

HONG KONG COLLEGE OF PHYSICIANS

HONG KONG COLLEGE OF PHYSICIANS  
香港內科醫學院

# SYNAPSE



Sapientia et Humanitas

MARCH 2008

RESTRICTED TO MEMBERS ONLY



*Snow in Forest* Photographer: Dr. Jeffrey Shu-chung TSANG

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Sapientia et Humanitas

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 enquiry@hkcp.org  
College Website <http://www.hkcp.org>

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# The President's Annual Report 2007

**KN Lai** President, HKCP

In the year of the Pig 2007, Hong Kong SAR has enjoyed a booming economy. With a vigilant and attentive approach, our medical community has successfully smothered the constant threat of Avian flu and local food safety issues. Progress has been made in the working hours and compensation settlement for some of our Fellows, Members and Trainees who are working in the Hospital Authority. Encouragingly, a mutually acceptable solution will arise in the near future.

This is my third annual report since elected to the Presidency in 2004. I appreciate greatly 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. Last year, the College celebrated her twentieth anniversary with a two-day scientific program. The College was honored by the attendance of presidents of overseas physician colleges from London, Edinburgh, Glasgow, Australasia and Singapore. Our friendship and academic link are strongly well maintained with these sister colleges. Moving into the third decade since the founding of our College, we aim to consolidate our global networking with other major physician colleges and rekindle our interaction with physician societies in China. This September, I was invited by the Chinese Society of Internal Medicine to speak on the "Structure of physician training program and specialist accreditation in Hong Kong" in the annual scientific meeting held in Hangzhou. I was also asked to conduct a clinicopathological conference in English. The interest from Chinese physicians of a structural clinical training program on a college/society basis instead of the university-run degree-based training may signal the beginning of a paradigm shift in postgraduate medical training in China. On the local front, our College has launched a computerization system in training and examination matters allowing paper documentation be conducted from the desktop computer using the Web.

The Annual Report outlines the various events and achievements 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. Several new developments in training are established in the last 12 months.

1. The College published the fourth edition of the *Guidelines on Postgraduate Training in Internal Medicine, July 2007* which had been distributed to all trainees and trainers in the Hospital Authority.
2. The Specialty Board in AIM had introduced the requirement for writing of case reports at its Annual Assessment. Examiners' mark sheets and comments of the case reports are sent back to the supervisors and candidates. Through this, candidates can improve their skills in the presentation and writing up of case reports. A column has been added in Synapse to provide tips on how to write good case reports together with common mistakes made by candidates, so that trainees may learn the format of writing case reports.
3. The statistics on the pass and failure rates of Exit Assessments in 1997-2006 have been sent to all Specialty Boards, so that they can review the training programs of hospitals with relatively lower passing rates. Regular updates on examination results will continue to be distributed to the Specialty Boards.
4. With the Academy's proposed CME/CPD guidelines for the year 2011, our College sent questionnaire to all College Fellows who need to undergo CME, to seek their opinion on the newly proposed items. A total of 389 Fellows had returned the completed questionnaires to express their views, which were sent to the Academy for information.
5. The CME board has revised the CME/CPD requirement ensuring active CME will not be less than 30 units per three-year cycle.

## National and International Liaison Committee

Under the dedicated Chairmanship of Professor W.K. Lam, continues to liaise with national and international professional bodies in

Medicine on matters of mutual interest, including postgraduate training, professional examinations, scientific and academic interaction and continuous professional development in the practice of Internal Medicine.

Our College continues to provide input and professional assessment to the three Royal Colleges of Physicians in United Kingdom with regard to local clinician nominated for College Fellowship.

On behalf of the College, the President and the Immediate Past President attended the Golden Jubilee Anniversary of the Singapore Academy of Medicine in June 2007.

### 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. An *ad hoc* PACES examination was held in June 2007 due to large number of candidates. Two new centers, Tuen Mun Hospital and Caritas Medical Center, are accredited for PACES examination.

### Scientific Committee

The Scientific Committee had organized a Scientific Meeting of Hong Kong College of Physicians on October 14-15, 2006. A comprehensive program was organized to celebrate the College's 20<sup>th</sup> 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 2007, with a medal to award to the best presenter.

### Membership Committee

As of 31 August 2006, 51 applicants were proposed for Membership and 45 applicants for Fellowship.

### Professional and General Affairs Committee

The Committee continues to handle issues related to professional and general medical affairs this year.

### Synapse

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

To celebrate the 20<sup>th</sup> anniversary of the Hong Kong College of Physicians, a special edition of Synapse was published, which included congratulatory messages from overseas Colleges. The College milestones charted our past achievements together with memorable photographs of the founding years.

### 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 2007

**KN Lai** President, HKCP

Today is a great day for the College. We gather here to witness 66 physicians being admitted to the Fellowship and another 63 to our Membership following their success in qualifying examinations. Let me extend the College's congratulation to the new members and fellows. In last year's conferment ceremony, I spoke about the career path of the clinician-scientist. On this occasion, I will address the issue of media. Media intrudes into a major part of our daily lives, and our profession has to handle it with caution, alertness, openness, sensitivity and respect. Interaction with the media may not be frequent for some of our new fellows and members but this will, no doubt, become an important part in their practice of Medicine. For the term media, I refer to newspapers, magazines, radio and television. Let me give you my views on this subject.

Media is an important and indispensable component of modern society, influencing virtually every aspect of our lives. Hence, to keep track on the media is regarded as of the utmost importance by all government bodies, no matter whether they are democratic or pseudo-democratic. Hong Kong leads in having possibly the most liberal media worldwide. No doubt, this also applies to news related to medicine. This is both beneficial, yet occasionally impacts our profession in quite a contentious way. I will categorize such impacts with regard to four areas.

First, is the issue we term a medical incident. The media always believes that the public has the right to know. Hence, by corollary, the media assumes that it too must have the right to know on behalf of the public. I am sure this is totally correct especially in reporting medico-legal court hearings and proceedings of investigation panels. The report should be up-to-date and accurate and this also applies to serious medical incidents. In case of the so-called alleged medical incidents, such as a patient with known cancer suddenly collapsing after admission, the first and most important responsibility of the doctor is to treat the individual instead of giving an immediate press release, whenever the relatives complain to the media. Organizations acting for patient's rights often suspect that there is a cover-up if a public statement is not forthcoming within a short time. In fact, obtaining first-hand

information and drawing sensible conclusion frequently takes much longer. For example, I headed the investigation of a medical incident that involved the sudden death of several haemodialysis patients due to formaldehyde toxicity. It took us at least 36 hours to figure out all the events leading to the contamination of the dialysis circuit that resulted in the mishap. There was actually no cover-up: it was just that a satisfactory explanation could not be offered within 24 hours. In the meantime, the doctor's role was to actively treat any affected patients.

The second area relates to medical knowledge directed at the public. Compared to media worldwide, medical news is extremely abundant in Hong Kong. Daily health columns are published in newspapers, health talk-shows are scheduled every alternate day on the radio, and sometimes, television series air their episodes every week. As a result, is our public better informed about medical knowledge than the rest of the world? I will leave this for you to judge. So far, the members of the public have a poor knowledge of health costing. I suspect they have little idea that the government allocates no more than five thousand dollars per year to each Hong Kong citizen to cover health costs. Moreover, this only covers two days of admission to a general ward, one day in a critical care unit, or one course of special intravenous antibiotics. Worse still, we continue to see patients die after receiving un-orthodox treatments, though they should have been managed satisfactorily with evidence-based therapy right from the beginning. Thus, sometimes, these media may not be aware that they are being used for advertising.

This brings me to the third area. Over the last ten years, different institutions have increasingly collaborated with the media to provide tailor-made medical news to the public. This has made Hong Kong a world leader in this type of media coverage. Such exposure has never been possible elsewhere, not even via tabloid newspapers in the United Kingdom, not to say the New York Times or Washington Post in the United States. Let me quote a few examples in our local news. Longevity drugs available in two years! First time in the world for the use of a new device in Chinese patients! In fact, that device has been manufactured and used in overseas for years. Certain fruit is superior for constipation though the patient sample was less than 40! Not infrequently, such news

amplifies the expectation of patients who ultimately cast their anger and dissatisfaction on frontline staff, especially in public health service. One may then ask why we don't see these phenomena in countries that have similar press freedom. Simply, I have been told that, in these countries, you would be sued for liability for issuing of faulty information. Your lawyer will advise you to plead guilty to limit the damage and compensation. That has not been the case in Hong Kong (for these institutions). In the United States, medical information has also been given to the public by educational institutions, but in an accurate and responsible manner. The Mayo Clinic has a website called MayoClinic.com which is devoted to outlining diagnosis, investigation, and standardized treatments for common medical illnesses. The National Institute of Health runs a website called Medline Plus, summarizing diagnosis, investigation, and standardized treatments for common as well as rare medical disorders in alphabetical order from A to Z. In the United Kingdom, anyone can have access to authentic medical information through the web or by writing to the National Library of Guidelines. This is a database of UK approved evidence based clinical guidelines in full text, and includes associated information from all Medical Colleges or Specialist Societies. Any patient can know whether their family doctors or specialists are giving them evidence-based and recommended treatment. Now the question in Hong Kong therefore becomes "Shall our Academy or College embark on such meaningful commitments and should our institutions behave in a more mature and responsible manner?"

Now let me come to fourth and final area. Nowadays, whenever there is a problem, it is fashionable and politically correct to blame the system. However, I have to point out that sometimes the living subject is at fault, whereas the non-breathing system is innocent. In this scenario, I refer to the doctor. Questions have arisen as to whether more and more doctors are using the media to indirectly advertise themselves right under the nose of the Medical Council. Examples are numerous and I only cite three. Example 1: A doctor in private practice has a column in a tabloid newsmagazine. Instead of using his or her pen-name, he or she uses his/her real name with honorary appointment at the university and specialist qualifications. Of course, the doctor writes about his/her specialty experience in the newspaper or magazine column. Example 2: Whenever there is an alleged medical incident, reporters approach a specialist

who is always eager and active in giving comments, although he or she may not have the first-hand clinical experience. Again, not infrequently, his or her real name is used together with any honorary appointment at the university with specialist qualifications, despite working in private practice. Why don't reporters approach the Specialist Colleges? Simply College spokespersons will not come up with a statement immediately without fact-finding. This may not satisfy the reporter whose article has a printing deadline of 11 pm to meet. Example 3: A paper on a large cohort of over 10,000 patients with a metabolic disorder was published in a leading world-renowned journal earlier this year. This was immediately followed by a local press conference at which a doctor (who was not involved in this publication) claimed that he/she also had similar findings in his/her handful number of patients. Mind you, none of these patients from Hong Kong was recruited for this study. Could these examples be considered advertising in the media? Once again, I will leave that judgment to you.

As the President of the College and as a clinician who honors and values our professional merit and code of conduct, I have the duty to remind you about the impact and importance of the media. Napoleon the Great in his writing "*Maxim*" stated and let me quote "Four hostile newspapers are more to be feared than a thousand bayonets." A bayonet is a blade adapted to fit the muzzle end of a rifle and used as a weapon to stab or kill in close combat. Oscar Wilde, the famous Irish playwright and poet, said in 1891 and I quote: "But what is the difference between literature and journalism? ...Journalism is unreadable and literature is not read. That is all." I certainly will not agree with Oscar Wilde on the issue of Journalism in this modern era of year 2007. Journalism is important and can reveal the truth. I hope you will respect the media but also be honest, be responsible, be helpful and be ethical when you interact with it in the future.

I think I have already spoken too much. There is a Slovenian proverb: "Speak the truth, but leave immediately after." With this, I wish you every success in your future career and a very pleasant evening.

*This address was delivered at the Fellowship Conferment Ceremony of the Hong Kong College of Physicians on 13 October, 2007*



# The AJS McFadzean Oration 2007

## Higher Education in Hong Kong – Opportunity to be an International Hub?

**John C.Y. Leong**

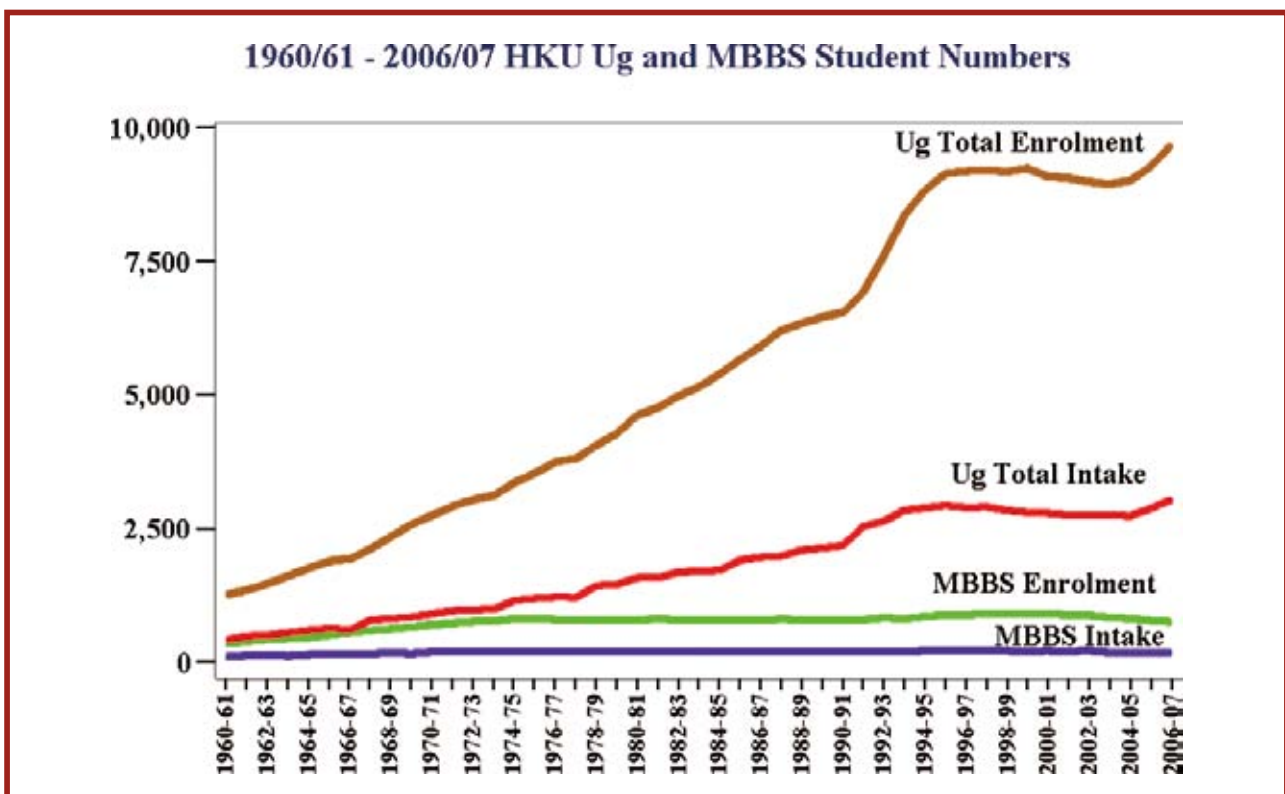
President, The Open University of Hong Kong  
Professor Emeritus, The University of Hong Kong

It may seem superfluous to remind this audience about who Alec McFadzean was, and his contributions to the Department of Medicine, of the University of Hong Kong, to the Faculty of Medicine, and indeed to the development of medicine as a whole in Hong Kong during the 50s & 60s. However, relatively few of us here tonight have actually experienced the man. Graduates of the Medical School of HKU of my vintage and earlier have that unique experience. He was a formidable and imposing man, and he struck fear and apprehension in the hearts of all medical students. He used to hold bi-weekly clinical teaching sessions on a patient with an unusual problem for half the class, the senior medical clerks, in a room on the Department of Medicine Floor of Queen Mary Hospital, immediately after a lecture given by the Pathology Department, which was located at the eastern far end of the Hospital compound. The 30 something members of the our half class used to race from the Pathology Department Lecture Theatre to the Medical Floor, in

order to secure a seat in the back rows, and thereby avoiding being called to examine the patient and be the target of a barrage of difficult questions by Prof. McFadzean. But he obviously knew the tactics of the students. He would deliberately change his pattern of from which rows he would pick the students. So it was luck of the draw. If one was lucky, one felt great relief for 2 weeks.

I entered the Medical Faculty in 1960, and graduated in 1965. During that decade, and indeed up to 1980, university education operated on an elitist system, in the sense that only 2% of the so-called "Relevant Age Groups" (Age 17-20) benefited. Unlike the present situation, the best students at that time, usually from a small number of "brand-name" schools, entered the University (there was only one). Students who performed less well but wished to receive a university education and could afford to do so go to overseas universities. The cream of the best performing ones entered the local medical school.

Figure 1 University of Hong Kong total undergraduate (Ug) student numbers and medical student numbers from 1960 to 2007.

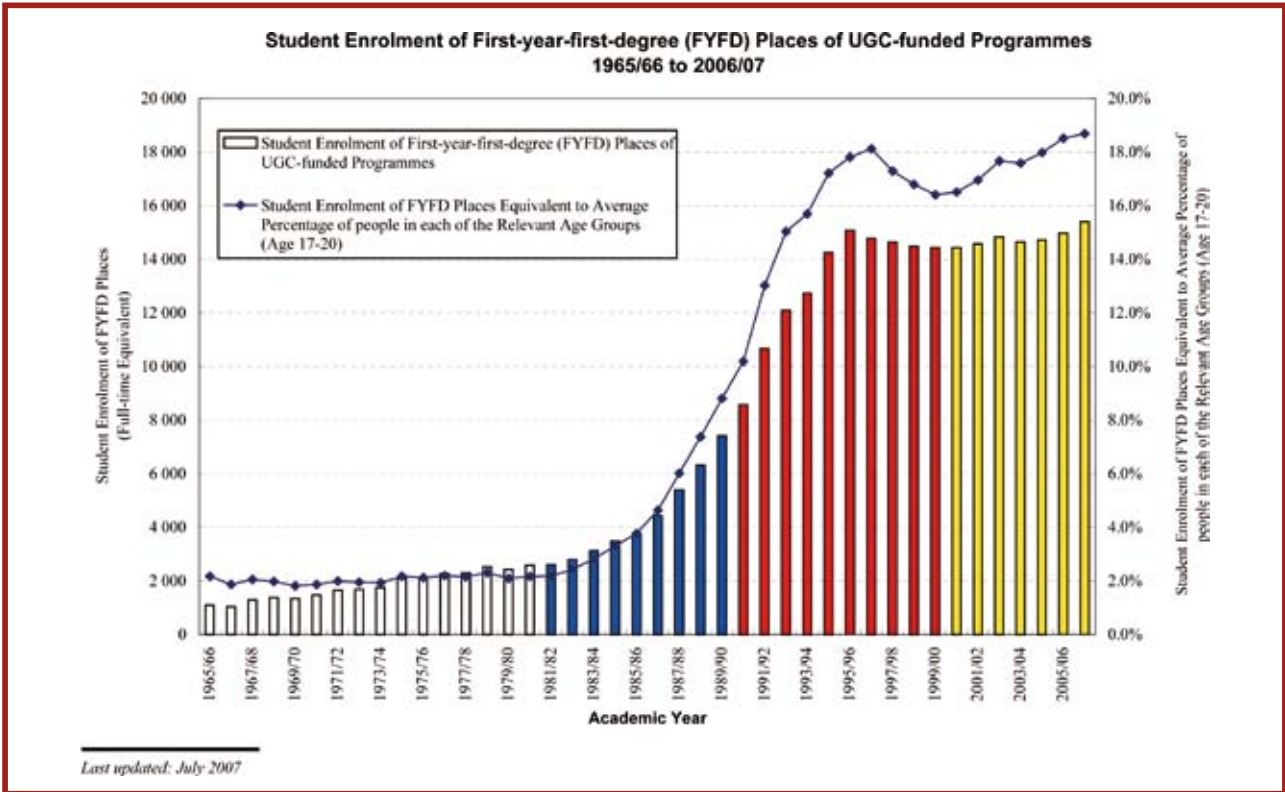


Obviously, such an elitist system was unsustainable. The factors which caused the government to increase opportunities for higher education included (a) Social/societal changes generating pressures to have equity of opportunities for the citizens (b) Hong Kong's economy changing from low-tech industries to higher-tech

industries, (c) Hong Kong's economy changing from dependence on manufacturing industries to service industries (d) Globalization and emergence of knowledge-based economies.

The expansion of opportunities for tertiary education can roughly be divided into three phases:

Figure 2 Student enrollment of first-year-first-degree places of UGC-funded programs 1965/66 to 2006/07.



## First Phase (1981 – 1990)

The establishment of the Chinese University of Hong Kong in 1983 was an important component. In addition, the then Hong Kong Polytechnic, City Polytechnic and the HK Baptist College started offering some degree programs in 1983 and 1986 respectively. During this phase, the available first-year-first-degree (FYFD) places climbed slowly from 2% to about 9% for the Relevant Age Groups (Age 17-20).

Figure 3

**FIRST PHASE (1981-1990)**  
**FYFD Places**  
**2% to 9% of Relevant Age Group**  
**Chinese University 1983**  
**HK Polytechnic 1983**  
**City Polytechnic 1983**  
**HK Baptist College 1986**

## Second Phase (1990 – 2000)

Figure 4

**SECOND PHASE (1990-2000)**  
**FYFD Places**  
**9% to 18% of Relevant Age Group**  
**UST 1991**  
**HK PU/City U/BU 1999**  
**APA 1992**  
**OLI 1989**

The expansion of degree places during this period was consequent upon

- (a) Establishment of the University of Science and Technology (UST) in 1991;
- (b) Upgrading to university status of the Hong Kong Polytechnic, City Polytechnic, and Hong Kong Baptist College in 1995, and Lingnan College in 1999.
- (c) The HK Academy for Performing Arts (APA) also started to offer degree programs in 1992.



(d) Establishment of the Open Learning Institute (OLI) in 1989, and upgrading to University in 1997.

The OLI was established because the Hong Kong Government recognized that “for the majority who have sought employment without the benefit of tertiary education, the prospect of advancing their careers through obtaining academic qualifications lies in continuing education”. “We are thinking in terms of a large-scale, comprehensive alternative to institutionalized education ..... in higher education”. The OLI was a plan to significantly increase the opportunities for tertiary education especially for working adults who did not have an opportunity to do so, but without any increase of the expenditure for tertiary education by government. Apart from some set-up grants, and occasional one-off grants for projects, no recurrent expenditure subsidy was given except for the first 3 years. The Institute was formally upgraded to university status in 1997. Although it was established by Government, and therefore a public university, it operates on a self-financing mode.

### Third Phase (2001 – The Present)

Figure 5



The 2000 Policy Address of the then Chief Executive, Tung Chee Hwa stated “Our objective is that within 10 years, 60% of our senior secondary school leavers will receive tertiary education”. It was further elaborated in Chapter 7 that the EMB’s intention was “to facilitate the progressive increase in the provision of post-secondary education for the 17-20 age group”. An increase from the then 30% to 60% was a very ambitious target. This target was to be achieved without incurring extra significant recurrent expenditure to support more first-year-first-degree places in the UGC-funded institutions. Instead, it was a project to provide interest-free loans and land space at a nominal fee to encourage self-financing institutions, known as community colleges, to mount Associate Degree programs.

Students enter Associate Degree programs after completion of Form 6. The length of study is for 2 years. The Associate Degree program has a greater emphasis on general education, rather different from its counterpart, the Higher Diploma, which has the same length of study, but is more vocational oriented.

Although it is hailed as a success by the HKSAR Government, and even though the original target of 60% has been exceeded, the Associate Degree graduates are generally not satisfied. Indeed it has created a serious new problem. Although the civil service has a small number of job categories to fit these graduates, the qualification has not received widespread recognition from the commercial world, which is the biggest employer for these graduates, in the sense that Associate Degree holders do not have an edge over Form 7 graduates in salary scales or preference for employment.

Many, quite naturally, wish to articulate to full bachelor’s degree, but the UGC- funded institutions can only take in about 1,200 students,

and the mushrooming of the community colleges provided more than 28,000 places for Associate Degree students and the yearly graduate numbers exceed 25,000 (according to EB figures). They therefore have to look further afield. For example of the 17,000 students enrolled in the Open University of Hong Kong, some 3,000 are in full-time face-to-face programs doing a four-year bachelor’s degree. 30% of these are Associate Degree or Higher Diploma holders articulating into the 3<sup>rd</sup> year. Other local options include Shue Yan University, or the few degree programs available at Chu Hai College, or the agency programs of overseas universities operating in Hong Kong, some of which have a questionable reputation.

I would like to draw your attention to the fact that there are some 1,156 courses offered by overseas universities in Hong Kong, either through an agency, or in partnership with the continuing education arms of the UGC-funded universities, or with self-financing post secondary education institutions.

Against the above background, I would like to share with you some thoughts about the possibility and practicability of Hong Kong being an international educational hub.

If one ponders about the countries that are already international hubs, there are at least the following contributing factors:

- Countries whose official language is used by a significant number of other countries. More often than not, these are countries with a long history of colonization of other parts of the world, e.g. U.K., France, Spain. Their former colonies are usually a large and sustained source of students.
- Countries which have a well-developed system of higher education, with good quality assurance. USA, Australia and Singapore are good examples.
- Countries with well-developed higher education systems and prestigious world-class universities attracting the brightest foreign students, as well as more run-of-the-mill universities attracting mediocre students who cannot secure places in a university in their own countries.
- The university campuses are very spacious, and with dormitories that can house a large number of foreign students. Or there are reasonably inexpensive private rental accommodations available to foreign students in the vicinity.

The way Singapore has developed itself into an international higher education hub deserves a closer look. Figures available from their Ministry of Education show the following:

- There are about 10 leading international universities operating a campus in Singapore, including MIT, INSEAD, Johns Hopkins University, Stanford University, Shanghai Jiaotong University etc.

Figure 6

Singapore's Global School House (approx. student numbers)	
World-Class University	Student No.
Johns Hopkins	20 (will close by 2008)
Georgia Institute of Technology	30
Graduate School of Business, University of Chicago	30
Stanford University	50
INSEAD	400 in Master's Prog; 1,500 / year Executive training
Technische Universiteit Eindhoven	20
Technische Universitat Munchen	10
Shanghai Jiaotong University	100

- Statistics in 2005 showed that there were about 70,000 international students in Singapore.
- For local universities, international student enrollment is kept at 20% of the overall student enrollment.
- The disciplines range from business management, art, design, media, hospitality, culinary arts to education.

## The Hong Kong Situation

It is quite evident that our local tertiary education institutions cannot provide enough places for undergraduate education leading to a bachelor's degree to the extent of developed countries and some major cities in Asia.

Yet the qualities of our universities are at least on a par with the top 30% of universities in developed countries. Why are we more of an *importer* of higher education rather than a *provider* of higher education for international students?

The reasons include:

- Limited by policy of the Government through the UGC. Since the UGC-funded institutions receive some 80% subvention from taxpayers' money, there is significant societal pressure to offer most, if not all, available places to local candidates.
- There is a serious lack of residential places in the campuses of the institutions. Only a proportion of local students have the opportunity to stay in dormitories, and for these fortunate ones, only during a part of the 3-5 year degree programs.
- There is no policy to actively recruit overseas students until the recent 5 years or so. Even then, the steps taken have been fragmentary, as only a small percentage of new under-graduate student recruitment from overseas is allowed by the UGC.
- Most of the "overseas students" recruited by the UGC-funded institutions have come from Mainland China, with a large proportion being funded by very generous local donations.
- Entry visas and permits to stay still require lengthy bureaucratic procedures.

How can the aspiration of transforming Hong Kong to be an international education hub be realized?

- The encouraging aspect is that the Government, under pressure from local universities, has actually announced that this is an area of policy. Indeed, a high-level task force under the immediate past Chief Secretary, Mr. Hui Sze-yan, has been set up to discuss this matter. Unfortunately, nothing has emerged from the task force that has been made known to the public. Surprisingly too, no participation from university heads has been included in the task force. With the change of Chief Secretary, it is unlikely that significant progress will be made in the near future.
- A reconstituted high-level *transparent* task force, whose membership should not exclude non-UGC degree-granting institutions, should be put in place as soon as possible, and to act expeditiously.
- The concept of Hong Kong as an international higher education hub needs a fundamental change of government's attitude to formulate higher education policy. It needs to be much less blinkered, and to include all institutions which offer degree and higher-level programs in the discussion and future implementation plans, not just the UGC-funded ones.

- Government needs to play a central role in promotion and marketing of these programs in the initial 2 to 5 years, until there is a wider global knowledge of the international education hub in Hong Kong, and a big enough momentum of increasing numbers of foreign students to be self-sustaining.
- There should be some degree of role differentiation in promotion for the various institutions to attract appropriate potential students, e.g. the Medical Faculty of HKU and CUHK have an international reputation and can comfortably attract overseas medical students. City University and Hong Kong Polytechnic University have a variety of applied health and physical sciences and engineering programs to attract students who are likely to work in commercial industries. Baptist University has a good-quality Chinese medicine program. The non-UGC institutions have a variety of programs on Chinese Law, Chinese Business Law, and Chinese Culture and Humanity Studies which can attract foreigners who may plan to work and live in Mainland China for a considerable period of time.
- A comprehensive plan to deal with the serious lack of dormitory places for students must be debated and agreed upon for urgent implementation. I have repeatedly suggested to the education authorities that government should set aside land grants and funding for building communal dormitories. The infrastructure of such communal dormitories can be run by the government, with the dormitory places be made available to all degree-granting institutions, particularly those without such facilities at present. Apart from being more economical when compared with granting land and funding for each institution to build their own dormitories, these communal dormitories are ideal venues for cross-fertilization and cultural exchanges between students enrolled in different institutions, and coming from different countries.

## Hong Kong as an International Hub – Preferred Model?

- Singapore Model: invite foreign universities to set up a local campus. Generally undesirable because the Hong Kong Education Hub will end up as an extension of overseas universities. Besides, the financial advantage to Hong Kong is small, as the overseas universities obviously have to take a sizable cut of the income. It also has not been particularly successful.
- A coordinated effort of all the higher education institutions to plan and promote subject areas that are of good quality and popular to overseas students, with some degree of role differentiation between the local institutions.
- Implement a true credit transferal system among local universities, so that overseas students who wish to have an opportunity to sample the experience in different institutions, each with its own characteristics, can do so.
- Further development of distance education, on-line education and mixed mode education.

In conclusion, the HKSAR government has many targeted projects with exceedingly generous funding to nurture them. Many have not been successful, such as the Cyberport, Chinese Medicine Port, Industrial Development Fund etc. But the international education hub can be a winner, if only government will act quickly and decisively, with adequate financial input.

# SPECIAL NOTICE – Revision of Fees

## Adjustment of College Subscription Fees

Owing to the rise of the operational costs in running the College, the College has recently reviewed and adjusted the various subscription fees, which have been reduced since the SARS period. Details are shown below.

Type	New amount	Effective date
<b>Membership subscription</b>	<b>HK\$800.00</b>	1 January 2008
<b>Fellowship subscription</b>	<b>HK\$1,200.00</b>	1 January 2008
<b>BPT training fee</b>	<b>HK\$3,000.00</b> for the whole BPT training period	1 July 2008
<b>HPT training fee</b>	<b>HK\$6,000.00</b> for the whole HPT training period	1 July 2008
<b>Fellowship entrance fee</b>	<b>HK\$3,000.00</b>	1 January 2008

### Fees for Joint HKCPIE/ MRCP(UK) examinations

Since 1994, the College has co-organised the Joint HKCPIE/MRCP(UK) examinations with the Royal Colleges of Physicians. Trainees can save the costs of travelling and accommodation in the United Kingdom should they take the examinations in Hong Kong. Recently, our College has reviewed the whole Joint HKCPIE/MRCP(UK) examinations. Our College has made a financial loss for running the whole Joint HKCPIE/MRCP(UK) examinations in the past few years. Compared with the PACES examination fees in other countries, the fee we charge in Hong Kong is the lowest (in 2007, the PACES examination fees for Egypt and Malaysia was HK\$13,440 while that for Singapore was HK\$15,040). Our College decided to increase the PACES examination fee from HK\$9,000 to HK\$12,800 to reduce the deficit in running the examinations.

### Charges for late applications for College Fellowship

At its 196<sup>th</sup> Meeting of 29 January 2008, our College Council noted that several doctors had already passed the Exit Assessment, but they did not apply for College Fellowship. The Council decided that doctors should apply for College Fellowship within one year after they had passed the Exit Assessment. The Council decided that, any late applicants who applied for College Fellowship after one year of passing the Exit Assessment, would be charged HK\$3,000.00 as entrance fee and HK\$1,500.00 per year till the date they had been admitted as College Fellows. This new arrangement will take effect from 29 January 2008.

## Annual Scientific Meeting (13-14 October 2007)

The theme of this year's meeting was "Daily practices and recent advances". The audience was updated in infectious and neurological diseases on the first day of the meeting. This was followed by the Sixth Gerald Choa Memorial Lecture given by Father Alfred J Deignan who shared his views on life and basic human values.

The second day of the meeting featured presentations by our top researchers, including recipients of the Best Thesis Award and the Distinguished Research Paper Award for Young Investigators 2007. The prestigious Sir David Todd Lecture was delivered by Professor Francis Chan on his extensive work on NSAID-induced peptic ulcer bleeding.

## 20<sup>th</sup> Annual General Meeting, 9<sup>th</sup> Congregation and 21<sup>st</sup> College Dinner

At the AGM, Professor KN Lai reported on the work and achievements of the College's various subcommittees in the past year, as well as efforts to strengthen academic ties with physician colleges, both nationally and internationally. The college portal was now operational and provided a computerized access to training records for members and fellows.

The ceremony proceeded with the conferral of Fellowships and Memberships to 66 and 63 doctors respectively, officiated by a distinguished platform party.



The HKCP Council with the official Platform Party and distinguished guests at the Annual Dinner 2007

The annual dinner concluded the first day of the meeting. Over fine food and wine, honourable guests, fellows and members enjoyed the AJS McFadzean Oration delivered by Professor John CY Leong. He addressed the audience on the opportunities for Hong Kong to develop into an international hub for higher education.



Professor Rosie Young and Professor Richard Yu enjoying cocktails before the College Dinner



# Sir David Todd Lecture

Research on NSAID-Induced Peptic Ulcer Bleeding:  
Changing the World's Clinical Practice

Professor Francis Ka Leung Chan



## Distinguished Research Paper Award for Young Investigators 2007

The following doctors together with their research teams received the awards at the Annual Scientific Meeting.

### Dr Hui Chee Kin

Department of Medicine, QMH

**Kinetics and risk of de novo hepatitis B infection in HBsAg-negative patients undergoing cytotoxic chemotherapy**

Hui CK, Cheung WW, Zhang HY, Au WY, Yueng YH, Leung AY, Leung N, Luk JM, Lie AK, Kwong YL, Liang R, Lau GK.

*Gastroenterology*. 2006 Jul;131(1):59-68.

### Dr Kong Pik Shan

Department of Medicine and Therapeutics, PWH

**Effects of Treatment Targets on Subsequent Cardiovascular Events in Chinese Patients with Type 2 Diabetes**

Kong AP, Yang X, Ko GT, So WY, Chan WB, Ma RC, Ng VW, Chow CC, Cockram CS, Tong PC, Wong V, Chan JC.

*Diabetes Care*. 2007 Apr;30(4):953-9.



### Dr Tang Chi Wai Sydney

Department of Medicine, QMH

**Alleviation of sleep apnea in patients with chronic renal failure by nocturnal cyclor-assisted peritoneal dialysis compared with conventional continuous ambulatory peritoneal dialysis**

Tang SC, Lam B, Ku PP, Leung WS, Chu CM, Ho YW, Ip MS, Lai KN.

*J Am Soc Nephrol*. 2006 Sep; 17(9):2607-16.



### Dr Wu Che Yuen Justin

Department of Medicine and Therapeutics, PWH

**Obesity is associated with increased transient lower esophageal sphincter relaxation**

Wu JC, Mui LM, Cheung CM, Chan Y, Sung JJ.

*Gastroenterology*. 2007 Mar;132(3):883-9.



# The HKCP Council 2007-2008



**President** Professor Lai Kar Neng

**Vice-Presidents** Professor Lam Wah Kit  
Dr Yam Yin Chun, Loretta

**Honorary Secretary** Professor Li Kam Tao, Philip

**Honorary Treasurer** Dr Tse Tak Fu

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Professor Liang Hin Suen, Raymond  
Dr Matthew Ng  
Professor Sung Jao Yiu, Joseph  
Dr Szeto Ming Leung  
Dr Tong Kwok Lung, Matthew  
Dr Wong Chun Por  
Professor Wong Ka Sing, Lawrence  
Dr Lai Sik To, Thomas

**Founding President** Prof Sir David Todd

**Past President** Professor Yu Yue Hong, Richard

## Chairmen of College Committees

Examination Committee – Prof Raymond Liang  
Education and Accreditation Committee – Dr Loretta Yam  
National and International Liaison Committee – Prof WK Lam  
Professional and General Affairs – Dr Matthew Ng  
Scientific Committee – Prof YL Kwong  
Membership Committee – Dr Patrick Li  
Administration and Finance Committee – Dr TF Tse  
Working Group in Traditional Chinese Medicine – Dr TF Tse  
Research Committee – Prof KS Wong  
Synapse – Dr Matthew Ng

# 11<sup>th</sup> meeting of the Chinese Society of Internal Medicine

The Chinese Society of Internal Medicine (under the auspices of the Chinese Medical Association) held its 11<sup>th</sup> national meeting at Hangzhou during September 19-22, 2007. The meeting was attended by over 1000 physicians and part of the program was televised to other major Chinese cities. Six international experts were invited from overseas to introduce the structural training program of their respective countries.

Professor K.N. Lai, President of the Hong Kong College of Physicians, was one of the six invited speakers. Professor Lai gave a plenary entitled: "Training of Physicians in Hong Kong". The summary of his speech was published in the Chinese Journal of Internal Medicine (see next page). He also conducted a clinico-pathological conference at the conference.



Invited Speakers at the 11<sup>th</sup> meeting of the Chinese Society of Internal Medicine, Hangzhou.

From left to right:

Professor J.M. Drazen (Editor-in-Chief, New England Journal of Medicine), Professor Getu Zhaori (Editor-in-Chief, Chinese Medical Journal), Professor K.N. Lai (President, Hong Kong College of Physicians), Professor H.P. Kohler (Vice-President, Internal Society of Internal Medicine), Professor N. Thomson (President, Royal Australasian College of Physicians).



## 香港内科医生的培训和资格考试

黎嘉能(K.N. Lai)教授  
香港内科学院主席

### 一、概述

香港内科医生的培训和资格考试由香港内科学院全程监管。内科学院成立于1986年，隶属于1993年成立的香港医学科学院。医学院毕业生需担任1年的实习医师，然后接受3年的基本内科医师培训。通过联合中级资格考试后，再接受3年或更长时间的高级内科医师培训。

香港内科学院负责制定各专业培训要求，由医院或卫生机构执行培训计划。内科学院可通过项目主管间接指导培训的实施。培训经费由政府、大学或私立医院提供。培训认证由香港医学科学院和香港医务委员会组成的独立机构负责，通过香港内科学院进行。

香港的培训医院主要分三种：一是地区医院，提供大众医疗服务；二是教学医院，附属于大学，同时承担教学和科学研究；三是社区医院，提供平诊和降级的医疗服务。

### 二、基本内科医师培训与中级资格考试

香港本地毕业生在香港医务委员会注册后，需注册一个通过内科学院认证的培训项目。非香港本地毕业生必须首先通过行医执照考试，才能在医务委员会注册。培训时间至少为3年。包括以下内容：至少24个月的普通内科训练，至少12个月的急诊医学训练，每周不少于5个小时的门诊和每月不少于5次的24小时值班，6个月的三级学科的训练，包括CCU、ICU或血透室，总共不超过6个月的精神病学、儿科学、放射学、病理学、麻醉学、放疗学或急诊医学的轮训。

内科学院的中级资格考试与英国皇家内科医师协会资格考试（MRCP, UK）联合进行。包括三个部分。第一部分，医学基础知识考核，共300个5选1的选择题，考1天；第二部分，临床分析和治疗知识考核，共270个5选1的选择题，考2天；第三部分：临床实践技能考核，考1天。

### 三、高级内科医师培训

高级内科医师培训覆盖多个专业，包括：普通内科学，皮肤性病学，血液学和血液肿瘤，传染病学，肾脏病学，呼吸病学，心脏病学，重症监护医学，内分泌，糖尿病及代谢病学和神经病学等。

培训途径有三种：单专业（3年），双专业（4年）和双专业+特殊技能（5年），特殊技能包括心电生理和消融术，冠脉支架置入术和内镜下治疗等。分别在第1和第2年举行年度考核。第3和第4年举行第1次和第2次专业考试，第5年进行特殊技能考核。

年度考核是由三级学科专家委员会组织每年进行2次面试。专业考试包括一次面试和一篇论文。论文长度大约5000字，内容为一项临床研究或一篇有深度的临床综述。论文题目必须在参加专业考试前9个月通过医学院审核。

（杜颖、厉有名翻译整理）





## Sir David Todd Lecture

# Research on NSAID-Induced Peptic Ulcer Bleeding: Changing the World's Clinical Practice

**Ka Leung CHAN**

Department of Medicine & Therapeutics  
The Chinese University of Hong Kong,  
Prince of Wales Hospital

Hong Kong is well known for having a very high incidence of peptic ulcer bleeding. A high prevalence of *Helicobacter pylori* infection and an increasing use of nonsteroidal anti-inflammatory drugs (NSAIDs) including low-dose aspirin are major contributory factors. In the United States, the direct medical cost of treating NSAID-induced ulcer complications is over \$US 500 million in the United States every year. Traditionally, research on prevention of NSAID-induced ulcer was largely monopolized by pharmaceutical industry. While the outcomes of these multi-center trials have substantially influenced our clinical practice, many important clinical questions have never been addressed by industry-sponsored trials. Our research team had conducted a series of industry-independent randomized trials to address the following questions:

1. Among patients with *H. pylori* infection who require NSAIDs or low-dose aspirin, does eradication of *H. pylori* reduce the risk of ulcer with NSAIDs or low-dose aspirin?
2. How effective are proton-pump inhibitors (PPIs) and cyclooxygenase-2 (COX-2) inhibitors in preventing ulcer bleeding in patients with very high GI risk (i.e., prior ulcer bleeding)?
3. What is the best prophylactic strategy for patients requiring anti-inflammatory analgesics who are at very high GI risk?
4. Are non-aspirin anti-platelet drugs justified in patients with cardiovascular diseases who have prior ulcer bleeding?

The outcomes of the above Hong Kong studies have surprised both the international academic arena and the pharmaceutical industry.

In an editorial of *The New England Journal of Medicine*, the author has made the following comment: "The results were unexpected... We have developed a false sense of security about the protective value of proton-pump inhibitors and COX-2 inhibitors, and now it is clear that the problem needs to be reexamined completely...." A leading international working party (The Maastricht Consensus) has adopted the study findings as one of the indications for treating *H. pylori* infection. Currently, the American College of Gastroenterology is currently working with the American College of Cardiology and the American Heart Association to revise the practice guidelines on the use of aspirin and non-aspirin anti-platelet drugs.

### References

1. Chan FK, Sung JY, Chung SC, To KF, et al. Randomised trial of eradication of *Helicobacter pylori* before non-steroidal anti-inflammatory drug therapy to prevent peptic ulcers. *Lancet* 1997;350:975-97.
2. Chan FK, To KF, Wu JC, et al. Eradication of *Helicobacter pylori* and the risk of peptic ulcers in patients starting long-term treatment with non-steroidal anti-inflammatory drugs: A randomised trial. *Lancet* 2002;359:9-13.
3. Chan FK, Chung SC, Suen BY, et al. Preventing recurrent upper gastrointestinal bleeding in patients with *Helicobacter pylori* infection who are taking low-dose aspirin or naproxen. *New England Journal of Medicine* 2001;344:967-73.
4. Chan FK, Leung WK. Peptic-ulcer disease [review]. *Lancet* 2002;360:933-41.
5. Chan FK, Hung LC, Suen BY, et al. Celecoxib versus diclofenac and omeprazole in reducing the risk of recurrent ulcer bleeding in patients with arthritis. *New England Journal of Medicine* 2002;347:2104-10.
6. Chan FK, Hung LC, Suen BY, et al. Celecoxib versus diclofenac plus omeprazole in high-risk arthritis patients: results of a randomized double-blind trial. *Gastroenterology* 2004;127:1038-43.
7. Chan FK, Wong VW, Suen BY, et al. Combination of a cyclo-oxygenase-2 inhibitor and a proton-pump inhibitor for prevention of recurrent ulcer bleeding in patients at very high risk: a double-blind, randomised trial. *Lancet* 2007;369:1621-6.
8. Chan FK, Ching JY, Hung LC, et al. Clopidogrel versus aspirin and esomeprazole to prevent recurrent ulcer bleeding. *New England Journal of Medicine* 2005;352:238-44.

## Best Thesis Award – **Gold Award Winner** **Inactivation of secreted Wnt antagonists (*WIF1* and *SFRPs*) in Nasopharyngeal Carcinoma: Epigenetic Perspective**

**Stephen Chan LAM** Department of Medicine and Therapeutics, Prince of Wales Hospital

**A** aberrant activation of Wnt pathway is evident during nasopharyngeal carcinogenesis yet the detailed mechanism is unclear. Wnt inhibitory factor 1 (*WIF1*) and secreted frizzled-related protein family (*SFRPs*) are two important secreted Wnt antagonists, which are silenced by epigenetic mechanism in various cancers. However, data about *WIF1* and *SFRPs* are scanty in nasopharyngeal carcinoma (NPC).

In the first chapter of this dissertation, the concepts of epigenetics and its emerging role in the pathogenesis of NPC will be reviewed. In the second chapter, the canonical Wnt pathway (with emphasis on the secreted antagonists *WIF1* and *SFRPs*) and its involvement in nasopharyngeal carcinogenesis will be discussed. In the third chapter, we sought to prove the following three hypotheses

(1) *WIF1* and *SFRPs* are inactivated by epigenetic mechanism in NPC (2) The epigenetic modifications of *WIF1* and *SFRPs* can be reversed by epigenetic therapy. (3) *WIF1* and *SFRPs* possess tumor suppressor properties in NPC.

We found frequent silencing of *WIF1* and *SFRP* genes in a panel of NPC cell lines. High methylation rates (6 out of 6 cell lines; 100%) were identified in promoters of *WIF1*, *SFRP 1*, *2*, *4* and *5*. Methylation of *WIF1* and *SFRP* genes was demonstrated in 58-81% of primary nasopharyngeal tumor samples. In-vitro demethylation and reactivation of *WIF1* and *SFRPs* can be achieved by application of 5-aza-2'-deoxycytidine. Ectopic expressions of *WIF1* and *SFRPs* in cell lines were found to inhibit the colony formations. For *WIF1*, ectopic expression also leads to downregulation of intracellular  $\beta$ -catenin level. This highlights the tumor suppressor role of *WIF1* and *SFRPs* in nasopharyngeal carcinogenesis and the potential of epigenetic therapeutics in NPC.



## Best Thesis Award – **Silver Award Winner** **Burden of Microbleeds in Patients with Ischaemic Stroke**

**Yannie Oi Yan SOO** Department of Medicine and Therapeutics, Prince of Wales Hospital

**Purpose** – Silent cerebral microbleeds (MB) are frequently identified in stroke patients by gradient-echo T2\* weighted magnetic resonance images (MRI). Several retrospective studies suggest that MB are associated with increased risks of intracerebral haemorrhage, leukoaraiosis and lacunar infarct. Treatment for ischaemic stroke patients with MB, has therefore, become challenging. The aim of this study is to assess the burden of MB in ischaemic stroke patients and their influence on patients' outcomes. We also aim to evaluate the role of MB as a predictor for future intracerebral haemorrhage (ICH).

**Methods** – We analysed the MRI images of 1016 patients admitted consecutively for acute ischaemic stroke to the Acute Stroke Unit in a regional hospital between January 1999 and November 2004. Lesion load and distribution of MB, as well as white matter changes were documented. Radiological features were correlated with outcomes events (subsequent intracerebral haemorrhage, recurrent infarct and mortality) using multivariate analyses.

**Results** – MB were identified in 28.5% (290/1016) of patients. Presence of MB was significantly more common in patients with

hypertension, prior ICH and subsequent ICH. MB were more frequently found in the thalamus. Multivariate analysis showed that MB (HR 6.142,  $p = 0.002$ , 95% CI 1.976 – 19.113) and age (HR 1.082,  $p = 0.008$ , 95% CI 1.021 – 1.147) were the only independent predictors for subsequent ICH. White matter changes were a common associated finding. The combination of MB and white matter changes might represent an advanced stage of microangiopathy with bleeding tendency. ROC showed that MB  $\geq 8$  has a sensitivity of 58.3% and specificity of 80.6% in predicting subsequent ICH.

**Conclusion** – In ischaemic stroke, gradient-echo T2\* weighted MRI sequence is important for risk stratification. Asymptomatic MB can be commonly found in ischaemic stroke patients and is an independent predictor for future ICH. When managing patients with MB, risks and benefits of anti-thrombotic agents should be carefully weighed. Extra caution should be taken to minimise risk of future ICH. Nevertheless, MB should not be used alone for risk stratification. Other clinical factors, especially age, should be taken into consideration when determining risk of haemorrhage.



Best Thesis Award – **Bronze Award Winner**

# Candidaemia in a Regional Hospital in Hong Kong: Epidemiology, Risk Factors, Treatment and Clinical Outcomes

Man Yee CHU Department of Medicine, Queen Elizabeth Hospital

**Background** – Candida species is one of the commonest pathogen in bloodstream infections and is associated with high morbidity and mortality. However, local data on candidaemia is currently lacking.

**Objective** – To study the epidemiology of Candida bloodstream infections, risk factors, treatment, clinical outcomes and predictors for mortality in adult candidaemic patients in a regional hospital in Hong Kong.

**Method** – A 5-year retrospective study was conducted from 2001 to 2005. Patients aged 18 years or above with at least one positive blood culture yielding Candida species were included. Cases were identified from the records of the microbiology laboratory. The medical records of the patients were subsequently reviewed to obtain the relevant information.

**Results** – Ninety-nine episodes of candidaemia were identified. The annual incidences of candidaemia were 0.26 episodes per 1,000 hospital admissions and 0.47 episodes per 10,000 patient-days. The incidence had not changed significantly over the 5-year period. Around 60% of the cases were caused by Candida albicans. The risk factor for Candida albicans infection was recent or concurrent bacteremia ( $p = 0.05$ ). The average length of stay was  $60.4 \pm 86.8$  days, with a crude 30-day mortality rate of 58%. Endotracheal intubation, underlying medical comorbidities e.g. cardiovascular and respiratory diseases, were poor prognostic indicators ( $p = 0.01, 0.05, 0.03$  respectively).

**Conclusion** – The epidemiology of Candida bloodstream infection had not changed significantly during the 5-year study period. It was associated with significant morbidity and mortality. Severe dysfunction of major organ systems and multiple underlying medical comorbidities predicted poor clinical outcomes.

## Examination Calender for Joint HKCPIE/ MRCP(UK) examinations in 2008

### Part I examination

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

## Results Pass List of the October 2007 PACES examination

Au Hon Da Kenneth	Au Tai Kwan Eva
Au Yuen Ling Elaine	Chan Fei
Chan Hing Ling Betty	Chan Hoi Yan
Chan Shing Nam	Chan Wing Tak Wendy
Chen Xiao Rui Catherine	Cheng Suet Lai
Cheung Lai Ying Grace	Chiu Wing Yan Joanne
Chung Chun Kin	Hau Wai Yin
Koh Chiu Choi	Kwan Wing Shan Iris
Kwok Hau Chung	Kwok Shun Lai
Lai Yik Kiu Dominic	Lam King Yun Joanne
Lee Ming Kai	Li Ying Wah Andrew
Ng Chung Hoi	Ngai Chun Wai
Ngan Pui Yan	Shum Ho Cheung
Tan Ben Shih Benjamin	Tang Hing Cheung
To Kai Wang Kelvin	Tsai Nga Wing Polly
Tsang Kwok Ying Ingrid	Tsui Kam Chi
Wong Ching Ching Alice	Wong Tsz Lun
Wu Kwok Leung	Yiu Hung Chan

*The above doctors will receive the College's Intermediate Examination Certificates at the Annual General Meeting in October 2008.*



# CME Update

## Principles & Guidelines on Continuing Medical Education for 2008

Loretta Yam

Chairman

Board of Continuing Medical Education/Continuous Professional Development

### 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 5.2.

### 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.

#### 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 FCAA, 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.

## 5.2.2 Active Participation

- (a) Active Participation includes chairing or presenting in a FCAA, for which prior approval has been obtained from the College.
- (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.

## 5.3 Publications (Active CME/CPD)

- a) Publication in journals
    - (i) Only original and review articles in peer-reviewed journals, including original research, editorials and case reports, will be considered "publication" for the purpose of awarding CME/CPD Points.
    - (ii) 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.
    - (iii) 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.
  - b) Publication in books
    - i) A maximum of 10 CME/CPD Points may be awarded to the first author of each chapter or section of a medical textbook.
    - ii) A maximum of 5 Points for co-authors of each chapter or section of a medical textbook.
  - c) 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 CME/CPD Points.
  - b) A maximum of five CME/CPD Points may be awarded to each author for the production of a College-approved Quality Assurance Report.
  - c) Quality Assurance Report in the form of abstracts will not be accredited CME/CPD Points.
  - d) Quality Assurance Reports may be accredited a maximum of 30 Points per three-year cycle.

## 6 Minimum CME/CPD Requirement

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

- 6.2 The minimum annual CME/CPD requirement is 10 Points regardless of the proportion of active and passive categories.

## 7 Proportion of Active and Passive CME/CPD activities

- 7.1 Active CME/CPD activity
  - a) Every Fellow should attain a minimum of 30 active CME/CPD Points per 3-year cycle.
  - b) Active Participation may be accredited a maximum of 60 Points per 3-year Cycle.
- 7.2 Passive CME/CPD activities
  - a) Every Fellow should attain a minimum of 30 passive CME/CPD Points per 3-year cycle.
  - b) Passive Participation as defined above may be accredited a maximum of 60 Points per 3-year cycle.
- 7.3 For Fellows whose first CME/CPD cycle is shorter than three years, the following minimum active and passive CME/CPD Points are required.
 

CME/CPD Points per cycle	Minimum active CME/CPD Points	Minimum passive CME/CPD Points
36-45	15	15
46-60	20	20
61-89	25	25
- 7.4 New Fellows whose first CME/CPD cycles require fewer than 35 CME/CPD Points will only have to acquire the prescribed CME/CPD Points regardless of the proportion of active and passive categories.

## 8 Exclusions

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

- 8.1 Acting as Examiner in College Examinations
- 8.2 Research
- 8.3 Research Grant Application
- 8.4 Development of New Technologies
- 8.5 Undergraduate Teaching
- 8.6 Postgraduate Teaching other than those listed under Sections 5.2.
- 8.7 Attending seminars or lectures in the enrollment of a postgraduate diploma or degree course.
- 8.8 Thesis or treatise

## 9 Certification

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

## 10 CME/CPD Registry

The Board of CME/CPD will maintain a Register of Physician Fellows who has been awarded certification under Section 9.

*Version 1 01.01.08, updated on 17 September 2007*

For approved Self-Assessment Programmes (appendix 1), please refer to <http://www.hkcp.org/>

# CME/CPD Operational guidelines 2008

## 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. All Fellows should attain a minimum of 30 passive Points and a minimum of 30 active Points in the cycle. For ease of accounting, new Fellows whose first CME/CPD cycles require fewer than 35 CME/CPD Points each will only have to acquire the CME/CPD Points prescribed regardless of the proportion of active and passive categories.
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.  
  
Overseas Fellows should submit the formal CME/CPD reports from national accreditation bodies on an annual basis in order to be recognised as having satisfied the CME/CPD requirement of our College. Additional submission of CME/CPD active/passive participation is not required.
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.  
  
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.
    - 1.3 Meetings solely organised by the industries/pharmaceutical companies will not be accredited for CME/CPD.
    - 1.4 Local and overseas meetings or conferences organised by the pharmaceutical or equipment industry will not be accredited for CME/CPD.
  - 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.
  - 5 Every Fellow is required to acquire a minimal of 10 CME/CPD Points per year regardless of the proportion of active and passive categories. A maximum of 70 CME/CPD Points therefore may only be acquired in the first year, and a maximum of 80 CME/CPD Points may be acquired for the first and second year combined. Applications for exemption from the minimal annual requirement will be individually assessed by the CME/CPD Board.

	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	<ol style="list-style-type: none"> <li>Maximum of 2 Points per session of active participation for Chairman.</li> <li>Maximum of 2 Points per presentation of active participation for speaker.</li> <li>1 Point per hour of passive participation.</li> </ol>	30 Points for active participation. 30 Points for passive participation.	60 Points for active participation. 60 Points for passive participation.	<ol style="list-style-type: none"> <li>Prior approval from the CME/CPD Board is required.</li> </ol>
A2	FCAA organised by professional societies/associations	Active (Chairman & Speaker) OR Passive	<ol style="list-style-type: none"> <li>Maximum 2 Points per session of active participation for Chairman.</li> <li>Maximum of 2 Points per presentation of active participation for speaker.</li> <li>Maximum 1 Point per hour of passive participation.</li> </ol>	30 Points for active participation. 30 Points for passive participation.	60 Points for active participation. 60 Points for passive participation.	<ol style="list-style-type: none"> <li>Prior approval from the CME/CPD Board is required.</li> <li>Activities organized by pharmaceutical / equipment industry will not be approved for CME.</li> <li>Time spent on lunch/tea break will not be accredited as CME activity.</li> <li>Meetings on topics in Internal Medicine or its Specialties will be accredited the maximum CME/CPD Points.</li> <li>Meetings on Internal Medicine-related subjects may be accredited at up to 50% of the maximum CME/CPD Points.</li> <li>Speakers delivering lectures related to Internal Medicine at meetings of other Colleges/professional societies should request the organizers to apply CME/CPD Points from our College and/or prospectively apply for CME/CPD Points from our College. Applications after the meetings will not be entertained.</li> </ol>
A3	Local or overseas Conference	Active (Chairman & Speaker) OR Passive	<ol style="list-style-type: none"> <li>Maximum 2 Points per session of active participation for Chairman.</li> <li>Maximum of 2 Points per presentation of active participation for speaker.</li> <li>1 Point per hour of passive participation for maximum of 8 Points/day AND maximum of 35 Points per conference/meeting.</li> </ol>	30 Points for active participation. 30 Points for passive participation.	60 Points for active participation. 60 Points for passive participation.	<ol style="list-style-type: none"> <li>A Fellow may not claim both active and passive CME/CPD Points for the same session in which he/she is a Chairman.</li> <li>Time spent on lunch/tea break will not be accredited as CME/CPD activity.</li> <li>Meetings on topics in Internal Medicine or its Specialties will be accredited the maximum CME/CPD Points.</li> <li>Meetings on Internal Medicine-related subjects may be accredited at up to 50% of the maximum CME/CPD Points.</li> <li>Prior approval for local conference from the CME/CPD Board is required.</li> <li>Speakers delivering lectures related to Internal Medicine at meetings of other Colleges/professional societies should request the organizers to apply CME/CPD Points from our College and/or prospectively apply for CME/CPD Points from our College. Applications after the meetings will not be entertained.</li> </ol>
A4	Certificate course	Passive	Approved for defined number of CME/CPD Points, up to a maximum of 10 Points per course.	15 Points for passive participation.	30 Points for passive participation.	<ol style="list-style-type: none"> <li>Prior approval from the CME/CPD Board is required.</li> <li>Courses organised by hospitals for hospital doctors (in-house training for hospital) will not be accredited as Certificate Courses.</li> <li>Courses on topics in Internal Medicine or its Specialties may be accredited the maximum CME/CPD Points.</li> <li>Courses on Internal Medicine-related subjects may be accredited at up to 50% of the maximum CME/CPD Points.</li> </ol>
B	Self study			30 Points (Total)	60 Points (Total)	
B1	Journal Reading	Active	Not more than 1 Point per article.	25 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.	30 Points	60 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.	25 Points	45 Points	<ol style="list-style-type: none"> <li>The following must be submitted: Title of publication, journal, textbook with year, volume and page numbers for journal articles, and chapter/section, and page numbers for textbook.</li> </ol>



C2	Indexed international journals and journals published by HKAM.	Active	Maximum 6 Points and 3 Points for first and co-authors respectively.	25 Points	45 Points	2. Publications on topics in Internal Medicine or its Specialties may be accredited the maximum CME/CPD Points.
C3	Medical textbook	Active	Maximum 10 Points and 5 Points for first author and co-authors respectively of each chapter or section.	25 Points	45 Points	3. Publications on Internal Medicine-related subjects may be accredited at up to 50% of the maximum CME/CPD Points.
D	College-approved Quality Assurance report	Active	Maximum 5 CME Points for each author depending on venue of publication	15 CME Points	30 CME Points	<ol style="list-style-type: none"> <li>1. Prior approval from the CME Board is required.</li> <li>2. Full QA report and venue of publication should be submitted for approval.</li> <li>3. Quality Assurance Report in the form of abstracts will not be awarded CME/CPD Points.</li> <li>4. Presenting authors of Quality Assurance report in local/overseas conferences may be considered for award of active CME/CPD Points as speakers, provided prior approval is obtained from the CME/CPD Board.</li> </ol>
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					
E8	Online video-taped seminars for both local and overseas seminars					
E9	Self study by reading books					

For approved Self-Assessment Programmes (appendix 1), please refer to <http://www.hkcp.org/>

## Statistics on No. of Trainees in all Specialties

Updated in January 2008

		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	31	1 2-I 3 4	1 4	1 2-I 3-I 4	2 2 3 4	2 2 3 4	0 0 0 0	1 2 3 4	0 0 3 3	1 2 3 4	0 0 3 4	1-IV 2 3-I 4	5 2 3 6	1 2 3 4	0 0 0 0
CLINICAL PHARMACOLOGY & THERAPEUTICS	2	1 2 3 4	0 0 0 0	1 2 3 4	0 0 0 0	1 2 3 4	0 0 0 0	1 2 3 4	0 0 0 0	1 2 3 4	0 0 0 0	1 2 3 4	0 0 2 4	1 2 3 4	0 0 0 0
CRITICAL CARE MEDICINE	16	1 2 3-IV 4-I	5 2 2 4	1 2 3 4	0 0 0 0	1 2 3-I 4	1 1 0 0	1 2 3 4	0 0 0 0	1 2 3 4	0 0 0 0	1 2 3-II 4	2 2 3 4	1 2 3 4	0 0 0 0
DERMATOLOGY & VENEREOLOGY	8	1 2 3 4	0 0 0 0	1 2 3 4	0 0 0 0	1 2 3 4	0 0 0 0	1 2 3 4	0 0 0 0	1 2 3 4	0 0 0 0	1 2 3 4	0 1 3 4	1 2 3 4	0 0 0 0
ENDOCRINOLOGY, DIABETES & METABOLISM	12	1 2 3 4	0 0 0 0	1 2 3 4	0 0 2 4	1 2 3 4	0 0 2 2	1 2 3 4	0 0 0 0	1 2 3 4	0 0 0 0	1 2 3-I 4	1 1 6 4	1 2 3 4	0 0 0 0
GASTROENTEROLOGY & HEPATOLOGY	35	1-II 2 3 4	2 6	1-I 2 3 4	1 2 3 4	1 2 3 4	0 0 0 0	1 2 3 4	0 0 0 0	1 2 3 4	0 0 0 0	1-I 2-III 3 4-I	5 2 3 6	1 2 3 4	0 0 1 1
GERIATRIC MEDICINE	9	1 2 3 4	0 5	1 2 3 4	0 II	1 2 3 4	0 3	1 2 3 4	0 3 4	1 2 3 4	0 0	1 2 3 4	0 2 2 4	1 2 3 4	0 0 0 0
HAEM/HAEM ONCOLOGY	8	1-I 2 3 4	1 3	1 2 3 4	0 0	1 2 3 4	0 0	1 2 3 4	0 0 0	1 2 3 4	0 0	1-I 2 3 4	1 7	1 2 3 4	0 0 0 0
IMMUNOLOGY & ALLERGY	0	1 2 3 4	0 0	1 2 3 4	0 0	1 2 3 4	0 0	1 2 3 4	0 0	1 2 3 4	0 0	1 2 3 4	0 1	1 2 3 4	0 0 0 0
INFECTIOUS DISEASE	9	1 2-I 3 4	1 0	1 2-I 3 4	1 0	1 2 3 4	0 0	1 2 3 4	0 0	1 2 3 4	0 0	1-I 2 3 4	1 0	1 2 3 4	0 0 0 0
INTERNAL MEDICINE	204	1-III 2-III 3-II 4-V	13 30	1-I 2-II 3-II 4	5 19	1 2-I 3-I 4	2 6	1 2 3 4-I	1 2 3 2	1 2-I 3 4	1 4	1-X 2-IV 3-VI 4-IV	24 45	1 2 3 4	0 7
MEDICAL ONCOLOGY	8	1-I 2 3 4	1 0	1 2 3 4	0 0	1 2 3 4	0 0	1 2 3 4	0 0	1 2 3 4	0 0	1 2 3 4	0 6	1 2 3 4	0 0 0 0
NEPHROLOGY	7	1 2 3-I 4	1 4	1 2 3 4	0 0	1 2 3 4	0 0	1 2 3 4	0 0	1 2 3 4	0 0	1-I 2 3 4	1 7	1 2 3 4	0 2
NEUROLOGY	20	1 2 3 4	0 4	1 2 3-I 4	1 3	1 2-I 3 4	1 0	1 2 3 4	0 0	1 2 3 4	0 0	1-I 2-II 3-II 4	5 5	1-I 2 3 4	1 0 0 0
PALLIATIVE MEDICINE	7	1 2 3 4	0 0	1 2 3 4	0 1	1 2 3 4	0 0	1 2 3 4	0 0	1 2-I 3 4	1 2	1 2 3 4	0 0	1 2 3 4	0 0
REHABILITATION	2	1 2 3 4	0 0	1 2 3 4	0 3	1 2 3 4	0 3	1 2 3 4	0 1	1 2 3 4	0 0	1 2 3 4	0 1	1 2 3 4	0 4
RESPIRATORY MEDICINE	22	1 2-I 3-I 4	2 2	1 2 3-I 4	1 6	1 2 3 4	0 0	1 2 3 4	0 1	1 2 3 4	0 7	1-I 2 3 4	1 6	1 2 3 4	0 0
RHEUMATOLOGY	14	1 2 3 4	0 2	1 2 3 4	0 1	1 2 3 4	0 2	1 2 3 4-I	1 0	1 2 3 4	0 0	1-I 2 3-I 4	2 1	1 2 3 4	0 2

SPECIALTY		TRAINEES																			
		KOWLOON CENTRAL CLUSTR		KOWLOON EAST CLUSTER			KOWLOON WEST CLUSTER														
		KH	QEH	HOHH	TROH	UCH	CMC	KWH	OLMH	PMH	WTSH	YCH									
TRAINEES TOTAL (PP/DH/HA/OTHERS)		YEAR		YEAR			YEAR														
CARDIOLOGY	31	1-1 2 3 4	1 2-III 3-I 4-I	5 2 3 8	0 2 3 4	0 1 3 4	0 2 3 4	0 2 3 4	1-1 2-I 3 4	2 2-I 3 4	1 2 3 4	1 2 3 4	0 2 3 4	1-1 2 3 4	2 2 3 4	0 2 3 4	1 2 3 4	0 2 3 4	0 2 3 4	0 2 3 4	3
CLINICAL PHARMACOLOGY & THERAPEUTICS	2	1 2 3 4	0 1 3 4	0 1 3 4	0 2 3 4	0 1 3 4	0 2 3 4	0 1 3 4	0 1 3 4	0 2 3 4	0 1 3 4	0 2 3 4	0 1 3 4	0 2 3 4	0 1 3 4	0 2 3 4	0 1 3 4	0 2 3 4	0 1 3 4	0 2 3 4	0
CRITICAL CARE MEDICINE	16	1 2 3 4	0 1 3-I 4	2 2-I 3-I 5	0 2 3 4	1 2-I 3 4	1 2 3 4	0 1 3 4	0 2 3 4	0 1 3 4	0 2 3 4	0 1 3 4	0 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	0 1 3 4	1 2 3 4	0 1 3 4	0 2 3 4	0
DERMATOLOGY & VENEREOLOGY	8	1 2 3 4	0 1 3 4	0 1 3 4	0 2 3 4	0 1 3 4	0 2 3 4	0 1 3 4	0 2 3 4	0 1 3 4	0 2 3 4	0 1 3 4	0 2 3 4	0 1 3 4	0 2 3 4	0 1 3 4	0 2 3 4	0 1 3 4	0 2 3 4	0 1 3 4	0
ENDOCRINOLOGY, DIABETES & METABOLISM	12	1 2 3 4	0 1 3-II 4	3 2 3 5	1 2 3 4	0 1 3 4	0 2 3 4	1 2 3 4	1 2-I 3 4	1 2 3 4	2 2 3 4	1 2 3 4	0 2 3 4	1 2 3 4	0 2 3 4	1 2 3 4	0 1 3 4	1 2 3 4	0 2 3 4	1 2 3 4	0
GASTROENTEROLOGY & HEPATOLOGY	35	1 2 3 4	0 1 3-I 4-I	5 2 3 5	1 2 3 4	0 1 3 4	1 2 3 4	1 2 3 4	2 2-I 3-II 4	2 2 3 4	2 2 3 4	4 2 3 4	1 2 3 4	0 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	0 1 3 4	1 2 3 4	1 2 3 4	2 3 4
GERIATRIC MEDICINE	9	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	0 1 3 4	0 2 3 4	0 1 3 4	1 2-I 3 4	2 2-I 3 4	1 2 3 4	1 2 3 4	0 2 3 4	1 2 3 4	2 2-I 3 4	1 2 3 4	1 2 3 4	1 2 3 4	0 1 3 4	1 2 3 4	0
HAEM/HAEM ONCOLOGY	8	1 2 3 4	0 1 3 4	1 2 3 4	1 2 3 4	0 1 3 4	0 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	0 2 3 4	0 1 3 4	0 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	0 1 3 4	1 2 3 4	0 1 3 4	1 2 3 4	0
IMMUNOLOGY & ALLERGY	0	1 2 3 4	0 1 3 4	0 1 3 4	0 2 3 4	0 1 3 4	0 2 3 4	0 1 3 4	0 2 3 4	0 1 3 4	0 2 3 4	0 1 3 4	0 2 3 4	0 1 3 4	0 2 3 4	0 1 3 4	0 2 3 4	0 1 3 4	0 2 3 4	0 1 3 4	0
INFECTIOUS DISEASE	9	1 2 3 4	0 1 3 4	0 1 3 4	0 2 3 4	0 1 3 4	0 2 3 4	0 1 3 4	0 2 3 4	0 1 3 4	0 2 3 4	0 1 3 4	0 2 3 4	1-1 2 3 4	1 2 3 4	1 2 3 4	0 1 3 4	1 2 3 4	0 1 3 4	1 2 3 4	0
INTERNAL MEDICINE	204	1-1 2 3 4	1 2-III 3-III 4	24 2 3 50	1-1 2 3 4	1 2-III 3 4	3 2-III 3-III 4	21 2-III 3-III 29	1-1 2-III 3-III 4	7 2-III 3-III 22	1-1 2-III 3-III 4	17 2-III 3-III 24	1 2 3 4	1-1 2-III 3-III 4	10 2-III 3-III 45	1 2 3 4	2 2-III 3-III 4	1-1 2-III 3-III 4	5 2-III 3-III 19	1-1 2-III 3-III 4	5
MEDICAL ONCOLOGY	8	1 2 3 4	0 1 3-I 4	1 2 3 4	0 1 3 4	0 2 3 4	0 1 3 4	0 2 3 4	0 1 3 4	0 2 3 4	0 1 3 4	0 2 3 4	0 1 3 4	0 2 3 4	0 1 3 4	0 2 3 4	0 1 3 4	0 2 3 4	0 1 3 4	0 2 3 4	0
NEPHROLOGY	7	1 2 3 4	0 1 3 4	0 1 3 6	0 2 3 4	0 1 3 4	0 2 3 4	1 2 3 4	1 2 3-I 4	1 2 3 4	2 2-I 3-I 5	1 2 3 4	0 2 3 4	1 2 3 4	0 2 3 4	0 1 3 4	0 2 3 4	0 1 3 4	0 2 3 4	0 1 3 4	2
NEUROLOGY	20	1 2 3 4	0 1 3 4	2 2-I 3 6	1 2 3 4	0 1 3 4	0 2 3 4	1 2 3 4	2 2-II 3 4	2 2 3 4	2 2-I 3-I 4	2 2 3 4	0 2 3 4	1 2 3 4	0 2 3 4	0 1 3 4	0 2 3 4	0 1 3 4	1 2 3 4	1 2 3 4	2
PALLIATIVE MEDICINE	7	1 2 3 4	0 1 3 4	0 2 3 4	1-1 2 3 4	2 2 3 4	0 1 3 4	0 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	0 2 3 4	0 1 3 4	1 2 3 4	0 2 3 4	0 1 3 4	0 2 3 4	1-1 2 3 4	1 2 3 4	1 2 3 4	0
REHABILITATION	2	1 2 3 4	1 2 3 4	0 1 3 4	0 2 3 4	0 1 3 4	0 2 3 4	0 1 3 4	0 2 3 4	0 1 3 4	0 2 3 4	0 1 3 4	0 2 3 4	0 1 3 4	0 2 3 4	0 1 3 4	0 2 3 4	0 1 3 4	0 2 3 4	0 1 3 4	0
RESPIRATORY MEDICINE	22	1 2 3 4	0 1 3 6	1 2 3 7	1 2 3 4	0 1 3 4	0 2 3 4	1 2 3 4	2 2 3 4	2 2 3 4	4 2 3-II 1	1 2 3 4	0 2 3 4	1 2 3 4	0 2 3 4	0 1 3 4	0 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	0
RHEUMATOLOGY	14	1 2 3 4	0 1 3-I 4	2 2 3 4	1 2 3 4	0 1 3 4	0 2 3 4	1 2 3 4	1 2-I 3-I 4	1 2-I 3 4	1 2 3 4	0 2 3 4	0 1 3 4	1 2 3 4	1-1 2 3 4	1 2 3 4	0 2 3 4	1 2 3 4	0 1 3 4	1 2 3 4	0

# TRAINING

		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	31	1—1 2 3 4	1 2 3 4	1—1 3—II 4	3 2 2	1—1 2 3—I 4	2 2 3 5	1 2 3 4	0 0 0 0	1 2 3 4	0 0 0 0	1—II 2—III 3 4	5 5 5 5	
CLINICAL PHARMACOLOGY & THERAPEUTICS	2	1 2 3 4	0 0 0 0	1 2 3 4	0 0 0 0	1—1 2—1 3 4	2 2 3 3	1 2 3 4	0 0 0 0	1 2 3 4	0 0 0 0	1 2 3 4	0 0 0 0	
CRITICAL CARE MEDICINE	16	1 2 3 4	1 0 0 1	1 2—1 3 4	1 1 2 2	1 2 3 4	0 0 1 1	1 2 3 4	0 0 0 0	1 2 3 4	0 0 0 0	1 2—1 3 4	1 1 2 2	
DERMATOLOGY & VENEREOLOGY	8	1 2 3 4	0 0 0 0	1 2 3 4	0 0 0 0	1—1 2 3 4—1	2 2 3 0	1 2 3 4	0 0 0 0	1 2 3 4	0 0 0 0	1 2 3 4	0 0 0 0	
ENDOCRINOLOGY, DIABETES & METABOLISM	12	1 2 3 4	0 0 2 0	1 2—1 3 4	1 1 0 0	1 2 3—1 4	1 1 3 9	0 0 3 4	1 2 3 0	0 0 0 0	1 2 3 4	0 0 0 0	1—II 2—1 3 4	3 1 1 1
GASTROENTEROLOGY & HEPATOLOGY	35	1 2 3 4	0 0 0 0	1—1 2—1 3 4—1	3 2 3 2	1—1 2 3—III 4	4 4 5 5	1 2 3 4	0 0 0 0	1 2 3 4	0 0 0 0	1 2—1 3—II 4	3 5 5 5	
GERIATRIC MEDICINE	9	1 2 3 4	0 0 2 0	1 2 3 4	0 0 1 1	1 2 3 4	0 0 4 4	1 2 3 4	1 1 7 0	1 2 3 4	0 0 1 2	1 2 3 4	0 0 10 0	
HAEM/HAEM ONCOLOGY	8	1 2 3 4	0 0 0 0	1 2 3 4	0 0 0 0	1 2 3—1 4	1 1 3 3	1 2 3 4	0 0 0 0	1 2 3 4	0 0 0 0	1 2 3—1 4	1 4 4 4	
IMMUNOLOGY & ALLERGY	0	1 2 3 4	0 0 0 0	1 2 3 4	0 0 0 0	1 2 3 4	0 0 0 0	1 2 3 4	0 0 0 0	1 2 3 4	0 0 0 0	1 2 3 4	0 0 0 0	
INFECTIOUS DISEASE	9	1 2—1 3 4	1 0 1 1	1—1 2 3 4	1 1 0 0	1 2—1 3—1 4	2 2 3 1	1 2 3 4	0 0 0 0	1 2 3 4	0 0 0 0	1 2 3 4	0 0 4 4	
INTERNAL MEDICINE	204	1—1 2—1 3 4	2 16 0	1—IV 2—III 3—IV 4—II	13 12	1—IV 2—III 3—VIII 4—III	18 39	1—II 2 3—1 4—III	6 7	1 2 3 4	0 3 3 4	1—V 2—XII 3—III 4—III	23 38	
MEDICAL ONCOLOGY	8	1 2 3 4	0 0 0 0	1 2 3 4	0 0 0 0	1—1 2—1 3—II 4—1	5 8	1 2 3 4	0 0 0 0	1 2 3 4	0 0 0 0	1 2—II 3 4	2 0 0 0	
NEPHROLOGY	7	1 2 3 4	0 2 0 0	1 2 3 4	0 1 0 0	1 2 3 4	0 4 4 4	1 2 3 4	0 0 0 0	1 2 3 4	0 0 0 0	1 2 3 4	0 7 0 0	
NEUROLOGY	20	1 2 3 4	0 1 0 0	1 2 3 4	0 2 2 0	1—1 2 3 4	1 3 3 4	1—1 2 3 4	1 0 0 0	1 2 3 4	0 0 0 0	1 2—1 3 4	1 2 2 2	
PALLIATIVE MEDICINE	7	1 2 3 4	0 0 0 0	1 2 3 4	0 0 0 0	1 2 3 4	0 0 0 0	1—1 2 3 4	1 1 1 1	1 2 3 4	0 0 0 0	1 2 3 4	0 0 0 0	
REHABILITATION	2	1 2 3 4	0 0 0 0	1 2 3 4	0 0 0 0	1 2 3 4	0 2 4 4	1 2 3 4	0 0 1 1	1 2 3 4	0 0 1 1	1 2 3 4—1	1 3	
RESPIRATORY MEDICINE	22	1 2 3 4	0 3 0 0	1 2 3—II 4—1	3 2	1 2—1 3—1 4	2 4	1 2 3—1 4	1 1 0 0	1 2 3 4	0 0 1 1	1—1 2—1 3 4—1	3 5	
RHEUMATOLOGY	14	1 2 3 4	0 0 0 0	1 2 3 4	0 0 0 0	1 2—1 3 4	1 3 3 4	1 2 3 4	0 0 0 0	1 2 3 4	0 0 0 1	1 2—II 3 4	2 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	8	1—I 2—II 3 4—III	6   <i>II</i>
IMMUNOLOGY & ALLERGY	0	1 2 3 4	0   2
RESPIRATORY MEDICINE	22	1 2—I 3 4	1   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 January 2008

SPECIALTY	FELLOWS TOTAL (PP/DH/HA/ OTHERS)	FELLOWS									HONG KONG EAST + WEST CLUSTER
		HONG KONG EAST CLUSTER				HONG KONG WEST CLUSTER					
		PYNEH	RH	TWEH	Subtotal	FYKH	GH	QMH	TWH	Subtotal	
CARDIOLOGY	180	7	3	0	10	0	5	10	0	15	25
CLINICAL PHARMACOLOGY & THERAPEUTICS	5	0	0	0	0	0	0	1	0	1	1
CRITICAL CARE MEDICINE	57	5	0	0	5	0	0	8	0	8	13
DERMATOLOGY & VENEREOLOGY	78	0	0	0	0	0	0	1	0	1	1
ENDOCRINOLOGY, DIABETES & METABOLISM	76	4	2	3	9	0	0	8	0	8	17
GASTROENTEROLOGY & HEPATOLOGY	113	7	2	0	9	0	0	8	1	9	18
GERIATRIC MEDICINE	153	8	12	4	24	3	0	4	0	7	31
HAEM/HAEM ONCOLOGY	41	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	25	1	0	0	1	0	0	3	0	3	4
INTERNAL MEDICINE	959	48	26	10	84	2	9	68	8	87	171
MEDICAL ONCOLOGY	34	0	0	0	0	0	0	8	0	8	8
NEPHROLOGY	104	7	0	0	7	0	0	8	2	10	17
NEUROLOGY	69	5	3	0	8	0	0	5	1	6	14
PALLIATIVE MEDICINE	13	0	1	0	1	0	2	0	0	2	3
REHABILITATION	43	0	3	4	7	1	0	1	4	6	13
RESPIRATORY MEDICINE	142	8	7	1	16	1	11	7	0	19	35
RHEUMATOLOGY	45	3	2	1	6	0	0	1	2	3	9

		FELLOWS														KOWLOON CENTRAL + EAST + WEST CLUSTER
		KOWLOON CENTRAL CLUSTER			KOWLOON EAST CLUSTER				KOWLOON WEST CLUSTER							
SPECIALTY	FELLOWS TOTAL (PP/DH/HA/OTHERS)	KH	QEH	Subtotal	HOHH	TKOH	UCH	Subtotal	CMC	KWH	OLMH	PMH	WTSH	YCH	Subtotal	
CARDIOLOGY	180	0	10	10	0	3	5	8	1	4	1	8	0	3	17	35
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	6	8	4	5	0	2	0	2	13	26
DERMATOLOGY & VENEREOLOGY	78	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
ENDOCRINOLOGY, DIABETES & METABOLISM	76	0	5	5	0	3	4	7	2	3	2	5	0	2	14	26
GASTROENTEROLOGY & HEPATOLOGY	113	0	6	6	0	4	3	7	5	4	1	10	0	6	26	39
GERIATRIC MEDICINE	153	6	4	10	7	2	12	21	8	11	1	11	4	5	40	71
HAEM/HAEM ONCOLOGY	41	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	25	0	3	3	0	0	2	2	0	1	0	4	0	1	6	11
INTERNAL MEDICINE	959	5	62	67	9	21	44	74	29	36	7	58	4	26	160	301
MEDICAL ONCOLOGY	34	0	1	1	0	0	0	0	0	0	0	1	0	0	1	2
NEPHROLOGY	104	0	9	9	2	2	4	8	2	5	0	8	0	2	17	34
NEUROLOGY	69	0	6	6	0	1	3	4	0	3	1	3	1	0	8	18
PALLIATIVE MEDICINE	13	0	0	0	3	0	1	4	3	0	1	0	0	0	4	8
REHABILITATION	43	9	0	9	1	0	3	4	1	1	0	2	4	0	8	21
RESPIRATORY MEDICINE	142	6	8	14	5	3	4	12	6	4	0	4	6	1	21	47
RHEUMATOLOGY	45	1	3	4	0	0	2	2	1	2	0	2	0	1	6	12

		FELLOWS										NEW TERRITORIES EAST + WEST CLUSTER
		NEW TERRITORIES EAST CLUSTER						NEW TERRITORIES WEST CLUSTER				
SPECIALTY	FELLOWS TOTAL (PP/DH/HA/OTHERS)	AHNH	NDH	PWH	SH	TPH	Subtotal	POH	TMH	Subtotal		
CARDIOLOGY	180	3	4	10	0	0	17	1	6	7	24	
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	78	0	0	1	0	0	1	0	0	0	1	
ENDOCRINOLOGY, DIABETES & METABOLISM	76	2	2	11	1	0	16	0	2	2	18	
GASTROENTEROLOGY & HEPATOLOGY	113	2	3	6	0	0	11	0	8	8	19	
GERIATRIC MEDICINE	153	2	0	4	7	4	17	0	12	12	29	
HAEM/HAEM ONCOLOGY	41	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	25	1	0	1	0	0	2	0	4	4	6	
INTERNAL MEDICINE	959	19	20	55	7	6	107	3	62	65	172	
MEDICAL ONCOLOGY	34	0	0	12	0	0	12	0	0	0	12	
NEPHROLOGY	104	3	1	6	0	0	10	1	6	7	17	
NEUROLOGY	69	1	2	7	1	0	11	0	3	3	14	
PALLIATIVE MEDICINE	13	0	0	0	1	0	1	0	0	0	1	
REHABILITATION	43	0	1	2	1	1	5	0	4	4	9	
RESPIRATORY MEDICINE	142	4	3	6	0	1	14	1	6	7	21	
RHEUMATOLOGY	45	1	1	3	0	3	8	0	3	3	11	



## Professor John Vallance- Owen

### John Mackay

When the late Professor Gerald Choa, Dean of the Faculty of Medicine of the fledgling Chinese University Medical School at Shatin, was looking for an academic of distinction to be the Foundation Professor and Chairman of the Department of Medicine, he was advised by the late medical educationalist Professor Sir Melville Arnott to choose Professor Vallance-Owen, then aged 63 and at the peak of a distinguished career.

Professor John Vallance-Owen, ('JVO' to his friends), had been consultant Physician and Professor of Medicine at The Queen's University of Belfast for the previous twelve years, was a Councillor of the Royal College of Physicians of Ireland, a member of a Northern Ireland Board of Health and Social Services, and Director of Medical Services of Malta. He had an international reputation as a diabetologist and had written extensively on that subject. His book, 'Diabetes: Its Physiological & Biochemical Basis', had been published in 1975. He had earlier written a well-received book on Cardiology.

To leave all this in 1983 to take up a demanding role in Hong Kong was a major undertaking, especially as the medical school buildings had not been completed, only the Choh Ming Li basic Sciences Building had been ready in time for the first admission of 60 students in 1981. Additional reasons for him to hesitate might have been that Hong Kong commerce was only just emerging from a world-wide recession, and the difficult negotiations between Britain and China regarding the status of the territory after 1997 was a cause for considerable public uncertainty. The Governor, Sir Edward Youde, was representing Hong Kong interests at that time. Despite these factors he decided to take up the challenge.

As foundation Professor and Chairman of the Department of Medicine, Professor Vallance-Owen chaired a number of committees at Senate and Faculty level, and especially those related to the interface between the University and Medical and Health Department. For its first six months he was House Governor of the Prince of Wales Hospital. Appointed Associate Dean in 1984 he was involved in every aspect of the development of the new medical school, from the management of the student hostels to the general and academic policy of the Faculty.

A complication was the need to outsource the clinical teaching to The United Christian Hospital in Kwun Tong, and the Kowloon Hospital in Kowloon for the first year, until the Prince of Wales Hospital facilities were completed in 1984. Another problem was

the recruitment of senior academics of a suitable calibre. Some senior members of the medical fraternity in Hong Kong felt that Shatin was too far off in the wilds of the Kowloon mainland, an attitude that lingers even today in some quarters! So JVO recruited from overseas, academics of distinction from Australia, USA and UK. Professor Jean Woo was recruited locally to develop Geriatric Medicine but because of her training in England was included in the "Cambridge Mafia".

The culmination of these efforts was the graduation of the first group of students in 1986, their M.B., Ch.B. degrees being recognised by the General Medical Council of UK, a recognition that JVO had had to fight for – one of his proudest achievements.

For the next two years Professor Vallance-Owen presided over the further development of the Medical School, leaving it in 1988 with the satisfaction of knowing that it had grown into an institution deserving of the highest respect.

Appointments outside the University were as Physician to the Governor, Sir Edward Youde, a fellow Welshman; and Honorary Consultant in Medicine to the British Military Hospital.

His son Andrew, who after a distinguished surgical career, is now the Group Medical Director of BUPA, (British United Provident Association), had this to say about his father's time in Hong Kong. "Dad was committed to his research but he was really in his element when he was teaching in a clinical environment; this is why he so enjoyed his time in Hong Kong. He loved the enthusiasm of the students and young doctors, and I remember him ringing me in England one day in great excitement having just done a cardioversion – not a procedure that the Prof usually undertook in Belfast! I have met many people who worked with him in Hong Kong and they all think of him as a great clinician – he is always delighted to be remembered in that way."

It has been a long career. His education started with school in Bangor in his native Wales, continued at Epsom College, Surrey, from where he won the De Havilland Scholarship to St. John's College, Cambridge. He recalls during his time at Cambridge, being on look-out duty on top of the tower of St. John's College chapel when a German plane flew over, dropping bombs on the city – the only time this happened during his time in Cambridge. From Cambridge he won an Open Entrance Scholarship to The London Hospital. At the London Hospital he won the Dressers' prize in Clinical Medicine and Anderson Prize in Clinical Surgery, and the Letheby Prize in Chemical Pathology. He had some notable teachers: Professor of Biochemistry, Sir Gowland Hopkins who discovered

vitamins; Professor of Physiology, (later Lord) Adrian who pioneered electrocardiography; and the pathologists Drs. Taylor and Race, who discovered the Rhesus factor.

Apart from his academic success he excelled in sport and music. He captained the tennis teams at Epsom College, St. John's College, and the London Hospital, and played in the United (London) Hospitals team. He rowed for his college at University. His other major sport is golf which he still enjoys playing, especially in Scotland. These notable achievements were despite lack of full movement of his right arm, the result of a subarachnoid haemorrhage, a birth injury. A continuing interest is music; he played the French Horn in the Cambridge University Medical School orchestra. In quieter moments he plays chess, of sufficiently high standard to represent his club The East India Club in St. James's in London.

Dr. Vallance-Owen's first House Job starting in July 1946, was with Dr. Donald Hunter. Remarkably, he passed his MRCP examination only three months after qualifying and before the end of this first job! The next five years were spent at The London Hospital, under some distinguished clinicians, Sir Henry Souttar who did the first successful mitral valvulotomy in 1925, Sir John Parkinson of the Wolf Parkinson White Syndrome, and culminating in the position of Medical First Assistant to Sir Horace Evans, later created Lord Evans for his services as Physician to Queen Mary (wife of King George V), to whom he was introduced. It was said of Sir Henry Souttar that he offered private patients a choice of fee for operative care, Standard Rate using blunt knives, or First Class at twice the cost using sharp knives! Everyone chose First Class.

From 1951 to 1958 he was at the Royal Postgraduate Medical School of London at the Hammersmith Hospital, where he perfected a rat diaphragm technique of measuring blood insulin, eight years before radioimmune assay was available.

In 1955 he was a Rockefeller Travelling Fellow at the University of Pennsylvania, Philadelphia. He remembers with pride a trip he and his wife took in an old US\$500 Buick Special in which they drove west to Rochester for him to deliver a lecture at the Mayo Clinic; from there on to Los Angeles, up to Vancouver, back through Canada to Montreal and down to Boston, finally back to Philadelphia, a round trip of 17,000 miles – and sold the car for US\$400.

Moving to the north of England he took up the appointment of Consultant Physician and Lecturer, then Reader, in Medicine at the University of Newcastle upon Tyne, where he continued his research on Diabetes and lectured all over the world. In 1966 he became Consultant Physician and Professor and Chairman of the Department of Medicine at The Queen's University of Belfast. It was a time of conflict between the Irish Republicans and the Royalists, but he felt safe going out on the streets - as long as he wore his white coat. In 1981 he was, in addition, appointed Director of Medical Services of Malta, and organiser of medical teaching, positions he had to relinquish in 1983 when he took up the position of Professor of Medicine at the new Chinese University of Hong Kong.

On his return to England Professor Vallance-Owen took up appointments as Visiting Professor at the Royal Postgraduate Medical School, Hammersmith Hospital, teaching General Medicine; as Adviser on Clinical Complaints for the North (later also the South) Thames Regional Health Authority; and as Consulting Physician at the London Independent Hospital, later The Wellington Hospital – this was his last appointment before retirement in 2004, aged 84.

JVO came from a scientific background. His father had been the Professor of Physics at the University of North Wales at Bangor. He married in 1950, meeting his wife Renee, on a tennis court. His

wife used to teach music before she married and until 1957 when she was unfortunate enough to develop poliomyelitis. Of their four children, Andrew, the eldest, after a distinguished surgical career, is now the Medical Director of BUPA, (British United Provident Association). His second son is in business. Of two daughters, one teaches at Ley's School in Cambridge and the other is a homemaker, both daughters excelled at tennis, one becoming the Junior Champion of Ireland, and the other Junior Champion of Scotland. He has eleven grandchildren.

Now free of all clinical and advisory responsibilities Professor Vallance Owen lives comfortably in a pleasant village, Great Shelford, just outside Cambridge. From there he and his wife sometimes go up to London to concerts; and enjoy an annual cruise to the Caribbean.

Looking back, some of his happiest memories were when working with Sir Horace Evans, Physician to the Royal Family; also his time in Hong Kong where he enjoyed working with colleagues at the Chinese University, and came to know well Professor Sir David Todd, and Professor Rosie Young at the University of Hong Kong.

Asked for his advice for young doctors, he emphasised the continuing importance of taking a careful history and examination, despite the many diagnostic investigations available today.

He had little good to say of the British National Health Service, feeling that the hospitals were over-staffed with administrators, citing Addenbrookes at Cambridge where there were 400 administrators for 860 beds. He was appalled at the number of multi-drug resistant infections in hospitals, a consequence of poor standards of hygiene.

Professor John Vallance-Owen is a remarkable man, yet despite his achievements remains the most considerate of hosts, insisting on meeting me off the train at Cambridge Station, driving me to his home and taking me back. In the interval I had a fascinating time listening to his reminiscences, ranging from the time when as a boy he was introduced by his father to one of his neighbours, the British Prime Minister from 1916-1922 David Lloyd-George, Earl of Dwyfor; to the time when he was being taught by the pioneers of modern science; and later, meeting Royalty with Sir Horace Evans.

Hong Kong's second medical school has been fortunate to have had 'JVO' to help get it started. Professor Gerald Choa had made a wise choice.



1987 – (seated) Professor Rosie Young, Mrs Vallance-Owen, Professor Sir David Todd, Professor John Vallance-Owen and Professor Gerald Choa (standing) Dr EK Yeoh, Dr Leung Nai Kong, Professor Richard Yu, Professor TK Chan, Dr Tse Tak Fu and the late Dr Wu Wai Yung Raymond