annual Assessments. Case reports should contain 1000 to 2000 words with no more than 10 references.
3. The Higher Physician Subcommittee continues functioning to set policies and guidelines in the conduct of Annual and Exit Assessment exercises. The examination format is structural and fully vetted by a panel of examiner prior to the examination for accuracy and fairness.
4. The revised guidelines on Continuing Medical Education/ Continuous Professional Development (CPD) stipulates the requirement of more active participation under the new CPD system.

National and International Liaison Committee

Under the dedicated Chairmanship of Professor WK Lam, the committee is instrumental in establishing the following new programmes.

1. Nomination and Vetting Subcommittees (the Committees) have been established under the Council to nominate and vet nominations for London or Edinburgh College Fellowship for Hong Kong Physicians. Criteria are clearly laid down by the Colleges.
2. Presidents from the London, Edinburgh, and Glasgow Colleges visited our College on several occasions this year. The New Fellows Admission Ceremony of the Edinburgh College ("Signing of the Roll") was held on 13 May 2006 in Hong Kong. Professor Neil Douglas, President of RCPE, came to Hong Kong specially to conduct the Ceremony.

Examination Committee

The Joint MRCP(UK)/HKCPIE Part II written examination had expanded to 3 papers since December 2005. The examination lasts two days. Annually, two written Part I, three written Part II, and two clinical PACES examination are now held in Hong Kong. The College is exploring additional local centers for PACES examination.

Scientific Committee

The Scientific Committee had organized a Scientific Meeting of Hong Kong College of Physicians on November 5-6, 2005. This year, the Scientific Committee continues to organize a special annual scientific meeting on October 14-15, 2006 to celebrate the College's 20th anniversary.

Research Committee

The Research Committee had selected four young investigators for Distinguished Research Paper Award. All are invited to present their papers in the Annual Scientific Meeting of the College in October 2006, with a medal to award to the best presenter.

Membership Committee

As of 31 August 2006, 40 applicants were proposed for Membership and 37 applicants for Fellowship.

Professional and General Affairs Committee

The Committee continues to handle issues related to professional and general medical affairs this year. A working group was formed under the Hospital Authority to provide training in clinical toxicology for Basic and Higher Physician trainees. A seminar in clinical toxicology for Physicians co-organised by our College and the training sub-committee of the COC(Medicine), Hospital Authority was held in July 2006.

SYNAPSE

SYNAPSE continues its important role of fostering communication between the College and its Fellows, Members and trainees.

There were many special articles in ***SYNAPSE*** this year, notably the Gerald Choa Memorial Lecture by Dr CH Leong, our Honorary Fellow and the AJS McFadzean Oration by Mr Andrew Sheng, Past Chairman of the Securities and Futures Commission. Updated statistics on the number of Higher Physician Trainees in all Medical Specialties in Hong Kong are published regularly as a reference for trainees deciding on their career pathway.

Administration and Finance Committee

We are grateful to our Hon Treasurer for his very shrewd book-keeping such that the College remains in a healthy state financially.

Finally no word of appreciation or thanks can express my gratitude to the two Vice-Presidents, Chairpersons of different committees, College Council members, and the previous Presidents for their invaluable support and advice. My final vote of thanks goes to all the very hardworking secretaries of the College who have maintained our engine running smoothly.

The President's Address to the Congregation

KN Lai President, HKCP

Today is an important day for the College. For we gather here to witness 46 physicians being admitted to the Fellowship and another 53 to our Membership following their successful qualification examinations. Let me extend the College's congratulations to the new members and fellows. In last year's conferment ceremony, I spoke about the virtue of "naiveness". On this occasion, I will address the issue of clinician-scientist, a career path that may be new to some of our trainees but is an important asset in the advancement of Medicine. Let me give you my view on this.

In the past, every time when I filled in a registration form in an international meeting for the column of the nature of my work, I hesitated for a second and finally chose clinician-scientist instead of clinician, teacher, administrator, or scientist. My hesitation lies in the rarity of genuine clinician-scientist in Hong Kong. In North America or Europe, this title usually refers to those with both MD (MBBS equivalent in Commonwealth and Hong Kong system) and PhD training. Normally, they spend 30-50% of their time in clinical medicine with direct patient contact and for the remaining time in either laboratory or clinical research. In these countries, this arrangement is possible due to the establishment of academic track with tenure in university-affiliated hospitals and also the sizable research grant that may support part of their salary. Such career structure is virtually non-existent in Asia in the past, even in Japan.

One may ask what is the attraction of being a clinician-scientist? Why not just practise as a full-time clinician or, likewise, a full-time

scientist? The beauty and attraction of being a clinician-scientist lies in his/her ability to transcribe a mechanistic concept and to translate it into a clinical practice. Vice versa, a clinician-scientist often identifies a clinical problem and tries to explore alternate means to solve the puzzle by studying the pathophysiological basis of the issue. More often then usual, a scientist, per se, studies an issue in depth based on personal interest with lesser concern in the practical or clinical application. For most practising clinicians, they understand the crux of the clinical issue but often are frustrated by the limited option of effective therapy. To give an example of the power of clinician-scientist interaction, the recent development of targeting therapy for lung cancer is based on the discovery of the signaling role of the epidermal growth factor. With this information, treatment strategies can possibly be devised to target the upstream or downstream events of the pathologic cascade.

In the past (i.e. 70-80), there was no structural program within our local medical system that supported the training of a clinician-scientist. In those days, the only way to do more scientific work in depth after graduating from the medical school was to take up a full-time studentship for a PhD. In the last 15 years, both universities offer a combined MBBS-PhD program, similar to those in North America, to selected students. The responses are not enthusiastic and the number remains small. Why does our program appear to be less attractive? The MD-PhD program in North America is workable as there are many established research centres both funded by academic institutions, foundations, and pharmaceutical industries. One can set mind in a research path early in his/her career path as there are such positions in the pipeline. A similar set-up is virtually non-existent in Asia, with some exceptions in Japan. The other observation about the MD-PhD program is that the areas of study are usually in basic science or para-clinical subjects as the supervisors are usually from these departments. If one wishes to move onto clinical training after qualification, he/she needs to compete for residency and then fellowship program with junior doctors. The other system that has more often been practised in Australasia and United Kingdom is doing the MD or PhD program during the latter years of the fellowship training. In these circumstances, the areas of study are usually in clinical science or in medical subspecialties and the supervisors are usually academics from clinical departments.

What happened in Hong Kong over the last few years? We have increasing number of clinicians who continue to enroll for MD or even PhD degree after completing their fellowship training. The Hong Kong College of Physicians recognises 6 months of full-time research out of the three-year fellowship program. At both teaching hospitals, physician trainees are exposed to laboratory techniques if they are keen to participate in laboratory research. Most of them are comfortable and competent to handle and to engage in laboratory work when they are undergoing overseas training in other major centres. Not infrequently, they are able to extend their work initiated in overseas centres when they return to Hong Kong. This often forms the basis for their MD or PhD thesis. Over the last 5 years, the Research Grant Council (Hong Kong) and the Hospital Authority (HA) have initiated a Clinical Fellowship Program that enables two medical staffs from HA to enroll in a two or three-year research program at either university each year. The clinical duty during these two years is capped at 20%.

What is the future of clinical research in Hong Kong? I believe it remains very bright. For example, at different HA hospitals, we have now well over two dozen of resident specialists or associate consultants with MD or even both MD and PhD degrees. They form a formidable force in our clinical research progress with publications in top world renowned journals. This batch of physicians will master both a good clinical skill and a scientific mind to practice medicine. For those few "mellowed" clinician-scientists, they will not walk alone. They are no longer the dying dinosaurs of Medicine in Hong Kong as a new crop of young clinicians have joined them in the stride forward to put medical research from Hong Kong to the next horizon.

With this, I wish you every success in your future career and a very pleasant evening.

Thank you.

This speech was delivered at the Fellowship Conferment Ceremony of Hong Kong College of Physicians on 14 October, 2006

AJS McFadzean Oration
Litigation and Medicine

The Hon Wong Yan Lung SC, JP, Secretary for Justice

Professor Lai, Ladies and Gentlemen,

I. Introduction

It is indeed my honour and pleasure to be invited to speak at the prestigious 11th McFadzean Oration.

2. The person instrumental in my having the opportunity to speak on this auspicious occasion is my late father-in-law, Mr. Chan Tou-suen, who passed away in June this year. He was the husband of the late Dr. Li Mingchen, Anita, who was a founding fellow of your College.

3. If I may, also publicly dedicate my address this evening to my late parents-in-law, who had respectively contributed greatly to the well being of Hong Kong.

II. Medical negligence suits in Hong Kong

4. The topic "Litigation and Medicine" immediately provokes doctors' anxiety and disdain about medical negligence claims.

5. In the United States, damages from medical malpractice claims have become so high that President Bush had appealed for reform of America's tort system, which he identified as one of his administration's top health care priorities.

6. Indeed, the quantum of damages awarded in individual cases in Hong Kong has been on the rise quite rapidly in the past 10 years or so. However, in terms of the number of medical malpractice cases, it is still relatively infrequent when compared to the situation in other countries. Government's figures show that in the 10-year period between 1994 and 2004, there has been a 30% rise in the number of litigation cases involving medical malpractice.

7. This, of course, is reflective of the general high standard of our medical practitioners and service. Another reason, I believe, is that most people in our predominantly Chinese community still respect doctors and value harmony.

8. However, the scene is changing in Hong Kong.

(1) In as early as March 1997, a commentator of the Economist already noted, "What makes health care unique among public services is the way an underlying trend of rising expectations interacts with new technology. As people get richer, they want better."[1]

(2) 9 years since the Reunification, we have seen a rise in litigation based on human rights guaranteed under the Basic Law. Our society has become more conscious of, and receptive to, Western medical ethics which focus on individual rights, autonomy and self-determination, and accordingly have become more litigious.

(3) The medical negligence claim, which recently hit the headlines, whereby the plaintiffs sued a local private hospital in the order of HK$500 million, is likely to turn up the heat of the debate. It involves the use of a drug called Syntocinon to a mother who went into labour. A top UK Queen's Counsel specialising in medical negligence and up to 12 leading world experts including paediatric neurologists have been engaged.

9. No doubt, the thorny issues of high damages, litigation costs and insurance premium are likely to get thornier. The Administration is aware of the concern of the medical profession about the rise of premium for professional indemnity insurance, especially for the higher-risk specialities such as obstetrics and gynaecology.

10. However, I hope you can appreciate any law reform to limit liability is no easy task.

(1) Under common law, compensation in tort is compensatory, to restore the victim in such manner that his original position can be restored insofar as this can be done by money. Any artificial capping of the quantum of compensation will be inconsistent with that common law principle.

(2) Capping of damages has only emerged in two countries in response to quite distinct circumstances. Firstly, some states of the USA introduced capping of damages to counter the increasing amounts awarded to plaintiffs by courts. However, this situation arose because in the US, they had a system of contingency fee under which the juries, rather than judges, assess compensation. This is not the system in Hong Kong.

(3) Secondly, in Australia, capping also emerged as a response to a dramatic rise in professional negligence claims. According to the Attorney General of New South Wales, the situation had developed to the point where "plaintiffs are looking to their professional advisers as a source of recovery of loss." So far, only two Australian states[2] had operated it although other states had also legislated. Personal injuries claims are excluded. And in exchange for liability capping, the professional organisations had to subject themselves to stringent regulations and risk management strategies, usually backed up by professional indemnity insurance. The full effect of such changes is yet to be seen.

(4) It should be borne in mind that in medical negligence cases, any capping of damages might lower deterrence and might be seen as a disincentive to maintaining high professional standard and risk management. It would also transfer the burden from wrongdoers to the injured party or the community through the security and health care systems.

(5) We shall keep a close watch on the development. However, I do not think there is, at present, sufficient justification to introduce such a drastic change to our law.

11. I know medical negligence litigation is highly contentious and emotional. It is very emotional on the side of the patient and his or her family. It is equally taxing on the medical practitioner concerned. It is not just the strain and the dire consequences of losing the legal battle.

[1] The Economist, 15 March 1997
[2] New South Wales and Western Australia

The mere fact that a doctor is being sued for medical negligence is already a grave slur on his reputation, which may have taken years to build up.

12. You have my sympathy. I remember talking to a doctor shortly after I started my legal practice. He said the pressure on you lawyers can never be comparable to ours. Any failure on your part can still be remedied by an appeal. In our case, there is many a time no appeal from any professional judgment!

III. The standard of care

13. It is of course at the end of the day a matter of judgment, i.e. professional judgment. The standard of care is still essentially the Bolam test, enunciated in a judgment of 1957 vintage[3]. The standard of care that must be met by a medical practitioner is that of his reasonable professional peer. A medical practitioner is not guilty of negligence if he has acted in accordance with practice accepted as proper by a reasonable body of medical men skilled in the particular art.

14. This may sound elementary enough. However, in as recently as July last year, Suffiad J dismissed a medical negligence claim[4], which was founded on the opinion of a medical expert whom the Judge held to be wholly oblivious of the Bolam test. From the cross-examination cited in the judgment, it seems that the expert was giving an opinion as to how the incident could have been avoided, not criticising the defendant doctor's performance as falling short of what the ordinary competent medical practitioner would have done, i.e. medical negligence.

15. The standard is an objective one.

(1) It does not take account of the relative experience or inexperience of the individual practitioner. The court does not set the performance of the individual practitioner against what is reasonably required of a person of his qualification and experience. Otherwise it would mean that the standard of care which the patient is entitled to demand would vary according to the chance of recruitment and rostering.

(2) Rather, the standard is set by reference to the position held by the practitioner in the unit in which he or she worked. A junior member of a team could not be expected to show the skill of a consultant. The inexperienced doctor called upon to exercise a specialist skill beyond his or her experience must seek the advice and help of superiors. If such help is obtained, it is likely that the proper standard will have been met.

(3) Similarly, a general practitioner cannot be expected to have the expertise of that of a specialist, but should know when it is necessary to take appropriate advice from a specialist. And, following from that, a specialist will be held to the higher standard of those practising within the specialist field.

16. In determining liability, the key issue is whether the defendant doctor has or has not followed or complied with the practice of the profession.

(1) However, as an anonymous commentator put it, developments in medicine bring litigation in their wake.

(2) The experience with SARS and Avian Flu provides good examples. Upon the emergence of a new disease of unknown pathology, and not curable by any conventional treatments, how can one evaluate a doctor's judgment on, for example, prescription of an innovative treatment? What would constitute "the general and approved practice of the medical profession"? Inevitably, there would be controversy.

17. Yet, you should be relieved to know that the Court has always emphasized that the standard by which to judge a particular practitioner is that of reasonably competent medical men at the time of the alleged act of negligence. As was graphically pointed out in one case, "We must not look at the 1947 accident with the 1954 spectacles."[5]

18. Also, it is not the function of the court to choose between different schools of medical thought. Lord Scarman in a 1984 case[6] added this important caveat to the Bolam test: "A judge's preference for one body of distinguished professional opinion to another also professionally distinguished is not sufficient to establish negligence."

19. However, this does not mean the medical profession is the sole judge of its own court when it comes to medical negligence. In another case of the House of Lords decided in 1997[7], Lord Browne-Wilkinson warned that the court must be satisfied that: "the exponents of the body of the opinion relied upon can demonstrate that such opinion has a logical basis. In particular in cases involving, as they so often do, the weighing of risks against benefits, the judge, before accepting a body of opinion as being responsible, reasonable and respectable, will need be satisfied that, in forming their views, the experts have directed their minds to the question of comparative risks and benefits and have reached a defensible conclusion on the matter."

IV. The proof of the objective professional standard required: the expert evidence

20. In ascertaining what amounts to "reasonable care" in relation to the legal standard, the courts pay considerable deference to the practices of the medical profession as established by expert evidence.

21. This brings me to the subject of expert medical evidence in litigation, which is a matter of interest whether you are the expert giving it, or the defendant whose fate in the litigation will be seriously affected by it.

22. I remember when I started out in my legal practice some 20 years ago, I had come across one case where a medical negligence claim had to be dropped because of the plaintiff's inability to procure a medical expert. The doctor involved was too well-known in Hong Kong, and the plaintiff, who did not qualify for legal aid, could not afford to go overseas to search for expert assistance.

23. This, I believe and I certainly hope, is no longer the case now.

(1) Firstly, the pool of medical experts should be much bigger now with the two medical schools being so well established for so long.

(2) Further, in respect of overseas medical experts, the costs might not be so inhibitive now after the opening of the Technology Court in Hong Kong enabling evidence to be received by video link.

24. In doing the research for this oration, I have come across familiar names, who have received commendation by the court for their performance as expert witnesses. For example, in one case[8], Dr. York Chow, our Secretary for Health, Welfare and Food, and my fellow principal official and senior from Queen's College, received repeated rounds of applause by Seagroatt J. The learned judge found Dr. Chow, who was then still the Chief Executive of Queen Elizabeth Hospital, "a careful, considered expert witness who approached his task with care and authority." "… an impressive witness. He approached matters thoroughly and objectively." I see that York is here. He would have to buy me lunch.

25. Hong Kong's medical community is of course a small one. One can understand the reluctance to stand up in court to criticize colleagues, with whom you might be sharing the same golf course. However, I truly

[3] Bolam v Friern Hospital Management Committee [1957] 1 WLR 582
[4] Ng Yuk-ha v Yip Siu-keung, HCPI 1167/02, 19 July 2006
[5] Roe v Minister of Health [1954] 2 QB 66
[6] Maynard v West Midlands RHA [1984] 1 WLR 634, HL
[7] Bolitho v City and Hackney Health Authority [1997] 4 All ER 771, HL
[8] Bruno Atzori v Dr. Chan King-pan, HCPI 792/1998,30 July 1999

believe when leaders in the fields are forthcoming to help the court resolve disputes on medical issues in the most professional manner, it could only be beneficial to the public, and to the standard and credibility of the medical profession alike.

26. May I now take a few minutes to say something about the role of medical experts in litigation.

(1) It is of fundamental importance for experts to know that their duty is owed to the court, not to the party engaging them. I was once told by some senior barristers that one medical specialist was well known for the No.1 question he put to the solicitor before giving his opinion: "Just let me know whether you are acting for the plaintiff or the defendant." This is deplorable but I hope only an isolated case.

(2) However, the partisanship of the medical expert might be subconscious, and creeps in by reason of a failure to appreciate his proper role. Although I have not done too many personal injuries cases, I have come across medical expert opinions where the author had assumed the role as the advocate or even the crusader, which sadly devalued the experts' role in the judicial process.

(3) We, both lawyers and physicians alike, must be careful not to allow ourselves to be deceived by our own eminence. We should take heed of the downfall of Professor Sir Roy Meadow. He was considered one of the world's greatest experts on the subject of child abuse. He discovered Munchausen Syndrome by Proxy, the pattern of behaviour in which a person in charge of a child deliberately produces symptoms and signs of illness in that child. He gave evidence that convinced juries to convict in at least three "cot death" murder cases and coined the now infamous "Meadow's Law", namely: "One sudden infant death is a tragedy, two is suspicious and three is murder until proven otherwise." But this proposition "lacked scientific rigour". His statistical claims were totally inaccurate and were ultimately refuted when the guilty verdicts were finally overturned.

27. There is an aftermath to that story which may be of importance or interest to you.

(1) Following the quashing of convictions and discovery of the flaw in the medical evidence, Professor Meadow was condemned by the General Medical Council for serious professional misconduct, although the Council also found that the professor had acted in good faith.

(2) On the professor's appeal, Collins J quashed the Council's finding, and held that the professor still enjoyed immunity from the disciplinary proceedings for his conduct as a witness in court. The interest of administration of justice required that the witnesses should not be deterred from giving evidence for fear of litigation. The same consideration applied to disciplinary proceedings. However, that immunity was not absolute. Where the judge who heard the expert found the expert's shortcomings to be so serious as to require his removal from practice, the judge could refer him to the disciplinary body[9].

28. With a view to improving the system regarding expert opinion, the Final Report on Civil Justice Reform made various recommendations, which are likely to become the law of Hong Kong soon. For example, it was recommended that there be:

(1) A rule declaring that expert witnesses owe a duty to the court which overrides any obligation to those instructing or paying the expert.

(2) A requirement that the expert should declare in writing he understands his duty, and to verify his expert report by a statement of truth. Anyone who verifies without believing the truth of that statement may, if certain conditions are met, be prosecuted for contempt of court.

(3) A power for the court to order appointment of a single joint expert if satisfied that the refusal by one party to agree a joint expert is unreasonable.

29. Medical negligence cases are of course civil suits. Only in a small percentage of civil cases is medical expert evidence adduced. The bulk will be personal injuries cases. But very often medical practitioners will also appear as experts in criminal cases. In the latter case, my department has issued a Code of Practice for Expert Witnesses engaged by the Prosecution Authority. It sets out some useful guidance on the general obligations, as well as format of an expert report. There is a also a specific provision on disclosure by the expert to the prosecuting counsel regarding any criminal conviction, investigation or disciplinary proceedings affecting the expert concerned. This provision implements the Court of Final Appeal's ruling in a recent criminal case, for the sake of protecting the rights of the accused.[10]

V. The tricky ethical questions where medicine and the law meet

30. Talking about rights, the advent of the constitutional guarantee on fundamental human rights, coupled with the increasing knowledge, technology, affluence and complexity of society have also raised very intricate ethical issues, which may call for judicial decision and/or legislative intervention.

Right to life

31. For example, Article 6 of the International Covenant on Civil and Political Rights ("ICCPR"), which applies to Hong Kong by virtue of Article 39 of the Basic Law, provides that every human being has the inherent right to life. This right shall be protected by law. No one shall be arbitrarily deprived of his life. This should be contrasted with Article 7 of the ICCPR which provides that no one shall be subject to torture or to cruel, inhuman or degrading treatment or punishment. In particular, no one shall be subjected without his free consent to medical or scientific experimentation.

32. Although the right to life is expressed to be absolute or unqualified, the ICCPR should be read as a whole. For example, one can envisage a situation where to continue or prolong life via artificial means

[9] Meadow v General Medical Council [2006] 1 WLR 1452
[10] HKSAR v Lee Ming Tee (2003) 6 HKCFAR 336

Prof Lai presented the AJS McFadzean Oration Medal to the Hon Wong Yan Lung

would be considered as inhuman or degrading treatment for the purpose of Article 7. In such circumstances, to decline to prolong life might not contravene the right to life.

33. One high profile case from the United Kingdom in which these issues were considered was that of Diane Pretty. She suffered from motor neurone disease and had sought an assurance that her husband would not be prosecuted if he assisted her suicide. The case was considered by the European Court of Human Rights[11]. The Court held that (1) the "right to die" could not be read into the "right of life". (2) The obligation to prevent inhuman or degrading treatment could not be considered to include permitting actions designed to cause death. There was no requirement to undertake not to prosecute the Applicant's husband if he helped her commit suicide.

34. The Court also held that the right to refuse treatment was within the ambit of the right to privacy. The failure of English law to allow Mrs. Pretty the assistance of her husband to end her life did amount to interference with her private life. However, the interference was prescribed by law and pursued a legitimate aim. A blanket ban on assisted suicide was not disproportionate. The interference was justifiable as necessary in a democratic society.

35. Another UK case which dealt with withholding and withdrawing life-prolonging treatment was that of Ms. B, a tetraplegic social worker[12]. She won the right to have the ventilator keeping her alive switched off. The Court upheld this right on the ground that this amounted to refusal of treatment, as opposed to active ending of life.

36. Ms B's case highlighted the dilemma facing many medical practitioners. It is clear that a patient with the mental capacity to take decisions has an absolute right to refuse treatment. Ms. B was deprived of this right because no doctor in the hospital treating her was willing to carry out her wishes. She applied through her lawyers to the courts for this to be done.

37. However, many commentators have argued that these two cases have caused anomalies and called for reform of the law. Indeed, even lawyers may find it confusing when the Court pronounced that, on the one hand, there is "no right to die", and yet confirmed, on the other hand, there is also "no duty to live". In practice, the line may well be very difficult to draw.

38. But back to more pragmatic matters, many of you, Ladies and Gentlemen, are familiar with the concept of "Advance Directives".

(1) "Advance Directives" provide a means for addressing the sort of dilemma created by cases like Ms B. An "advance directive" or a "living will" is a set of instructions given by an individual as to the health care he wishes to receive at a later stage when he is no longer capable of making such decisions. A mentally competent patient may authorise and decline specific treatments including blood transfusion, feeding or hydration. The advance directive would only be activated where the patient is terminally ill, in an irreversible coma or in a persistent vegetable state.

(2) The Law Reform Commission has recently considered this issue and has made recommendations on a model form of advance directive to be used. To remove the possibility of coercion, it recommends that the form should be signed before two witnesses, one of whom should be a medical practitioner who would be in a position to explain the nature of the advance directive and its implication.

Others

39. There are still many more contentious and difficult questions arising in the context of human rights. For example, the meaning of death: should it be brain death or natural death, abortion, sex selection, posthumous conception and embryo transfer policy, etc. They have all given rise to hot debates, which will continue as the relevant jurisprudence develops.

40. However, you will be starving if I were to start on any of these topics. I dare not deprive eminent physicians of their fundamental human rights or interfere with your gastric or gastronomy routine.

VI. Conclusion: The medical and the legal professions

41. Ladies and Gentlemen, your profession is an ancient one. It is perhaps older than mine, i.e. of lawyers, as the Hippocratic Oath itself dates back to ancient Greece.

42. The relationship between physicians and the law also goes back a long way. Hammurabi was a ruler and lawmaker in Babylon around the year 1800 BC. He caused his code of laws to be carved upon a black stone monument rearing eight feet high so that all could read and know the law. No less than eight of the Articles of the Code of Laws of Hammurabi deal with physicians. It is instructive, but perhaps not entirely surprising, that these articles are mostly concerned with payment of fees to physicians

43. In fact, the medical and the legal professions have much in common. In saying that, I am not thinking about charges, or endorsing George Bernard Shaw's famous remarks that "All professions are conspiracies against the laity".

44. Quite on the contrary, I mean that both professions pledge to put the interests of others ahead of their own while providing their specific professional services. There is a balance between public interest and the interest of the professions. The professions are given statutory recognition and a monopoly to practise in their area of expertise. In exchange they must maintain the integrity and standards of professional service to the public whom they serve. As society changes, that balance must also be adjusted accordingly.

45. In fact, there is much room for cooperation between the medical and legal practitioners, to promote the public benefit the pursuit of which has been stated in the Basic Law. For example:

(1) Under Article 138, the HKSAR shall, on its own, formulate policies to develop Western and traditional Chinese medicine and improve medical and health services.

(2) Article 139 of the Basic Law provides that the HKSAR shall decide on scientific and technological standards and specifications applied to Hong Kong. These are matters on which both lawyers and physicians can work together to make Hong Kong yet a better place for our families to live in.

46. Albert Einstein once said: "The significant problems we face cannot be solved at the same level of thinking we were at when we created them." So, let's gear up in our thinking when we tackle the difficult problems facing us with foresight and insight.

47. In this connection, may I congratulate your college for your very good work over the years, for being pioneers in this field, for bringing up new generations of physicians to serve Hong Kong, and for developing the good practice of Medicine by ensuring the highest professional standards of competence and ethical integrity.

48. Thank you very much and I wish you all good health and happiness.

(#329423 v6)

[11] Pretty v United Kingdom [2002] 35 EHRR 1
[12] Ms B v An NUS Hospital Trust [2002] 2 All ER 449

Twenty Years of the Hong Kong College of Physicians

Richard YH Yu Immediate Past President, HKCP

Sapientia et Humanitas (Excellence and Humanity) 於精於仁

With this motto as guide and creed, the Hong Kong College of Physicians was inaugurated on the first day of December, Nineteen Hundred and Eighty Six.

It was Professor David Todd (as he was then) who proposed the formation of a professional body for physicians before the changeover of sovereignty, and on his initiative a preparatory committee was formed in March 1986 to draft and finalize its Memorandum, Articles of Association and Bye-laws. What emerged was provisionally named the 'Hong Kong Association of Physicians'.

Why 'Association' and not 'College'? Because Professor Todd, with typical courtesy, did not wish to pre-empt the choices available to another post-1997 statutory body – what we now know as the Hong Kong Academy of Medicine – which was then also in the making.

In November 1986, marshaled by Professor Yeung Chap Yung, the paediatricians expressed a wish to join the Association. At the inauguration ceremony the wise counsel and eloquent persuasion of the late Professor Gerald Choa prevailed, and thus it was that the Hong Kong Association of Physicians became formally christened as the Hong Kong College of Physicians and Paediatricians.

A General Meeting followed: Professor David Todd was elected President, with Professor Gerald Choa and Professor Yeung Chap Yung as Vice-Presidents – the latter representing the paediatricians. Other officers elected on this momentous occasion were:

Hon Secretary	Dr Richard YH Yu
Hon Treasurer	Dr Tse Tak Fu
Council Members	
Dr Fung Hing Pun, Robert	Dr Leung Nai Kwong
Dr Tsao Yen Chow	Dr Tso Shiu Chiu
Prof Vallance-Owen, John	Dr Wu Wai Yung, Raymond
Dr Yeoh Eng Kiong	Prof Rosie Young
Dr Yu Yu Chiu Donald	
Hon Legal Advisor	Mr Peter Mark
Hon Auditor	Mr Walter M

The physicians embraced the paediatricians as parents do their own children, leading to a close meeting of minds, happy sharing over issues of common interest, and to jointly organized annual scientific meetings. Reaching collective maturity in 1991, the paediatricians embarked upon the formation of their own College. This endeavour came to fruition on 28 May 1991, after the College's 4th AGM. To an old-timer, it was gratifying to see how quickly the toddlers grew up into Peter Pans and Tinker-belles.

In the twenty years that have passed, the College has been fortunate to enjoy unstinting support from four Presidents.

When Professor David Todd resigned as College President to assume the Presidency of the Hong Kong Academy of Medicine, Professor Chan Tai Kwong was elected in his place on 20 October 1992. The following Office-Bearers and Council Members were elected at the same time:

HKCP Council in 1992

Vice-Presidents	Prof Gerald H Choa	Dr EK Yeoh
Hon-Secretary	Dr Richard YH Yu	
Hon-Treasurer	Dr T F Tse	
Council Members		
Prof KN Lai	Dr CW Tsang	Dr SC Tso
Dr Loretta YC Yam	Dr Lam Wah Kit	Dr Ng Ngai Sing
Prof Jean Woo	Prof DC Anderson (Co-opt)	Dr Donald Yu
Dr Avery Chan	Prof David Todd, Past President (Ex-official)	

On 11 June 1998, Dr Richard Yu was elected President, together with the following Office-Bearers and Council Members:

HKCP Council in 1998

Vice-Presidents	Prof KN Lai	Dr EK Yeoh
Hon-Secretary	Dr Loretta YC Yam	
Hon-Treasurer	Dr TF Tse	
Council Members		
Dr Christopher KW Lai	Prof SK Lam	Prof WK Lam
Dr Patrick CK Li	Dr CS Li	Prof Joseph JY Sung
Dr CW Tsang	Dr Alexander SP Wong	Dr H Yuen
Dr CP Wong	Prof TK Chan, Past President (Ex-official)	
Hon Legal Advisor	Mr Peter WH Mark	
Hon Auditor	Walter Ma & Co	

Professor Lai Kar Nang, our current President, assumed the post on 23 October 2004. Because of increases in administrative workload and the basic and higher trainee population, the Council was expanded from 10 to 12 members in 2002. Also elected in 2004 were therefore:

HKCP Council in 2004

Vice-Presidents	Prof WK Lam	Dr Loretta YC Yam
Hon-Secretary	Dr Philip KT Li	
Hon-Treasurer	Dr T F Tse	
Council Members		
Prof Anthony TC Chan (co-opted)		
Dr Carolyn P L Kng	Prof SK Lam	Prof CS Lau
Dr Patrick CK Li	Dr CS Li	Prof Raymond HS Liang
Dr Matthew Ng	Prof Joseph JY Sung	Dr ML Szeto
Dr Matthew KL Tong	Dr CP Wong	Prof Lawrence KS Wong
Dr Edward MF Leung (co-opted)		
Prof Richard YH Yu, Past President (Ex-official)		
Hon Legal Advisor	Mr Peter WH Mark	
Hon Auditor	Walter Ma & Company	

It is customary for professional bodies to establish distinguished lectures, in tribute to the memory of individuals whose contributions and vision have advanced the field of medicine and benefited the community. In the case of the Hong Kong College of Physicians, there have been such occasions galore. Allow me to boast about some of them:

The first is **the AJS McFadzean Memorial Lecture**, for delivery at the Annual Scientific Meeting.

Started in 1992 with Dr Anna Lok, followed by Dr. Joseph Sung, Dr. Raymond Liang and Professor KN Lai

In 1996, the **AJS McFadzean Oration** replaced the McFadzean Memorial Lecture. It is delivered at the College Annual Dinner by distinguished guests from the community and the profession.

Orators:

Professor CN Yang	Ms Elsie Leung	Prof Cheng Yiu Chung
Prof.Leslie Turnberg	Prof Li Lei-shi	Prof.Arthur KC Li
Prof. Ross Lorimer		

The Sir David Todd Lecture was established in 1996, to succeed the AJS McFadzean Memorial Lecture. It is delivered at the Annual Scientific meeting by College Fellows below the age of forty-five, preferably on some area of distinction in basic research. Submissions are judged by a panel of three leading international medical scientists.

Lecturers:

Prof WC Leung, Joseph	Dr.YL Kwong	Prof. CP Lau
Prof. Annie Kung	Dr. Philip Li	Dr. Sydney Tang
Prof. TM Chan	Dr. Annie Chan On	Dr. Raymond Cheung
Prof. Yu Cheuk Man		

Gerald Choa Memorial Lecture

This lecture was established following the lamented loss of Professor Gerald Choa, the doyen of Hong Kong clinicians, administrator par excellence and mentor of the College, on 3 December 2001.

Lecturers:

Dr. Chew Chin Hin	Prof. Arthur Li	Prof. Rosie Young
Dr. CH Leong	Prof. Chan Kwong Fai, Laurence	

Details about the named lecturers and their subjects are available in the October 20006 issue of Synapse.

The Honorary Fellowship

Honorary Fellowship of the College is bestowed on individuals who do not necessarily hold a medical qualification, but who are deemed to have rendered exceptional services to the art and science of medicine and to the College.

May 29, 1997:	Prof Sir David Todd	Prof Rosie Young
June 11, 1998:	Prof Gerald Choa	
May 27, 1999:	Prof the Rt Hon Lord Turnberg	
May 25, 2000:	Prof Li Lei-Shi	Prof Kan Yuet Wai
June 1, 2001:	Prof Vivian Chan	
October 26, 2002:	Prof Chan Kwong Fai Laurence	
	Dr Chew Chin Hin	Dr Lo Ka Shui
	Prof Yuen Kwok Yung (Fellowship without Examination)	
October 11, 2003:	The late Dr Cheng Ha Yan (Posthumous)	
	The late Dr Tse Yuen Man (Posthumous)	
October 23, 2004:	Prof Chan Tai Kwong	Dr Leong Chi Hung
	Dr Yeoh Eng Kiong	Prof Zhong Nan Shan
November 5, 2005:	Prof Tsui Lap-Chee	Dr Liu Lit Chung, Vincent

Gathering of New Honorary Fellows

Dr Tse Yuen Man & Dr Cheng Ha Yan

It was a sad and solemn ceremony on 11 October 2003, yet one tinged with pride – we gathered to pay tribute to two young physicians, one a newly accredited Fellow in Respiratory Medicine and Advanced Internal Medicine and the other a basic physician trainee, who bravely and selflessly gave their lives in the line of duty during the SARS epidemic of 2002. Let me reiterate that this award of Honorary Fellowships is an inadequate but heartfelt gesture to express the College's gratitude to Dr Tse and Dr Cheng, and by implication to all Fellows, Members and Trainees who, at the risk of life and family, gave of their best without complaint to battle a devastating and only partially-known disease. Let me also thank all family members for exhibiting such grace under pressure.

When the SARS was finally defeated, not only were these courageous and dedicated souls not given the recognition they so richly deserved, many had to suffer the unhappy experience of hostile interrogation and hectoring from certain members of a Select Committee of the Legislative Council. This – alas – showed how cold and mean the politics of finger-pointing can be. And what happened afterward? I would like to quote from our Honorary Fellow, Dr CH Leong, in his 2004 AJS McFadzean Oration:

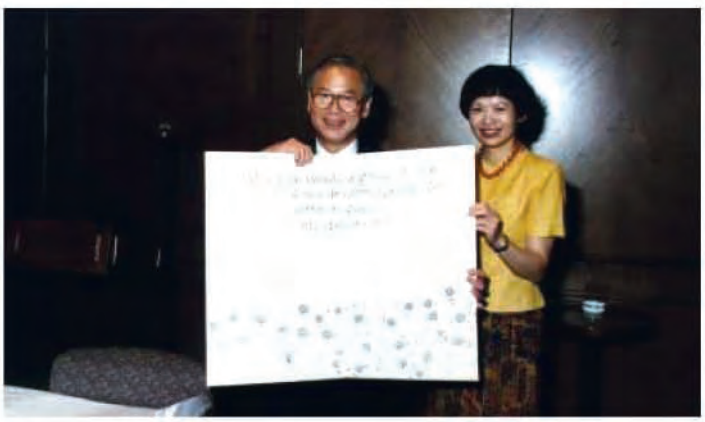
"Of the eleven members of the Select Committee, only four were returned to LegCo. Of the remaining seven, two elected to step down and five were defeated. They were all replaced."

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

Professor David Todd's Knighthood

Let me turn to a more joyous occasion. On 4 August 1995 the Council held a dinner to celebrate the knighthood awarded to Professor David Todd, in recognition of lifelong contributions to medicine, education and community service.

To borrow the title of a television series "First amongst Equals", David Todd is the first among the physicians to be knighted, the first graduate from the Faculty to Head the Department of Medicine, the first President of the Hong Kong College of Physicians, and the first Professor of Medicine to remain single. It is therefore inevitable that Her Majesty the Queen should bestow on Professor Todd the accolade of 'Knight Bachelor'.



In celebration of Sir David Todd's Knighthood

The HKCP and International Contacts

Undergraduate and post-graduate medical education in Hong Kong was modeled on the British system, so it has been a matter of fundamental importance that our College should develop and maintain close and special relationships with the UK Colleges. The continuation of the MRCP (UK) examination, which was first brought to Hong Kong in 1985 by Professor Todd, has played a particularly significant role in this happy outcome. Let me outline other important events and exchanges that have taken place in the past 20 years, this time with regard to the College's international relations.

March 1992

Joint Scientific Conference – Royal College of Physicians London
Presidential Lecture – Prof Dame Margaret Turner-Warwick

October 1994

Joint Scientific Conference – Royal College of Physicians – Edinburgh - President, Dr Anthony D Toft
Sir Stanley Davidson Lecture – given by Prof David Todd

December 1994

Symposium on Medical Training – Internist Perspective
Dr J Stephen Doyle – President, Royal College of Physicians Ireland
Dr Anthony D. Toft – President, Royal College of Physicians Edinburgh
Prof Alex Cohen – President, Royal Australasian College of Physicians
Prof Leslie Turnberg – President, Royal College of Physicians, London

December 1996

Joint Scientific Conference –Royal Australasian College of Physicians
President, Prof Richard Smallwood

March 1997

Joint Scientific Conference (Beijing) –
Chinese Medical Association, Prof Zeyi Cao – Executive Vice-President
Royal College of Physicians London, Prof Sir Leslie Turnberg – President
Royal Australasian College of Physicians, Prof Richard Smallwood – President
Chinese Academy of Medical Sciences
Peking Union Medical College Hospital

November 1998

Joint Scientific Conference –
Royal College of Physicians London Prof George Alberti – President
Royal Australasian College of Physicians Prof Donald Cameron – President
Chinese Medical Association in Shanghai Prof Zeyi Cao, ExecVice President CMA

October 2000

Joint Scientific Conference –
Federation of Royal Colleges (UK) Prof Michael Besser (London)
Dr Niall Finalyson (Edinburgh)
Singapore Academy of Medicine, Dr Chew Chin Hin (Singapore)
Hong Kong College of Paediatricians "East Meets West".

February 1993

Signing of First Memorial of Understanding (MOU) for Conjoint MRCP(UK)/HKCP/HKCPaed Intermediate Examination twice a year in Hong Kong - PACES October 2001.
Since 1985 – whole MRCP(UK) Examination conducted in Hong Kong once a year.
Prof Leslie Turnberg (London)
Dr Anthony D Toft (Edin)
Prof Donald Campbell (Glasgow)
Prof CY Yeung, Hong Kong College of Paediatricians
Prof TK Chan, Hong Kong College of Physicians

November 1998

Signing of the Second Memorandum of Understanding for Continuation of the Conjoint MRCP(UK)/HKCP Intermediate Examination – Prof George Alberti (London)
Prof JC Petrie, President (Edinburgh)
Mr C MacKay, President (Glasgow)
Dr Richard YH Yu, President, HKCP
Dr Leung Nai Kong, President, HK College of Paediatricians

12 October 2004

Signing of the Third Memorandum of Understanding for Continuation of the Conjoint MRCP(UK)/HKCP Intermediate Examination.
Prof Richard Yu – President, Hong Kong College of Physicians
Prof Carol Black – President, Royal College of Physicians of London
Prof NJ Douglas – President, Royal College of Physicians of Edinburgh.
Prof G Teasdale – President, Royal College of Physicians and Surgeons of Glasgow
Dr JA Vale – Medical Director and Chairman, MRCP(HK) Management Board Federation of Royal Colleges of Physicians of the United Kingdom.

In between scientific meetings, we enjoyed frequent visits by Royal College representatives and Presidents in other capacities – such as examiners for the final MB or the College's exit assessments. The Council has always exploited these occasions to meet informally with distinguished visitors and discuss matters of mutual interest.

Among the oversea pundits we may name:-

From London

Professor Sir Leslie Turnberg, Professor Sir George Alberti, Sir John Badenoch Professor Ian Gilmore, Professor Roy Pounder, Professor Michael Besser, Prof David London, Professor Dame Carol Black, Prof John Bennett, Prof Leslie Rees, Dr Norman Jones

From Edinburgh

Dr AT Proudfoot, Dr CJH Kelnar, Prof.Anthony Toft, Professor James Petrie, Dr Niall Finlayson, Prof SJG Semple, Professor Neil Douglas

From Glasgow

Professor Ross Lorimer

From Australia

Professor Donald Cameron, Prof Alex Cohen, Professor Richard Smallwood, Professor James Lawrence, Professor Napier Thompson, Professor Robin Mortimer, and Professor Richard Larkins

From Shanghai

Prof Zeyi Cao Prof Li Lei Shi

From USA

Prof Laurence Chan Colorado

Signing of the Roll – Admission Ceremony RCPE

1st Signing of the Roll

22 October 1994 Officiated by Dr Anthony Toft, President
Fellows attending: 126

2rd Signing of the Roll

15 October 2000 Officiated by Dr NDC Finlayson – Vice President & President-elect
Fellows attending: 128

3rd Signing of the Roll

21 February 2003 Officiated by Dr NDC Finlayson - President
Fellows attending: 37

4th Signing of the Roll

13 May 2006 Officiated by Prof Neil Douglas – President
Fellows attending: 41

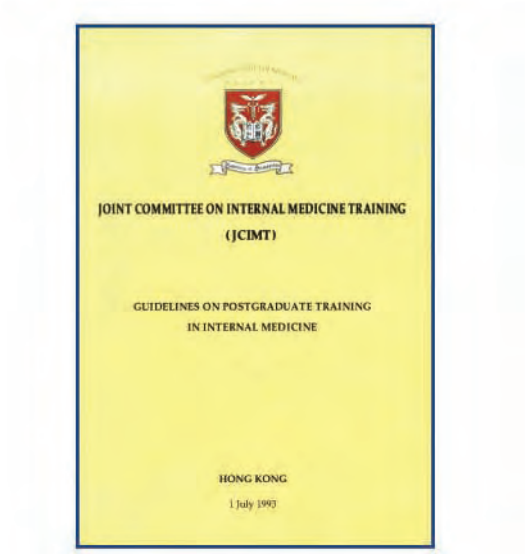
HKCP Fellows who are Fellows of Overseas Colleges

Edinburgh	487	(the greatest number outside UK)
London	210	
Glasgow	236	
Australasian	40	

Postgraduate Specialist Training

Let me now turn to the role of the College in the post-graduate specialist training.

Upon assuming the duties of setting standards and accrediting trainers and training posts, the College entered into a close collaboration with the Hong Kong Hospital Authority through the Joint Committee on Internal Medicine Training and Subspecialty Advisory Committee. The first Guidelines on Post-graduate Training in Internal Medicine was published in 1993.



The following Specialty Boards were established:

1. Internal Medicine
   - Clinical Pharmacology and Therapeutics
   - Infectious Disease
2. Cardiology
3. Critical Care Medicine
4. Dermatology and Venerology
5. Endocrinology, Diabetes and Metabolism
6. Gastroenterology and Hepatology
7. Geriatric Medicine
   - Rehabilitation
8. Haematology and Haematological Oncology
   - Medical Oncology
9. Nephrology
10. Neurology
11. Respiratory Medicine
12. Rheumatology
    - Immunology and Allergy

In response to changing community needs, scientific advancement and technological progress, revisions to the Guidelines were undertaken at suitable intervals. A second edition was published in 1998, followed by the third edition in 2002.

A fourth edition is expected to be completed by end of this year. For the purpose of promulgating the Guidelines, the College's Education and Accreditation Committee was formed in May 1996. The primary purpose of the Guidelines has always been to establish the highest professional standards in the training of specialists. In line with the functions of the Committee, the Guidelines' core Chapters therefore cover:

Training guidelines

Assessment criteria and procedure for trainees

Accreditation criteria for trainers

Evaluation of Training Programmes and Training Units by the Specialty Boards.

In 1995, an exercise commenced which aimed to integrate medical and geriatrics departments throughout Hong Kong's healthcare sector. This initiative was introduced to prepare for the expansion of geriatric services and accelerated training for Geriatricians and Specialists in Rehabilitation, in anticipation of population aging and its healthcare implications.

It is the policy of the College since the establishment of its Education and Accreditation Committee that all higher physician trainees must undergo 12 months of either concurrent or sequential training in general internal medicine. In the process the trainee becomes a 'proper' physician capable of supplying holistic care to patients.

Examination Committee

The purpose of this Committee, which was established in October 1992, is to oversee the Conjoint MRCP(UK)/HKCP Intermediate Examination and Annual and Exit Assessments for Higher Physician Trainees

The period of basic training extends over three years, during which a trainee will sit for the MRCP (UK)/HKCP Intermediate Examination. Three years of structured Higher Training in the various specialties then follow. Trainees will be required to pass two Annual and one Exit Assessments to qualify as a Fellow of the College.

Projection of community needs suggest that four specialties require urgent revision and restructuring. In addition to Geriatrics and Rehabilitation Services, Infectious Diseases and Medical Oncology should be targeted for these purposes.

Infection Diseases - Evaluate and restructure training programmes to ensure emancipation of trainers and trainees from the 19th century concept of 'contagious' diseases. This involves in particular training in Microbiology – Epidemiology and Infection Control.

Medical Oncology - Rising incidence in Malignancy in the aging population has been coupled with the development of new cytotoxic and monoclonal drugs which promise enhanced survival and quality of life. In view of toxicity which can cause serious morbidity and mortality, usage should be restricted to specialists competent in general medicine, the more so because majority of patients are elderly with frequent co-morbidity and general medical problems.

Collaboration and Cooperation with Other Colleges

College of Family Physicians and College of Emergency Medicine

- To supply sound fundamental knowledge in general internal medicine

College of Pathology

- Trainees in the following specialties will undergo training in the respective subspecialty with the College of Pathologists.

  Infectious disease – Microbiology

  Endocrinology – Chemical Pathology

  Immunology & Rheumatology - Immunology

  Haematology – Laboratory Haematology

Information on the number of Fellows in the Four Specialties

Specialty	Number of Fellows	Remark
Geriatric Medicine	34 (Mar 1996) 144 (Sept 2006)	Specialty Board in Geriatric Medicine established in Mar 1996
Infectious Disease	9 (Nov 1998) 22 (Sept 2006)	Subcommittee in Infectious Disease established in Nov 1998
Medical Oncology	3 (Nov 1997) 33 (Sept 2006)	Specialty Board in Medical Oncology established in Nov 1997
Rehabilitation	8 (April 1998) 22 (Sept 2006)	Subcommittee in Rehabilitation established in April 1998

As of 20 September 2006, the College has on its registers:

Fellows: 1129

Members: 286

Trainees: 453

Subscription Fees

1986	Fellows: $300.	Members: $150
1993	Fellows: $500.	Members: $300
1995	Fellows: $800.	Members: $500

Fellowship Subscription Fees of Selected Local Colleges

College	Annual Fellowship Subscription
Hong Kong College of Anaesthesiologists	$2500
Hong Kong College of Community Medicine	$2000
College of Dental Surgeons of Hong Kong	$2000
Hong Kong College of Emergency Medicine	$1500
Hong Kong College of Family Physicians	$1200
Hong Kong Academy of Medicine	$2500
Hong Kong College of Obstetricians & Gynaecologists	$800
College of Ophthalmologists of Hong Kong	$500
Hong Kong College of Orthopaedic Surgeons	$1000
Hong Kong College of Otorhinolaryngologists	$3000
Hong Kong College of Paediatricians	$1500
Hong Kong College of Pathologists	$2000
Hong Kong College of Physicians	$800
Hong Kong College of Psychiatrists	$1000
Hong Kong College of Radiologists	$3000
College of Surgeons of Hong Kong	$1000

Presidents come and go, but every year since 1986 the College has been indebted to one person. Thanks to his able administration and shrewd investments, College finances are in a very healthy state indeed – a reserve in eight figures! Let us therefore salute our Hon Treasurer – Dr Tse Tak Fu. Likewise a salute to our Hon Legal Advisor. From the preparatory committee days when he was the chief architect of the College's Memorandum, Articles of Associations and By-Laws, Mr Peter Mark has been in the thick of the action. HKCP heroes are not only doctors…

For achieving so much in just twenty years, praise and acclaim must be lavished on all Council Members past and present, Chairpersons of the various Committees and Specialty Boards, and the Secretariat. It is one of the rare occasions where the labour theory of value applies. I would like to offer my gratitude to each and every one of the individuals in question. What the future holds for the Hong Kong College of Physicians is clear – we will strive to enhance the great tradition which began twenty years ago under our Founding President Professor David Todd, and we will continue to uphold our motto.

Ladies and gentlemen, thank you.

The Physician and The Community

CH Leong Honorary Fellow, Hong Kong College of Physicians

Let me begin by thanking the College of Physicians for the invitation yet again to address this august gathering – fellows and guests of your great College. I stand here feeling utterly humble, for amongst the lecturers speaking as Hon. Fellows are the Vice Chancellor of the University of Hong Kong, the President of the Chinese Medical Association and hero of SARS etc who by any standards are world renowned internal medicine experts, or "internists" as the Americans would call you, whilst I am the odd "surgeon" out. I am equally humbled about the topic I have chosen. Whilst my peers have and will be delivering knowledge on the cutting edge of medicine, I have nothing to contribute. It is on this basis that I thought I would "return to basics" and talk about "The Physician and the Community". Let me hasten to add that the term "physician" in my context denotes, "doctors at large"

Allow me then to bring you my thoughts on the following areas.

- The changing perception of the community towards the physician.
- How did we get there
- Lead or be led
- Sans faith. Sans hope. Sans everything
- Servant and leader

The Changing Perception

The "Old days" were called "Good" old days not without a reason, nor was it simply nostalgia. In 1999 I delivered the Digby Memorial Lecture to the Department of Surgery, University of Hong Kong, and the following was my description of the life and times of Digby, reminiscent of the status of the physician during those times, "Digby must have lived in glorious times with an air of superiority, with special professional skills and often holding the health if not the lives of the population from the Governor to the man on the street in his hands, he must have been very much wanted in high social circles and loved by the public" Nor was this characteristic of Hong Kong alone.

The doctor then was seen as a rare breed – a learned individual who had gone though at least six years of university education; a proud individual to whom kings and princes would have to pay homage to should disease befall them; yet a caring soul who would do his best to comfort lepers in their colonies, climb aboard fishing junks in the middle of the night to act as an "honourable midwife"; a guest at any social function for governors and dignitaries and a community leader, perhaps the only person who could speak enough English in the Hong Kong context to communicate with the then colonial British officials. Little wonder that every parent would crave for a doctor as their son in law.

It was in that environment that I, and I am sure your past president Professor Yu grew up, not yet as physicians but as benevolent sons of two society-loved doctors whose patients not only paid for their service but showered them with salt fishes, catches of the ocean, the best of poultry from their own backyards (Luckily avian flu was "unknown" then).

No, this was not nostalgia, those where the days when doctors were demigods, a very selective group of people who were armed with the knowledge of not only the anatomy and physiology of the human body but also of the diseases and pathologies that could afflict it. Who was there to question, let alone argue? Furthermore, with their total commitment to the doctrine of the Hippocratic Oath, their honourable roles were never in doubt.

Where are we now? Perhaps a couple of examples might be illustrative. Today even a simple appendicitis is seldom subjected to the necessary treatment after a basic clinical diagnosis. Most patients demand not just one, but several investigations. "Are you sure it is appendicitis doctor?" "Who is responsible if it is not?" "What about an ultrasound, a CT Scan?" The end result, medical costs are exorbitantly jacked up. Worse, doctor patient relationship goes down the drain. Instead doctors practice defensive medicine. Take another example. It is not uncommon to see CT Scan/MRI performed in public hospitals for non emergency and non life-threatening conditions in the middle of the night, all at tax payers expense. When asked why, the answers are uniform – patients grumble; district councillors appeal to HCE and Legislative Councillors complaint to CCE. Clinical decisions are forced to give way to political expediency.

The physician is thus being perceived by the public in the following way:-

- As a pure "service provider" strictly on a business level and professionalism is not taken on board. Paradoxically such an attitude is more obvious in the public sector where patients are not involved in direct service payment. The argument is that, "We are tax payers, you doctors are paid by the tax we contribute, so do as we demand."
- Doctors are looked upon as the "haves" and the public themselves as the "have nots". "Do we not demand when the opportunity arises?" they say.

- The medical profession is being considered as part of the "establishment". Nothing is lost, and much is gained, by bringing the "establishment" to task.

With widespread medical knowledge through the internet and periodicals, albeit half baked, the public believe that they are now in the know. Coupled with the widespread demand for rights, the physician, once the 'overdog', today becomes the underdog. The days of demigods are over, and never to return.

In Hong Kong, the whole process is made more obvious by the so called development of democratization. Overnight the public is given a long deserved right to vote. Regrettable whilst a vote is a right and a power, it is often used as a right to demand, a demand for ones own need, a tool for politicians to gain votes, not a right to improve the society as a whole.

Overnight the issue of human rights rolls into patients' rights. Properly interpreted, patients' rights signify that patients should be better informed, patients' rights signifies the complete transparency of health care systems and health care administration. At no point does it imply nor should patients' rights denote dictating and overturning professional autonomy. Regrettably, doctors' rights are never mentioned, let alone considered. The Hospital Authority received some 1650-2240 complaints from 2001-2005 and the trend is that the numbers are rising yearly. Of these the majority are not substantiated complaints, most are on attitudes of health care workers.

The 'overdogs' are now the underdogs, the masters are now the servants.

How did we get there?

In the last paragraph I have painted a picture of the "public's misguided involvement". I have pointed my finger at the ignorance, or at least incomplete understanding of the public. But is our own profession, the doctors in total, the leaders in particular, completely absolved from blame?

For a start, the profession has never analysed the complete reasons behind our being assaulted nor do we have a united front to fend off these accusations, and to turn the tide.

The profession as a whole has never come out in full force to explain to the public that effective and successful health delivery is dependent on partnership between the public and the profession and that a doctor is at best a captain of this partnership team in the provision of medical service.

Whenever there is a medical mishap, the profession takes a defensive attitude, blaming overwork. Yes, we have to be sympathetic about the work load. Even the media has repeatedly brought this to the public's attention. Yet the public expects the profession to be the almighty and that having contributed by paying tax it demand nothing less than the best service. Sympathy notwithstanding, overwork is never an excuse.

Whether "protectionism" is genuine, or otherwise, it is being seen as so, and the profession is every bit to be blame. A doctor who was accused of overcharging, claimed that the fees were for some 13 endoscopic examinations done at the same time (between 8.15 a.m. to 9:30 a.m. on the same date), was only given a light sentence by the Medical Council. Did the peers ever consider the possibility that the doctor was playing around with the term "endoscopic" examination relying on the ignorance of the patient?.

Take the infamous case of the doctor and the mobile phone (手機醫生), Yes, it might be unavoidable for the doctor to answer an unexpected call on mobile phone during surgery, the complications so happening in that incident in no way relating to the telephone conversation. Yet the verdict of the Medical Council and their recommendation left much to be desired. The tone gave the show away – the public felt they were NOT adequately protected.

It must be remembered that the Medical Council, though constituted mainly of members of the profession, is a body to monitor the profession on behalf of the public. In no way, and let me state in no way, should members of this Council use their influence to protect the doctors. Ironically, in a recent promotional pamphlet to lobby for votes to be returned to this Council, one candidate actually mentioned that his ultimate aim, if elected, would be "to protect the interest of the doctor". Little wonder that the membership of the GMC which our Medical Council mirrors has a good number of lay members and that there is a move to have all members of the GMC to be appointed. Please take note that the motto of the GMC is "protecting patients guarding doctors" something we in Hong Kong ought to properly digest.

Let us not forget, whilst unfortunately of late we have been wrongly addressing our patients as "clients", we still practice medicine where professionalism prevails. Yes, with business, the motto is consumerism, in professional practice it is altruism. Here, image is vital. Nowhere in the world for example would the public support doctors going on strike irrespective of whatever honourable causes.

The legal battle between the doctors and the Hospital Authority over working hours has tarnished the images of both the doctors and the employer, and dare I say more the image of the doctors. Yes, the plight of the doctors is to be sympathized with, yet even the judgment of the court has this to say "The fact that doctors are not entitled to overtime compensation, whether in overtime allowance or time-off in lieu, appears on the evidence to have been clearly understood by the public doctors". Furthermore one of the plaintiffs has agreed to this submission, "The doctor's responsibilities for continuing patient care transcend normal working hours. In order to provide timely treatment to patients and to save lives, it has long been an established practice worldwide for doctors working in hospitals to work with [sic] an on-call or shift duty roster basis so as to provide 24-hour service coverage. In HA, all medical staff are expected to work overtime and to perform on-call duties in line with the operational requirements of the specialty according to their appointment condition". As of today, the dispute is still hanging in the air, it would therefore be to the advantage of both parties that quick settlement be made before further damage to the image of the profession becomes unavoidable.

Much as I hate to say it, to a very significant extent therefore we as a profession are responsible for what we are today.

Sans faith. Sans hope. Sans everything.

Does this mean sans faith, sans hope, and sans everything? In the year 2000, I attended a Singapore - Malaysia Academy yearly congress as a representative of the Hong Kong Academy of Medicine. The keynote address was given by Dr. Mahathir, the Premier of Malaysia, a medical doctor himself. In his address aiming to jeer at Lee Kuan Yew, the Prime Minister of Singapore, a lawyer, he was highlighting the human side of the medical profession, the humanitarian side of the medical practice and our image, as compare with the lawyers who as Dr. Mahathir suggested, at the drop of a hat could switch from representing the accuse to the prosecution and vice versa depending on the fee.

In the same year, there was a survey done in Hong Kong on the level of trust that the public give to different professions. Of comfort, whilst I could hope that the confidence rate be higher, doctors still top the list of public's trust among the various professions listed including of course lawyers and law enforcers.

Servant and Leader

All is not lost. There is yet time to recover lost ground. To me it seems the medical profession must show that we can both "lead and serve".

How then could we lead:-

- Stop internal bickering

  Turf fighting, finger pointing, back stabbing do not benefit the image of the profession. Regrettably there have been too many divisions, the private and the public sectors, the juniors and the seniors, the generalists and the specialists, – the media has a field day playing Peter against Paul – the public love the fight, the government is reaping the benefit, of the game of divide and rule. The never ending bickering over compulsory continuing medical education has not only resulted in the profession being made a laughing stock in the eyes of the public, it has demonstrated further the "protectionist" attitude of the profession, and that we have still not placed the interest of the public in the highest position. Every member of the profession well knows and agrees that medical science never stays still, and that life long learning is not only necessary to upgrade ourselves but to provide the best for the patients we serve. Declaring the need for compulsory Continuing medical Education (CME) by the profession therefore is the best way to show the public we care. Regrettably this is not to be. Let us have no illusion, compulsory CME will come, it is part of the registration process even of TCMP, it is part of the registration process of real estate agents. Whether the profession will declare on its own the need for compulsory CME and gain the good will of the public and regain professional autonomy, or allow the public to stuff it down the throat of the profession and therefore kiss good-bye to professional autonomy is for the profession to decide. Why fall into the trap of 敬酒不飲, 飲罰酒.

  Of late a senior academic working in the public sector, for some the reason that I can not comprehend, has been critical of standards of the profession in the private sector. I would be the first to applaud any senior academician, mentor to many in practice, to constructively criticize within the profession, those in the private domain on their standards of professional service, but to air dirty linens to the public through the media is uncalled for; worse, many of the allegations may not even by evidence based.

- A United Force.

  Having dealt with internal bickering, the profession needs to act in a united force to sell the concerns of the profession to the community regarding health care. Few in the community realize that many doctors in the private sector do provide discount or free consultation, even free medicine on a regular basis for patients who express financial difficulties. Few realize that most doctors in private practice go out of their way, within the law, to argue and persuade insurance organizations to reimburse medical claims, at no financial benefit to themselves.

  The profession should in a united force lead the public to understand, to accept or to repeal public policies for the benefit of the community. The recent proposal of "Advance Directives" by the Law Reform Commission is an example at issue. The majority in the community has taken "Advance Directives" as consent for Euthanasia. It is therefore an act that would gain mileage if the profession who is in the know were to come out to explain what it is, its pros and cons and the view of the profession. Regrettably this has not happened. The public is still confused. The profession has allowed another chance to pass by.

  Take another example, the proposal for a Goods and Services Tax (G.S.T). The profession should take a lead to discuss the need for a wider tax base in Hong Kong, to outline whether G.S.T. is the preferred method and if so whether the revenue generated should be ploughed into the support of the ailing public health care financing system. Again this is not to be, golden opportunities to show the leadership of the doctors in the community are allowed to slip by.

- Be proactive

  For years I have no doubt the leaders of the profession, the hierarchy in the Medical Council, have realized that the code controlling doctors advertising is outdated. The writing is clear on the wall that the public is craving for transparency and the right to know. It is really up to the profession to quench the insatiable thirst of the public by relaxing the advertising code yet maintaining professional dignity. Few for example in the profession would like to see us advertising in this manner. Regrettably the profession failed to take a leading active role, until internal bickering

reach its pinnacle when a group of professionals challenged their own monitorial body – the Medical Council – with a judicial review, and won.

At that stage the Medical Council in my humble opinion should have eaten quietly the humble pie – relax this code of practice to balance the rights of public knowledge and professional dignity. Appeal against the Judicial .Review decision only lead to further exposure of the profession's short-comings and narrow mindedness.

- Be visionary, show no self vested interest.

Some years ago, I pushed for proper registration of Traditional Chinese Medical Practitioners realizing that TCM could not be ignored forever since where there are Chinese there will be a need for TCM and that TCM is the mainstream medical care in our mother country. Proper registration of course is only the first step. To incorporate them under one single roof of health care with us western doctors to fight for issues vital to improving and financing health care is in my mind the ultimate goal. Needless to say we have to accept our difference and work for the common good 求大同, 存小異. No this was not to be, many in the profession could not accept TCM as partners in health care. The whole movement vanished in thin air.

Regrettably this was against the tide. TCMPs are now properly registered, they have their own monitorial body, Government is heeding to the request of the public to provide publicly subsidised TCM. Today TCM in-patients care is being planned in our public hospitals. There is a move to allow TCMPs to issue sick leave certificates – once the guarded right of the medical profession. Ironically many in the medical profession who oppose TCM have taken up interest in TCM, joining courses to study TCM hopefully to register in TCM to practice both streams of medicine. Many who have objected to TCMPs are quietly or openly referring their patients to TCMPs when western medicine fails especially when these patients are their friends and relatives.

TCMPs are now well on the way to establishing themselves as a separate if not a rival team of health care service from western medicine. The chance of the medical profession to show its leadership of the health care team, bringing in all health care professionals under one roof, overseeing all health care professionals to be properly monitored and ultimately to improve standards of holistic care for our patients has been lost and never to return. How sad!

Mr. Chairman, ladies and gentlemen for the last twenty minutes or so I have been very critical of the profession in relation to the community. In the same period I have made suggestions, and I dare say rational ones, to regain lost ground. If what I said hurts the feeling of some in the profession I offer no apologies. My emotion flows from my commitment to the profession; my passion for the profession; my respect for the profession and my committed goal that everyone in the profession should abide by the Hippocratic Oath to the last letter.

Thank you!

This speech was delivered at the HKCP's 20th Anniversary Annual Scientific Meeting on 15 October 2006

19th Annual General Meeting, 8th Congregation and 20th Anniversary College Dinner (14 October 2006)

Professor KN Lai delivered the annual President's report which highlighted the achievements of the College's various subcommittees in the past year. The Hon Treasurer, Dr TF Tse reported on the healthy financial status of the College.

The ceremony proceeded with conferral of Fellowships and Memberships to 37 and 40 doctors respectively.

The College Dinner was a grand occasion attended by many visiting Presidents of overseas Colleges and our Honorary Fellows. We were especially honoured by the presence of the Honorable Wong Yan Lung, Secretary for Justice, HKSAR, who delivered the AJS McFadzean Oration, titled "Litigation and Medicine". Our distinguished overseas guests included Prof Neil Douglas, PRCP(Edinburgh), Prof Ian Gilmore, PRCP(London), Dr Lim Shih-Hui, President, College of Physicians, Singapore, Prof Sir Graham M Teasdale, PRCP(Glasgow) and Prof Napier Thomson, PRACP.

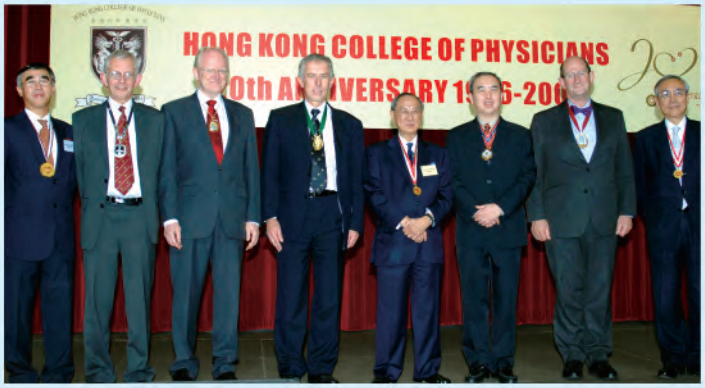
The official platform party with guests at the Fellowship Conferment ceremony

From L to R: Prof P Li, Dr L Yam, Prof WK Lam, Prof R Young, Dr CH Leong, Prof R Yu and Prof KN Lai

Sir David Todd Lecture

Professor Cheuk Man Yu delivered the lecture titled "Cardiac Resynchronization Therapy : The Unique Role of Research in Hong Kong"

Annual Scientific Meeting (14-15 October 2006)



From L to R: Prof Lai, Prof Gilmore, Prof Sir Teasdale, Prof Douglas, Prof Yu, Dr Lim, Prof Thomson and Prof Chan

The celebratory theme of the meeting was "Twenty Years of Excellence in Medicine". It featured a series of Advances in Medicine Lectures, with updates in each sub-specialty in medicine. Highlights included lectures by our Honorary Fellows Professor Tsui Lap-Chee and Dr Leong Che Hung, the Sir David Todd Lecture, Distinguished Research Paper Award for Young Investigators 2006 and the Best Thesis Awards. Professor Laurence Chan delivered the Fifth Gerald Choa Memorial Lecture. The meeting at the Hong Kong Academy of Medicine Jockey Club Building was attended by over 588 delegates.

The HKCP Council 2006-2007

The HKCP Council 2006-2007 with overseas guests, *(2nd row from L to R)* **Prof Napier Thompson, Prof Ian Gilmore, Prof Neil Douglas, Dr. Lim Shih-Hui and Prof Sir Graham Teasdale**

Pesident	Professor Lai Kar Neng
Vice-President	Professor Lam Wah Kit Dr Yam Yin Chun, Loretta
Hon Secretary	Professor Li Kam Tao, Philip
Hon Treasurer	Dr Tse Tak Fu
Council Members	Professor Chan Tak Cheung, Anthony Dr Kng Poey Lyn, Carolyn Professor Lau Chak Sing Dr Leung Man Fuk, Edward Dr Li Chung Ki, Patrick Dr Li Chun Sang Professor Liang Hin Suen, Raymond Dr Ng Mar Tai, Matthew Professor Sung Jao Yiu, Joseph Dr Szeto Ming Leung Dr Tong Kwok Lung, Matthew Dr Wong Chun Por Professor Wong Ka Sing, Lawrence
Co-opted Council Members	Professor Kwong Yok Lam Dr Lai Sik To, Thomas
Founding President	Professor Sir David Todd
Past President	Professor Yu Yue Hong, Richard

Chairmen of College Committees

Examination Committee - Professor Raymond Liang
Education and Accreditation Committee – Dr Loretta Yam
National and International Liaison Committee – Professor WK Lam
Professional and General Affairs – Dr Matthew Ng
Scientific Committee – Professor CS Lau (from 1 June 2007 the new Chairman will be Professor Kwong Yok Lam)
Membership Committee – Dr Patrick Li
Administration and Finance Committee – Dr TF Tse
Working Group in Traditional Chinese Medicine – Dr TF Tse
Research Committee – Professor KS Wong
Synapse – Dr Matthew Ng

The HKCP Council 2006-2007

Distinguished Research Paper Award for Young Investigators 2006

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

1. Dr Henry Lik-Yuen CHAN

"Long-term Follow-up of Peginterferon and Lamivudine Combination Treatment in HBeAg-positive Chronic Hepatitis B"
Hepatology, June 2005, pp 1357-1364

2. Dr Chi Chiu MOK

"Incidence and Risk Factors of Thromboembolism in Systemic Lupus Erythematosus: A Comparison of Three Ethnic Groups"
Arthritis & Rheumatism, Vol. 52, No. 9, Sept. 2005, pp 2774-2782

3. Dr Sydney Chi Wai TANG

Activation of Tubular Epithelial Cells in Diabetic Nephropathy and the Role of the PPAR-γ Agonist
J Am Soc. Nephrol 17:1633-1643, 2006

4. Dr Shiu Man WONG

Treatment of Lateral Epicondylitis with Botulinum Toxin: A Randomized, Double-Blind, Placebo-Controlled Trial"
Annals of Internal Medicine, Volume 143, Number 1, December 2005, pp 793-797

News from the Royal College of Physicians (London)

Professor Ian Gilmore, President, has published a short bulletin every two to three weeks to give Fellows and Members quick updates on emerging issues of the College.

The first bulletin reported the introduction by the Home Office of a new work permit sub-category to allow international medical graduates sponsored by a Royal College to take up appropriate posts. These "medical training initiatives" can last for a maximum of 24 months and the trainees must return to their overseas countries. The Home Office website was http://www.workingintheuk.gov.uk/content/working in the uk/en/homeage.html

Sir David Todd Lecture

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

Cheuk Man Yu Department of Medicine and Therapeutics
The Chinese University of Hong Kong,
Prince of Wales Hospital

Synopsis

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.[1] 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.

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] Furthermore, it benefits the heart by improving contractile (systolic) function as well as regressing LV enlargement process, the so called "reverse remodeling" effect.[2]

Despite the convincing benefits of CRT which is now recommended as one of the standard therapies for heart failure worldwide, about one-third of patients do not respond favorably to CRT.[3] 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.[4] This finding has also ignited a series of studies world-wide to examine further the potential predictors of "non-responders" to CRT. In this line, echocardiography has been found to play a pivotal role in CRT as illustrated below.

Assessment of Regional Asynchrony by tissue Doppler imaging (TDI)

Tissue Doppler imaging (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. Therefore it is an ideal tool to assess systolic asynchrony (uncoordinated contraction). Initial application of TDI in an early study has provided insight into the understanding of the mechanism how systolic synchronicity was achieved after CRT.[2] The study illustrated that regional wall motion was homogenously delayed so that myocardial segments contracted in a belayed but simultaneous manner. This was in contrast to the previous hypothesis that pacing might pre-excite regions of delayed contraction.

Predict Responders of CRT by TDI

The ability of identifying potential responders of CRT is crucial as about 1/3 of patients may not response favorably to CRT despite following the current indications according to ACC/AHA and ESC. TDI is the most widely used tools in this regard. Based on the measurement of the time to peak systolic contraction (or velocity) from a mathematical model consisted of 12 LV segments, systolic Asynchrony Index was developed.[5] From the Asynchrony Index, a cutoff value was defined which was demonstrated to be useful to predict responders of CRT with high accuracy.[5] We also compared Asynchrony Index 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 the best balance between sensitivity (96%) and specificity (78%) to predict LV reverse remodeling response.[3] Currently multi-centre trials are on-going to determine what is the best echocardiographic predictor of CRT response, in particular the PROSPECRT study.[6]

Real-time 3-Dimensional Echocardiography – A New Tool to predictor Responders of CRT

The application of real-time 3-dimensional echocardiography to assess systolic asynchrony is a potentially powerful tool. Our report

validated its usefulness in evaluating systolic asynchrony when compared with TDI and Asynchrony Index.[7] Furthermore, this method allows the development of various indices of systolic dyssynchrony by methods similar to TDI ($r=0.74$, $p<0.05$).

Relationship between LV Reverse Remodeling and Long-Term Prognosis

Despite the proven clinical importance of LV reverse remodeling in pharmacological trials of heart failure, the implication of reverse remodeling in device therapy has been questioned. Our recent study showed that LV mass regressed significantly after CRT for 3 months (Yu CM et al, Eur Heart Journal 2006, published in web and in print). The clinical importance of LV reverse remodeling in CRT was illustrated by another recent study who illustrated 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 included all-cause mortality, cardiovascular mortality, heart failure hospitalization and the composite end-point of mortality and cardiovascular hospitalizations.[8]

Is there a Role of CRT for Heart Failure Patients with Normal QRS Duration?

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 consists of the majority (three-quarter) of heart failure population. As electromechanical may not be revealed by ECG, it has been hypothesized that mechanical asynchrony may actually present in heart failure patients with normal QRS duration. By employing TDI technology to construct the Asynchrony Index, it was found that 43% of heart failure patients with normal QRS duration had significant systolic asynchrony.[9] Subsequently, this finding was confirmed by other studies with other TDI derived 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. Based on the initial results from our group and 2 other centers, these patients appeared to benefit from CRT with improvement of symptoms and showed evidence of LV reverse remodeling.

New Echocardiographic Tools to Assess Systolic Asynchrony

There are other echocardiographic tools under development which 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" .[10] This technique has been validated to provide accurate quantitative assessment of regional delay in contraction, and yet qualitative evidence of LV lateral wall delay provided a high specificity (of 89%) for predicting a favorable response to CRT. This information is particularly helpful when employed in conjunction with Asynchrony Index.[10]

Conclusion

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.[11,12] 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.

References

1. In: Yu CM, Hayes DL, Auricchio A, editors. Cardiac resynchronization therapy. Blackwell, 2006: 1-328.
2. Yu CM, Chau E, Sanderson JE, Fan K, Tang MO, Fung WH, Lin H, Kong SL, Lam YM, Hill MR, Lau CP. Tissue Doppler echocardiographic evidence of reverse remodeling and improved synchronicity by simultaneously delaying regional contraction after biventricular pacing therapy in heart failure. *Circulation*. 2002;105:438-445.
3. Yu CM, Fung JW, Zhang Q, Chan CK, Chan YS, Lin H, Kum LC, Kong SL, Zhang Y, Sanderson JE. Tissue Doppler imaging is superior to strain rate imaging and postsystolic shortening on the prediction of reverse remodeling in both ischemic and nonischemic heart failure after cardiac resynchronization therapy. *Circulation*. 2004;110:66-73.
4. Yu CM, Fung JWH, Zhang Q, Sanderson JE. Understanding non-responders of cardiac resynchronization therapy – current and future perspectives. J Cardiovasc Electrophysiol. 2005;in press.
5. Yu CM, Fung JWH, Lin H, Zhang Q, Sanderson JE, Lau CP. Predictors of left ventricular reverse remodeling after cardiac resynchronization therapy for heart failure secondary to idiopathic dilated or ischemic cardiomyopathy. *Am J Cardiol*. 2003;91:684-688.
6. Yu CM, Abraham WT, Bax J, Chung E, Fedewa M, Ghio S, Leclercq C, Leon AR, Merlino J, Nihoyannopoulos P, Notabartolo D, Sun JP, Tavazzi L. Predictors of response to cardiac resynchronization therapy (PROSPECT) – study design. *Am Heart J*. 2005;149:600-605.
7. Zhang Q, Yu CM, Fung JW, Zhang Y, Chan YS, Chan HC, Yip GW, Sanderson JE. Assessment of the effect of cardiac resynchronization therapy on intraventricular mechanical synchronicity by regional volumetric changes. *Am J Cardiol*. 2005;95:126-129.
8. Yu CM, Bleeker GB, Fung JW, Schalij MJ, Zhang Q, van der Wall EE, Chan YS, Kong SL, Bax JJ. Left ventricular reverse remodeling but not clinical improvement predicts long-term survival after cardiac resynchronization therapy. *Circulation*. 2005;112:1580-1586.
9. Yu CM, Lin H, Zhang Q, Sanderson JE. High prevalence of left ventricular systolic and diastolic asynchrony in patients with congestive heart failure and normal QRS duration. *Heart*. 2003;89:54-60.
10. Yu CM, Zhang Q, Fung JW, Chan HC, Chan YS, Yip GW, Kong SL, Lin H, Zhang Y, Sanderson JE. A novel tool to assess systolic asynchrony and identify responders of cardiac resynchronization therapy by tissue synchronization imaging. *J Am Coll Cardiol*. 2005;45:677-684.
11. Bax JJ, Abraham T, Barold SS, Breithardt OA, Fung JW, Garrigue S, Gorcsan J, III, Hayes DL, Kass DA, Knuuti J, Leclercq C, Linde C, Mark DB, Monaghan MJ, Nihoyannopoulos P, Schalij MJ, Stellbrink C, Yu CM. Cardiac resynchronization therapy: Part 2 – issues during and after device implantation and unresolved questions. *J Am Coll Cardiol*. 2005;46:2168-2182.
12. Bax JJ, Abraham T, Barold SS, Breithardt OA, Fung JW, Garrigue S, Gorcsan J, III, Hayes DL, Kass DA, Knuuti J, Leclercq C, Linde C, Mark DB, Monaghan MJ, Nihoyannopoulos P, Schalij MJ, Stellbrink C, Yu CM. Cardiac resynchronization therapy: Part 1 – issues before device implantation. *J Am Coll Cardiol*. 2005;46:2153-2167.

Best Thesis Award – Gold Award Winner

Nonalcoholic Fatty Liver in Hong Kong Chinese

Wai Sun Wong Department of Medicine & Therapeutics, Prince of Wales Hospital

Nonalcoholic fatty liver disease (NAFLD) is one of the most common chronic liver diseases, and may result in cirrhosis and hepatocellular carcinoma. Data in Asia are scarce. In this report, we present four studies on Hong Kong Chinese with biopsy-proven NAFLD. Eighty-six percent of the patients had necroinflammation and 26% had fibrosis. Over a median follow-up of 6 years, nearly half of the patients had progression in fibrosis. Liver enzymes like alanine aminotransferase had poor correlation with disease stage, and might even normalize in advanced disease. NAFLD was strongly associated with diabetes and obesity. In particular, isolated post-challenge hyperglycemia (raised 2-hour plasma glucose but normal fasting glucose during oral glucose tolerance test) was common in NAFLD patients and was associated with steatohepatitis. A quarter of the diabetic NAFLD patients had normal fasting glucose. Hypoadiponectinemia was associated with NAFLD patients had normal fasting glucose. Hypoadiponectinemia was associated with NAFLD independent of other metabolic risk factors, while patients with nonalcoholic steatohepatitis had raised tumor necrosis factor-alfa level. These adipokines may have pivotal role in the pathogenesis of NAFLD.

Best Thesis Award – Silver Award Winner

Management of Conn's Syndrome

Wing Yan Lau Department of Medicine & Therapeutics, Prince of Wales Hospital

Primary hyperaldosteronism is increasingly recognized as an important cause of secondary hypertension and cardiovascular morbidity. The treatment of primary hyperaldosteronism can reduce morbidity and mortality associated with hypertension, hypokalaemia and cardiovascular damage. Twenty-eight patients receiving unilateral laparoscopic adrenalectomy for primary hyperaldosteronism from 2000 to 2003 were evaluated for the factors associated with resolution of hypertension. All patients were found to have hypokalaemia at the time of diagnosis. The mean age of the patients was 45.7 years (± 8.1 years). The diagnosis of aldosterone- producing adenoma was made in twenty patients (71%) using the combination of postural test and CT scanning. Percutaneous venous sampling of the adrenal vein was performed in six patients (21%). There was no operative mortality. Sixteen patients (57%) had resolution of hypertension while twelve patients (43%) remained hypertensive. Hypokalaemia was resolved in twenty-seven patients (96%). Resolution of hypertension was independently associated with younger age at the time of diagnosis (p=0.01), hypertension less than 5 years (p=0.04) and positive response to spironolactone before operation (p=0.04). Apart from laparoscopic adrenalectomy, other minimally invasive treatments have been described for the treatment of Conn's adenoma. CT guided radiofrequency ablation has been used to treat primary and metastatic adrenal cortical carcinoma. Radiofrequency ablation (RFA) of Conn's adenoma was performed in a separate study to evaluate the effectiveness and follow-up results in terms of resolution of hypertension and hyperaldosteronism. Among eleven patients who underwent radiofrequency ablation, the plasma aldosterone levels fell to within normal range in ten patients (91%). Normalization of blood pressure was seen in nine patients (81%). The mean follow-up period was 10 months (range 4-16 months). One patient suffered from hypertensive crisis during the procedure and one patient developed peri-nephric haematoma after RFA. Overall, RFA is a safe and effective treatment for Conn's adenoma although long term outcome remains unanswered.

MRCP Examination Dates

Part I examination

23 January 2007 (Tuesday)
11 September 2007 (Tuesday)

Part II (Written) examination

11 April 2007 (Wednesday)
12 April 2007 (Thursday)

25 July 2007 (Wednesday)
26 July 2007 (Thursday)

5 December 2007 (Wednesday)
6 December 2007 (Thursday)

PACES 2007

5-9 March 2007
25-29 June 2007
22-26 October 2007

MRCP Pass Rates

Pass rate of the MRCP (UK) Part I examinations

	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%)
Sep 05	24	15 (62.5%)
Jan 06	95	74 (80%)
Sept 2006	21	13 (62%)

Pass list of October PACES 2006

Au Yeung Yick Toa Benjamin	Kwok Yan Kitty
Lai Sze Wah	Lam Pui Shan
Lau Yuk Lun Alexander	Leung Wai Fung Anders
Li Leung	Liu Chung Ngar Dorothy
Luk Yan Yan	Poon Wing Tat
Tai Ling Fung	Tang Miu Yee Michele
Tong Wai Hung Raymond	Wong Shung Yee
Wu Pui Yee	Yuen Ho Chuen

The AIM Corner

Moon Sing Lai

Examination Coordinator, Specialty Board in AIM

This article provides feedback to candidates for the Annual and Exit Examinations from the AIM Training Board.

1 Exit Assessment

The structured assessment system for AIM Exit Assessment was started from June 2005. Each candidate is assessed in three stations by one pair of examiners in each station. He/she is asked on two questions related to acute medical problems, chronic medical problems and ethics/ communication /statistic/others in consecutive stations. For candidate(s) who has submitted dissertation, he/she is assessed by an additional pair of examiners on his/her dissertation.

The passing rates of the three stations in December 2006 are: 1) Acute medical problems - 100% 2) Chronic medical problems - 81% 3) Ethics /Communication /Statistics/ others - 95%

The questions which candidates performed disappointingly are: 1) The pros and cons of continuation of anti-epileptic drugs with a patient with controlled epilepsy 2) The way to stop an anti-epileptic drug 3) Diagnosis of OSA and the relationship between OSA and catecholamine level

Finally, the candidates whose training will be completed the following 31 March are eligible to sit the Exit Assessment in December of the previous year and those whose training will be completed the following 30 September are eligible to sit the Exit Assessment in May-June of the same year.

However, those candidates are reminded that the uncompleted training must be accomplished on 31 March if he/she passes the Exit Assessment in December of the previous year. Similarly, the uncompleted training must be completed on 30 September if the involved candidate(s) passes the Exit Assessment in May/June of the same year.

2 Annual Assessment

Case reports as part of the AIM annual assessment was started from June, 2006. The marks of case reports contribute about 22% of the total marks of the assessment. The case reports submitted must follow the standard format strictly and those which do not comply will be sent back to the candidates for re-writing. In the AIM annual assessment held in December 2006, out of 114 case reports submitted, only 2 (1.8%) failed with marks below 5. It was found that the references of some case reports were obsolete or inaccessible and could not be retrieved through e-KG or internet. Some candidates just cut-and-pasted some parts into their case reports directly from the original articles. Candidates are strongly advised against those actions and marks will be deducted.

Starting from December, 2006, the Specialty Board in AIM will send back the examiners marking sheets with their comments (if any) to the supervisors. The supervisors should forward the marking sheets to candidates with discussion on the performance and comments made by the examiners. Through this, the candidates can improve their skills in presentation and writing up of case reports.

Higher Physician Training - Exit Assessments

All candidates taking the Exit Assessments are reminded to adhere to the following stipulations of the Annual and Exit Assessment guidelines as published in the "Guidelines on Postgraduate Training in Internal Medicine, third edition, July 2002".

"Candidates whose training will be completed the following 31 March are eligible to sit the Exit Assessment in November-December of the previous year (regardless of whether or not the Exit Assessment has been put further forwards for administrative reasons), and those whose training will be completed the following 30 September are eligible to sit the Exit Assessment in May-June of the same year (regardless of whether or not the Exit Assessment has been put further forwards for administrative reasons)".

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					

Statistics on No. of Trainees in all Specialties

Updated in December 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			YEAR			
CARDIOLOGY	16	1—I 1 2 3 4 *4*	1 1 2—I 3 4 *2*	1 0 2 3 4 *0*	1 0 2 3 4 *0*	1 0 2 3 4 *4*	1 2 2—I 3—I 4 *6*	1 0 2 3 4 *0*
CLINICAL PHARMACOLOGY & THERAPEUTICS	0	1 0 2 3 4 *0*	1 0 2 3 4 *0*	1 0 2 3 4 *0*	1 0 2 3 4 *0*	1 0 2 3 4 *0*	1 0 2 3 4 *0*	1 0 2 3 4 *0*
CRITICAL CARE MEDICINE	14	1 3 2—II 3—I 4 *2*	1 0 2 3 4 *0*	1 *0* 2 3 4 *0*	1 0 2 3 4 *0*	1 0 2 3 4 *0*	1 2 2—II 3 4 *4*	1 0 2 3 4 *0*
DERMATOLOGY & VENEREOLOGY	7	1 0 2 3 4 *0*	1 0 2 3 4 *0*	1 0 2 3 4 *0*	1 0 2 3 4 *0*	1 0 2 3 4 *0*	1 0 2 3 4 *0*	1 0 2 3 4 *0*
ENDOCRINOLOGY, DIABETES & METABOLISM	14	1 0 2 3 4 *0*	1 0 2 3 4 *2*	1 1 2 3 4—I *2*	1 0 2 3 4 *0*	1 0 2 3 4 *0*	1 1 2—I 3 4 *7*	1 0 2 3 4 *0*
GASTROENTEROLOGY & HEPATOLOGY	20	1 0 2 3 4 *6*	1 0 2 3 4 *2*	1 0 2 3 4 *0*	1 0 2 3 4 *0*	1 0 2 3 4 *0*	1 1 2 3—I 4 *6*	1 0 2 3 4 *1*
GERIATRIC MEDICINE	10	1 2 2 3—I 4—I *5*	1 0 2 3 4 *11*	1 0 2 3 4 *3*	1 0 2 3 4 *3*	1 0 2 3 4 *0*	1 1 2 3 4—I *2*	1 0 2 3 4 *0*
HAEM/HAEM ONCOLOGY	6	1 1 2 3—I 4 *2*	1 0 2 3 4 *0*	1 0 2 3 4 *0*	1 0 2 3 4 *0*	1 0 2 3 4 *0*	1 1 2 3—I 4 *8*	1 0 2 3 4 *0*
IMMUNOLOGY & ALLERGY	0	1 0 2 3 4 *0*	1 0 2 3 4 *0*	1 0 2 3 4 *0*	1 0 2 3 4 *0*	1 0 2 3 4 *0*	1 0 2 3 4 *1*	1 0 2 3 4 *0*
INFECTIOUS DISEASE	9	1—I 2 2 3—I 4 *0*	1 1 2 3 4—I *0*	1 0 2 3 4 *0*	1 0 2 3 4 *0*	1 0 2 3 4 *0*	1 0 2 3 4 *0*	1 0 2 3 4 *0*
INTERNAL MEDICINE	160	1—II 11 2—II 3—V 4—II *29*	1 3 2—II 3 4—I *19*	1—II 4 2—I 3 4—I *5*	1 1 2 3—I 4 *1*	1—I 1 2 3 4 *4*	1—II 14 2—VII 3—III 4—II *45*	1 0 2 3 4 *8*
MEDICAL ONCOLOGY	7	1 0 2 3 4 *0*	1 0 2 3 4 *0*	1 0 2 3 4 *0*	1 0 2 3 4 *0*	1 0 2 3 4 *0*	1 *1* 2—I 3 4 *6*	1 0 2 3 4 *0*
NEPHROLOGY	11	1 1 2—I 3 4 *4*	1 0 2 3 4 *0*	1 0 2 3 4 *0*	1 0 2 3 4 *0*	1 0 2 3 4 *0*	1 0 2 3 4 *6*	1 0 2 3 4 *2*
NEUROLOGY	18	1 1 2 3—I 4 *4*	1 0 2 3 4 *3*	1—I 1 2 3 4 *0*	1 0 2 3 4 *0*	1 0 2 3 4 *0*	1—II 3 2—I 3 4 *4*	1 0 2 3—I 4 *0*
PALLIATIVE MEDICINE	4	1 0 2 3 4 *0*	1 0 2 3 4 *1*	1 0 2 3 4 *0*	1 0 2 3 4 *0*	1—I 1 2 3 4 *2*	1 0 2 3 4 *0*	1 0 2 3 4 *0*
REHABILITATION	4	1 0 2 3 4 *0*	1 0 2 3 4 *3*	1 0 2 3 4 *2*	1 0 2 3 4 *0*	1 0 2 3 4 *0*	1 0 2 3 4 *0*	1 0 2 3 4 *3*
RESPIRATORY MEDICINE	19	1 2 2—I 3—I 4 *2*	1 1 2—I 3 4 *5*	1—I 1 2 3 4 *0*	1 0 2 3 4 *0*	1 0 2 3 4 *7*	1 0 2 3 4 *4*	1 0 2 3 4 *1*
RHEUMATOLOGY	11	1 1 2 3—I 4 *1*	1 0 2 **3** 4 *1*	1 0 2 **3** 4 *0*	1 1 2 3—I 4 *0*	1 0 2 **3** 4 *0*	1 1 2—I **3** 4 *2*	1 0 2 **3** 4 *2*

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	16	1 0 2 3 4 *0*	1—I 3 2—I 3—I 4 *8*	1 0 2 3 4 *0*	1 0 2 3 4 *2*	1 1 2 3—I 4 *4*	1 1 2 3 4—I *1*	1 1 2 3—I 4 *3*	1 0 2 3 4 *1*	1 1 2 3 4—I *6*	1 0 2 3 4 *0*	1 0 2 3 4 *3*
CLINICAL PHARMACOLOGY & THERAPEUTICS	0	1 0 2 3 4 *0*	1 0 2 3 4 *0*	1 0 2 3 4 *0*	1 0 2 3 4 *0*	1 0 2 3 4 *0*	1 0 2 3 4 *0*	1 0 2 3 4 *0*	1 0 2 3 4 *0*	1 0 2 3 4 *0*	1 0 2 3 4 *0*	1 0 2 3 4 *0*
CRITICAL CARE MEDICINE	14	1 0 2 3 4 *0*	1—I 2 2—I 3 4 *5*	1 0 2 3 4 *0*	1—I 1 2 3 4 *1*	1 2 2 3—II 4 *4*	1 1 2 3—1 4 *2*	1 1 2 3—I 4 *2*	1 0 2 3 4 *0*	1 2 2 3—I 4—I *1*	1 0 2 3 4 *0*	1 0 2 3 4 *2*
DERMATOLOGY & VENEREOLOGY	7	1 0 2 3 4 *0*	1 0 2 3 4 *0*	1 0 2 3 4 *0*	1 0 2 3 4 *0*	1 0 2 3 4 *0*	1 0 2 3 4 *0*	1 0 2 3 4 *0*	1 0 2 3 4 *0*	1 0 2 3 4 *0*	1 0 2 3 4 *0*	1 0 2 3 4 *0*
ENDOCRINOLOGY, DIABETES & METABOLISM	14	1 0 2 3 4 *0*	1 2 2—II 3 4 *5*	1 0 2 3 4 *0*	1 1 2 3 4—I *1*	1 0 2 3 4 *2*	1 0 2 3 4 *1*	1 2 2—II 3 4 *1*	1 0 2 3 4 *1*	1 0 2 3 4 *3*	1 0 2 3 4 *0*	1 0 2 3 4 *1*
GASTROENTEROLOGY & HEPATOLOGY	20	1 0 2 3 4 *0*	1—I 2 2—I 3 4 *5*	1 0 2 3 4 *0*	1 1 2 3—I 4 *3*	1 3 2—II 3—I 4 *2*	1 1 2—I 3 4 *4*	1—I 1 2 3 4 *5*	1 0 2 3 4 *0*	1 1 2 3—I 4 *11*	1 0 2 3 4 *0*	1 1 2 3—I 4 *3*
GERIATRIC MEDICINE	10	1 1 2 3—I 4 *5*	1 0 2 3 4 *3*	1 1 2 3 4—I *4*	1 0 2 3 4 *1*	1 1 2 3—I 4 *9*	1 0 2 3 4 *7*	1 1 2 3—I 4 *6*	1 0 2 3 4 *1*	1 2 2—I 3 4—I *10*	1 0 2 3 4 *3*	1 0 2 3 4 *3*
HAEM/HAEM ONCOLOGY	6	1 0 2 3 4 *0*	1 2 2 3—I 4—I *3*	1 0 2 3 4 *0*	1 0 2 3 4 *1*	1 0 2 3 4 *1*	1 0 2 3 4 *0*	1 0 2 3 4 *0*	1 0 2 3 4 *0*	1 1 2—I 3 4 *1*	1 0 2 3 4 *0*	1 0 2 3 4 *0*
IMMUNOLOGY & ALLERGY	0	1 0 2 3 4 *0*	1 0 2 3 4 *0*	1 0 2 3 4 *0*	1 0 2 3 4 *0*	1 0 2 3 4 *0*	1 0 2 3 4 *0*	1 0 2 3 4 *0*	1 0 2 3 4 *0*	1 0 2 3 4 *0*	1 0 2 3 4 *0*	1 0 2 3 4 *0*
INFECTIOUS DISEASE	9	1 0 2 3 4 *0*	1 1 2 3—I 4 *0*	1 0 2 3 4 *0*	1 0 2 3 4 *0*	1 1 2 3 4—I *1*	1 0 2 3 4 *0*	1 1 2 3 4—I *0*	1 0 2 3 4 *0*	1 0 2 3 4 *4*	1 0 2 3 4 *0*	1 0 2 3 4 *1*
INTERNAL MEDICINE	160	1 0 2 3 4 *3*	1–IV 20 2–VII 3–IV 4–IV *48*	1 1 2 3—I 4 *5*	1—II 5 2—I 3—II 4 *13*	1—I 13 2—II 3–VIII 4–II *28*	1 4 2—I 3—II 4–I *20*	1—I 12 2–VI 3—II 4–III *23*	1 2 2—I 3 4—I *2*	1 9 2–II 3–III 4–IV *45*	1 1 2 3—I 4 *2*	1—I 4 2—I 3—II 4 *17*
MEDICAL ONCOLOGY	7	1 0 2 3 4 *0*	1 1 2—I 3 4 *0*	1 0 2 3 4 *0*	1 0 2 3 4 *0*	1 0 2 3 4 *0*	1 0 2 3 4 *0*	1 0 2 3 4 *0*	1 0 2 3 4 *0*	1 0 2 3 4 *1*	1 0 2 3 4 *0*	1 0 2 3 4 *0*
NEPHROLOGY	11	1 0 2 3 4 *0*	1 1 2 3—I 4 *6*	1 0 2 3 4 *0*	1 1 2—I 3 4 *1*	1 1 2 3 4—I *3*	1 1 2 3—I 4 *1*	1 1 2—I 3 4 *5*	1 1 2 3 4—I *0*	1 1 2 3—I 4 *6*	1 0 2 3 4 *0*	1 0 2 3 4 *2*
NEUROLOGY	18	1 0 2 3 4 *0*	1—II 2 2 3 4 *5*	1 0 2 3 4 *0*	1 0 2 3 4—I *1*	1 2 2—I 3—I 4 *2*	1 0 2 3 4 *0*	1 2 2—I 3 4—I *3*	1 0 2 3 4 *0*	1 0 2 3 4 *1*	1 0 2 3 4 *0*	1 1 2 3—I 4 *0*
PALLIATIVE MEDICINE	4	1 0 2 3 4 *0*	1 0 2 3 4 *0*	1 1 2 3—I 4 *1*	1 0 2 3 4 *0*	1 1 2 3—I 4 *1*	1 1 2 3—I 4 *3*	1 0 2 3 4 *0*	1 0 2 3 4 *0*	1 0 2 3 4 *0*	1 0 2 3 4 *0*	1 0 2 3 4 *0*
REHABILITATION	4	1 2 2 3—I 4—I *4*	1 0 2 3 4 *0*	1 0 2 3 4 *1*	1 0 2 3 4 *0*	1 0 2 3 4 *2*	1 0 2 3 4 *0*	1 0 2 3 4 *1*	1 0 2 3 4 *0*	1 0 2 3 4 *1*	1 0 2 3 4 *4*	1 0 2 3 4 *0*
RESPIRATORY MEDICINE	19	1 0 2 3 4 *6*	1 1 2 3 4—I *3*	1 1 2 3 4—I *5*	1 0 2 3 4 *2*	1 1 2 3—I 4 *3*	1 0 2 3 4 *3*	1 2 2—II 3 4 *1*	1 0 2 3 4 *0*	1 0 2 3 4 *3*	1 1 2 3—I 4 *4*	1 0 2 3 4 *1*
RHEUMATOLOGY	11	1 0 2 3 4 *1*	1 1 2—I 3 4 *1*	1 0 2 3 4 *0*	1—I 1 2 3 4 *0*	1 1 2 3 4—I *2*	1 0 2 3 4 *1*	1 1 2 3 4—1 *1*	1 1 2—I 3 4 *0*	1 0 2 3 4 *1*	1 0 2 3 4 *0*	1 0 2 3 4 *0*

SPECIALTY	TRAINEES TOTAL (PP/DH/HA/ OTHERS)	TRAINEES						
		NEW TERRITORIES EAST CLUSTER					NEW TERRITORIES WEST CLUSTER	
		AHNH	NDH	PWH	SH	TPH	POH	TMH
		YEAR					YEAR	
CARDIOLOGY	16	1 0 2 3 4 ***2***	1 2 2—II 3 4 ***2***	1 2 2—I 3—I 4 ***5***	1 0 2 3 4 ***0***	1 0 2 3 4 ***0***	1 0 2 3 4 ***0***	1—I 1 2 3 4 ***6***
CLINICAL PHARMACOLOGY & THERAPEUTICS	0	1 0 2 3 4 ***0***	1 0 2 3 4 ***0***	1 0 2 3 4 ***0***	1 0 2 3 4 ***0***	1 0 2 3 4 ***0***	1 0 2 3 4 ***0***	1 0 2 3 4 ***0***
CRITICAL CARE MEDICINE	14	1 0 2 3 4 ***1***	1 0 2 3 4 ***2***	1 0 2 3 4 ***1***	1 0 2 3 4 ***0***	1 0 2 3 4 ***0***	1 0 2 3 4 ***0***	1 0 2 3 4 ***1***
DERMATOLOGY & VENEREOLOGY	7	1 0 2 3 4 ***0***	1 0 2 3 4 ***0***	1 1 2 3—I 4 ***0***	1 0 2 3 4 ***0***	1 0 2 3 4 ***0***	1 0 2 3 4 ***0***	1 0 2 3 4 ***0***
ENDOCRINOLOGY, DIABETES & METABOLISM	14	1 0 2 3 4 ***1***	1—I 1 2 3 4 ***1***	1 3 2—I 3—I 4—I ***9***	1 1 2 3—I 4 ***0***	1 0 2 3 4 ***0***	1 0 2 3 4 ***0***	1—I 2 2 3 4—I ***1***
GASTROENTEROLOGY & HEPATOLOGY	20	1 0 2 3 4 ***0***	1—I 3 2 3—I 4—I ***2***	1 3 2—III 3 4 ***6***	1 0 2 3 4 ***0***	1 0 2 3 4 ***0***	1 0 2 3 4 ***0***	1—I 3 2—II 3 4 ***6***
GERIATRIC MEDICINE	10	1 0 2 3 4 ***1***	1 0 2 3 4 ***1***	1 0 2 3 4 ***3***	1 1 2 3—I 4 ***6***	1 0 2 3 4 ***1***	1 0 2 3 4 ***1***	1 0 2 3 4 ***9***
HAEM/HAEM ONCOLOGY	6	1 0 2 3 4 ***0***	1 0 2 3 4 ***0***	1 0 2 3 4 ***3***	1 0 2 3 4 ***0***	1 0 2 3 4 ***0***	1 0 2 3 4 ***0***	1 1 2 3—I 4 ***2***
IMMUNOLOGY & ALLERGY	0	1 0 2 3 4 ***0***	1 0 2 3 4 ***0***	1 0 2 3 4 ***0***	1 0 2 3 4 ***0***	1 0 2 3 4 ***0***	1 0 2 3 4 ***0***	1 0 2 3 4 ***0***
INFECTIOUS DISEASE	9	1—I 1 2 3 4 ***1***	1 0 2 3 4 ***0***	1—I 2 2—I 3 4 ***1***	1 0 2 3 4 ***0***	1 0 2 3 4 ***0***	1 0 2 3 4 ***0***	1 0 2 3 4 ***3***
INTERNAL MEDICINE	160	1—I 2 2 3 4—I ***12***	1—II 9 2—V 3—II 4 ***10***	1—III 20 2–VIII 3—II 4—VII ***39***	1 4 2 3—III 4—I ***6***	1 1 2 3 4—I ***4***	1 0 2 3 4 ***2***	1–VIII 16 2—III 3—III 4—II ***37***
MEDICAL ONCOLOGY	7	1 0 2 3 4 ***0***	1 0 2 3 4 ***0***	1—I 5 2—I 3—III 4 ***9***	1 0 2 3 4 ***0***	1 0 2 3 4 ***0***	1 0 2 3 4 ***0***	1 0 2 3 4 ***0***
NEPHROLOGY	11	1 0 2 3 4 ***2***	1 0 2 3 4 ***0***	1 1 2 3 4—I ***5***	1 0 2 3 4 ***0***	1 0 2 3 4 ***1***	1 0 2 3 4 ***0***	1—II 2 2 3 4 ***7***
NEUROLOGY	18	1 1 2 3 4—I ***1***	1 1 2—I 3 4 ***1***	1 1 2 3—I 4 ***4***	1 2 2 3—I 4—I ***0***	1 0 2 3 4 ***0***	1 0 2 3 4 ***0***	1—I 1 2 3 4 ***1***
PALLIATIVE MEDICINE	4	1 0 2 3 4 ***0***	1 0 2 3 4 ***0***	1 0 2 3 4 ***0***	1 0 2 3 4 ***1***	1 0 2 3 4 ***0***	1 0 2 3 4 ***0***	1 0 2 3 4 ***0***
REHABILITATION	4	1 0 2 3 4 ***0***	1 0 2 3 4 ***0***	1 0 2 3 4 ***2***	1 0 2 3 4 ***1***	1 0 2 3 4 ***2***	1 0 2 3 4 ***1***	1 2 2—I 3 4—I ***3***
RESPIRATORY MEDICINE	19	1 0 2 3 4 ***3***	1 3 2—II 3—1 4 ***3***	1—I 2 2—I 3 4 ***4***	1 1 2—I 3 4 ***0***	1 0 2 3 4 ***1***	1 0 2 3 4 ***0***	1—I 2 2 3—I 4 ***6***
RHEUMATOLOGY	11	1 0 2 3 4 ***0***	1 0 2 3 4 ***0***	1—I 1 2 3 4 ***3***	1 0 2 3 4 ***0***	1 0 2 3 4 ***1***	1 0 2 3 4 ***0***	1—II 2 2 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—I 2 3—IV 4—I	6 *12*
INTERNAL MEDICINE	160	1 2 3 4—I	1 ***0***
IMMUNOLOGY & ALLERGY	0	1 2 3 4	0 *2*
RESPIRATORY MEDICINE	19	1—I 2 3 4	1 *7*

* *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*

Statistics on No. of Fellows in all Specialties
Updated in December 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	172	7	3	0	**10**	0	5	10	0	**15**	**25**
CLINICAL PHARMCOLOGY & THERAPEUTICS	5	0	0	0	**0**	0	0	2	0	**2**	**2**
CRITICAL CARE MEDICINE	49	5	0	0	**5**	0	0	7	0	**7**	**12**
DERMATOLOGY & VENEREOLOGY	76	0	0	0	**0**	0	0	1	0	**1**	**1**
ENDOCRINOLOGY, DIABETES & METABOLISM	69	3	2	3	**8**	0	0	9	0	**9**	**17**
GASTROENTEROLOGY & HEPATOLOGY	110	7	2	0	**9**	0	0	8	1	**9**	**18**
GERIATRIC MEDICINE	148	6	12	5	**23**	3	0	4	0	**7**	**30**
HAEM/HAEM ONCOLOGY	39	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	23	1	0	0	**1**	0	0	1	1	**2**	**3**
INTERNAL MEDICINE	869	45	36	10	**81**	1	7	68	9	**85**	**166**
MEDICAL ONCOLOGY	34	0	0	0	**0**	0	0	8	0	**8**	**8**
NEPHROLOGY	98	7	0	0	**7**	0	0	8	2	**10**	**17**
NEUROLOGY	65	4	3	0	**7**	0	0	5	1	**6**	**13**
PALLIATIVE MEDICINE	13	0	1	0	**1**	0	2	0	0	**2**	**3**
REHABILITATION	41	0	3	3	**6**	1	0	1	4	**6**	**12**
RESPIRATORY MEDICINE	136	7	7	1	**15**	0	10	8	1	**19**	**34**
RHEUMATOLOGY	44	3	2	1	**6**	0	0	2	2	**4**	**10**

SPECIALTY	FELLOWS TOTAL (PP/DH/HA/ OTHERS)	FELLOWS														
		KOWLOON CENTRAL CLUSTER			KOWLOON EAST CLUSTER				KOWLOON WEST CLUSTER							KOWLOON CENTRAL + EAST + WEST CLUSTER
		KH	QEH	Subtotal	HOHH	TKOH	UCH	Subtotal	CMC	KWH	OLMH	PMH	WTSH	YCH	Subtotal	
CARDIOLOGY	172	0	10	10	0	2	5	7	1	4	1	7	0	3	16	33
CLINICAL PHARMCOLOGY & THERAPEUTICS	5	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
CRITICAL CARE MEDICINE	49	0	5	5	0	2	4	6	3	2	0	1	0	2	8	19
DERMATOLOGY & VENEREOLOGY	76	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
ENDOCRINOLOGY, DIABETES & METABOLISM	69	0	5	5	0	2	4	6	1	3	2	5	0	2	13	24
GASTROENTEROLOGY & HEPATOLOGY	110	0	6	6	0	3	3	6	5	5	0	12	0	6	28	40
GERIATRIC MEDICINE	148	6	4	10	6	2	11	19	8	11	1	10	4	5	39	68
HAEM/HAEM ONCOLOGY	39	0	5	5	0	1	1	2	0	0	0	3	0	0	3	10
IMMUNOLOGY & ALLERGY	6	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
INFECTIOUS DISEASE	23	0	2	2	0	0	2	2	0	0	0	4	0	1	5	9
INTERNAL MEDICINE	869	6	60	66	7	16	38	61	25	33	4	53	3	23	141	268
MEDICAL ONCOLOGY	34	0	1	1	0	0	0	0	0	0	0	1	0	0	1	2
NEPHROLOGY	98	0	8	8	2	2	4	8	1	5	0	7	0	2	15	31
NEUROLOGY	65	0	7	7	0	1	3	4	0	3	1	3	1	0	8	19
PALLIATIVE MEDICINE	13	0	0	0	3	0	1	4	4	0	0	0	0	0	4	8
REHABILITATION	41	8	0	8	1	0	3	4	1	1	0	2	4	0	8	20
RESPIRATORY MEDICINE	136	7	7	14	5	4	3	12	4	4	0	4	6	1	19	45
RHEUMATOLOGY	44	1	3	4	0	0	2	2	1	1	0	3	0	1	6	12

SPECIALTY	FELLOWS TOTAL (PP/DH/HA/ OTHERS)	FELLOWS									
		NEW TERRITORIES EAST CLUSTER						NEW TERRITORIES WEST CLUSTER			NEW TERRITORIES EAST + WEST CLUSTER
		AHNH	NDH	PWH	SH	TPH	Subtotal	POH	TMH	Subtotal	
CARDIOLOGY	172	3	3	9	0	0	15	0	9	9	24
CLINICAL PHARMCOLOGY & THERAPEUTICS	5	0	0	3	0	0	3	0	0	0	3
CRITICAL CARE MEDICINE	49	2	4	1	0	0	7	0	2	2	9
DERMATOLOGY & VENEREOLOGY	76	0	0	1	0	0	1	0	0	0	1
ENDOCRINOLOGY, DIABETES & METABOLISM	69	2	1	11	0	0	14	0	1	1	15
GASTROENTEROLOGY & HEPATOLOGY	110	2	2	7	0	0	11	0	7	7	18
GERIATRIC MEDICINE	148	2	1	4	6	4	17	1	11	12	29
HAEM/HAEM ONCOLOGY	39	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	23	1	0	1	0	0	2	0	4	4	6
INTERNAL MEDICINE	869	18	15	54	6	6	99	2	55	57	156
MEDICAL ONCOLOGY	34	0	0	12	0	0	12	0	0	0	12
NEPHROLOGY	98	2	0	5	0	1	8	0	7	7	15
NEUROLOGY	65	1	2	6	0	0	9	0	3	3	12
PALLIATIVE MEDICINE	13	0	0	0	1	0	1	0	0	0	1
REHABILITATION	41	0	0	2	1	2	5	1	3	4	9
RESPIRATORY MEDICINE	136	4	3	7	0	1	15	0	7	7	22
RHEUMATOLOGY	44	1	1	3	0	3	8	0	3	3	11

Doctor Leong Che Hung

Dr CH Leong was conferred Honorary Fellowship at the AGM in 2004

John Mackay

Clinician, teacher, researcher, surgical pioneer, politician, administrator, and family man, Dr.Leong Che Hung is no ordinary person.

We had met many times before, but always in crowded medical gatherings, so it was a pleasure to sit with Dr. Leong in his Wellington Street business office for an extended one-to-one conversation. Even the fact that he has an office separate from his clinic in Central building gives an indication of the different facets of his busy life.

CH was born in Hong Kong in 1939, the oldest of seven children, on the same year that his father qualified as a doctor at Hong Kong University. The young family moved to Guangzhou during the Japanese occupation where his father worked in a hospital. After the war the family moved back to Hong Kong where his father established a successful practice in Aberdeen.

CH was enrolled at St. Joseph's College in 1949. In his first class there were children twice his age who had never had the opportunity of schooling because of the war. He was a quick learner, twice he jumped a year. It was at school that he decided to become a doctor, inspired by the example set by his father. This meant leaving St. Joseph's because biology was not taught there, and moving for his final year to Queen's College.

At Hong Kong University Medical School CH earned distinctions in Anatomy, and Obstetrics and Gynaecology. Already showing his talent for leadership he became the President of the student's medical society, enjoying the distinction of wearing the official green gown with yellow strip; and became editor of 'Elixir', the publication of the Hong Kong University Student Union.

He qualified in 1962 and completed his House Jobs at the Queen Mary Hospital. Choosing Surgery rather than Medicine as a career was a decision based on his enjoyment of active hands-on procedures, and recognition that he had a temperament more akin to that of flamboyant surgeons than the quieter physicians. He remembers with gratitude the teaching of Professors Kenneth Hui and Joseph Fung.

From 1964 to 1978 Dr Leong was in the Department of Surgery at Hong Kong University rising from Assistant Lecturer to Reader. In 1971 he went for a year to the University of California at Los Angeles where he joined the Urology department, the first six months as a Resident, later doing research and studying histocompatability with the world authority Professor Paul Terasaki. On return to Hong Kong University he set up the first specialist urological department and subsequently carried out Hong Kong's first renal transplant.

Other trips from Hong Kong took him, in 1974, on a Li Koon Chun Travelling Fellowship to lecture at each of the Australian medical schools, and in 1975 to give the Hunterian Lecture at the Royal College of Surgeons of England. This was a particular honour because after Professor Frank Stock and Professor G.B.Ong he was only the third person, and the youngest, from Hong Kong to give the lecture: he was also the only one who had graduated from Hong Kong University. His subject was his original research on dogs, later applied to humans, of replacing the urinary bladder with a stomach graft.

In 1978 Dr. Leong left Hong Kong University to enter private practice and to pursue his wider interests in the community. By this time he had accumulated Fellowships from the Surgical Colleges of England, Edinburgh, Australia, and America; to these were added in later years another ten Fellowships and Honorary Fellowships, and a D.Sc. (Hon) from both Aberdeen University and Hong Kong University.

He was now much in demand, becoming the founding chairman of the Hong Kong Society of Nephrology; a Visiting Professor at the Sun Yat Sen Medical College in Guangzhou where he did monthly lectures and operations; and an Honorary Consulting Surgeon at the Kiang Wu Hospital in Macau – starting their urological and dialysis services.

Before long, CH began making his mark outside the world of clinical surgery. Starting in 1984 he was a member for two years of the Medical

Graduation 1955 St. Joseph's College

Chairman 1959 HKU Medical Society speaking on Annual Ball

Graduation 1962 with parents Dr & Mrs K L Leong

Development Advisory Council of the Hong Kong Government. In 1985 he became a member of the Consultative Committee for the Basic Law of the Hong Kong Special Administrative Region, arguing strongly with others such as Dr. Raymond Wu, for a fully autonomous medical system in Hong Kong.

In 1986 he was elected President of the British Medical Association (Hong Kong Branch), and was appointed to the Medical council of Hong Kong.

By 1988 the pace had quickened. Dr. Leong had now finished his term at the British Medical Association, and had been elected President of the Hong Kong Medical Association. He was a Member of the Provisional Hospital Authority: Founding Chairman of the Hong Kong Urological Association; Chairman of the Committee on Scientifically Assisted Reproduction: and Chairman of the Medical Development Advisory Committee.

Importantly, Dr. the Honourable Leong Che-hung, JP was now the elected representative of the Medical and Dental Functional Constituency in the Legislative Council.

Dr. Leong's membership of the Legislative Council was distinguished by the fact that he held office for twelve years. He served for nine years under the administrations of Sir David Wilson, and of Mr. Christopher Patten, the last Governor of Hong Kong as a British dependant territory. Her Majesty the Queen awarded Dr. Leong in 1992 with the Order of the British Empire, O.B.E., in recognition of his many years of public service.

His Legislative Council appointment continued from July 1st 1997 under Chief Executive Tung Chi Wah during the interim administration of the Provisional Legislative Council. Finally, following the June 1998 elections, he served for two years under the new constitution of the Special Administrative Region of the People's Republic of China. In 2001 he was awarded a high honour by the Chief Executive Tung Chi-wah, the Gold Bauhinia Star, G.B.S.

This was a time of achievement. One of the more satisfying moments, after a long campaign, was the passage of strong anti-smoking legislation in 1997, at the very end of the British administration – legislation which is only now, nine years later, about to be strengthened. Dr. Leong still found time to write a weekly column for five years on medical matters for the Hong Kong Standard newspaper.

The greatest negative affect of Dr. Leong's career as a legislator, according to his medical colleagues, was the lack of time he had available for his surgical practice. Despite this he was honoured with the Founding Presidency of the College of Surgeons from 1990 to 1993, and Presidency of the Hong Kong Academy of Medicine from 2002 to 2004

In 1990 he was appointed a Member of the Hospital Authority, becoming Chairman in 2002.

The devastating SARS epidemic in 2003 was a huge challenge for the medical community. Dr. Leong believes that the front-line doctors did a magnificent job in extraordinary circumstances. The International Panel of Experts under Sian Griffiths, President, Faculty of Public Health, Royal Colleges of Physicians of United Kingdom, praised the 'exemplary' response of the medical community and made a series of 46 recommendations regarding management structures and practice. The report in 2004 of the Legislative Council Select Committee was more critical, apportioning blame to individuals as well as to organisational systems. To the regret of the medical community Dr. Leong resigned. He did so as a matter of principal and to try and draw to an end the witch-hunt that was in progress. The Secretary for Health, Welfare and Food, Dr. E.K.Yeoh also resigned, sadly ending a very successful term of office.

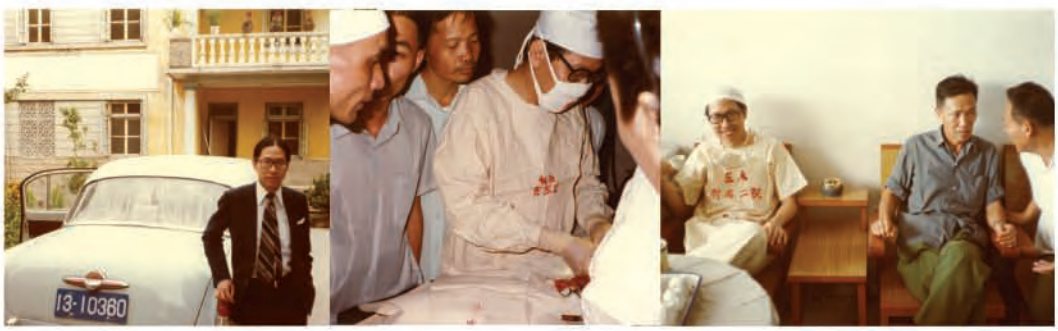
Later in 2004 Dr. Leong was honoured by his medical colleagues to give the McFadzean Oration at the annual meeting of the College of Physicians, and the Ho Hung Chiu Lecture to the College of Radiologists; and in 2005 the Gerald Choa Memorial Lecture to the College of Physicians.

Dr. Leong was appointed to the Executive Council in 2005, and continues as chairman of several government committees. Despite his public duties he finds time to continue his first love, clinical practice. He enjoys clinical practice and doing surgery because it is straightforward: he can proceed confident that he has the knowledge and skill to do the right thing; whereas in politics and administration he has to cope with constant pressure from people with competing views that have to be accommodated before any step can be taken.

It is a pleasant surprise to find that despite his numerous other commitments CH still found time to get married and raise a family. His wife is a radiologist, Chief of the Hong Kong Island West Cluster; his elder son, a computer expert, is married with two children and lives in Hong Kong. He is unhappy that he sees less of his daughter who lives in London working in Information Technology Security, and of his younger son who is in the international hotel business and often away from Hong Kong.

For recreation CH enjoys reading, and is writing two books; and playing the occasional round of golf in the evenings at Deep Water Bay. He regrets that his training through school, university and hospital never gave him the time to develop a wider breadth of general knowledge. He feels that students would benefit from first doing an undergraduate liberal arts course, then reading for Medicine as a postgraduate, becoming well rounded people rather than simply experts in medicine.

Asked what he looked forward to in the future CH says he wishes to continue his surgery as long as possible. He modestly dismisses his nick-name used in the Chinese press, 'Golden Knife'(金刀), claiming that he has neither the skill nor the fees to warrant the description. I am not convinced.



1978 Performing Surgery in Fujian China

Chairman Elderly Commission

Mr Peter WH Mark

A Tribute

The sudden passing of Peter Mark was a sad shock . He was an Honorary Fellow of this College and its Honorary Legal Adviser since 1986. Always a staunch friend and supporter of the College's objectives and activities, it is fair to say that the founding and continued success of the College owe much to him.

After graduating BA from the University of California at Berkeley in 1955, Peter qualified in law in London and became a Solicitor of Hong Kong in 1963; Solicitor of the Supreme Court of Judicature of England in 1969; a Notary Public in Hong Kong in 1970 and Barrister and Solicitor of the Supreme Court of Victoria, Australia in 1984.

I first met Peter when we were establishing the College; his advice on the drafting of the legal documents and the organisation of the membership were invaluable. Much work was involved but he gave his time and wise counsel unstintingly, and always with a smile in his inimitable way. He was not only very well versed in law, but astute, kind, always helpful and a man of integrity. Perhaps what places him apart was his deep understanding of medical doctors and their sometimes unique thought processes! When the Hong Kong Academy of Medicine was being formed, Peter kindly agreed to join the Preparatory Committee in 1990 and was its Honorary Legal Adviser since 1992. It was inevitable that he was invited to be honorary legal adviser to our Sister Colleges: Obstetricians and Gynaecologists; Pathologists, Paediatricians and Radiologists and to many other medical organisations varying from the University of Hong Kong Medical Alumni Association Ltd. to the Asian Pacific Menopause Federation!

He was very public spirited and was a Director, Tung Wah Group of Hospitals in 1959 and remained a voting member; and he gave his services to many organisations which included the Hong Kong Federation of Youth; Seamen's Board of Reference; the Disciplinary Committee Panel - Legal Practitioners Ordinance and the Hong Kong Society of Notaries of which he was President since 1995.

It is fitting that we pay tribute to this outstanding gentleman and thank him for his significant contributions to the medical profession's postgraduate activities, as well as to the community at large. He had a successful practice but somehow found the time to help so many without thought of reward. To his Family we extend our heartfelt condolences and hope that they will take some comfort in the knowledge that they are not alone in their feeling of grief. We thank them for letting us share a part of his remarkably meaningful life.

David Todd