HONG KONG COLLEGE OF PHYSICIANS

SYNAPSE

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The Gerald Choa Memorial Lecture 2006
Controversies in Organ Donation

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Mr. President, Fellows and Members of the College.

It is a great honor to stand before you today to deliver the Fifth Gerald Choa Memorial Lecture. No words can adequately express Professor Gerald Choa's enormous accomplishments and services to Hong Kong and to the medical community as a Physician, Teacher and Leader. The late Professor Gerald Hugh Choa was a Renaissance Man. He had a deep interest in history and was an authority on the development of Western Medicine in China. In his book entitled *"Heal the Sick"*, Dr. Choa provides a historical perspective of Christian Medical Missionaries in China. As a tribute to his teacher Professor Gordon King, Dr. Choa has written a special chapter on the experiences of those medical students of Hong Kong University who escaped from the Japanese Occupation during World War II to continue and finish their studies in Free China through the efforts of Professor King. His other book entitled *"The Life and Time of Sir Kai Ho Kai"* also reflects his deep appreciation on the early development of the medical and legal profession in Hong Kong. He has contributed many articles on bioethics and public policy on healthcare delivery. I was privileged to be able to travel with Dr. Gerald Choa and Dr. Richard Yu to Shanghai in November 1998 for a Conference jointly organized by the College and the Chinese Medical Association. It was during this trip that I had the opportunity to talk to Dr. Choa about my interest in kidney transplantation and to learn first hand from Dr. Choa about his interests and values, which encompass the teachings of Hippocrates, Confucius and Christianity. His values impact upon us in a number of ways, as healthcare professionals, in dealing with the ethical and moral dilemmas which pervade the practice of organ transplantation. It is on this aspect, the controversies in organ donation, that I would like to address you today.

Transplantation in Hong Kong

It was in 1969, when Dr. Choa was the Director of Medical and Health, that the first cadaveric renal transplant operation was performed in Hong Kong. Over the years the renal services including dialysis and transplantation has been well integrated under the leadership of Dr. C.H. Leong and Dr. Richard Yu. In a letter to the Legislative Council, dated 17 December 1998, regarding Human Organ Transplant Ordinance (Cap 465), I was reminded of my successful attempt, during early 1973, in getting consent for organ donation from the family of a traffic accident victim. That was the beginning of my education in transplantation.

The problem of organ shortage for transplantation in Hong Kong is well known. Because deceased or cadaveric donors are not easy to come by, we often have to rely on living donation. This low rate of organ donation is generally attributed to a negative traditional Chinese attitude towards organ donation. To improve the donation rate, we must generate public awareness, promote legislative initiatives, and minimize bureaucratic barriers to organ donation.

There were numerous organ donation campaigns aiming to increase the awareness of organ donations. As noted by Dr. Tong Kwok Lung, President of the Hong Kong Transplant Society, the transplant rate in Hong Kong, especially in kidney, is one of the lowest in the developed economy. There were over 1,500 patients on the kidney transplant waiting list in Hong Kong. Only 51 patients received a deceased donor kidney transplant (include transplants performed in China) while there were only eight patients received a living donor kidney transplants in 2005. Despite the technical challenges, 39 living-donor liver transplants versus 25 deceased-donor liver transplants were performed in the same year. Indeed, the liver transplant program in Hong Kong, under the direction of Professor S. T. Fan, is one of the leading live-donor liver transplant centers in the world. Given the large number of patients on the kidney transplant waiting list, more efforts should be directed towards live-donor kidney transplantation.

Global Growth of Transplantation

The transplantation of solid organs, such as kidney, liver, heart or lung, is increasingly a regular component of health care in all countries world wide, and is no longer a feature of health care in high-income countries alone. Globally, of the 70 000 or so solid organs transplanted annually, 50 000 are kidney transplants; more than one-third of the latter operations are done in low- or medium-income countries. Chronic shortage of human organs for transplantation is one of the most pressing health policy issues. Live donor kidney transplantation is emerging as the predominant practice of kidney transplantation around the world. Enhanced public awareness of living donor kidney transplantation has promoted increases in the number of living related and unrelated donors. The number of living donors has actually surpassed that of deceased donors in many countries. The advent of laparoscopic donor nephrectomy has further propelled this change in practice.

When renal transplants first began to be done in 1954, stringent selection criteria were established for the access of recipients to kidneys. Patients were reviewed by Transplant Committees ("The God Committee"), and hierarchies of need and suitability were established. Young children were initially rejected, and infants were not accepted until the early 1980s. Improvements in surgical

techniques, clinical care, and anti-rejection therapy produced longer patient and graft survivals. At present, there are few reasons to exclude a patient from renal transplantation, and successes have been achieved in patients at both extremes of life, in the mentally retarded, and in those with multisystem diseases. Similar strict criteria were imposed for potential living donors as well. Kidney transplantation has now become the preferred treatment for those with end stage kidney disease (ESRD). Organ replacement from either a live or a deceased donor is preferable to dialysis therapy because transplantation provides a better quality of life and improved survival. The demand far exceeds the number of organs available from deceased donors.

In the United States, there are about 16,000 kidney transplant performed each year. There are about 90, 000 patients on the waiting list for a kidney transplant and the list continue to grow each year. Living related donor transplants comprise about 40% of all transplants performed in the U, S., whereas their proportion is much less (10% to 15%) in Europe and Australia. The shortage of kidneys, improvements in techniques and care, and the use of new treatment have made living non-related donation a viable option. Excellent results were also observed in kidney transplants from spousal and living unrelated donors.

Globally, barriers to wider development of effective deceased donor kidney transplant programs were not totally due to religious objections. The main factors seemed to be a lack of public concern about the need for cadaver donor programs in patients with ESRD. Instead of facing years on the transplantation waiting list, some patients seek to identify relatives or others who would be willing to donate the needed organ or "partial" organ directly or, in some cases through a donor exchange program. There is no doubt that organ donation for by living donors clearly saves lives, improves transplant outcomes, and reduces recipients' waiting times. It also increases opportunities for patients without living donors to receive organ from deceased donors.

On the other hand, the proposal that kidneys might be purchased from living unrelated donors should be condemned. It is with these issues in mind that the Transplantation Society has issued guidelines for the practice of transplantation that avoid exploitation and commercialization of organ donation. Similarly, the U.S.Organ Transplantation Act of 1984 (HR5580, Title II) introduced by former Vice-President Al Gore, makes it a federal crime to engage in organ sale and commerce. As a result of the legal and public policy decision to ban organ sales in the U.S., not only is there a serious disparity between organ demand and supply, but a thriving global black marketplace ripe for abuse and exploitation as well. It is illegal in nearly all developed nations to sell or buy a human organ—only in Iran and Pakistan is there a legal market. Nevertheless, many other countries, including Israel, India, South Africa, Turkey, Russia, Iraq, Argentina, and Brazil do not stringently enforce laws prohibiting the sale and purchase of human organs. Moreover, given the life-or-death consequences, many patients are not deterred in the least by the illegality of cash transactions.

World Health Organization and the Transplant Society

In 1991, the World Health Assembly approved a set of guiding principles which emphasize voluntary donation, non-commercialization and a preference for cadavers over living donors and for genetically related over non-related donors. While they have great influence on professional codes and legislation, these principles do not address current concerns and they face challenges from leaders in the field who urge the policies be changed to allow the use of "incentives" to increase the numbers of organs for transplantation. Furthermore, the widespread acceptance of live organ transplantation is clearly contrary to what historically has been a medical dictum to do no harm.

Because of the emerging hazard for some individuals who are medically well and volunteer to donate an organ for transplantation, forums in Amsterdam and Vancouver were developed by The Transplantation Society to present definitive and timely statements regarding the responsibility of the transplant community to care for the live organ donor. The ethics of a continuing practice of live organ transplantation demands an international recognition that prioritizes a sustained well being of the donor despite the life saving transplant that may be provided by the donor for the recipient. The person who gives consent to be a live organ donor should be competent, willing to donate, free of coercion, medically and psychosocially suitable, fully informed of the risks and benefits as a donor, and fully informed of risks, benefits, and alternative treatment available to the recipient.

After United States, China has carried out the second highest number of transplant operations for kidneys, lungs, hearts, pancreas and bone marrow. In 2005, more than 11,000 solid organ transplants were performed in China. It is estimated currently that at least 2 million patients in China need organ transplant each year but only up to 20,000 transplants can be performed because of shortage of donated organs. Majority of the organs are likely to have been obtained from executed prisoners. While the organization, as a professional society cannot judge on the ethics of capital punishment, there are concerns expressed by various international organizations regarding the process of organ recovery from executed prisoners.

In seeking to accomplish change of public policy related to organ transplantation in China, interaction with Chinese officials is the only true route to effect long term change and this change must be derived from Chinese Governmental policies. In a recent meeting during the annual Chinese Transplantation Society, new guidelines and legislative efforts have been introduced. These include:

- Create a legal framework for Chinese oversight,
- Establish credentialing standards for transplant centers and professionals,
- Strengthen existing legislature banning the purchase and sale of human organs,
- Establish deceased organ donation through brain death criteria, and
- Develop national self-sufficiency donor base and donor awareness

Hopefully, the new legislation will help to strengthen the organ procurement program and increase the number of cadaver kidneys as well as living donor available for transplantations.

These new developments in China should have a positive influence on Hong Kong. It is therefore important for the profession in Hong Kong to work with the legislature to strengthen existing policy and to develop new initiatives to meet these new challenges. Greater efforts are needed locally to educate not only the public but also the legislators on the importance of organ donation and transplantation. Since the number of deceased donor has not improved over the years, it is more important in promoting live donation, especially for kidney transplantation.

New Initiatives and Controversies in Living Organ Donation

Directed versus Nondirected Donation (NDD):

A directed organ donor has an established relationship or familiarity with an identified transplant recipient. The directed donor could be a genetically related family member (i.e., sibling, parent,) or a genetically unrelated individual (i.e., spouse, friend, acquaintance, or another person who has an emotional bond or rapport with the recipient). In rare instances, a directed donor may know of a particular recipient in need of a donated organ and only develop a relationship with that recipient for the purpose of the transplant (e.g., church members, individuals who respond to public or media notice). These donors have been accepted if they are medically and psychosocially suitable.

In contrast, the NDD volunteers to donate an organ for a recipient that he or she does not know or select. The recipient, in effect, is a "stranger." Thus, media reports and some potential donors have used the term "good Samaritan donor" to convey the novel concept and charity of nondirected donation. Transplant centers across the country in the U.S. are receiving inquiries from individuals who want to donate a kidney to a complete stranger. The initial inquiry from a person seeking to become an NDD may come by internet, mail, or telephone. Any person who is competent, willing to donate, free of coercion, and found to be medically and psychologically suitable, can be a living kidney donor in the U.S. In most other regions in the world, acceptance of such unconventional living nonrelated donors has not occurred because of difficult legal and ethical issues raised by this practice.

Public Solicitation of Organ Donation:

Colorado experienced a case of a live organ donation that had been arranged through a commercial internet website. The surgical director did not realize this was the source of the donation and initially refused to perform the operation (the operation was eventually performed). On December 14, 2004, the University and its private, related hospitals issued a policy that, until professional organizations, such as United Network for Organ Sharing (UNOS) and Advisory Committee on Organ Transplantation (ACOT), issue a public statement on this issue, the hospital would not perform living donor donations arranged through commercial internet sites. Commercial sites present the risk of leading to organ marketing.

The National Organ Transplant Act (42 United section 274e) makes it a crime to purchase or sell organs for profit. This law is intended to prevent the commercial trafficking in organs that occurs in other places in the world. The law permits payment to the donor for travel expenses, housing and lost wages because this is reimbursement for out-of-pocket expenses and is not considered the payment of valuable consideration. In March 2006, Colorado held its Controversies in Transplantation Conference. Participants and topics included the founder of Matchingdonors.com; and representatives from UNOS. Discussions covered organ trafficking, ethical issues (e.g., consent), and legal perspectives. The hope is that matchingdonors.com will become a non-profit organization to mitigate the issue of financial gain. Other Donor Web sites are also in existence. These web sites will probably continue to operate because these are volunteers who want to choose their recipients and because there are so many people with end-stage renal disease who are desperate for a transplant.

Risks versus Benefits:

Living-donor transplants have been controversial since their inception. Living-donor surgery was initially performed for kidney transplants as a matter of necessity due to the inability to provide adequate immunosuppression for unrelated donors. From the start, concerns from the public and physicians about the central medical tenet of primum non nocere, first do no harm, raised ethical questions about putting a healthy person at risk to aid another. Fifty years ago, the first transplantation team suggested that organs from living donors should be used only when the likelihood of success for the recipient was high and the risk to the donor was low. In 1954, the kidney transplantation between the Herrick twins was performed without vascular imaging of the donated kidney, because at that time arteriography involved greater risk than surgery itself. Imaging of the renal vasculature has since evolved and is now standard procedure before kidney donation. It may identify unsuspected vascular disease and thereby benefit the potential donor, or it may uncover anatomy that renders transplantation technically difficult. Adverse events, however, are always possible whenever contrast material is used, although newer imaging methods such as three-dimensional computed tomography and magnetic resonance angiography are available and exposure to contrast medium is minimal for most donors. The short-term physical risks are generally small. Although on rare occasions renal donors have died, the death rate is 0.03 percent, similar to or less than that for any operation involving the use of general anesthesia. It can take a few weeks to recover fully from surgery, although the increasing use of laparoscopic donation means that a donor may now be discharged from the hospital in just a few days. Most return to work within four or five weeks.

Long-term health risks are less apparent following donor nephrectomy. Most people do well with a single kidney. Donors may even live longer than nondonors, although this observation may simply reflect the careful selection of living donors from among very healthy candidates. However, kidney function normally declines with age, and kidney donors have an age-related decline in renal function consistent with that observed in the general population. Renal failure has gradually developed in a small proportion of donors, and according to the United Network for Organ Sharing,

56 of more than 50,000 previous kidney donors have ultimately been listed for transplants themselves. Although hypertension has developed in some donors over time, hypertension is so common in the developed world that ascribing it to kidney donation is probably not warranted.

In the U.S., there are currently more solid organ transplants performed using live donors than deceased donors. This trend represents the rapid growth in live-donor kidney transplantation. The reason for this growth in live-donor kidney transplantation is that the outcomes are substantially better using kidneys from live versus deceased donors and currently wait-times for a kidney in the country can be more than five years. Importantly in this regard, survival after kidney transplantation is substantially better than survival on dialysis. Thus, a very compelling argument can be made to aggressively pursue live-donor kidney transplantation.

However, it is difficult to make a similar compelling argument for live-donor liver transplantation. Living-liver donation was first performed in children in 1989, not due to immunologic barriers, but due to a shortage of small liver grafts and high waiting-list mortality. Adult-to-adult right lobe living-liver donation (LDLT) was first reported in the U.S. in 1998. Centers in the U.S. have performed more than 1,700 living-donor procedures and worldwide there have been more than 10,000. Adult LDLT has remained controversial due to donor morbidity and two highly publicized donor deaths, as well as concerns about inferior recipient outcomes. Data from the nine-center, NIH-funded Adult-to-Adult Living-Donor Liver Transplantation Cohort Study (A2ALL) however has shown similar outcomes between LDLT and Deceased-Donor Liver Transplant (DDLT). In experienced centers, LDLT offers similar post-transplant survival to DDLT with marked reduction in waiting-list mortality. A reduced waiting period for an organ, the principal benefit of LDLT, may decrease the risks of decompensation or death prior to transplantation, thus improving overall survival. Furthermore, every transplant with a liver obtained from a living donor potentially frees up a deceased-donor organ, as living-donor recipients are not part of the deceased-donor recipient pool.

In the U.S., while the number of kidney transplants using live donors has continued to rise, the number of live-donor liver transplants that are performed annually has remained relatively flat. As transplantation has become safer and outcomes have improved, the guidelines for donation and the fair allocation of organs have strived to keep pace with the development. The selfless, uncoerced, free donation of blood or bone marrow to strangers is already an established practice. With proper guidance and oversights, the donation of a kidney or part of a liver, even by an altruistic stranger, will become another accepted practice. Hopefuly, this will have a positive impact on deceased organ donation.

Conclusions

Given the large number of patients waiting for a kidney transplant, the annual number of available deceased donors will not resolve the ongoing organ shortage. Further, the significant mortality and morbidity that occurs for those patients awaiting an organ transplant necessitates the consideration of possibility of live organ donation. Nevertheless, the needs of transplant recipients however, do not outweigh the priority of the long-term health of organ donors (kidney versus liver). Concern for donor health is a pivotal ethical consideration. Public solicitation of live donor organs cannot be regulated or restricted legally as long as no felonious or illegal activity is involved. A centrally administered program of compensated donation may increase organ supply with good outcomes. On the other hand, unregulated commercial donation in impoverished area can be associated with morbidity, lack of economic benefit for donor and donor regret.

Organ donation is "A Gift of Life" – *The Ultimate* Gift (Sir Roy Calne). We should value the beauty of the gift and the wonder of living organ donation. In his encyclical *Evangelium Vitae*, Pope John Paul II summed up his thought regarding organ donation: "The Gospel of Life is celebrated above all else in the daily living of life which should be filled with daily giving for others…. A particular praiseworthy example of such gestures is the donation of organs performed in an ethically acceptable manner, with a view to offering a chance of health and even life itself to the sick who sometimes have no other hope." (Evangelium Vitae, n86)

Nonmonetary recognition of donation appeals to our notion of equity and does not subvert the altruistic social good. The dilemma for the transplant community is to maximize the number of organs in order to save lives in a manner that meets ethical standard and a prudent balance of equity and utility, and adheres to the principle of, *"Primum Non Nocere"*.

Professor Gerald Choa, I hope you would have agreed.

May your teaching and cherished values long continue -

"Life is short; art is long; opportunity fugitive; experience delusive; judgment difficult. It is the duty of the physician, not only to do that which immediately belongs to him but likewise to seek cooperation of the sick, of those who are in attendance……."

Hippocrates- Aphorism:

Vita brevis; ars longa; occasion celeries; experimentum periculosum; judicum difficile….

www.americantransplantfoundation.org

www.organdonor.gov/acot5-2006.htm

Payment of the Hong Kong Academy of Medicine Fellowship Subscription

Starting from 2008, the HKCP College secretariat will no longer collect the Annual Fellowship Subscriptions on behalf of the Hong Kong Academy of Medicine.

From the year 2008 onwards, please kindly forward your payment for the Annual Fellowship Subscriptions directly to the Hong Kong Academy of Medicine upon the notification sent by the Academy.

"Pushing the Boundaries in Multidisciplinary Cancer Care" Meeting (10th - 11th May 2008)

The Royal College of Physicians and Surgeons of Glasgow has invited the Hong Kong College of Physicians to jointly organise a cancer care meeting in Hong Kong in May 2008.

The meeting is named 'The William and Elizabeth Davies Foundation Trust International Meeting, Hong Kong', and will be held on 10th - 11th May 2008 (Sat - Sun) at the Hong Kong Academy of Medicine Building.

The theme of the meeting is "Pushing the Boundaries in Multidisciplinary Cancer Care". The programme will include two plenary lectures on molecular diagnostics and molecular therapeutics respectively in 'Oncology in Clinical Practice'. There will be plenary sessions on early diagnosis/screening, advances in surgical oncology, adjuvant therapy, treatment in advanced disease for prevalent cancers in Hong Kong (colorectal, lung, breast, liver, and lymphoma), advances in endoscopic and minimally invasive techniques, and palliative care. There will also be posters sessions with prize awards.

In addition, there will be a "FRCPSGlasg Fellowship Admission and Signing of the Roll" Ceremony on the evening of 10th May 2008 conducted by the President of the RCPSGlasg, followed by a Gala Dinner at the Academy of Medicine Hall.

Please mark in your diary these important dates.

Addendum

In the February 2007 issue of Synapse, the photographer of the cover photo 'Mt Blanc' was incorrectly printed as Dr Kwok Yuk Lung instead of Dr Li Wa. The Editorial Board would like to extend sincere apologies to both photographers for the mistake.

Specialty Update

Endocrinology and Diabetes
A Literature Review (2006-2007)

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Introduction

As vintages go, the past year can be regarded as a "blockbuster vintage" for the field of endocrinology and diabetes. Several major landmark studies have been published, and major breakthroughs have appeared in the area of genetics as well as treatment of type 2 diabetes, some of which are likely to have long-lasting impact on clinical practice. Whilst it will only be possible to cover some of these advances, this article aims to provide clinicians with an up-to-date snapshot of some of the highlights in the field of endocrinology and diabetes over the past year, along with some relevant references.

Diabetes

Diabetes featured prominently in the headlines on several fronts. Last year marked the passing of a United Nations resolution on diabetes to recognize the need to promote diabetes awareness, the first time the United Nations has passed such a resolution for a non-communicable disease (www.unitefordiabetes.org). Starting from 2007, the current World Diabetes Day, 14 November, will be designated a United Nations Day. This was highlighted by a special issue in the Lancet [1]. The scale of the problem within the Asian region was highlighted in a review [2], where it was noted that from 1980 to 1996, the prevalence of type 2 diabetes within the region has tripled. This is particularly alarming, since Asians develop diabetes at lesser degrees of obesity and at a younger age, suffer longer with diabetes and die younger. Indeed, it has been estimated that should the scale of the crisis continue to go unnoticed, within the 10 years from 2005 to 2015, net loss of income from diabetes, stroke and cardiovascular disease will total more than USD 550 billion in China alone. Indeed, a recent population-based study carried out in Ontario, Canada reported a substantial increase in the prevalence of diabetes, so much so that by 2005 it already exceeded the global rate that was predicted for 2030 [3].

Part of this increasing burden of diabetes is due to the epidemic of childhood obesity. A local cross-sectional population-based study revealed that among adolescents recruited from schools, 8.9% of boys and 9.1% of girls had central obesity defined by waist circumference $\geq 90^{th}$ percentile for age and sex, and the prevalence of metabolic syndrome was already 2.4% among these adolescents [4]. How best to define obesity and metabolic syndrome in children is still much debated [5], though a recent study has provided waist circumference reference cut-off relevant to local children, which will provide much-need information to aid assessment of the problem in our younger population [6].

Management of Type 2 diabetes

An increasing number of treatments have appeared recently for the treatment of type 2 diabetes. In an effort to guide healthcare practitioners to prescribe appropriate interventions for the treatment of type 2 diabetes, in an unprecedented effort, the American Diabetes Association (ADA) and the European Association for the study of Diabetes (EASD), have joined forces and put together a consensus algorithm for the initiation and adjustment of therapy [7]. The algorithm is summarized in figure 1. One of the main features of the algorithm is the use of metformin, along with lifestyle modification, as first line treatment in all subjects with type 2 diabetes. The algorithm also proposes that addition of sulphonylureas, thiazolidinediones or insulin should be considered as the next line of treatment should metformin and lifestyle modification fail to achieve the target HbA1c. Details of how insulin should be titrated was also provided in the algorithm. The guidelines have generated much discussion in the literature and among clinicians, but they do provide a useful framework for clinicians which is easy to follow and implement.

Much of the debate surrounding the algorithm has been the place that thiazolidinediones (TZDs) should occupy in the treatment algorithm. The large-scale A Diabetes Outcome and Progression Trial (ADOPT), which examined the treatment of recently diagnosed type 2 diabetes with rosiglitazone, metformin and glyburide, published in late 2006, suggested that treatment with rosiglitazone, compared to metformin and glyburide, was associated with a lower risk of monotherapy failure, and better durability of efficacy, suggesting that rosiglitazone treatment could delay deterioration in pancreatic β-cell function [8]. This study provided important proof that the progressive decline in β-cell function in type 2 diabetes, the underlying problem which underpins the development of oral drug failure, can be at least kept under check. It opened up exciting opportunities for potentially impacting on the natural history of type 2 diabetes. Some authors proposed that TZDs should be considered first line treatment for type 2 diabetes, though others were more cautious. This controversy took on a different spin, following a controversial article published in June 2007, which suggested a

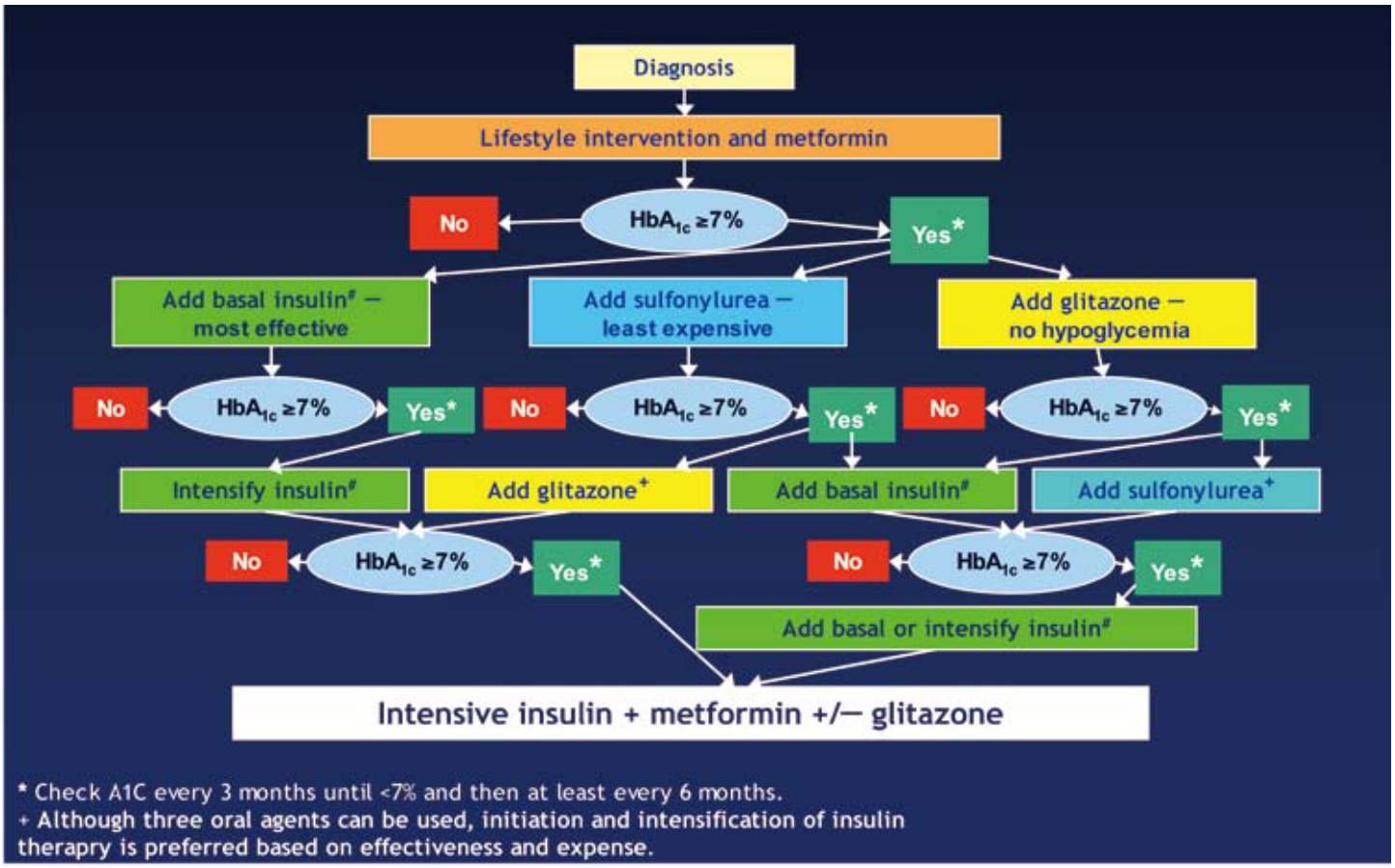

figure 1
Algorithm for the metabolic management of type 2 diabetes.
Adpated from Nathan D, et al. *Diabetes Care* 2006;29(8):1963-72.

possible link between the use of rosiglitazone and myocardial infraction and increased cardiovascular mortality [9]. This has led to the publication of a series of related articles, which debated the safety profile of TZDs [10, 11]. This is still the subject of much heated debate, though the US FDA has recently requested an updated label to highlight the potential risk of heart failure for this class of agent. (http://www.fda.gov/bbs/topics/NEWS/2007/NEW01683.html).

Several new agents are also soon to be available for the treatment of diabetes. In addition to inhaled forms of insulin [12], several new classes of oral agents have been developed. One group of such compounds explore our recent understanding of the incretin pathway, which underlies the augmented insulin secretion in response to ingested glucose or a meal, due to production of glucagon-like peptide 1 (GLP-1) from the gastrointestinal tract. This group of compounds, which include degradation-resistant agonists which act on the GLP-1 receptor, or agents which inhibit dipeptidyl peptidase-4 (DPP-4), the enzyme which breakdowns GLP-1, are due to appear locally within the next few months (figure 2). Early clinical studies suggest that this class of compounds, in addition to improving glycaemic control, was also associated with no weight gain, and will be a welcomed addition to the currently available treatments for type 2 diabetes [13].

Several interesting insights emerged last year regarding the development of diabetes complications. A study which utilized the continuous glucose monitoring system (CGMS) suggested that glycaemic variability, as indicated by glucose fluctuations, may play an important role in mediating complications associated with diabetes, via a specific triggering effect on oxidative stress [14]. A local study suggested that among patients with type 2 diabetes, chronic HBV infection was associated with a 4-fold increased risk of progression to end-stage renal disease, an effect that appeared to be independent of other confounding risk factors. Given the prevalence of hepatitis B in our locality, this has important implications on the screening and management of patients with type 2 diabetes and chronic hepatitis B [15].

Genetics of Type 2 Diabetes and novel biomarkers

One of the major breakthroughs in the diabetes field over the last year has been the identification of a number of genes associated with increased susceptibility to Type 2 diabetes. These genes, identified largely through genome wide association studies, a novel approach increasingly used for identifying candidate genes for common complex polygenic disorders, has already led to breakthrough discoveries in many disorders. Over the last year, several novel candidates, *CDKAL1, CDKN2A-2B, FTO, HHEX- IDE, IGFBP2* and *SLC30A8*, have been identified through this approach, in addition to 2 other recently identified candidates TCF7L2 and WFS1 [16]. Preliminary studies suggest that at least some of

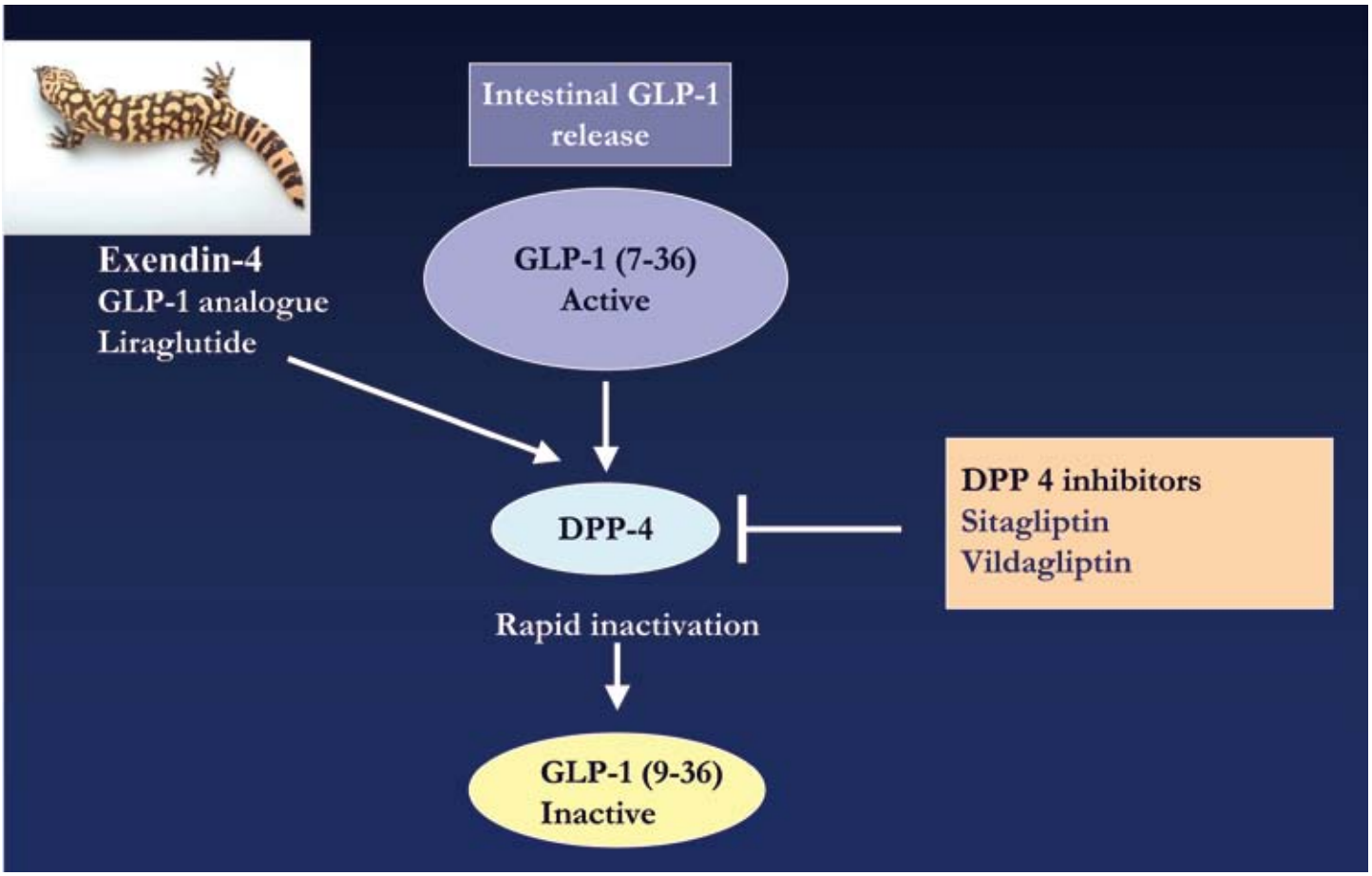

figure 2
The incretin pathway as a therapeutic strategy for type 2 diabetes
Key: GLP-1 glucagon-like peptide-1

these genes also play an important role in Chinese patients, thus indicating that the same mechanism may underpin pathogenesis of Type 2 diabetes in different ethnic populations [17, 18]. Interestingly, the majority of these candidate genes are believed to impact on pancreatic β-cell function, and thus has opened up exciting opportunities for the study of new pathways regulating β-cell function and their potential roles in the pathogenesis of type 2 diabetes.

In addition to genetic predictors of type 2 diabetes, several important biomakers have emerged as important molecules both for substrate metabolism and in the prediction of subsequent development of diabetes and atherosclerotic heart disease. One of these adipose tissue-derived molecules, or adipokine, adiponectin, is already recognized to be an important predictor of subsequent diabetes or cardiovascular disease [19, 20]. Adipocyte-fatty acid binding protein (A-FABP) is another molecule that has emerged as an important molecule in the pathogenesis of atherosclerotic cardiovascular disease, and was found to be an independent predictor of subsequent development of metabolic syndrome among local subjects in a prospective study [21].

What can be done after identifying subjects at increased risk of type 2 DM is of utmost importance, given advances in our ability to predict development of type 2 diabetes. A recent long term follow-up study to the Finnish Diabetes Prevention Study suggested that intensive lifestyle intervention could result in sustained lifestyle changes even after the active intervention period, and this translated to a 36% reduction in relative risk of incident diabetes. benefit from exercise [22]. In addition to lifestyle measures, pharmacological intervention with metformin, acarbose and orlistat have also been demonstrated to be effective in preventing diabetes in high-risk individuals [23]. Furthermore, in the Diabetes Reduction Approaches with Ramipril and Rosiglitazone Medications (DREAM) study, use of the thiazolidinedione rosiglitazone among subjects with impaired glucose t olerance or impaired fasting glucose was shown to reduce the incidence of diabetes or death [24]. The use of ramipril in the same study failed to demonstrate a beneficial effect in terms of incidence of diabetes [25].

Obesity

Efforts to identify genes associated with type 2 diabetes through genome-wide association studies has led to the identification of the obesity gene FTO, which is associated with body mass index and obesity risk in the general population [16]. Effective treatment to deal with the emerging epidemic of obesity is much-needed, and the current treatment choices were discussed in a recent review article [26]. Among these is a new class of agents, which targets the endocannabinoid system. Rimonabant, the first of the endocannabinoid receptor antagonists, appears to exert central as well as peripheral action, and has been noted to lead to reduced

waist circumference, improved lipid profiles and metabolic risk factors. Bariatric surgery remains the most effective treatment for subjects who are morbidly obese, and reduction in long-term mortality has prompted discussion recently whether bariatric surgery should be offered to those who have lesser degrees of obesity [27, 28].

Pituitary, thyroid and adrenal

Although an association between neuroendocrine dysfunction and traumatic brain injury was previously recognized, it has recently become apparent that this complication is more prevalent than previously recognized. In a prospective study designed to evaluate pituitary function following traumatic brain injury, it was noted that 50% of patients have at least one anterior pituitary hormone deficiency 1 year after the injury, though pituitary function may improve or worsen over this period in a significant proportion of patients [29]. There are at present no guidelines concerning who should be screened, though one approach suggested screening in the acute setting following head injury in all subjects with GCS <13, manifestations of hypopituitarism or imaging abnormalities such as haemorrhagic lesions, and in selected cases at 3-6 months and 12 months post-injury [30].

Radioactive iodine is often used for definitive treatment of recurrent Graves' thyrotoxicosis. Anti-thyroid drugs (ATD) are often used before, during, or after RAI treatment and there has been much debate regarding the benefits and risks of ATD around the time of RAI. In a meta-analysis, it was concluded that use of anti-thyroid drugs within a week of RAI was associated with increased risk of failure of RAI, and thus should be avoided [31].

Fine-needle aspiration cytology is frequently performed in the evaluation of thyroid nodules. Its utility was reviewed in a local retrospective study involving subjects undergoing thyroidectomy. It was noted that the sensitivity, specificity, positive predictive value and negative predictive value of FNA cytology, were 54%, 100%, 100%, and 75% respectively. Among those with indeterminate FNA cytology, atypical cell lesion and age >40 years conferred increased risk of malignancy [32]. However, clinicians are reminded of the need to monitor the size of thyroid nodules, as increase in size of nodules may suggest malignancy [33].

Another clinical problem that clinicians are increasing faced with is how to investigate adrenal lesions discovered by imaging, i.e. the incidentally discovered adrenal mass. Assessment should include thorough history, examination and investigation, with the aims to establish functional status and also to assess imaging characteristics, including lesion size, in order to exclude malignancy and decide when surgical intervention is warranted [34]. One indication for surgical resection is a diagnosis of aldosterone-producing adenoma, though it is increasingly recognized that, in contrast to previous belief, bilateral adrenal hyperplasia is in fact more common than unilateral adenoma as a cause of primary hyperaldosteronism, and for which medical treatment to target aldosterone action, rather than surgery, is the treatment of choice [35].

Osteoporosis

Osteoporosis is a common disease with a strong genetic component. Whilst the results of genome-wide association studies are awaited with keen interest, numerous candidate genes have been identified and replicated. These genetic predictors of osteoporosis were discussed in a comprehensive review [36]. In some practices, measurement of bone density may not be readily available. In a local prospective study involving 1435 post-menopausal women, clinical risk factors were found to be a reliable predictor of 10-year risk of osteoporotic fracture. The clinical risk factors included use of walking aids, history of fall, being homebound, a calcium intake of <400mg/day, age >65 years, prior history of fracture, and BMI<19kg/m^2, whereby a subject with ≥ 3 risk factors were found to have a 10-year risk of osteoporotic fracture of 25% . Whilst bisphosphonates have been established as effective treatment for osteoporosis, compliance to treatment is often suboptimal. In the Health Outcomes and Reduced Incidence with Zoledronic Acid Once Yearly (HORIZON) study, once-yearly infusions of zoledronic acid was found to be associated with reduction in fractures in post-menopausal women with osteoporosis [38], with anti-fracture efficacy that is similar to other established first-line agents such as alendronate and risedronate.

Osteonecrosis of the jaw has been increasing reported among users of bisphosphonates, and this potential adverse effect became the focus of much attention over the last year. The current data was summarized in a comprehensive review [39]. It was suggested that patients with myeloma or metastatic carcinoma, those who are receiving nitrogen-containing bisphosphonates, appear to be at highest risk. The risk associated with the use of oral bisphosphonates is still largely unknown. Reassuringly, in the HORIZON study, only 2 patients were diagnosed to have osteonecrosis during the study period, one of which occurred in the placebo arm, and both cases resolved with appropriate treatment.

Polycystic Ovary Syndrome (PCOS)

PCOS is a common endocrine disorder among women of reproductive age, and has over recent years, been linked with insulin resistance and the metabolic syndrome. Accumulating evidence suggest that treatment of subjects with PCOS with metformin is associated with increased reproductive outcome, as well as improved metabolic indices [40]. In a randomized study involving 626 infertile women with PCOS, the use of clomiphene was found to be superior to metformin in terms of achieving live birth, though clomiphene treatment was also associated with increased risk of multiple pregnancies [41]. Nevertheless, there is much ongoing work to investigate the role of insulin resistance in the pathogenesis and treatment of PCOS.

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Examination dates for the Joint HKCPIE/MRCP(UK) examinations in 2008

Part I examination
22 January 2008 (Tues)
9 September 2008 (Tues)

Part II (Written) examination
9 – 10 April 2008 (Wed and Thurs)
30 – 31 July 2008 (Wed and Thurs)
3 – 4 December 2008 (Wed and Thurs)

PACES
3 – 7 March 2008
20 – 24 October 2008

Pass list of the Joint HKCPIE/MRCP(UK) Part II PACES — March 2007

Chan Ching Man Vivien
Chan Ki Wan Kelvin
Chan Tze Ho Benjamin
Chan Wai Sze
Chan Yu Ho
Cheng Yik Hon Marc
Cheuk Ming Yan
Cheuk Yuen Yi
Cheung Tsang Tommy
Chu Cheuk Yan Elsa
Ho Chun Ming
Ho Ka Yee
Hui Wai Man
Lai Ho Kei
Lai Kin Bon
Lam Cheung Chi Simon
Lam Chi Kwai
Lam Hong Kei Connie
Lamb Sophia Sharon
Lau Wing Yun
Lee Hoi Yi Heidi
Lee Ting Lam
Leung Hoi Sze
Li Cho Wing
Li Wai Ling
Lui Ka Luen
Lui Mei Sze
Ma Chung Yee Arisina
Ma Kam Man
Ng Lai Yun
Ng Tsz Lam Lindy
Pang Yin Yu Shirley
Seto Wai Kay Walter
Siu Ming Fai
Siu Yuk Leung Seamus
Tao Wai Lun
Wong Hiu Yan Hilda
Wong Wai Sheung
Yap Yat Hin Desmond
Yau Pak Yuen Anthony
Yeung Koon Sing
Yip Wai Man
Young Kit Yu
Yuen Mang Ho

Pass list of the Joint HKCPIE/MRCP(UK) Part II PACES — June 2007

Au Lik Hang
Au Yeung Yick Cheung
Chan Chun Yin Johnny
Chan Man Chun
Chan Tuen Ching
Chan Yin Cheung Philip
Chan Yuk Kit
Chau Chi Hong
Cheung Kit Yan
Cheung Lap
Cheung Li Li
Cheung Wai Yin
Chow Ho Ying
Choy Chi Fung
Chu Wai Ming
Ip Ka Ling Rosalina
Kwok Chi Hang
Kwok Sung Shing Jeffrey
Kwong Tsz Shan
Lau Wai Yan
Lee Man Leung Patrick
Leung Ching Man
Lo Wai Ting Joyce
Lock Ka Yuen
Lui Yan Ni
Lun Chung Tat
Ma Chi Ming
Ng Ho
Ng Ho Leung
Ng Ka Ho
O'Young Kit Ying Cecilia
Pang Wing Fai
Say Chun Yu
So Ho
Tam Pui Kit
Tang Siu Fai
Tang Wing Sen Joyce
Wai Ka Yan
Wong Siu Man
Wong Yuk Yi
Wu Saliangi
Yeung Sze Wai
Yung Ka Man Amy
Zee Sze Tsing Jonpaul

The above doctors received the College's Intermediate Examination Certificates at the Annual General Meeting in October 2007.

Examination Pass Rates

Joint HKCPIE/MRCP Part I examinations (2002-2007)	
September 2002	33/100 = 33%
January 2003	55/124 = 44%
May 2003 (SARS Special)	7/21 = 33%
September 2003	29/54 = 54%
January 2004	39/93 = 42%
September 2004	16/29 = 55%
January 2005	68/96 = 70.8%
September 2005	15/24 = 62.5%
January 2006	74/95 = 80%
September 2006	13/21 = 62%
January 2007	67/87 = 77%

Joint HKCPIE/MRCP(UK) Part II (Written) examination (2002-2007)	
July 2002	27/53 = 51%
November 2002	24/50 = 48%
August 2003	62/110 = 56%
December 2003	31/54 = 57%
July 2004	42/65 = 65%
December 2004	32/46 = 70%
April 2005	15/32 = 47%
July 2005	56/76 = 74%
December 2005	16/26 = 62%
April 2006	13/29 = 45%
July 2006	68/91 = 75%
December 2006	18/33 = 55%
April 2007	22/34 = 65%
July 2007	70/80 = 88%

Joint HKCPIE/MRCP(UK) Part II PACES examination (2001-2007)	
October 2001	36/72 = 50%
February 2002	34/74 = 46%
October 2002	29/72 = 40%
February 2003	30/69 = 43%
October 2003	27/59 = 46%
March 2004	39/64 = 61%
October 2004	26/69 = 38%
March 2005	35/75 = 47%
October 2005	28/75 = 37%
March 2006	36/75 = 48%
October 2006	16/73 = 22%
March 2007	44/74 = 59%
June 2007	44/74 = 59%

The AIM Corner

Moon Sing LAI
Examination Coordinator , Specialty Board in AIM

1. Exit Assessment

All the thirty-one candidates passed the exit assessment held in June 2007. This is the best result after the structured assessment system for AIM Exit Assessment was introduced from June 2005.

The passing rates of the three stations are 1) Acute medical problems – 98.3% 2) Chronic medical problems – 98.3% and 3) Ethics / communication / statistics / others – 93.6%.

The question which some of candidates found difficult is the one on Evidence Based Medicine (EMB). Most candidates can give the definition of EMB. However, many cannot point out correctly the four levels (I-IV) of evidence and four classes (A-D) of strength.

One candidate submitted his application for Exit Assessment after the deadline because he was on leave when his COS posted up the letter from the College to call for applications for exit assessment.

The HPT trainees are reminded that AIM exit and annual assessments are held twice yearly, usually on the first Friday afternoon (for exit) and the first Saturday afternoon (for annual) of June and December respectively. The letter from the College calling for applications is usually sent to COSs in March and September of each year. Therefore, HPT trainees who wish to apply for the AIM exit or annual assessment should look out for the letter calling for applications. If they cannot find the letter, they should contact their COS or the programme directors.

2. Annual Assessment

One out of the forty candidates failed barely and the rest passed in the AIM annual assessment held in June 2007.

Case reports were included as part of the AIM annual assessment starting from June 2006 and the final result of AIM Annual assessment is based on marks from the viva section (75% of total mark) plus marks from the case reports and supervisor's evaluation section (25% of total mark). Candidates with overall bare failure (overall score 16-19) in AIM Annual Assessment are required to repeat the Assessment on failed section(s) only. An example is such if a candidate has a bare fail in the annual assessment with overall score of 18 and he/she fails only in the viva section but passes the case reports and supervisor's evaluation section, then he/she is required to repeat assessment on the viva section only.

Finally, HPT trainees on concurrent or sequential training are reminded that they should take their first annual assessment in the FIRST specialty with the minimal duration of 9-12 months' Higher Physician training, and their first annual assessment in the SECOND specialty with a minimal duration of 15-18 months' Higher Physician training.

Questionnaire on CME/CPD Activities

The College would like to thank Fellows who completed the questionnaire regarding CME/CPD activities which was sent out on 29 November 2006.

The Education Committee of the Hong Kong Academy of Medicine has recently issued new Principles and Guidelines on Continuing Medical Education (CME) and Continuous Professional Development (CPD)" for 2011. These guidelines have been widely debated among College presidents during the Academy Council meeting on 10 October 2006, as a result of which the Academy had asked each College to seek its Fellows' opinion on Academy-proposed CME/CPD activities which are currently not accredited by individual Colleges. Points with some controversies and which differ from our College guidelines are listed as follows:

1. Fellows must obtain 5 Points in each cycle from any one (or a mix) of the following activities
   - Quality Assurance and Medical Audits
   - Mortality and Morbidity Meetings
   - Activities for Improvement of Patient Care

2. CME Points will be given to the following activities
   - Preparing research grant
   - Preparing thesis for a separate academic degree
   - Conducting examination

3. Contents of CME activities and Formal College Approved Activities will be expanded to cover non-medical professional development activities, including knowledge and skills relating to:
   - Relevant laws
   - Information technology
   - Clinic management
   - Interpersonal communication skills

A total number of 389 Fellows responded and the statistics for the following questions are detailed below.

Section A

The following new CME activities proposed by the Academy to be **mandatory** by 2011

		No. of doctors indicating "Yes"	No. of doctors indicating "No"
1	Do you agree that CPD activity on "Quality Assurance and Medical Audits" should become mandatory from 2011 onwards?	**55 (14%)**	**333 (86%)**
2	Do you agree that CPD activity on "Mortality and Morbidity Meeting" should be mandatory from 2011 onwards?	**62 (16%)**	**326 (84%)**
3	Do you agree that CPD Points awarded to "Activities for Improvement of Patient Care" require clarification, since our clinical practice is already oriented towards improving patient care?	**292 (75%)**	**95 (24%)**

Section B

The College emphasizes the CME/CPD should be core programs aiming to improve your knowledge and skill closely related to your clinical practice. Do you think the following proposals to be included as CME/CPD activity have direct and positive bearing on your clinical practice?

		No. of doctors indicating "Yes"	No. of doctors indicating "No"
4	Preparing "thesis" towards award of a degree	**128 (33%)**	**261 (67%)**
5	Preparing research proposal in grant application	**113 (29%)**	**275 (71%)**
6	Conducting examination	**123 (32%)**	**265 (68%)**
7	Reviewing Hong Kong Medical Journal (HKMJ) or other indexed journals	**240 (62%)**	**149 (38%)**
8	Learning knowledge and skills relating to relevant laws	**186 (48%)**	**203 (52%)**
9	Learning knowledge and skills relating to information technology	**167 (43%)**	**221 (57%)**
10	Learning knowledge and skills relating to managing a clinic	**162 (42%)**	**225 (58%)**
11	Learning knowledge and skills relating to interpersonal communication	**199 (51%)**	**190 (49%)**
12	Developing CME/CPD materials	**209 (54%)**	**173 (44%)**
13	Developing new service or technology	**179 (46%)**	**204 (52%)**

Statistics on No. of Trainees in all Specialties

Updated in August 2007

		TRAINEES						
		HONG KONG EAST CLUSTER			HONG KONG WEST CLUSTER			
SPECIALTY	TRAINEES TOTAL (PP/DH/HA/ OTHERS)	PYNEH	RH	TWEH	FYKH	GH	QMH	TWH
		YEAR			YEAR			
CARDIOLOGY	20	1 1 2—I 3 4 *4*	1 1 2 3—I 4 *2*	1 0 2 3 4 *0*	1 0 2 3 4 *0*	1—I 1 2 3 4 *3*	1—II 3 2 3—I 4 *6*	1 0 2 3 4 *0*
CLINICAL PHARMACOLOGY & THERAPEUTICS	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 0 2 3 4 *0*	1 0 2 3 4 *2*	1 0 2 3 4 *0*
CRITICAL CARE MEDICINE	14	1 5 2 3—IV 4—I *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 3—II 4 *4*	1 0 2 3 4 *0*
DERMATOLOGY & VENEREOLOGY	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*	1 0 2 3 4 *0*	1 0 2 3 4 *0*	1 0 2 3 4 *0*
ENDOCRINOLOGY, DIABETES & METABOLISM	9	1 0 2 3 4 *0*	1 1 2 3 4 *2*	1 0 2 3 4 *2*	1 0 2 3 4 *0*	1 0 2 3 4 *0*	1 1 2 3—I 4 *7*	1 0 2 3 4 *0*
GASTROENTEROLOGY & HEPATOLOGY	30	1—II 2 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—I 5 2—III 3 4—I *6*	1 0 2 3 4 *1*
GERIATRIC MEDICINE	7	1 0 2 3 4 *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 0 2 3 4 *2*	1 0 2 3 4 *0*
HAEM/HAEM ONCOLOGY	7	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 0 2 3 4 *0*	1—I 2 2 3 4—I *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	5	1 1 2—I 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*
INTERNAL MEDICINE	163	1—II 12 2—III 3—II 4—V *28*	1 3 2—I 3—II 4 *19*	1 2 2—I 3—I 4 *5*	1 1 2 3 4—I *1*	1—I 2 2—I 3 4 *4*	1—VI 20 2—IV 3—VII 4—III *45*	1 0 2 3 4 *7*
MEDICAL ONCOLOGY	6	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	7	1 1 2 3—I 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—I 1 2 3 4 *7*	1 0 2 3 4 *2*
NEUROLOGY	17	1 0 2 3 4 *4*	1 1 2 3—I 4 *3*	1 1 2—I 3 4 *0*	1 0 2 3 4 *0*	1 0 2 3 4 *0*	1 4 2—II 3—II 4 *4*	1 0 2 3 4 *0*
PALLIATIVE MEDICINE	5	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 1 2—I 3 4 *2*	1 0 2 3 4 *0*	1 0 2 3 4 *0*
REHABILITATION	2	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	20	1 2 2—I 3—I 4 *2*	1 1 2 3—I 4 *5*	1 0 2 3 4 *0*	1 0 2 3 4 *0*	1 0 2 3 4 *7*	1—I 1 2 3 4 *5*	1 0 2 3 4 *0*
RHEUMATOLOGY	11	1 1 2 3 4—I *1*	1 0 2 3 4 *1*	1 0 2 3 4 *0*	1 1 2 3 4—I *0*	1 0 2 3 4 *0*	1 1 2 3—I 4 *1*	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	20	1 0 2 3 4 ***0***	1 4 2—II 3—I 4—I ***8***	1 0 2 3 4 ***0***	1 0 2 3 4 ***2***	1—I 2 2 3 4—I ***4***	1 1 2—I 3 4 ***1***	1 1 2 3 4—I ***2***	1 0 2 3 4 ***1***	1 0 2 3 4 ***6***	1 0 2 3 4 ***0***	1 0 2 3 4 ***3***	
CLINICAL PHARMACOLOGY & THERAPEUTICS	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 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 2 2—I 3—I 4 ***5***	1 0 2 3 4 ***0***	1 1 2—I 3 4 ***1***	1 0 2 3 4 ***4***	1 1 2 3 4—I ***2***	1 0 2 3 4 ***2***	1 0 2 3 4 ***0***	1 1 2 3 4—I ***1***	1 0 2 3 4 ***0***	1 0 2 3 4 ***2***	
DERMATOLOGY & VENEREOLOGY	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***	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	9	1 0 2 3 4 ***0***	1 2 2 3—II 4 ***5***	1 0 2 3 4 ***0***	1 0 2 3 4 ***1***	1 1 2—I 3 4 ***2***	1 0 2 3 4 ***1***	1 2 2 3—II 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	30	1 0 2 3 4 ***0***	1 3 2—I 3—I 4—I ***5***	1 0 2 3 4 ***0***	1 1 2 3 4—I ***3***	1 2 2 3—II 4 ***2***	1 1 2 3—I 4 ***4***	1—I 4 2—III 3 4 ***4***	1 0 2 3 4 ***0***	1 0 2 3 4—I ***10***	1 0 2 3 4 ***1***	1—I 2 2 3 4—I ***3***	
GERIATRIC MEDICINE	7	1 1 2 3 4—I ***5***	1 0 2 3 4 ***3***	1 0 2 3 4 ***5***	1 0 2 3 4 ***1***	1 1 2 3 4—I ***9***	1 0 2 3 4 ***7***	1 1 2 3 4—I ***6***	1 0 2 3 4 ***1***	1 2 2—I 3—I 4 ***10***	1 1 2—I 3 4 ***3***	1 0 2 3 4 ***3***	
HAEM/HAEM ONCOLOGY	7	1 0 2 3 4 ***0***	1 0 2 3 4 ***4***	1 0 2 3 4 ***0***	1—I 1 2 3 4 ***1***	1 1 2 3 4—I ***1***	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***	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	5	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 ***1***	1 0 2 3 4 ***0***	1 0 2 3 4 ***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	163	1 0 2 3 4 ***3***	1—II *18* 2—V 3—VII 4—IV *47*	1 0 2 3 4 ***5***	1—I 4 2—II 3 4—I *13*	1—I *17* 2—IV 3—III 4—IX *29*	1 5 2—II 3—I 4—II *19*	1—III *16* 2—V 3—VI 4—II *21*	1 1 2 3—I 4 ***3***	1 6 2—I 3—II 4—III *44*	1 2 2—I 3 4—I ***2***	1—I 5 2—I 3—I 4—II *17*	
MEDICAL ONCOLOGY	6	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***	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	7	1 0 2 3 4 ***2***	1 0 2 3 4 ***6***	1 0 2 3 4 ***0***	1 0 2 3 4 ***1***	1 1 2 3—I 4 ***3***	1 0 2 3 4 ***1***	1 2 2—I 3—I 4 ***5***	1 0 2 3 4 ***0***	1 0 2 3 4 ***6***	1 0 2 3 4 ***0***	1 0 2 3 4 ***2***	
NEUROLOGY	17	1 0 2 3 4 ***0***	1 1 2—I 3 4 ***5***	1 0 2 3 4 ***0***	1 1 2 3 4—I ***1***	1 3 2—II 3 4—I ***2***	1 0 2 3 4 ***0***	1 2 2—I 3—I 4 ***3***	1 0 2 3 4 ***0***	1 0 2 3 4 ***1***	1 0 2 3 4 ***0***	1 2 2—I 3 4—I ***0***	
PALLIATIVE MEDICINE	5	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 ***1***	1 1 2 3 4—I ***2***	1 0 2 3 4 ***0***	1 0 2 3 4 ***1***	1 0 2 3 4 ***0***	1—I 1 2 3 4 ***0***	1 0 2 3 4 ***0***	
REHABILITATION	2	1 1 2 3 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	20	1 0 2 3 4 ***6***	1—I 1 2 3 4 ***3***	1 0 2 3 4 ***5***	1 0 2 3 4 ***2***	1 2 2 3—II 4 ***3***	1 0 2 3 4 ***3***	1—I 3 2 3—II 4 ***1***	1 0 2 3 4 ***0***	1 0 2 3 4 ***3***	1 1 2 3 4—I ***4***	1 0 2 3 4 ***1***	
RHEUMATOLOGY	11	1 0 2 3 4 ***1***	1—I 2 2 3—I 4 ***2***	1 0 2 3 4 ***0***	1 1 2—I 3 4 ***0***	1 0 2 3 4 ***2***	1 1 2—I 3 4 ***1***	1 0 2 3 4 ***1***	1 1 2 3—I 4 ***0***	1 0 2 3 4 ***1***	1 0 2 3 4 ***0***	1 0 2 3 4 ***0***	

		TRAINEES						
		NEW TERRITORIES EAST CLUSTER					NEW TERRITORIES WEST CLUSTER	
SPECIALTY	TRAINEES TOTAL (PP/DH/HA/ OTHERS)	AHNH	NDH	PWH	SH	TPH	POH	TMH
		YEAR					YEAR	
CARDIOLOGY	20	1 0 2 3 4 ***2***	1 2 2 3—II 4 ***2***	1—I 2 2 3—I 4 ***5***	1 0 2 3 4 ***0***	1 0 2 3 4 ***0***	1 0 2 3 4 ***0***	1 2 2—II 3 4 ***5***
CLINICAL PHARMACOLOGY & THERAPEUTICS	2	1 0 2 3 4 ***0***	1 0 2 3 4 ***0***	1—I 2 2—I 3 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***
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 1 2—I 3 4 ***1***
DERMATOLOGY & VENEREOLOGY	9	1 0 2 3 4 ***0***	1 0 2 3 4 ***0***	1—I 2 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***
ENDOCRINOLOGY, DIABETES & METABOLISM	9	1 0 2 3 4 ***1***	1 1 2—I 3 4 ***1***	1 1 2 3—I 4 ***9***	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***
GASTROENTEROLOGY & HEPATOLOGY	30	1 0 2 3 4 ***0***	1 2 2—I 3 4—I ***2***	1—I 4 2 3—III 4 ***5***	1 0 2 3 4 ***0***	1 0 2 3 4 ***0***	1 0 2 3 4 ***0***	1 3 2 3—I 4—II ***6***
GERIATRIC MEDICINE	7	1 0 2 3 4 ***1***	1 0 2 3 4 ***1***	1 0 2 3 4 ***4***	1 1 2 3 4—I ***6***	1 0 2 3 4 ***1***	1 0 2 3 4 ***1***	1 0 2 3 4 ***9***
HAEM/HAEM ONCOLOGY	7	1 0 2 3 4 ***0***	1 0 2 3 4 ***0***	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 1 2 3—I 4 ***3***
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	5	1 1 2—I 3 4 ***1***	1 0 2 3 4 ***0***	1 2 2—I 3—I 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 ***4***
INTERNAL MEDICINE	163	1 1 2—I 3 4 ***12***	1 8 2—II 3—IV 4—II ***11***	1—IV 19 2—III 3—IX 4—III ***37***	1—I 4 2 3 4—III ***6***	1 0 2 3 4 ***3***	1 0 2 3 4 ***2***	1 17 2—X 3—III 4—IV ***36***
MEDICAL ONCOLOGY	6	1 0 2 3 4 ***0***	1 0 2 3 4 ***0***	1 4 2—I 3—II 4—I ***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	7	1 0 2 3 4 ***2***	1 0 2 3 4 ***1***	1 0 2 3 4 ***5***	1 0 2 3 4 ***0***	1 0 2 3 4 ***0***	1 0 2 3 4 ***0***	1 2 2—II 3 4 ***7***
NEUROLOGY	17	1 0 2 3 4 ***1***	1 0 2 3 4 ***1***	1—I 1 2 3 4 ***3***	1—I 1 2 3 4 ***0***	1 0 2 3 4 ***0***	1 0 2 3 4 ***0***	1 0 2 3 4 ***1***
PALLIATIVE MEDICINE	5	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	2	1 0 2 3 4 ***0***	1 0 2 3 4 ***1***	1 0 2 3 4 ***2***	1 0 2 3 4 ***1***	1 0 2 3 4 ***1***	1 0 2 3 4 ***1***	1 1 2 3 4—I ***3***
RESPIRATORY MEDICINE	20	1 0 2 3 4 ***3***	1 3 2 3—II 4—I ***3***	1 3 2—I 3—II 4 ***4***	1 0 2 3 4 ***0***	1 0 2 3 4 ***1***	1 0 2 3 4 ***0***	1 2 2—I 3 4—I ***6***
RHEUMATOLOGY	11	1 0 2 3 4 ***0***	1 0 2 3 4 ***0***	1 1 2—I 3 4 ***3***	1 0 2 3 4 ***0***	1 0 2 3 4 ***1***	1 0 2 3 4 ***0***	1 2 2—II 3 4 ***1***

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

SPECIALTY	TRAINEES TOTAL (PP/DH/HA/OTHERS)	TRAINEES
		DH
DERMATOLOGY & VENEREOLOGY	9	1—I 7 2—II 3 4—IV ***11***
IMMUNOLOGY & ALLERGY	0	1 0 2 3 4 ***2***
RESPIRATORY MEDICINE	20	1 1 2—I 3 4 ***7***

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

Statistics on No. of Fellows in all Specialties

Updated in August 2007

		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	185	7	3	0	**10**	0	5	10	0	**15**	**25**
CLINICAL PHARMACOLOGY & THERAPEUTICS	5	0	0	0	**0**	0	0	2	0	**2**	**2**
CRITICAL CARE MEDICINE	57	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	78	4	2	3	**9**	0	0	9	0	**9**	**18**
GASTROENTEROLOGY & HEPATOLOGY	117	7	2	0	**9**	0	0	8	1	**9**	**18**
GERIATRIC MEDICINE	156	8	12	4	**24**	3	0	4	0	**7**	**31**
HAEM/HAEM ONCOLOGY	42	4	0	0	**4**	0	0	9	0	**9**	**13**
IMMUNOLOGY & ALLERGY	6	0	0	0	**0**	0	0	1	0	**1**	**1**
INFECTIOUS DISEASE	27	2	0	0	**2**	0	0	3	0	**3**	**5**
INTERNAL MEDICINE	944	46	26	11	**83**	1	8	72	8	**89**	**172**
MEDICAL ONCOLOGY	35	0	0	0	**0**	0	0	8	0	**8**	**8**
NEPHROLOGY	107	7	0	0	**7**	0	0	8	2	**10**	**17**
NEUROLOGY	72	5	4	0	**9**	0	0	5	1	**6**	**15**
PALLIATIVE MEDICINE	14	0	1	0	**1**	0	2	0	0	**2**	**3**
REHABILITATION	42	0	3	4	**7**	1	0	1	4	**6**	**13**
RESPIRATORY MEDICINE	149	8	7	1	**16**	0	11	11	0	**22**	**38**
RHEUMATOLOGY	46	2	2	2	**6**	0	0	1	2	**3**	**9**

		FELLOWS														
		KOWLOON CENTRAL CLUSTER			KOWLOON EAST CLUSTER				KOWLOON WEST CLUSTER							KOWLOON CENTRAL + EAST + WEST CLUSTER
SPECIALTY	FELLOWS TOTAL (PP/DH/HA/ OTHERS)	KH	QEH	Subtotal	HOHH	TKOH	UCH	Subtotal	CMC	KWH	OLMH	PMH	WTSH	YCH	Subtotal	
CARDIOLOGY	185	0	10	10	0	3	7	10	1	4	1	9	0	3	18	38
CLINICAL PHARMACOLOGY & THERAPEUTICS	5	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
CRITICAL CARE MEDICINE	57	0	5	5	0	2	7	9	3	5	0	2	0	2	12	26
DERMATOLOGY & VENEREOLOGY	76	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
ENDOCRINOLOGY, DIABETES & METABOLISM	78	0	5	5	0	3	5	8	2	3	2	5	0	2	14	27
GASTROENTEROLOGY & HEPATOLOGY	117	0	7	7	0	4	4	8	5	4	0	11	0	6	26	41
GERIATRIC MEDICINE	156	7	4	11	7	2	12	21	8	11	1	12	4	5	41	73
HAEM/HAEM ONCOLOGY	42	0	6	6	0	1	1	2	0	0	0	3	0	0	3	11
IMMUNOLOGY & ALLERGY	6	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
INFECTIOUS DISEASE	27	0	3	3	0	0	2	2	0	1	0	4	0	1	6	11
INTERNAL MEDICINE	944	5	62	67	9	21	44	74	27	35	5	58	4	27	156	297
MEDICAL ONCOLOGY	35	0	1	1	0	0	0	0	0	0	0	1	0	0	1	2
NEPHROLOGY	107	0	9	9	2	2	4	8	2	5	1	8	0	2	18	35
NEUROLOGY	72	0	6	6	0	2	3	5	0	3	1	3	1	0	8	19
PALLIATIVE MEDICINE	14	0	0	0	3	0	1	4	3	0	1	0	0	0	4	8
REHABILITATION	42	8	0	8	1	0	3	4	1	1	0	2	4	0	8	20
RESPIRATORY MEDICINE	149	6	8	14	5	4	4	13	5	4	0	4	7	2	22	49
RHEUMATOLOGY	46	1	3	4	0	0	2	2	1	2	0	3	0	1	7	13

		FELLOWS									
		NEW TERRITORIES EAST CLUSTER						NEW TERRITORIES WEST CLUSTER			NEW TERRITORIES EAST + WEST CLUSTER
SPECIALTY	FELLOWS TOTAL (PP/DH/HA/ OTHERS)	AHNH	NDH	PWH	SH	TPH	Subtotal	POH	TMH	Subtotal	
CARDIOLOGY	185	3	4	11	0	0	18	0	9	9	27
CLINICAL PHARMACOLOGY & THERAPEUTICS	5	0	0	3	0	0	3	0	0	0	3
CRITICAL CARE MEDICINE	57	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	78	2	2	12	1	0	17	0	2	2	19
GASTROENTEROLOGY & HEPATOLOGY	117	2	3	6	0	0	11	0	8	8	19
GERIATRIC MEDICINE	156	2	1	4	6	4	17	1	12	13	30
HAEM/HAEM ONCOLOGY	42	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	27	1	0	1	0	0	2	0	5	5	7
INTERNAL MEDICINE	944	19	20	56	6	6	107	2	64	66	173
MEDICAL ONCOLOGY	35	0	0	13	0	0	13	0	0	0	13
NEPHROLOGY	107	3	1	7	0	0	11	0	7	7	18
NEUROLOGY	72	1	2	7	1	0	11	0	4	4	15
PALLIATIVE MEDICINE	14	0	0	0	1	0	1	0	0	0	1
REHABILITATION	42	0	1	2	1	1	5	1	3	4	9
RESPIRATORY MEDICINE	149	4	3	6	0	1	14	0	10	10	24
RHEUMATOLOGY	46	1	1	3	0	3	8	0	3	3	11

Prof R Yu and Prof Yeoh at the AGM in 2003

Professor Eng Kiong Yeoh

O.B.E., G.B.S., J.P.

John Mackay

How does a carefree Malaysian school boy in Ipoh get to be the Secretary for Health, Welfare and Food of the Hong Kong Special Administrative Region of China?

Changing his passport was only the last step in a long journey. Ipoh is the capital of Perak State about 200 kilometres north of Kuala Lumpur. Its fortune was founded on tin mining. EK's great grandparents came with their children to the city more than a hundred years ago from China, and started businesses. His father went into the family business at the age of 17 and became very successful, keeping it going during the Japanese occupation and expanding it after the war. He grew up with six siblings in a house which shared a large family compound with two other houses, in which lived his two uncles and their families. The large number of cousins meant that there were always children around, one of the main sports being badminton on the family court. As children they were often told of the terror and atrocities the local population encountered during the Japanese occupation — the 'water tortures' and 'beheadings' with the heads later displayed in the market to deter potential 'offenders'.

He went to school at St. Michael's a La Salle catholic institution for boys and one of the best schools in the country. In Perak State at that time there were only three schools that had 6th Form classes, St. Michael's, Anglo-Chinese school and Andersons. Competition was fierce to get into 6th Form. In addition to the 'O' Level Cambridge examinations, with results not available for three months, the students had to sit a Nation-wide competitive exam to advance to 6th Form. Most unfortunately, shortly before the exam, EK was the victim of a traffic accident which left him semi-conscious for days, followed by post traumatic headaches. Despite the accident he managed to pass the exam. One of the bonuses of getting into the 6th Form was the arrival of girls from the Ipoh convent school which did not have its own 6th Form.

As the eldest son in the family his choice of career was important. At that time he had no particular ambition regarding a career, his decision to study Medicine was influenced by his parents and by the fact that some other of his friends had made that choice. Hong Kong University was chosen because of its high reputation; an uncle had graduated from it in engineering. None of his immediate family had been doctors, but following him, a younger brother qualified as a doctor and is now an oncologist at the Royal Adelaide Hospital, a nephew is training as an oncologist at Oxford, and a second nephew is due to graduate from medical school in Adelaide this year. A sister lives in New Zealand. Another brother and sister are in England, leaving one brother to run the family business in Ipoh with his father, now a widower. Happily, now freed from onerous government duties, EK is able to visit the family home at regular intervals.

'I was not very serious about my pursuits in Medicine at the University, and sought other distractions during my time at HKU, such as running for, and serving in, executive positions in the Students Union, I was the Executive Committee member responsible for External relations and the next year, served as President of the Students Union. I became serious about medicine only after I graduated as I realised the onerous responsibility the profession had, being entrusted by society with relieving pain and suffering and saving lives. I was fortunate to have been given the opportunity to train in Medicine at the University Department of Medicine at Queen Mary Hospital, where I learnt medicine from the very eminent faculty lead by the legendary AJS McFadzean. He also remembers the teaching skills of Professors David Todd, Rosie Young, and G. B. Ong.

Qualifying in 1971 his first job was surgical, under Dr. C. H. Leong who invited him to return to the surgical department, but his interest lay in Medicine.

After four years at the University Department of Medicine at the Queen Mary Hospital, he spent one year as a Clinical Assistant at University College Hospital in London leading to an MRCP(UK) in 1977.

Back in Hong Kong he returned to the University Medical unit for six months then transferred to the Queen Elizabeth Hospital Medical Unit 'A' as a Medical Officer. This was a rude awakening. There was one consultant, one Senior Medical Officer, (SMO), and ten Medical Officers, (MOs), of whom he was the only one with a Membership. When on call for emergency admissions there were on average 100 new patients each day, under the care of four House Physicians and with one MO on back-up. Camp beds were everywhere, sometimes even in the toilets.

He was promoted to an SMO five months later. When his Consultant Physician retired two years later EK was the most junior of the SMOs in the territory but was promoted to Consultant and Head of the unit in 1979. He later learned that reports from Professor Alec McFadzean played an important part in that decision.

He took up his position as Consultant in 1980 on his return from six months in London training in hepatology under Professor Sheila Sherlock. His first year was very tough. He had to study hard with the help of books brought back from England to cope with every medical specialty, having no other specialists to whom he could refer.

He found the ten years as Consultant challenging and rewarding, and was able to build up a good department with well trained specialists who were also excellent with patients and to whom in the later years, he could delegate most of the tasks required to run the unit. It was in this process that he realised that if he wanted to improve things, he would need to be involved with management.

He became active in advocating change at the Queen Elizabeth Hospital, becoming a Council member, then Vice-Chair of the Government Doctors Association of Hong Kong.Getting the authorities to pay attention to their suggestions was difficult until the doctors took industrial action. They maintained patient care but obstructed the smooth running of the hospital administration, forcing government to take them seriously. The result of his efforts was the reduction of camp beds by about a third; and by the Government nearly doubling the number of consultants during the next year.

By 1989 he was Chairman of the Medical Executive Committee of the Queen Elizabeth Hospital and a Member of the Hong Kong Provisional Hospital Authority. In 1990 he became the Director of Operations of the Hospital Authority, becoming Chief Executive in 1994 a post he was to hold for the next five years until his appointment as Secretary of Health and Welfare. EK remembers his first months as Director of Operations as very stressful, a steep learning curve, giving him recurrent nightmares for the first and last time in his life. EK tells that his change of occupation from being a hospital clinician to a government executive was not planned – it grew out of his concern to improve the organisation of health delivery systems.

His move to administration meant he gave up a very busy clinical career, during which he had written over thirty papers on hepatitis while he was Head of the Department of Health, Hepatitis B vaccination programme from 1982 to 1990. He wrote papers on the HIV/AIDS, a disease which had just appeared in Hong Kong in the 1980s. From 1982 to 1989 he was appointed as Temporary Adviser to the World Health Organisation for several meetings in Japan and the Philippines on AIDS or Hepatitis.

He was involved at the same time in so many professional organisations that it is not surprising that he had little leisure time to himself. By this time he had been honoured by his medical colleagues with the Fellowships of the Royal Colleges of Edinburgh, London and Glasgow; Fellowship of the Hong Kong College of Physicians, and Hong Kong Academy of Medicine; and the Royal Australasian College of Physicians.

As head of the Hong Kong Hospital Authority he was charged with the responsibility of the management and transformation of the public hospital system into one which embraced the new values of being patient-centred, having a focus on outcomes, and an emphasis on quality. The extent to which he succeeded can be measured by the enthusiasm of the population, and the cries of alarm from the private doctors and hospitals as their patients deserted them.The downside from the government's point of view was the increasing cost. However, plans were in place to raise money and discourage trivial attendances at Accident and Emergency Departments by raising charges, and charging for medication, and to create a Savings Account. The money saved would enable a 2% increase in budget for research and upgrading facilities.

For his work in public service Dr Yeoh was appointed a Justice of the Peace, (JP) in 1993, and just before the change in Sovereignty he was honoured by the British Government with an O. B. E. His work in Hospital Administration was honoured by Fellowship of the Hong Kong College of Community Medicine, and Fellowship of the Faculty of Public Health Medicine in UK.

And then came SARS. World Health Organisation named it the 'Severe Acute Respiratory Syndrome', because they had no idea of the cause. From early March 2003 the Hong Kong health system was under severe strain and Dr E. K. Yeoh as Secretary for Health, Welfare and Food was in the thick of it. Heroic work by all sectors of the medical community brought the disease under control: Hong Kong was declared disease free in June 2003. The World Health Organisation recognised and praised the Herculean efforts taken by Hong Kong to control the outbreak and eradicate the disease.

The Expert Committee commissioned by the Hong Kong Government to review the handling of the SARS Outbreak and the lessons to be learnt, co-chaired by Prof Sian Griffiths and Prof Cyril Chantler consisted of a panel of international experts. An account of their findings presented by Professor Griffiths in 'Synapse' of August 2004 makes clear that although they found it necessary to make 46 recommendations for the improvement of systems, organisation and communication, they had been impressed by the speed with which the epidemic had been controlled and did not lay blame on any particular person.

Despite this verdict The Legislative Council thought it necessary to form a Select Committee which published a critical report in July 2004. The subsequent resignations of Dr E. K. Yeoh and Prof C. H. Leong were in line with the exercise of 'Political Accountability', which was then novel to Hong Kong. [The system of Political Appointments to the Government had only been introduced as an "Accountability System" in 2002.]

The resignations were greeted with regret by the medical community. Prof Richard Yu, President of the Hong Kong College of Physicians in his 'Message from the President' in 'Synapse' of August 2004 summed up the mood when he titled his message, "In Praise of Fallen Heroes". At the time of his resignation EK issued a statement that it had been a privilege to have been able to serve in the public sector for 33 years. Since then his view has not changed.He was very surprised and touched by the support from members of the profession and members of the public, who either wrote or published their support.

In September 2004 he was granted Fellowship of the Royal Australasian College of Medical Administrators. And for his distinguished service to the community Professor Yeoh was awarded Hong Kong's Gold Bauhinia Star in July 2005.

He has now returned to academia. He has an appointment as Honorary Clinical Professor, Department of Community Medicine, University of Hong Kong. He is also Professor of Public Health and Director of Systems for Health, at the School of Public Health and Department of Community and Family Medicine, of the Chinese University of Hong Kong. He is most excited by this latter appointment in which he is researching the application of systems thinking to the study of how the complex components of Health Systems, Organisations, Resources, Policies and Financing, Management and Delivery systems interact and interrelate to improve health.

Professor Yeoh has excelled as a clinician and as an administrator, it is to be expected that he will be as equally successful in his new role as a teacher and researcher into Health Systems.

(from left to right) AGM 2004 - Prof WK Lam, Prof L Leong, Prof V Chan, Prof TK Chan, Prof EK Yeoh, Prof R Yu, Prof Zhong Nan Shan, Dr CH Leong, Mrs Zhong, Dr L Yam