

# SYNAPSE

SEPTEMBER 2009 RESTRICTED TO MEMBERS ONLY

HONG KONG COLLEGE OF PHYSICIANS  
香港內科醫學院



*Sapientia et Humanitas*



“UMÉ”

*Professor Richard YH Yu*

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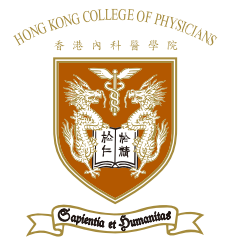
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# Professor AJS McFadzean – A TRIBUTE

*Professor Sir David Todd*  
Founding President, HKCP

“Professor McFadzean played many parts in the life of Hong Kong, but it was as a doctor and particularly as a teacher of medicine that he was at his best. From this flowed his inspiration and this was the source of his unrivalled influence. Indeed, no single man has had so great an influence on medicine here.”

This is taken from Dean of Medicine Professor JB Gibson’s eulogy at the memorial service in Hong Kong held soon after Professor McFadzean’s death in November, 1974. Professor McFadzean was born in Troon, Scotland in 1914. This is one of the centres of golf in the UK and early on he had to decide on a career in the sport or in medicine. Fortunately for us he chose the latter. He studied at the University of Glasgow and was awarded the Brunton Memorial Prize for the most distinguished graduate of the year and later a Gold Medal for his MD thesis. He was senior lecturer in Medicine at the Royal Infirmary, Glasgow before joining the University of Hong Kong where he was head of the Department of Medicine from 1948-74, Dean of Medicine from 1967-72 and Vice-Chancellor in 1965.

The combination of brilliance, a profound knowledge of medicine, a Churchillian command of English, compassion and devotion to education, research and patient care made him the ideal teacher and mentor. He stressed

principle rather than detail and encouraged clear and logical thinking rather than recall. Ockham's Razor: “essences are not to be multiplied without necessity” or “among competing hypothesis, favour the simplest” was often quoted. He had a quick temper and we were repeatedly chastised but he was revered because his ultimate goal was to make us good doctors. On one occasion he suddenly left the lecture room and returned about ten minutes later looking rather pale. He finished the teaching clinic. Later we learnt that he had had a severe haematemesis; such was his dedication to teaching.

An outstanding clinical scientist, his 'idol' was Sir Thomas Lewis and the first cardio-respiratory laboratory at Queen Mary Hospital was named after Lewis. Headed by Dr. Joseph Pan, it has nurtured many cardiologist and respiratory physicians. The laboratory was also a

match making venue for doctors and nurses! His astute observations at the bedside led to several landmark articles which were published



Professor Sir David Todd photographed with Professor and Mrs. McFadzean at his retirement dinner in 1974.

in prestigious journals such as “The Lancet”, “Blood” and “Clinical Science”. He noted that patients with cirrhosis of the liver suffered large bruises and bled excessively during surgery, out of proportion to the thrombocytopenia and abnormal clotting tests. While determining the prothrombin time of such a patient, the clot was seen to dissolve shortly after being formed. The cause was fibrinolysis and research on this subject, principally with HC Kwaan, was widely acclaimed. Together with Rosie Young are the classic descriptions of hypoglycemia in primary carcinoma of the liver (ca liver) and thyrotoxic periodic paralysis. Research on thalassaemia, haematological changes in cryptogenetic splenomegaly and erythrocytosis in ca liver added to the international standing of the Department. Injecting neoprene latex of different colours into cadaveric livers demonstrated that the tumor was supplied by the hepatic artery, quite unknown in the 1950’s. We collected the livers from the mortuary and were not overly careful about wearing gloves - these were the days before Hepatitis B was known! In collaboration with Professors PC Hou and GB Ong, and Dr. James Cook, surgical specialist at Queen Mary Hospital, the relationship of *Clonorchis sinensis*, bacterial infections and pyogenic cholangitis was elucidated. Despite the fact that there was only about 800 square feet of laboratory space, we were all encouraged to carry out research and given the limited funds and facilities, the results were gratifying. Happily the research tradition of the Department persists to this day.

His ward rounds with students and with the staff are legend. Woe be to those who were late (somehow TK Chan was forgiven), who did not include the family or social history

in their presentations, who lacked skills in physical examination and could not see with an ophthalmoscope (he lent money to undergraduates who could not afford to buy one)! He was able to “smell” typhoid, perhaps 70% of the time and detect the subtleties of tertiary syphilis and rheumatic fever, common in the 1950’s. He never referred to a patient as a case. For house staff there were no fixed working hours and Sunday morning briefings were common. He often responded in person when he was asked to see a “problem” patient. What he would make of the proposed 48 to 65 hour working week is anyone’s guess.

He was a man of vision and recognized the need for local academic staff and specialists. At the same time he realized the danger of inbreeding and ensured that trainees spent 1-2 years in overseas institutions, not only to sit professional examinations, but to acquire new clinical skills and techniques, and pursue research. I recall when negotiations to hold the MRCP examinations in Hong Kong began, he worried that this would deprive junior doctors of the opportunity to undergo postgraduate education and training abroad. How true! He established the Dean of Medicine’s consultative committee with

undergraduates, and also the Dean’s Loan Fund for needy students, where verbal agreement was the only guarantee required.

A champion golfer, he represented Hong Kong at international tournaments. Other interests included history, poetry and Chinese antiques and many happy hours were spent with Professor PC Hou learning about Chinese art and browsing in the Hollywood Road shops. The McFadzeans were gracious hosts, and we all left their annual Christmas party in high spirits and unfit to drive. On one occasion a not-too-sober interne dared to address the “Prof” as Alec!

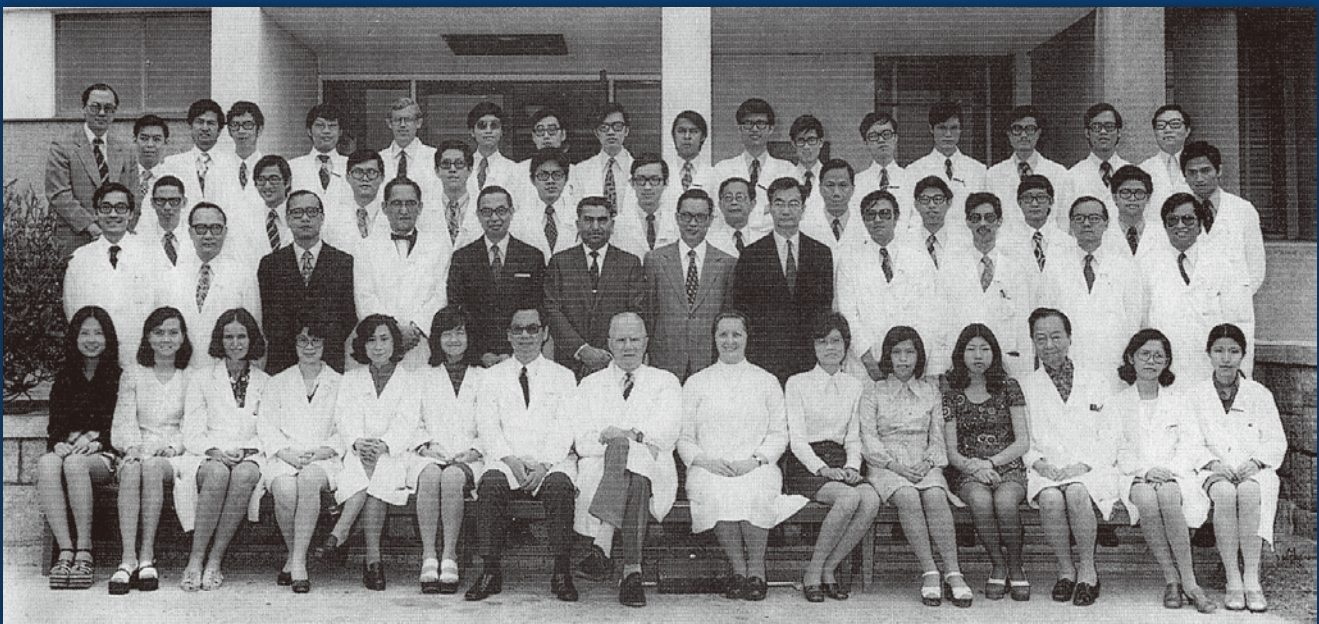


Professor A.J.S. McFadzean  
O.B.E., M.D., D.Sc., F.R.C.P., F.R.A.C.P.,  
F.A.C.P., F.R.S.E., Hon. F.R.C.S., J.P.  
Professor of Medicine, University of Hong Kong  
1948 - 1974

Professor McFadzean practiced the art and science of medicine according to the Hippocratic Oath and was an inspiration to us all. He is an excellent role model, as he was a physician with knowledge, integrity, wisdom and compassion, who dedicated his life to teaching and research to the betterment of the community, not only in Hong Kong, but in other areas of the world through his deeds, publications and students. He understood fully the meaning of medical professionalism which includes placing the interests of patients above those of the doctor, setting up and maintaining standards of competence and ethical practice, sharing

knowledge with others and providing expert advice to the community in matters of health. He did not die wealthy, but left a rich legacy in medical education, research and health care. On his retirement the Department of Medicine presented him with a bronze plaque inscribed with a passage from Khalil Gibran's *The Prophet* "And all knowledge is vain save when there is work, and all work is empty save when there is love".

It is 35 years since he died, but those of us who had the privilege of knowing him remember him with affection and gratitude.

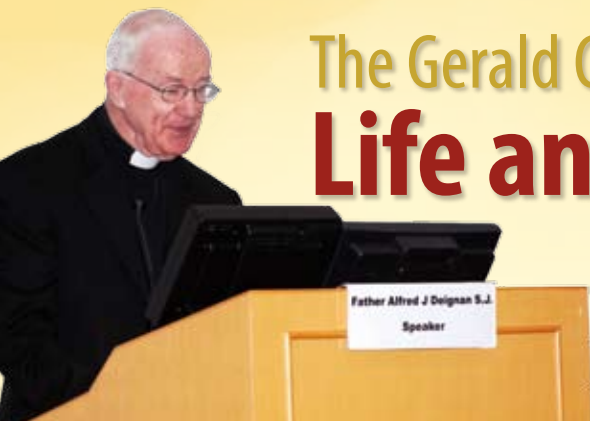


## Legends in Medicine

*The late Professor Alexander James McFadzean was a legendary figure in the medical history of Hong Kong. He came from Glasgow to Hong Kong to take up the Chair of Medicine at the University of Hong Kong in 1948. Despite the massive destruction during the Second World War, he had successfully rebuilt the Department and also the Faculty - incredibly in a short period. Not only was he a great teacher, he also nurtured the next generations of local medical graduates, many of whom have excelled in academic medicine both locally and abroad. He retired to Scotland in 1974. Ever since the formation of this College in 1986, an A.J.S. McFadzean Oration has been established to honor his contribution to Medicine in Hong Kong.*

*Professor Sir David Todd was the Head of Department of Medicine, University of Hong Kong from 1974 to 1989. Sir David has contributed tremendously in establishing the postgraduate medical training in Hong Kong. He was the Founding President of the Hong Kong College of Physicians in 1986 before becoming the Founding President of the Hong Kong Academy of Medicine in 1992. Our College has established a Sir David Todd Lecture to honor his contribution to Medicine in Hong Kong.*

**Professor KN Lai**  
President, HKCP



# The Gerald Choa Memorial Lecture

## Life and Basic Human Values

**Father Alfred J. Deignan S.J.**

Chairman  
Council, The Hong Kong International Institute of Educational Leadership  
Former Principal, Wah Yan College, Kowloon

*This address was delivered on 13 October 2007 at the Annual Scientific Meeting of the Hong Kong College of Physicians.*

### INTRODUCTION

When Professor Lai wrote to me inviting me to give a presentation on the issue of ethics for the Professor Gerald Choa Memorial Lecture, I really hesitated. I am sure there are others who are better qualified in this area than I ( and I suggested a few ) and more deserving of this honour. However he insisted, so you will have to put up with me and with what I share with you this morning. You can blame him if I am a disaster.

First of all I want to make it clear that I am not going to attempt to deal with the many serious ethical problems facing the medical profession as a result of all the advanced technology and experiments on human life still going on in the medical research of today - such as use of embryos and stem cells, IVF euthanasia etc. Research is good and necessary but sometimes I think the attitude of some scientists seems to be that science can and will answer everything. Life and the human person and death will no longer be a mystery. Like the temptation of Adam and Eve we want to be equal to God, to control everything and not be dependent on Him. My sympathy goes out to Doctors who sometimes have to make personal moral decisions in the face of bioethical dilemmas. Doctors are like priests, dealing with life, with the lives of human individuals, where there is a mixture of the human or physical and the spiritual.

### ETHICS AT A DEEPER LEVEL

I thought it best to deal with an area of ethics about which I am more familiar, the area of basic human values which are fundamental as a guide to our human behaviour. Maybe this is dealing with ethics at a deeper level

#### The HKIIEI

In 1997 we started an Institute which goes by the long name of "The Hong Kong International Institute of Educational Leadership". This Institute comes under the auspices of Lingnan University and its main concern is human behaviour and relationships between people. Life is about relationships. Doctors are always working in relationship with family or families, patients, colleagues, nurses, staff etc. How do we choose to behave? What is right?

### Example of 90/10 Principle; Author Stephen Covey

What is this principle? 10% of life is made up of what happens to you. 90% of life is decided by how you react. What does this mean? We really have no control over 10% of what happens to us. We cannot stop the car breaking down. The plane will be late arriving, which throws our whole schedule off. A driver may cut us off in traffic. We have no control over this 10%. The other 90% is different. You determine the other 90%. How? By your reaction. You cannot control the red light, but you can control your reaction. Don't let people fool you. You can control how you react.

Let's use an example. You are eating breakfast with your family. Your daughter knocks over a cup of coffee onto your business shirt. You have no control over what just happened. What happens next will be determined by how you react. You curse. You harshly scold your daughter for knocking the cup over. She breaks down in tears. After scolding her, you turn to your spouse and criticize her for placing the cup too close to the edge of the table. A short verbal battle follows. You storm upstairs and change your shirt. Back downstairs, you find your daughter has been too busy crying to finish breakfast and get ready for school. She misses the bus. Your spouse must leave immediately for work. You rush to the car and drive your daughter to school. Because you are late, you drive well above the speed limit the police hold you up and you get a traffic fine. You arrive at the school. Your daughter runs into the building without saying "goodbye". After arriving at the office late, you find you forgot your briefcase. Your day has started terrible. It seems to get worse and worse. You arrive home in the evening to find a split in your relationship with your spouse and daughter.

Why? Because of how you reacted this morning. Why did you have a bad day? Did the coffee cause it, your daughter cause it, the policeman cause it or you? You caused it. You had no control over what happened with the coffee. How you reacted in those 5 seconds is what caused your bad day.

Here is what could have and should have happened. Coffee splashes over you. Your daughter is about to cry. You gently say "It's O.K. Honey, you just need to be more careful next time". You rush upstairs, grab a clean shirt, put it on, and come down with your briefcase in time to see your daughter off on the school bus. She waves at you. You arrive in the office 5 minutes early and cheerfully greet the staff. You have a good day.

Two different scenarios. Both started the same. Both ended different. WHY? Because of how you REACTED. So you really do not have any control over 10% of what happens. The other 90% is determined by your reaction.

We were concerned about the attitudes and values of people especially young people. There seemed to be a general deterioration in respect for life, for self, respect for others- parents, teachers etc.; a decrease or loss in the sense of responsibility, of honesty and compassion. etc. We did some diagnosis by surveys on the attitudes of young people which confirmed our impressions. Money was a supreme value followed by success, pleasure and freedom.

Example; two students outside Ricci Hall Entrance. I open the door, they walk right in with no word of "Excuse me" or "I'm Sorry" or "Thank You" or letting me go out first.

## THE HONG KONG ENVIRONMENT

We are living in an environment which influences us – like the air we breathe. Life in Hong Kong is very fast, very busy, very competitive. People are inclined to be very focused on their work, on financial gains, on the stock market, on promotion, on achievement and success.

We have become dominated by our work, no longer free, relaxed. There is very little time for relationships, to love, to care, to listen, to notice, to share and enjoy the companionship of others. Now we seem to have less respect for each other. We are in a hurry. We become less aware of our responsibilities in the way we treat one another in the hurried pace of life.

Persons are becoming more like things. We make use of them when we need them and discard them when we don't. So the quality of our social lives is lowered. When we started the Institute we wondered what we could do to improve the standard of our lives and behaviour. We thought that education was the answer, education in basic moral or human values would help.

## THE INSTITUTE'S MISSION

So the Institute's mission is to promote and develop basic human values and to help individuals develop into persons who have respect for all others; who are honest, fair and compassionate; who are responsible citizens bringing harmony into society; persons of conscience who have critical decision-making abilities, based on a strong sense of justice and integrity; persons of compassion who care for those in need and are willing to serve them.

We started with courses for teachers as they play a very important part in educating and influencing youth, as they share with them their values and attitudes. Then we organized courses for parents who really appreciated them, as it is not easy bringing up a good child in today's environment. Parents wish their children to be educated but they also want them to be good. What is this good?

We are human persons. We find ourselves in this world. We had no choice. We live among our own family, relatives, friends and

colleagues. We have been given life and we set out on a journey through life from childhood to adulthood until we come to the end of our life on earth. We might ask what is necessary and important for us on the way?

Let us take the example of a plant. In order that it may grow to its most perfect – we will find out what kind of soil it needs, – how much water – whether it is an indoor or outdoor plant – does it do better in the sun or does it do better in a cool temperature etc. We consider the nature of the plant and what is best for that nature. I had a collection of cactuses which thrive on dry sandy soil. When away on holidays the servant kindly watered them and killed them. Can we look at the nature of human beings and find out what is most suitable for our nature, what is best for our growth and development ?

## OUR HUMAN NATURE IN CONTEXT

To do this we may need to put the nature of the human person in context.

I call this the World View: -

WORLD VIEW	
GOD	
TRINITY OF PERSONS - COMMUNITY OF LOVE	
CREATES OUT OF LOVE	
UNIVERSE FOR US TO LIVE IN	HUMAN PERSON: HUMAN FAMILY
GOOD	GOOD
WONDER: BEAUTY: VARIETY	MADE IN HIS OWN IMAGE
MYSTERY OF NATURE	"THE WONDER OF MY BEING"
ALL WE NEED FOR LIFE	CREATIVE AND LOVING
REFLECTIONS OF GOD'S BEAUTY	FREEDOM TO CHOOSE, TO LOVE

Our life is a gift to us, given to us by God, so human life is precious – the most valuable thing we have. Each person is a gift and so we should value each person as a precious gift so too the environment. This is the basis of our respect for life, for each person's life and respect for the environment which is also His gift...

What we value, we respect; what we respect, we value.

We do not belong to ourselves, but to God. We are dependent on Him. He gives us everything we have. We are born into a human family and wider community. As one human family, we are responsible to care for the members of that family our brothers and sisters, and to share our gifts and the world's resources with them, to care and help them in their need. Others should respect us and we should respect them.

## HUMAN NATURE'S NEEDS

What are the needs of our nature?

WE need to be:

1. Loved, cared for, supported, helped
2. To belong to a family- to have a home, security, a place to live in.
3. To have food and drink and exercise – good health



- 4. To be educated and learn the truth
- 5. To work; to discover our abilities and gifts
- 6. To be respected, appreciated, valued, encouraged, valued, justly treated
- 7. We need to love and share with others.
- 8. We need Peace and Freedom

If these needs are fulfilled then we will have a happier life. Deprived of these we suffer. You can see in this mirror of needs, why we struggle for justice, for human rights, for work, for equality, for better distribution of wealth and resources, for health care etc.

These are good for our nature and help us to grow to our full potential as human persons. These will bring greater harmony in our community.

What is valuable for our human nature?

LIFE: LOVE: FAMILY: FRIENDSHIP: KNOWLEDGE: HAPPINESS: WORK AND PEACE

## VALUES AND BEHAVIOUR

Let us now turn our attention to our behaviour in this environment in which we live.

THERE ARE TWO FOUNDATIONAL MORAL VALUES		
RESPECT	AND	RESPONSIBILITY
(INNER CHARACTER)		(TOWARDS OTHERS)
HONESTY		HELPLESSNESS
FAIRNESS		COMPASSION
TOLERANCE		CO –OPERATION
PRUDENCE		FORGIVENESS
SELF-DISCIPLINE		SEE THE GOOD IN OTHERS
HUMILITY		SOCIAL CONCERN

## RESPECT

This means recognizing another person as having value or worth. Respect for Life as having dignity and rights equal to our own. Respect is a basic value- respect for life -respect for self – respect for others – respect for the environment.

### RESPECT FOR SELF

- I am valuable as a person. If I am loved, I am valuable in that person’s eyes.
- This means treating our own life and person as valuable; taking good care of ourselves, of our physical health, our spiritual and emotional health.
- We need to keep a balance in our lives between time for sleep, work, rest, communication, recreation and exercise, food, education and prayer.
- We should not abuse our bodies with drugs, alcohol, smoking or overwork. Our life is precious and only we can take care of it with the help of doctors and others.

## RESPECT FOR OTHERS

Means to treat all human beings as having dignity and rights equal as our own. We should not hurt them, treat them badly, cheat them, rob them, abuse them or just use them for our own purposes and pleasure. We should do onto others what we would wish them to do unto us.

## RESPECT FOR THE ENVIRONMENT

Requires us to care for the natural environment which God has given us and on which we depend- the air, the rivers, the sea, the trees, flowers, plants and animals. Pollution has caused and is causing so much harm to our environment, affecting the weather and our health. There is so much waste of food, destruction of forests and other resources. If we abuse our environment we will suffer for it.

## RESPONSIBILITY

This means being dependable and trustworthy. We keep our promises or appointments.

It means commitment to my job, to do my best. We are ready to help as best we can, anyone in need. Living with others, we have a social responsibility to be fair and respect their rights. Laws limit our individual freedom for the good of the community.

## LAWS OF NATURE

There are laws written in our Nature and everyone accepts them but individuals out of ignorance or weakness or selfishness may chose not to obey. We are free to choose.

- to choose what is right or what is wrong.

We have definite standards by which we judge whether our action is good or bad. There is a natural moral law which, if we observe it, is good for our nature as we live together. We discover it by examining our nature in its fullness; not just our bodily nature but our nature as a spiritual being who can think and feel and love in a way that no animal can. The early tribe .discover how they can live together in peace. Do not kill, do not steal, do not tell lies. They discover without education what is good for their nature as persons living together.

Values have a permanence about them just as our human nature has permanence.

Human Nature basically does not change A value is something precious, of great worth; something for which one is ready to suffer, make sacrifices, even give up one’s life. Values give meaning to life.

Like the rails that keep a train on track, they provide direction, motive and purpose to our lives. They are non negotiable in our society:

Love	Justice
Respect	Freedom
Responsibility	Self-discipline
Honesty	Service
Truth	Cooperation
Peace	





These values have an enduring quality about them. They are true whether we like them or not, whether we follow them or not, because they are most suitable for our nature. We may disagree on certain practical issues but basically we can say that what is natural is good. It is good if it fits in with man's nature as a person and as a member of the human race; it is bad if it does not. We are free to choose and often through human weakness, selfishness or pride we deliberately ignore them with very serious consequences.

**RIGHT** – It is always right to love, to respect, to be honest, truthful, fair and just, to have compassion, to forgive

**WRONG** – It is always wrong to kill an innocent person; to injure him; to abuse him to steal, to be corrupt and to be selfish.

Our informed conscience, which grows through reflection on our experience is our guide.

We grow in our moral sense through reflection on our experiences, on the consequences of our choices or actions not just in the short term but also in the long term.

## RIGHTS AND DUTIES

From the study of our nature and the moral law we get our rights and duties. A right could be described as the receiving end of a duty. If I have a duty to honour my father, it follows that my father has a right to be honoured by me. If I have a duty to feed my children, my children have a right to be fed by me. When people try to describe the moral law in detail they do so either by giving a list of duties or a list of rights. In olden days it was usually a list of duties or commandments., like the 10 Commandments. - Honour Father and Mother, Do not kill, Do not tell lies, Do not steal ; Do not take your neighbour's wife or goods etc.

In modern days it is usually a list of rights like the United Nations Declaration of Human Rights of 1948. A list of duties, such as the 10 Commandments, and a list of Rights, such as the United Nations Declaration are saying the same thing from two different angles. The fifth Commandment says "Thou shalt not kill", which comes to the same thing as Article 3 of the Declaration of Human Rights "Everyone has a right to life". There must be a balance between personal rights and personal responsibilities to others as a member of a community.

## THE GOLDEN RULE

The Golden Rule is perhaps the most simple guide for all of us in our behaviour and the way we should treat others "DO UNTO OTHERS WHAT YOU WOULD WISH THEM TO DO TO YOU". It expresses love, unselfishness and generosity. When we are faced with a dilemma, we should consider "What is the most loving thing to do?" Love is what makes us valuable to others.

For specific cases our conscience guides us, with the help of reflection on experience and on the consequences and on the wisdom passed on to us. If we abuse nature, our own nature or the

nature of the environment we will suffer consequences. Reflection is very important for growth "There is no growth without reflection" or "An unreflected life is not worth living".

"To educate a person in mind and not in morals is to educate a menace to society"

(Theodore Roosevelt)

## SUMMARY

Let us return to the idea that life is living our relationships through my attitudes, values and behaviour.

### Relationship with God

– He is my Father, He loves me, has given me life, cares for me, given me many gifts, made me like Himself. I depend on Him, respect Him, ask His help, talk to Him, listen to Him, obey Him. He wants us to be happy. Religion is living out this relationship with God and with others.

### Relationship with Self

– As I grow in knowledge and experience , what is my Self-Image? And how do others see me? Do I recognize that I am given my nature to take care of it, respect my body, as a gift which I help to develop and grow, so that I can be of service to others.

### Relationship with Others

– I have a special relationship with my family, my children, relatives and friends, but I belong too to the human family each one of which I should treat as my brother or sister. This human family is all on the same journey through life from childhood to adulthood. We should treat one another with love and respect without discrimination. What is evil brings down the standard of our family. What is good lifts us up.

### Relationship with the Environment

– This created earth on which we live with all its wonders, beauty, - given to us to support and sustain us. If we abuse it, we will suffer diseases, famine, drought, pollution, global warming etc. Man's greed has spoiled the earth. But nature abused hits back.

## CONCLUSION

To conclude on a more practical note, what about Doctors' relationships with patients or clients. At a personal level, it means treating, not just a client's illness of body, but as a total person with emotions, fears, psychological and spiritual needs. Especially when a client's illness becomes very serious and medicine does not seem to work any more, we should still show them care and concern, and value the patient as a person. A patient's worst fears are feeling abandoned by the doctor.

Our motto to guide us is:

**"DO UNTO OTHERS WHAT WE WOULD WISH THEM TO DO UNTO YOU"**



Father Deignan presented with the Gerald Choa Memorial Lecture Medal from Professor KN Lai

*Rev. Alfred J. Deignan S.J. is a former Principal, teacher of Ethics and Supervisor of both Wah Yan Colleges. He was Warden of Ricci Hall 1970 – 1978.*

*He served as a foundation member of the Hong Kong Aids Foundation and is a member of the Executive and Management Committees of CMAC (The Catholic Marriage Advisory Council). Since 1997, he has been Chairman of the Council of the Hong Kong International Institute of Educational Leadership. He was awarded an honorary degree of Doctor of Social Science by the University of Hong Kong in 2003.*

Council News

## Newly Elected Fellows of the Royal College of Physicians, London

### FRCP (London) – Elected in 2009

Dr Chan Tak Hin

Dr Lo See Kit Raymond

Dr Mak Siu Ka

Dr Tse Hung Fat

Dr Yip Wai Kwok Gabriel

Dr Kwan Tze Hoi

Dr Lui Sing Leung

Dr Tse Wai Choi Eric

Dr Yeung Hon Ming Jonas

Dr Yue Chiu Sun Sunny

### Distinguished doctors, not Members of the College

Prof Lee Sum Ping

### Fellows or Members of other College of Physicians

Kun Wai Lin Emily

Please mark your diaries for our Annual Scientific Meeting on 10-11 October 2009 at the Hong Kong Academy of Medicine Jockey Club Building. The registration is FREE for Members and Trainees, and only \$100 for Fellows. Details will be mailed out later.

## Annual Scientific Meeting, Hong Kong College of Physicians (10-11 October 2009)

### “Infections in Internal Medicine”

#### 10 October 2009

1:00 – 2:00 pm	Lunch Symposium	
2:00 – 2:05 pm	<b>Opening Ceremony</b>	
2:05 – 3:20 pm	<b>Fungal infections in Medical Practice</b> Chairman: Prof Kwong Yok Lam Outbreak of Intestinal Mucormycosis in haematology patients	Dr Cheng Chi Chung Vincent
	Invasive fungal infections in immunocompromized patients	Dr Ho Pak Leung
	Strategies in the treatment of invasive fungal infections	Prof Kwong Yok Lam
3:20 – 3:50 pm	Coffee break	
3:50 – 5:05 pm	<b>Infection in Oncology Practice</b> Chairman: Prof Chan Tak Cheung Anthony Helicobacter pylori infection and gastroesophageal cancer	Dr Hung Fan Ngai Ivan
	Epstein Barr viral infection and oncogenesis	Dr To Ka Fai
	HPV infection and cervical cancer	Dr Tam Kar Fai
5:05 – 5:50 pm	<b>Gerald Choa Memorial Lecture</b>	Prof Lee Shiu Hung
6:00 – 6:30 pm	<b>Annual General Meeting</b>	
6:30 – 7:00 pm	<b>Cocktail</b>	
7:00 – 9:00 pm	<b>Fellowship Conferment Ceremony and Annual Dinner</b> <b>AJS McFadzean Oration</b>	The Honorable Prof Cheung Bing Leung

#### 11 October 2009

9:00 – 9:45 am	<b>Best Thesis Award</b>	
9:45 – 10:30 am	<b>Sir David Todd Lecture</b>	
10:30 – 10:45 am	Coffee break	
10:45 – 11:30 am	<b>Distinguished Research Paper Award for Young Investigators 2009</b>	
11:30 am – 12:00 noon	<b>Training for Physicians in the UK with particular focus on Infectious Disease</b>	Prof Sir Neil Douglas, PRCP(Edin)
12:00pm – 1:00 pm	<b>Emerging Infections</b> Chairman: Dr S.T. Lai Clostridium difficile associated colitis Multi-resistant Acinetobacter baumannii in hospital acquired pneumonia	Dr Wu Che Yuen Justin Dr Chan Hok Sum, Christopher

Specialty Update

# Palliative Care: Setting the scene for the future

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This article is based on the Position Paper of the Hong Kong College of Physicians (June 2008) submitted by the Subcommittee in Palliative Medicine

*"...Palliative care is relevant for most clinicians, not just palliative medicine specialists. The skills and knowledge required to give clinical palliative care during the final phases of a disease and to identify the point at which patients pass beyond remedy should be part of the training of all doctors.... How a society care for its dying is one indicator of its health...it is now time that the provision of clinical palliative care should be centrally supported with sufficient trained clinicians and adequate funding."*

*Professor Ian Gilmore, President of Royal College of Physicians  
"Palliative care services: meeting the needs of patients", November 2007<sup>1</sup>*

## Introduction

Death is inevitable for humans. While extending years of life is one of the triumphs of modern medicine, providing palliation and promoting comfort when cure is no longer possible are also the intrinsic goals of medicine since the times of Hippocrates. For patients whose lives are limited, there is a need to improve the quality of life in the remaining days. The uprise of palliative care is driven by these common and yet under addressed needs of the dying. Palliative care, as defined by World Health Organisation (WHO), is an approach that improves quality of life of patients and their families facing the problems associated with life-threatening disease, through the prevention and relief of suffering by means of early identification, impeccable assessment and the treatment of pain and other problems, physical, psychosocial and spiritual.<sup>2</sup> Palliative care affirms life and regards dying as a normal process; intends neither to hasten nor to postpone death; and adopts an interdisciplinary team approach to address the needs of patients and families.<sup>2</sup>

Palliative medicine (PM) is the branch of medicine involved in the treatment of patients with advanced, progressive, life-threatening diseases for whom the focus of care is maximising their quality of life through symptom control, providing psychological, social and spiritual support by a multi-professional team.<sup>3</sup> Palliative care is applicable early in the course of disease, in conjunction with other therapies that are intended to prolong life, and includes those investigations needed to better understand and manage distressing clinical complications.<sup>2</sup> As disease progresses, treatment of curative intent, disease modification, life prolongation treatment become less appropriate with respect to goals of care. (Fig.1) When death is imminent, end-of-life (EOL) care aims at maximising comfort. Bereavement care begins before patient's death and will be continued after death of patient.<sup>4</sup>

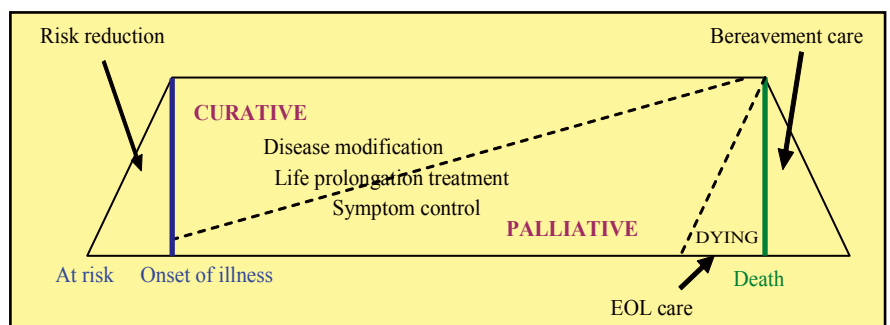
## Development of Palliative Medicine: Global Perspective

Global development of palliative medicine has been accelerated by its recognition as a subspecialty in UK in 1978 and later in various parts of the world; establishment of specialist palliative care service; evidence-based guidelines and audits to ensure standard and quality; and government policy recognising equitable EOL care as fundamental for all citizens.

Training in internal medicine has now been recognised as an essential component of the curriculum for specialist training in PM because (1) patients dying from cancer also have concomitant medical diseases, (2) palliative care for chronic progressive medical diseases is developing, and (3) symptom control techniques are not always transferable between non-cancer and cancer.<sup>5</sup> In UK, vast majority of PM specialists go through the route of MRCP (UK) before entry into specialist training. For the minority with other recognised qualifications, it is stipulated that 2-year training in internal medicine is mandatory, of which 6 months are involved in acute non selected intake of patients.<sup>6</sup>

A specialised palliative care team consists of PM specialists, palliative care nurse specialists, and a range of other expertise and those able to give spiritual and psychological support. The components of specialised palliative care service include<sup>4</sup>: (1) assessment, advice

Fig.1 Course of disease and health care needs (Adapted from WHO<sup>4</sup>)



and care for patients and families in all care settings; (2) specialist inpatient facilities for patients who benefit from the continuous care of specialist palliative care teams; (3) home support for patients with complex needs who wish to stay at home; (4) day care facilities that offer assessment, review of patients' needs, and enable the provision of interventions; (5) bereavement services for the families; (6) education and training; (7) audits and research.<sup>4</sup>

Projection of workforce is assisted by role delineation or job description of a PM specialist: (1) leading a interdisciplinary palliative care team, (2) clinical management of difficult and complex symptoms, (3) delivery of palliative care in various settings, (4) administration of the service, (5) conducting audit and research, (6) coordination work with other stakeholders in the palliative care service network, (7) teaching and education. As the role of teaching is important and yet time demanding, professional bodies have made it explicit in manpower projection.<sup>6,7</sup>

Because of the enormity of palliative care needs at different levels of intensity and complexity, and the relevance of palliative medicine to doctors in other specialties and general physicians, some countries have established pathways to training in PM at two levels. In UK, the Joint Royal Colleges of Physicians Training Board has established the specialist and the generic curriculum in PM.<sup>6</sup> The Royal College of Physicians recommends all doctors in other specialties to go through the generic curriculum for PM training to ensure a core competency in palliative care.<sup>1</sup>

The best time to inculcate palliative care in doctors is at the undergraduate level, but this is variably delivered in medical schools. In UK, a consensus syllabus is available for guidance of palliative medicine educators.<sup>8</sup> In Tzu Chi University in Taiwan, medical students learn their first lesson on death and dying in anatomy class. Dead bodies are donated by the bereaved families for dissection. Students get to know the corpse as a person and pay due respect to them.

Given the vulnerability of the dying patients, PM strives for evidence-based practices as in other branches of medicine. Evidence or studies in PM are accumulating steadily in the past decades.<sup>9,10</sup> Currently, there are eight peer-reviewed journals, peer review group in Cochrane collaboration, and systematic reviews in journals of high

quality and wide readership. Consensus papers among experts, evidence-based guidelines, policies on palliative care standards have been published in UK, Australia, US and other places.<sup>11-13</sup>

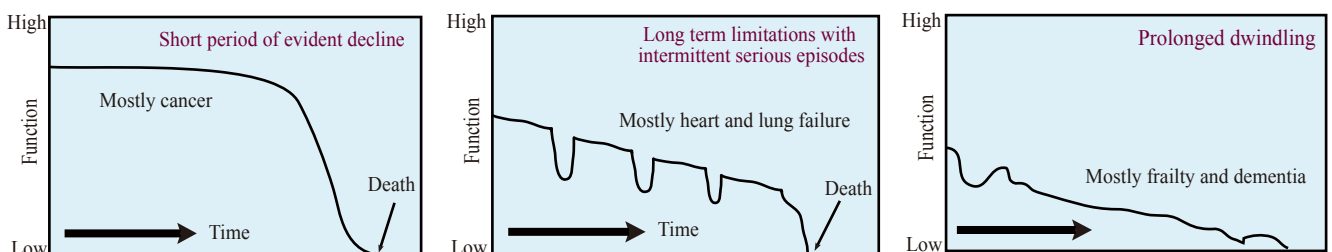
**Global health care challenges and the role of palliative care**

The world is ageing, and the growth in population is greatest in the group of age above 60 or even older. Multiple chronic diseases and their accumulating effect on bodily function, and vulnerability to risks of treatment contribute to the complexity of health condition in older people; yet these are often under addressed.<sup>14</sup> Palliative care for older people has emerged as a public health priority.<sup>14</sup> Health care expenditure for older people is most intense not when they are in healthy aging, but in their last year of life or not far from dying.<sup>15</sup>

The dying trajectory of patients has implications for health care planning, medical decision making and prognostication.<sup>16,17</sup> Advanced cancer patients tend to have a predictable dying trajectory. They remain quite functional till the last 6 months, when they begin to decline at a rate which accelerates rapidly 2 to 3 months before death. Palliative care is appropriate in the last months.<sup>16</sup> Patients who die from chronic organ failure tend to have exacerbations during the long term limitations. Predicting death is generally more difficult. Ongoing disease treatment, advance care planning and palliative care approach will help to optimise care.<sup>16</sup> Patients with marked fragility such as in recurrent stroke or dementia have a low functional capacity well before death and may linger for years. Substantial community support or institutionalised care is needed.<sup>16</sup> (Fig.2)

Evidence suggests that patients dying from non-cancer diseases also have palliative care needs or symptom burden no less than cancer, but equal access to palliative care for non-cancer is far from reality even in developed countries.<sup>18-20</sup> Multiple barriers have been identified, including major attitudinal, behavioral, educational, and institutional ones. Among them are the difficulty or reluctance of clinicians to identify the palliative phase, and the acceptability of palliative care among non-cancer patients.<sup>19,21</sup> Setting up referral guidelines for non-cancer patients based on more objective predictors of prognosis helps to identify patients for palliative care. In UK, the Prognostic Indicator Guidance was developed as part of the Gold Standards Framework Programme, a national initiative to

Fig. 2 Trajectories of chronic illness in elderly<sup>6</sup> (Lynn J, Adamson DM. *Living well at the End of Life: Adapting Health Care to Serious Chronic Illness in Old Age.* Reproduced with permission from RAND Corporation)



to improve care for patients during their last year of life in the community.<sup>22</sup> The Guidance includes predictors for cancer, major organ failures and chronic neuro-degenerative diseases.

### Palliative care in acute hospitals

Historically palliative care units were stand alone units, but now more integrated into acute care despite local hurdles to provide quality EOL care on-site.<sup>23</sup> Access to palliative care in acute setting can be improved by the following:<sup>23,24,25</sup>

(1) A palliative care unit in an acute hospital can facilitate palliative care as part of the comprehensive medical services and play an important educational role for other staff. Patients may benefit from better continuity of care, smooth transition and exchange of clinical information, and easy access to shared expertise, supporting facilities, equipment and administrative support.

(2) The consultative team is an option when there is no palliative care unit in place or when it is inappropriate to transfer a dying patient, but the actual implementation of palliative measures often depends on the parent team.

(3) Clinical pathways for care of the dying are introduced to improve EOL care irrespective of diagnosis and place of death. An example is the Liverpool Care for the Dying Pathway as promoted in UK, which incorporates comfort measures, anticipatory use of drugs, discontinuation of inappropriate interventions, psychosocial-spiritual care and family support.<sup>26</sup>

### Palliative care and dying in place of choice

Palliative care aims to facilitate patients to live and die in the place of choice, and this requires a system with input from PM specialists to ensure standard of care.<sup>15,27</sup> In UK, 50 to 70% of people receiving care for a serious illness say they would prefer home care at EOL, but the hospital or nursing home has become increasingly the actual place of death.<sup>28</sup> For patients who died in hospitals, it is possible that with some enhancement of home care services, more patients are able to die at home as preferred.<sup>29</sup> Home death may not be a universal preference, but it should be facilitated when requested.

## Palliative Medicine and Palliative Care: Hong Kong Scenario

Palliative care service was first set up in Hong Kong in 1982. NGOs played a major supportive role in the early years of development. Since 1994, palliative care was funded and coordinated by the government, under the auspices of Hospital Authority. A comprehensive range of palliative care services has been developed in the public hospitals, but is still not well established in the private sector.<sup>30,31</sup>

The Hong Kong Society of Palliative Medicine was founded in 1997. Palliative medicine was first recognised as a subspecialty by the Hong Kong College of Physicians in 1998 and then by the Hong Kong College of

Radiologists in 1999. Under the Hong Kong College of Physicians, specialist training in PM is coupled with specialist training in advanced internal medicine to ensure adequate training and competence in internal medicine.<sup>32</sup> The current curriculum of physicians' training recognises rotation of physician trainees to palliative care units, some of which are also recognised training centres for family medicine trainees. There is a modest but steady growth in number of PM specialists in the past years, but the volume still falls short of the needs envisaged.

Hong Kong is among the places where palliative care is assessed to be most developed globally.<sup>33</sup> Regular territory wide audit projects have been conducted in the HA palliative care units. A study on 494 cancer deaths was conducted in four HA hospitals, each with a physician specialist led palliative care unit attached.<sup>34</sup> Around 67% of the cancer deaths received palliative care. In the last 6 months, patients who ever received palliative care had less utilisation of acute and ICU services. At EOL, these patients also had fewer invasive interventions initiated, more symptoms documented, more analgesics prescribed, more DNR order in place and less CPR performed.

### Challenges for future development of palliative care in Hong Kong

Albeit what has been achieved in palliative care for cancer, we are facing gaps and challenges imposed by the current epidemiology and its future trend. Hong Kong is among the places with the longest life expectancy at birth. Beyond year 2033, 27% of Hong Kong population will be of age 65 and above, a significant rise from 11.7% in 2003.<sup>35</sup> There are around 38,000 deaths in Hong Kong per year. Cancer as the leading cause of death accounts for one-third of all deaths.<sup>36</sup> (Table 1) In the older persons with multiple chronic diseases, it may be difficult to identify with certainty a single disease as the major cause of death, diseases like dementia may remain undetected<sup>15</sup>, and hence the limitations of the mortality statistics in reflecting the change in disease epidemiology.<sup>37</sup>

Table 1: No. of registered deaths per 100,000 population in Hong Kong<sup>36</sup>

Cause of Death	2003	2004	2005	2006	2007
1. Malignant neoplasms	171.0	173.8	180.7	176.4	182.4
2. Diseases of heart	78.9	86.5	86.1	81.9	88.1
3. Pneumonia	57.6	54.2	63.0	61.3	68.6
4. Cerebrovascular diseases	51.4	50.4	50.4	48.2	50.2
All causes	541.1	550.2	567.8	545.6	577.0

Future challenges for Hong Kong exist at levels of strategic planning and health care policy, professional training in PM, and service remodelling to address unmet needs.

Palliative and EOL care is increasingly recognised as fundamental and necessary in developed countries; whereas regarding it as luxurious or optional will render the service extremely vulnerable. In 2004, the MSDC paper laid down the key directions for palliative care

development in Hong Kong (Table 2), but not all has been materialised. Appeal for new resources has not been successful during the economic downturn; and competition within existing health care resources is difficult as life saving services have their own natural appeal. Re-visiting of the strategies is needed.

Table 2. Recommendations on future palliative care service in MSDC Paper-P196, 2004

1. Each cluster should formulate a comprehensive palliative care service. Patients who are highly symptomatic or distressed should be referred for Specialist Palliative Care. Inpatient units should have designated ward area served by a specialist-led multidisciplinary team. Projection of palliative care bed requirement should also take into consideration the age factor and distribution of cancer deaths.
2. Those who are less symptomatic or distressed can remain under the care of the original clinical team. A cluster-based palliative care consultative program should ensure provision of palliative care to all patients in need, and facilitate smooth transition from curative to palliative treatment. The palliative care team should offer advice and training to staff involved in care of cancer and other terminally ill patients.
3. Career pathways should be established for trainees in palliative medicine, so as to attract new trainees, and ensure sustainability of specialist-led palliative care service.
4. Apart from the training to family medicine trainees, further training to private doctors in palliative care could be arranged in the form of open lectures to course organized in collaboration with other organizations such as professional societies or academic institutions. This could enhance participation of private doctors in palliative care.
5. Palliative care should be provided according to established standards and guidelines that are evidence based. Audits should be conducted to ensure adherence to guidelines and maintenance of standards.
6. In longer term, obstacles for dying at home would need to be rectified in order to smoothen the process of dying at home. Intensive multi-sectoral discussion and coordination will be required before such practice be accepted and realised as a norm.

At the level of professional development, the popularity, the general understanding and the transfer of knowledge in PM are limited by various factors. The existing pool of PM specialists poses limitations on training capacity. Exposure of doctors in the womb to PM is relatively limited, yet some elements or concepts, such as good communication skills, are of great relevance. Trainee rotation to palliative care units, which can facilitate cross cultivation, is variable or patchy. Training and serving as a PM specialist demands a fully committed doctor, and defining the career path for PM specialists in the public hospitals will attract younger doctors to join the service.

At the service level, remodelling is necessary to meet the needs of other non-cancer patients and the optimal mode of delivery of service. Designated palliative care beds have a distinct role in service, training and research, but community based care and extending coverage to patients in other settings by consultative team approach should be enhanced with additional resources to extend the coverage beyond walls. Provisions of home care beyond office hours, networking with NGOs and elderly homes are strategies for consideration.

Last but not least, a sustainable palliative care development should be supported by the commitment to upholding the quality and standard in PM. Besides audits, quality research and evidence-based guidelines, it is important to ensure the standard of PM specialist training by removing any factors that preclude the availability of on-site PM specialists who can dedicate time for supervision and training.

## Conclusions: The Position of the Hong Kong College of Physicians

The Hong Kong College of Physicians sees the need for a timely review of PM after 10 years of its establishment and to set the scene for the future. We recognise that medicine is not polarised to curative and palliative; nor to aggressive and conservative approaches. It is through interface, and not distinction, that palliative medicine and other relevant medical subspecialties can meet the complex needs of the changing population. Palliative care applies to both cancer and non-cancer diseases, and is not restricted to the dying phase. Palliative care for non-cancer patients should be promoted.

With an ageing population and prevalence of chronic progressive diseases, there is a growing need for palliative medicine specialists and palliative care services. Training in general and acute medicine is a necessary part of training of palliative medicine specialists in response to the needs. The curriculum for specialist training in medicine should take this into consideration, and should be reviewed as needed so that specialist training in palliative medicine can be kept abreast of times.

The philosophy, skills and knowledge in palliative medicine are not just relevant to a few specialists but also to undergraduates in medical school, basic physician trainees, higher physician trainees in acute internal medicine and specific subspecialties, such as medical oncology, renal medicine, respiratory medicine, neurology, geriatric medicine, cardiology, and critical care medicine.

The Hong Kong College of Physicians has its role as a prime mover in promotion of palliative medicine. While some of the goals can be achieved by coordination within the College, more has to be mediated through different platforms or stakeholders, including Hospital Authority, Hong Kong Academy of Medicine, University of Hong Kong and the Chinese University of Hong Kong.

The Position Paper on Palliative Care reviews and projects the role of palliative medicine, and proposes a framework for future planning.

Lastly, it requires a working group of relevant parties to deliberate on the specific strategies and actions in navigating the way to quality and equitable palliative care for those in need.

Table 3 : A proposed framework for future planning

1. Needs assessment
  - 1.1 Population
  - 1.2 Disease pattern
  - 1.3 Functional dependence
2. Professional training
  - 2.1 Palliative medicine specialists
    - Curriculum
    - Career pathway
    - Projected workforce
  - 2.2 Undergraduate training of medical doctors
    - Curriculum
    - Assessment
  - 2.3 Palliative medicine in basic and higher physician training
    - Rotation of trainees
    - Joint education programmes
    - Palliative care module in other subspecialty training
3. Service planning
  - 3.1 Influence on policy and strategic planning
  - 3.2 Advice on models of care and resource implications
  - 3.3 Set up referral criteria for non-cancer patients
  - 3.4 Interfacing with acute care
  - 3.5 Collaborative model with other subspecialties
4. Quality and standard
  - 4.1 Outcome measures or parameters
  - 4.2 Evidence-based guidelines



The full Position Paper on Palliative Care: Setting the scene for the future is available from <http://www.hkcp.org/docs/News/Position%20paper%20in%20Palliative%20Medicine.pdf>

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# PACES

## Modification of Station 5 — The Brief Clinical Consultation

The new model of Station 5 will be **effective October 2009** and will introduce skills based marking. The candidate sees **two** patients each over **10 minutes**. Within the available time the candidate is asked to act on a brief patient referral note, and undertake a **focused history and targeted examination** pertinent to the presenting problem. For the first time in PACES, candidates will be asked to integrate history and examination in a clinical encounter.

Eight minutes are available for the candidate to assess the patient and two minutes for discussion with the examiner. Although the four disciplines currently represented at Station 5 will not now always be represented, any of the four can still be included at the Station.

A seminar on The New Format Station 5 in PACES will be held at 2.30pm to 4.00pm on September 12, 2009 (Saturday) to brief potential candidates, basic physician program directors and trainers. The venue will be Lecture Hall, G/F, Centre for Health Protection Building (CHP) (opposite HA Head Office). The briefing will include a real-life mock examination demonstration and a video show on the running of the examination. The new marking scheme will be explained. Please contact Ms Winnie Lau, Secretary for Training Sub-committee, HA Head Office, on tel 2300 6764, for free registration.

### The New Structure and Content of Station 5

	Current Station 5	New Station 5
Total Station Duration	20 Minutes	20 Minutes
Number of Patient Encounters	4, Each of 5 Minutes	2, Each of 10 Minutes
Focus of Assessment	Examination and Diagnosis	Focused History, Relevant Examination, Problem Solving and Communication
System Content	Limited to Dermatology, Endocrinology, Rheumatology and Ophthalmology	Any System
Time With Patient	Variable	8 Minutes Per Encounter
Time With Examiner	Variable	2 Minutes Per Encounter

### The New Marking System

Candidates are now marked explicitly on between four and seven separate clinical skills at each encounter, as described below:

	Clinical Skill	Skill Descriptor
A	Physical Examination	Demonstrate correct, thorough, systematic (or focused in Station 5 encounters), appropriate, fluent and professional technique of physical examination
B	Identifying the Physical Signs	Identify physical signs correctly and not find physical signs that are not present
C	Clinical Communication	Elicit a clinical history relevant to the patient's complaint in a systematic, thorough (or focused in Station 5 encounters), fluent and professional manner. Explain relevant clinical information in an accurate, clear, structured, comprehensive, fluent and professional manner
D	Differential Diagnosis	Create a sensible differential diagnosis for a patient that the candidate has personally clinically assessed
E	Clinical Judgement	Select or negotiate a sensible and appropriate management plan for a patient, relative or clinical situation. Select appropriate investigations or treatments for a patient that the candidate has personally clinically assessed. Apply clinical knowledge, including knowledge of law and ethics, to the case
F	Managing Patients' Concerns	Seek, detect, acknowledge and address patients' or relatives' concerns. Listen to a patient or relative, confirm their understanding of the matter under discussion and demonstrate empathy
G	Maintaining Patient Welfare	Treat a patient or relative respectfully and sensitively and in a manner that ensures their comfort, safety and dignity

# PACES

Different numbers and combinations of the skills are assessed at each encounter, as per the table below:

Station	Encounter	Skills Assessed
1	Respiratory	A:B:D:E:G
1	Abdomen	A:B:D:E:G
2	History	C:D:E:F:G
3	Cardiovascular	A:B:D:E:G
3	Nervous System	A:B:D:E:G
4	Communication	C:E:F:G
5	New Station 5 (1)	All seven
5	New Station 5 (2)	All seven

More details on the format and marking scheme are available at the website below.

<http://www.mrcpuk.org/PACES/Pages/PACESChanges.aspx>

## Examination Dates

### Joint HKCPIE/MRCP(UK) Part I examination

19 January 2010

21 September 2010

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

7 & 8 April 2010

28 & 29 July 2010

24 & 25 November 2010

### Joint HKCPIE/MRCP(UK) PACES 2010

1 – 5 March 2010

18 – 22 October 2010

## Examination Results

### Pass rate for the Joint HKCPIE/MRCP(UK) Part I examination for the years 2002-2009

	Sitting	Pass
Sep 02	100	33 (33%)
Jan 03	124	55 (44%)
May 03 (SARS Special)	21	7 (33%)
Sep 03	54	29 (54%)
Jan 04	93	39 (42%)
Sep 04	29	16 (55%)
Jan 05	96	68 (70.8%)
Sep 05	24	15 (62.5%)
Jan 06	95	74 (80%)
Sept 06	21	13 (62%)
Jan 07	87	67 (77%)
Sep 07	23	12 (52%)
Jan 08	56	38 (68%)
Sep 08	47	32 (68%)
Jan 09	59	47 (80%)

### Pass rates of the Joint HKCPIE/MRCP(UK) Part II (Written) examination

	Sitting	Pass
2 Jul 02	53	27 (51%)
13 Nov 02	50	24 (48%)
13 Aug 03	110	62 (56%)
10 Dec 03	54	31 (57%)
28 Jul 04	65	42 (65%)
8 Dec 04	46	32 (70%)
13 Apr 05	32	15 (47%)
27 Jul 05	76	56 (74%)
7 & 8 Dec 05	26	16 (62%)
12 & 13 Apr 06	29	13 (45%)
26 & 27 Jul 06	91	68 (75%)
6 & 7 Dec 06	33	18 (55%)
11 & 12 Apr 07	34	22 (65%)
25 & 26 Jul 07	80	70 (88%)
5 & 6 Dec 07	19	13 (68%)
9 & 10 Apr 08	21	13 (62%)
30 & 31 July 08	47	36 (77%)
3 & 4 December 08	17	10 (59%)

### Pass rate for PACES examinations

October 2001	36/72 = 50%
February 2002	34/74 = 46%
October 2002	29/72 = 40%
February 2003	30/69 = 43%
October 2003	27/59 = 46%
March 2004	39/64 = 61%
October 2004	26/69 = 38%
March 2005	35/75 = 47%
October 2005	28/75 = 37%
March 2006	36/75 = 48%
October 2006	16/73 = 22%
March 2007	44/74 = 59%
June 2007	44/74 = 59%
October 2007	36/55 = 65%
March 2008	36/74 = 49%
October 2008	29/65 = 45%
February 2009	39/75 = 52%

### Pass list for the February PACES 2009

AU Shek Yin	CHAN Chee Yun Amanda	CHAN Kar Li Kelly
CHAN Man Yan Grace	CHAN Sau Yan Thomas	CHAU Chuen Tak
CHAU Suet Ming	CHEUNG Kit Ting Kitty	CHIU Pui Hing
CHOW Chi Wing	CHOW Hoi Fan Danny	FONG Man Kei
HO Man Ying	IP Kam Yuen	JAO Ho Ying
KAM Ka Ho Kevin	LAM Kwok Wai	LAM Yuk Fai
LAU Pui Kei Patrick	LAU Yat Ming	LEE Chi Ho
LI Ernest Han Fai	MAK Wing San	MAN Yu Hon
MOK Ming Yee	NG Wai Yin	SINGH Gill Harinder
TING Zhao Wei	TONG Chun Wai	TSUI Sui Na
WONG Sin Yue	WONG Sze Yiu	WONG Tin Wai
WONG Yam Hong	WONG Yiu Tung	YAU Wai Shan
YEUNG Kwok Kit Lawrence	YUEN Ka Lai	YUNG See Yue Arthur

# Change of Training Programme

**Loretta Yam** Chairman, Education and Accreditation Committee

## Scenario

Doctor A has undergone concurrent training in specialty I and specialty II. Doctor A passed the Exit Assessment in specialty I without writing a dissertation in June 2007. In January 2008, doctor A decided to withdraw from training in specialty II. Doctor A then applied to Specialty Board I to be assessed in dissertation in Specialty I so that he could be eligible to apply for College Fellowship.

## Council's decision

In accordance with the *Guidelines on Postgraduate Training in Internal Medicine, Fourth Edition, July 2007*, page 32 "In the context of concurrent training, a trainee may apply to undergo Exit Assessment in one of the two specialties after not less than three years of Higher Physician Training, provided the full period of 24 months (or 36 months as required by the Specialty of Dermatology & Venereology) of core training has been completed in that specialty. Exit Assessment for the second specialty may be undertaken at the end of the fourth (or fifth) year of training, again with the provision that the required period of core training has been completed". **At its 209<sup>th</sup> Meeting of 26 February 2009, the Council reiterated that trainees who opt to change the dual training programme to single specialty training must complete 36 months of training in the single specialty.**

In addition, in accordance with the *Guidelines on Postgraduate Training in Internal Medicine, Fourth Edition, July 2007*, page 142, "Candidates whose training will be completed the following 31 March are eligible to sit the Exit Assessment in November-December of the previous year (regardless of whether or not the Exit Assessment has been put further forwards for administrative reasons), and those whose training will be completed on 30 September are eligible to sit the Exit Assessment in May-June of the same year (regardless of whether or not the Exit Assessment has been put further forwards for administrative reason)". **As a result, candidates who are undergoing single specialty training can only take the Exit Assessment after they have completed at least 33 month's training in that specialty, leaving at most 3 months of training to be completed after he/she passes the Exit Assessment.**

As a result, doctor A has to take the full Exit Assessment in specialty I because of changing of training programme from dual training to single specialty training. Doctor A must also have completed 33 months training in specialty I before he can take the Exit Assessment in the specialty.

**The College does not encourage changes in training programmes during Higher Physician Training. Doctor A should get approval from Specialty Boards I and II should he wish to withdraw from training in specialty II.** All Specialty Boards should report to the Education and Accreditation Committee should they have trainees who plan to change from dual training to single specialty training. The Committee will discuss every application on a case-by-case basis and, obtain endorsement from the College Council before advising the Boards accordingly. The above decision will take effect from the May/June 09 Exit Assessment exercises onwards.

# Training in Obstetric Service

**Loretta Yam** Chairman, Education and Accreditation Committee

At the February Council Meeting, the Council discussed the merits of exposure to obstetric service as a training component in physician training. After due deliberation, the Council decided that all Basic Physician Training (BPT) and Higher Physician Training (HPT) trainees should be rotated to general medical units of hospitals with obstetric service for at least three months within their six years' physician training (three years of BPT and three years of HPT). This will be applicable to BPT trainees who start their BPT on 1 July 2009 onwards.

There is no need for accreditation duration for individual departments and hospitals to be altered, but trainees will be checked by the College Secretariat when they apply for College membership before they apply for HPT training. They will also be checked by their Programme Directors and relevant Boards on evidence of rotation to designated acute hospitals at the time of application for the Annual and Exit Assessment exercises during HPT.

In view of the outpatient-oriented training structure for Dermatology and Venereology, trainees who are undergoing single specialty trainees in that specialty must have already rotated to hospitals with obstetric service during BPT.

# Statistics on No. of Trainees in all Specialties

Updated in June 2009

		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		YEAR		YEAR		YEAR		YEAR		YEAR	
CARDIOLOGY	35	1—I 2—II 3—I 4	4	1—I 2 3—I 4—I	3	2 2 3 4	0	1 2 3 4	0	1 2 3 4	0	1 2—IV 3 4	4	1 2 3 4	0
CLINICAL PHARMACOLOGY & THERAPEUTICS	2	1 2 3 4	0	1 2 3 4	0	1 2 3 4	0	1 2 3 4	0	1 2 3 4	0	1 2 3 4	0	1 2 3 4	0
CRITICAL CARE MEDICINE	15	1 2—I 3 4	1	1 2 3 4	0	1 2 3 4	0	1 2 3 4	0	1 2 3 4	0	1 2—II 3 4—I	3	1 2 3 4	0
DERMATOLOGY & VENEREOLOGY	6	1 2 3 4	0	1 2 3 4	0	1 2 3 4	0	1 2 3 4	0	1 2 3 4	0	1—I 2 3 4	1	1 2 3 4	0
ENDOCRINOLOGY, DIABETES & METABOLISM	16	1—I 2 3 4	1	1 2 3 4	0	1 2 3 4	0	1 2 3 4	0	1 2 3 4	0	1—I 2 3 4	1	1 2 3 4	0
GASTROENTEROLOGY & HEPATOLOGY	29	1—II 2—II 3 4	4	1 2—I 3 4	1	1 2 3 4	0	1 2 3 4	0	1 2 3 4	0	1 2—I 3—II 4	3	1 2 3 4	0
GERIATRIC MEDICINE	11	1—I 2 3 4	1	1 2 3 4	0	1 2 3 4	0	1 2 3 4	0	1 2 3 4	0	1—I 2—I 3 4	2	1 2 3 4	0
HAEM/HAEM ONCOLOGY	10	1—I 2—I 3 4	2	1 2 3 4	0	1 2 3 4	0	1 2 3 4	0	1 2 3 4	0	1 2—I 3 4	1	1 2 3 4	0
IMMUNOLOGY & ALLERGY	0	1 2 3 4	0	1 2 3 4	0	1 2 3 4	0	1 2 3 4	0	1 2 3 4	0	1 2 3 4	0	1 2 3 4	0
INFECTIOUS DISEASE	10	1 2 3—I 4	1	1 2 3—I 4	1	1 2 3 4	0	1 2 3 4	0	1 2 3 4	0	1 2—I 3 4	1	1 2 3 4	0
INTERNAL MEDICINE	237	1—IX 2—VII 3—III 4—II	21	1—II 2—II 3—II 4	6	1 2 3—I 4	10	1 2 3 4	1	1 2—I 3—I 4	2	1—XIII 2—X 3—IV 4—VI	33	1 2 3 4	0
MEDICAL ONCOLOGY	7	1 2—I 3 4	1	1 2 3 4	0	1 2 3 4	0	1 2 3 4	0	1 2 3 4	0	1 2—I 3 4	2	1 2 3 4	0
NEPHROLOGY	14	1 2 3 4—I	1	1 2 3 4	0	1 2 3 4	0	1 2 3 4	0	1 2—I 3 4	1	1—I 2 3 4	1	1 2 3 4	0
NEUROLOGY	20	1—I 2 3 4	1	1—I 2—I 3 4	2	1 2 3—I 4	1	1 2 3 4	0	1 2 3 4	0	1 2—I 3—II 4—I	4	1 2 3 4	0
PALLIATIVE MEDICINE	6	1 2 3 4	0	1 2 3 4	0	1 2 3 4	0	1 2 3 4	0	1 2 3—I 4	1	1—I 2 3 4	1	1 2 3 4	0
REHABILITATION	3	1 2 3 4	0	1 2 3 4	0	1 2 3 4	0	1 2 3 4	0	1 2 3 4	0	1—II 2 3 4	2	1 2 3 4	0
RESPIRATORY MEDICINE	20	1 2 3—I 4—I	2	1 2 3 4—I	1	1 2 3 4	0	1 2 3 4	0	1 2 3 4	0	1 2—I 3 4	1	1 2 3 4	0
RHEUMATOLOGY	18	1—II 2 3 4	2	1 2 3 4	0	1 2 3 4	1	1 2 3 4	0	1 2 3 4	0	1—II 2—I 3 4	3	1 2 3 4	0

SPECIALTY		TRAINEES																					
		KOWLOON CENTRAL CLUSTR		KOWLOON EAST CLUSTER			KOWLOON WEST CLUSTER																
		KH	QEH	HOHH	TKOH	UCH	CMC	KWH	OLMH	PMH	WTSH	YCH											
TRAINEES TOTAL (PP/DH/HA/OTHERS)		YEAR		YEAR			YEAR																
CARDIOLOGY	35	1 2 3 4	0 1 1 0	1-I 2-I 3-III	5 2 3 8	1 2 3 0	0 2 3 2	1 0 3 2	0 2 3 4	1 2 3 2	0 1 3 4	1 2 3 1	0 2 3 6	1 2 3 4	0 1 3 4	1 2 3 0	0 2 3 3						
CLINICAL PHARMACOLOGY & THERAPEUTICS	2	1 2 3 4	0 1 3 0	0 2 3 0	0 4 3 0	1 0 3 0	0 2 3 4	1 0 3 0	0 2 3 4	1 0 3 0	0 2 3 4	1 0 3 0	0 2 3 4	1 0 3 0	0 2 3 4	1 0 3 0	0 2 3 0						
CRITICAL CARE MEDICINE	15	1 2 3 4	0 1 3 0	1 2 3 5	0 4 3 0	1 0 3 0	0 2 3 4	1-I 2 3-I	2 2 3	1 2 3 4	0 1 3 0	1 2 3 0	3 2 3 4	1 2 3 0	0 1 3 4	1 2 3 0	0 2 3 4						
DERMATOLOGY & VENEREOLOGY	6	1 2 3 4	0 1 3 0	1 2 3 0	0 4 3 0	1 0 3 0	0 2 3 4	1 0 3 0	0 2 3 4	1 0 3 0	0 2 3 4	1 0 3 0	0 2 3 4	1 0 3 0	0 2 3 4	1 0 3 0	0 2 3 0						
ENDOCRINOLOGY, DIABETES & METABOLISM	16	1 2 3 4	0 1 3 0	1-I 2-I 3	2 2 3 4	1 0 3 0	0 2 3 4	1-I 2 3	1 2 3 4	0 1 3 0	0 2 3 4	1 2 3 0	1 2 3 4	0 1 3 0	0 2 3 4	1 2 3 0	0 2 3 2						
GASTROENTEROLOGY & HEPATOLOGY	29	1 2 3 4	0 1 3 0	1 2-II 3-I	3 3 5	1 0 3 0	0 2 3 4	1 2-I 3 4	1 2 3 3	1 2 3 4	1 2 3 4	1 2 3 0	1 2 3 4	1 2 3 0	0 1 3 4	1 2 3 0	1 2-I 3 5						
GERIATRIC MEDICINE	11	1 2 3 4	0 1 3 4	1 2-I 3 2	1 2 3 4	1 0 3 1	0 2 3 4	1 2 3-II 8	2 2 3 4	1 2 3 0	0 1 3 6	1 2 3 0	1 2 3 4	1 2 3-I 10	1 2 3 3	1 2 3 4	0 2 3 5						
HAEM/HAEM ONCOLOGY	10	1 2 3 4	0 1 3 0	1-II 2-I 3	3 2 4	1 0 3 0	0 2 3 4	1 2-I 3 1	1 2 3 4	0 1 3 0	0 2 3 4	1 2 3 0	1 2 3 4	1 2 3 0	0 1 3 2	1 2 3 0	0 2 3 4						
IMMUNOLOGY & ALLERGY	0	1 2 3 4	0 1 3 0	1 2 3 0	0 4 3 0	1 0 3 0	0 2 3 4	1 2 3 0	0 2 3 4	1 0 3 0	0 2 3 4	1 0 3 0	0 2 3 4	1 0 3 0	0 2 3 4	1 0 3 0	0 2 3 0						
INFECTIOUS DISEASE	10	1 2 3 4	0 1 3 0	1-II 2 3	2 2 4	1 0 3 0	0 2 3 4	1 2 3 1	0 2 3 4	1 2 3 0	0 1 3 4	1 2 3 0	1 2 3 4	1-I 2-I 3	2 2 3	1 2 3 0	0 2 3 4						
INTERNAL MEDICINE	237	1 2 3 4	0 1 4 4	1-VIII 2-IX 3-V 4-VIII	30 3 48	1 2-I 3 4	1 5 4 13	1-III 2-II 3-II 4-III	7 13 13 35	1-I 2-IV 3-V 4-III	13 13 35 35	1-IV 2-II 3-II 4-I	10 22 22 22	1-IV 2-II 3-V 4-V	16 28 28 28	1-II 2-I 3-I 4-I	5 4 4 4	1-IV 2-VIII 3-I 4-III	16 45 45 45	1 2 3-I 4	1 2 3 4	1-I 2-II 3-I 4-I	5 20 20 20
MEDICAL ONCOLOGY	7	1 2 3 4	0 1 3 0	1 2 3 1	0 4 3 4	1 0 3 0	0 2 3 4	1 2 3 0	0 2 3 4	1 0 3 0	0 2 3 4	1 0 3 0	0 2 3 4	1 0 3 0	0 2 3 1	1 0 3 0	0 2 3 4						
NEPHROLOGY	14	1 2 3 4	0 1 3 0	1 2-I 3 7	1 2 3 4	1 0 3 0	0 2 3 4	1 2 3 1	1 2 3 4	0 1 3 0	0 2 3 4	1 0 3 0	0 2 3 4	1 0 3 0	0 2 3 7	1 0 3 0	0 2 3 4						
NEUROLOGY	20	1 2 3 4	0 1 3 0	1-I 2 3-II	3 5 4	1 0 3 1	0 2 3 4	1 2 3-II 3	2 2 3 3	1 2 3 0	1 2 3 4	0 1 3 0	0 2 3 4	1 0 3 0	0 2 3 4	1 0 3 0	0 2 3-I 4						
PALLIATIVE MEDICINE	6	1 2 3 4	0 1 3 0	1 2 3 0	0 4 3 4	1 0 3 0	0 2 3 4	1 2-I 3 1	1 2 3 4	1 0 3 0	0 2 3 4	1 0 3 0	0 2 3 4	1 0 3 0	0 2 3 4	1 0 3 0	0 2 3 4						
REHABILITATION	3	1 2 3 4	0 1 3 7	1 2 3 0	0 4 3 4	1 0 3 0	0 2 3 4	1 2 3 0	0 2 3 4	1 0 3 0	0 2 3 4	1 0 3 0	0 2 3 4	1 0 3 0	0 2 3 4	1 0 3 4	0 2 3 4						
RESPIRATORY MEDICINE	20	1 2 3 4	0 1 3 6	1 2-I 3	1 7 4	1 0 3 5	0 2 3 4	1-I 2-I 3	2 2 3 1	1 2 3 0	1 2 3 4	1 0 3 0	1 2 3 4	1-I 2 3 0	1 2 3 4	1 0 3 4	0 2-I 3 4						
RHEUMATOLOGY	18	1 2 3 4	0 1 3 1	1 2-I 3	1 2 4	1 0 3 0	0 2 3 4	1 2 3-I 0	1 2 3-I 2	1 2 3 4	1 0 3 2	0 2 3 1	1 2 3 4	1 0 3 1	1 2 3 4	0 2 3 4	1-I 2 3 4						

		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	35	1 2-I 3 4	1 2 3 4	1 2-II 3 4-I	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4
CLINICAL PHARMACOLOGY & THERAPEUTICS	2	1 2 3 4	0	1 2 3 4	0	1 2-II 3 4	2	1 2 3 4	0	1 2 3 4	0	1 2 3 4	0	1 2 3 4
CRITICAL CARE MEDICINE	15	1 2 3 4	0	1 2 3-I 4	1	1 2 3 4	1	1 2 3 4	0	1 2 3 4	0	1 2 3 4	0	1 2-I 3-II 4
DERMATOLOGY & VENEREOLOGY	6	1 2 3 4	0	1 2 3 4	0	1 2-I 3 4	1	1 2 3 4	0	1 2 3 4	0	1 2 3 4	0	1 2 3 4
ENDOCRINOLOGY, DIABETES & METABOLISM	16	1 2 3 4	0	1 2-I 3-I 4	2	1 2 3 4	0	1 2 3 4	0	1 2 3 4	0	1 2 3 4	0	1-I 2-II 3-I 4
GASTROENTEROLOGY & HEPATOLOGY	29	1 2 3 4	0	1 2-I 3-I 4	2	1 2-I 3 4	2	1 2 3 4	0	1 2 3 4	0	1 2 3 4	1	1-III 2 3-I 4
GERIATRIC MEDICINE	11	1 2 3 4	0	1 2 3 4	0	1 2 3 4	0	1 2 3 4	0	1-I 2 3 4	1	1 2 3 4	1	1 2 3 4
HAEM/HAEM ONCOLOGY	10	1 2 3 4	0	1 2 3 4	0	1 2 3 4	0	1 2 3 4	0	1 2 3 4	0	1 2 3 4	0	1 2-I 3 4-I
IMMUNOLOGY & ALLERGY	0	1 2 3 4	0	1 2 3 4	0	1 2 3 4	0	1 2 3 4	0	1 2 3 4	0	1 2 3 4	0	1 2 3 4
INFECTIOUS DISEASE	10	1 2 3-I 4	1	1 2-I 3 4	1	1 2 3-I 4	1	1 2 3 4	0	1 2 3 4	0	1 2 3 4	0	1 2 3 4
INTERNAL MEDICINE	237	1-III 2-I 3-I 4	5	1 2-VI 3-III 4-III	12	1-IV 2-IV 3-III 4-VII	18	1 2-I 3 4-I	2	1-I 2-I 3 4	2	1 2 3 4	4	1-VI 2-VII 3-XIII 4-II
MEDICAL ONCOLOGY	7	1 2 3 4	0	1 2 3 4	0	1 2-I 3-I 4-I	3	1 2 3 4	0	1 2 3 4	0	1 2 3 4	0	1 2 3 4
NEPHROLOGY	14	1-III 2 3 4	3	1 2 3 4	0	1 2 3 4	2	1 2 3 4	0	1 2 3 4	0	1 2 3 4	0	1 2 3-II 4
NEUROLOGY	20	1 2 3 4	0	1 2 3 4	0	1 2-I 3 4	1	1 2 3 4	0	1 2 3 4	0	1 2 3 4	0	1-I 2-I 3-I 4
PALLIATIVE MEDICINE	6	1 2 3 4	0	1 2 3 4	0	1 2 3 4	0	1 2 3 4	0	1 2-I 3 4	1	1 2 3 4	0	1 2 3 4
REHABILITATION	3	1 2 3 4	0	1 2 3 4	0	1 2 3 4	0	1 2 3 4	0	1 2 3 4	1	1 2 3 4	1	1-I 2 3 4
RESPIRATORY MEDICINE	20	1 2 3 4	0	1 2-I 3 4	1	1 2 3-I 4-I	2	1 2 3 4	0	1 2 3 4	1	1 2 3 4	0	1 2-I 3-I 4
RHEUMATOLOGY	18	1 2 3 4	0	1 2 3 4	0	1-I 2 3-I 4	2	1 2 3 4	0	1 2 3 4	1	1 2 3 4	0	1 2 3-II 4

\* 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	5	1 2—I 3—IV 4	5  12
IMMUNOLOGY & ALLERGY	0	1 2 3 4	0  2
RESPIRATORY MEDICINE	20	1 2 3—I 4	1  8

\* 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 June 2009

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	185	6	3	0	9	0	6	10	0	16	25
CLINICAL PHARMACOLOGY & THERAPEUTICS	6	0	0	0	0	0	0	1	0	1	1
CRITICAL CARE MEDICINE	65	10	0	0	10	0	0	8	0	8	18
DERMATOLOGY & VENEREOLOGY	82	0	0	0	0	0	0	1	0	1	1
ENDOCRINOLOGY, DIABETES & METABOLISM	79	4	2	3	9	0	0	8	0	8	17
GASTROENTEROLOGY & HEPATOLOGY	127	7	1	0	8	0	0	10	1	11	19
GERIATRIC MEDICINE	160	7	12	4	23	3	0	4	1	8	31
HAEM/HAEM ONCOLOGY	45	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	28	2	0	0	2	0	0	3	0	3	5
INTERNAL MEDICINE	960	49	23	10	82	1	11	72	8	92	174
MEDICAL ONCOLOGY	35	0	0	0	0	0	0	8	0	8	8
NEPHROLOGY	105	6	0	0	6	0	0	8	2	10	16
NEUROLOGY	76	5	2	0	7	0	0	6	1	7	14
PALLIATIVE MEDICINE	15	0	2	0	2	0	2	0	0	2	4
REHABILITATION	45	0	3	5	8	1	0	1	4	6	14
RESPIRATORY MEDICINE	154	8	8	1	17	0	9	11	0	20	37
RHEUMATOLOGY	50	2	2	1	5	0	0	3	1	4	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	185	0	11	11	0	3	6	9	1	5	1	9	0	3	19	39
CLINICAL PHARMACOLOGY & THERAPEUTICS	6	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
CRITICAL CARE MEDICINE	65	0	6	6	0	2	7	9	5	5	0	4	0	0	14	29
DERMATOLOGY & VENEREOLOGY	82	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
ENDOCRINOLOGY, DIABETES & METABOLISM	79	0	6	6	0	3	4	7	2	3	2	6	0	2	15	28
GASTROENTEROLOGY & HEPATOLOGY	127	0	8	8	0	4	5	9	5	3	1	8	0	6	23	40
GERIATRIC MEDICINE	160	7	4	11	7	1	12	20	7	10	2	14	4	6	43	74
HAEM/HAEM ONCOLOGY	45	0	4	4	0	1	2	3	0	0	0	4	0	0	4	11
IMMUNOLOGY & ALLERGY	6	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
INFECTIOUS DISEASE	28	0	3	3	0	0	1	1	0	1	0	4	0	1	6	10
INTERNAL MEDICINE	960	6	61	67	9	20	46	75	30	37	8	59	3	23	160	302
MEDICAL ONCOLOGY	35	0	2	2	0	0	0	0	0	0	0	1	0	0	1	3
NEPHROLOGY	105	0	9	9	2	2	5	9	2	6	1	8	0	2	19	37
NEUROLOGY	76	0	5	5	0	2	4	6	1	5	1	2	1	0	10	21
PALLIATIVE MEDICINE	15	0	0	0	4	0	1	5	3	0	1	0	0	0	4	9
REHABILITATION	45	9	0	9	2	0	3	5	1	1	0	2	4	0	8	22
RESPIRATORY MEDICINE	154	6	8	14	6	3	5	14	7	7	0	4	5	2	25	53
RHEUMATOLOGY	50	2	4	6	0	0	3	3	1	2	1	1	0	1	6	15

		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	185	4	5	10	0	0	19	1	7	8	27	
CLINICAL PHARMACOLOGY & THERAPEUTICS	6	0	0	4	0	0	4	0	0	0	4	
CRITICAL CARE MEDICINE	65	3	4	1	0	0	8	0	2	2	10	
DERMATOLOGY & VENEREOLOGY	82	0	0	1	0	0	1	0	0	0	1	
ENDOCRINOLOGY, DIABETES & METABOLISM	79	2	2	13	0	0	17	0	3	3	20	
GASTROENTEROLOGY & HEPATOLOGY	127	2	4	9	0	0	15	1	7	8	23	
GERIATRIC MEDICINE	160	1	1	6	6	3	17	1	11	12	29	
HAEM/HAEM ONCOLOGY	45	0	0	4	0	0	4	0	5	5	9	
IMMUNOLOGY & ALLERGY	6	0	0	0	0	0	0	0	0	0	0	
INFECTIOUS DISEASE	28	1	0	2	0	0	3	0	5	5	8	
INTERNAL MEDICINE	960	20	18	58	7	7	110	5	58	63	173	
MEDICAL ONCOLOGY	35	0	0	14	0	0	14	0	0	0	14	
NEPHROLOGY	105	3	1	6	0	0	10	1	6	7	17	
NEUROLOGY	76	2	2	6	2	0	12	0	4	4	16	
PALLIATIVE MEDICINE	15	0	0	0	1	0	1	0	0	0	1	
REHABILITATION	45	0	1	2	1	1	5	1	3	4	9	
RESPIRATORY MEDICINE	154	3	6	7	1	1	18	1	7	8	26	
RHEUMATOLOGY	50	3	0	3	0	3	9	0	2	2	11	

# Dr Judith Longstaff Mackay

## 麥龍詩迪教授

SBS, OBE, JP, FRCP (Edin), FRCP (Lon)

*John MacKay**BMJ Lifetime Achievement Awards**Taichi on roof of house*

**J**udith Longstaff was born in Yorkshire while the Second World War was at its peak. She remembers as a toddler hiding under the staircase of the family home during bombings raids.

Her father was a Captain in the British Merchant Navy, his ship transporting troops, dangerous work: she did not see him until she was two years old. Her mother was a graduate from Newcastle University at a time when there were few women graduates, lucky to have a father (Judith's grandfather) who was passionate about education for girls.

Judith did well at school, passing university entrance exams at the age of sixteen. Still too young to enter an English University she opted to go to Scotland, to study medicine at Edinburgh University.

Early signs of her enterprising nature were a trip to Moscow during the 'cold war'; and student electives spent at the Cairns Base Hospital in Australia, including learning to fly a Cessna with the flying ambulance service; and at Groote Schuur Hospital in Cape Town, South Africa, where she joined medical students in running clinics in the poor townships.

She graduated in 1966 and started her obligatory year of preregistration jobs at prestigious units in Edinburgh, first with John, later Sir John, Crofton, Professor of Respiratory Disease, and Dr. Andrew Douglas (co-authors of the famous textbook 'Respiratory Diseases'); and her surgical intern year on the professorial Unit at the Sick Children's Hospital in Edinburgh. Her aim was to become a Paediatric Medical Specialist.

This promising medical career was cut short when she made the rash decision to marry and move to Hong Kong in 1967, where bombs were still going off during the Cultural, Red Guard, revolution.

Her first project in Hong Kong was to learn Cantonese. She attended classes for the next nine months, stopping them only to start work as a Civilian Medical Practitioner for the British Army in Hong Kong. The shock that she had when she was told that female British Forces doctors were paid at Hong Kong Civil Servant rates, namely 75% of male rates, was enough to spark an interest in campaigning for gender equality that has continued to this day.

In 1971 she started a three year appointment as Research Assistant, Child Development Centre, Dept of Paediatrics, University of Hong Kong, under Professor Elaine Field and Dr. Flora

Baber, leading to the publication of the first Child Development Survey, 'Growing Up in Hong Kong'.

In 1973 she was accepted by Professor Alex McFadzean as an Honorary Medical Registrar in his university unit at the Queen Mary Hospital, a training post for the Membership of the UK College of Physicians. She remembers him as a stern but kindly man, an inspiring teacher. In 1976 she passed the examinations at her first attempt.

The next eight years were spent at the United Christian Hospital in Kwun Tong, where she was Deputy Head of the Medical Department.

During this time she published the first survey on wife battering in Hong Kong, and chaired the committee that set up the first refuge in Asia for battered women.

By now Dr. Longstaff, had come to realise that her interests were more in preventative than in curative medicine: nearly every male patient in her wards was being admitted with an often end-stage tobacco-related illness.

She became active in public health education, wrote a weekly medical column in the South China Morning Post for three years, and appeared on television and radio programmes. For her public health work she used her married name of Judith Mackay, the name by which she is now generally known.

Her advocacy on behalf of women led to her becoming a Founding Member of the International Women's Forum (HK), which has an abiding interest in women's issues, including women's health. Since 1978 she has been an Honorary Advisor to the Association of Female Senior Government Officers, fighting for equal pay and terms of service for women in the HK civil service; and was a founding member of The Women's Commission from 2001-2006.

From 1984 onwards she became committed to anti-smoking issues, and has held many appointments with World Health Organization and other international health organisations. She has worked in most of the countries in this region.

One particular success was in 1987 when she was instrumental in persuading the government to ban the importation, manufacture and sale of smokeless tobacco in Hong Kong: only the second jurisdiction in the world to do so.

Another success was when she gave evidence on behalf of the Thai government to a US

Congressional Committee, upholding the right of the Thai Government in forbidding advertising of US cigarettes.

The Hong Kong Council on Smoking or Health (COSH) was set up by Government in 1987, with Dr. Mackay as its first Executive Director. During the next two years she built up this organisation, handing it on only because demands for her time from many other countries had so increased. By now she was an advisor to many governments, including the Ministry of Public Health in the Peoples Republic of China, and advisor to the Asia Pacific Association for the Control of Tobacco.

In 1989 she established the Asian Consultancy on Tobacco Control, a non-profit coordinating organisation to facilitate the sharing of information, experience and expertise on tobacco control amongst countries in the Asia Pacific region. Reflecting on her success over the years she says the requirements of a tobacco control advocate have been; determination, realism, persistence and optimism.

Since the 1990s, she has been a Senior Policy Advisor to World Health Organization, and presented to the then WHO Director General, Gro Harlem Brundtland, the concept suggested by Professor Ruth Romer of a treaty on tobacco control. The negotiations took some years, but the 'Framework Convention on Tobacco Control' (FCTC), entered into force in 2005, the treaty established by the WHO, which places countries under international legal obligation to implement tobacco control measures. The FCTC has now been ratified by 164 nations, making it one of the fastest track United Nations treaties of all time.

Her current appointments include: Honorary Professor, Dept of Community Medicine, University of Hong Kong; Visiting Professor, Chinese Academy of Preventive Medicine; and Honorary Consultant of the Department of Health.

Since 1993 she has authored or co-authored a series of health atlases, which have been translated into several languages. She feels passionately about converting complicated health statistics into imaginative maps and graphics with the minimum of text, as a tool for broader understanding of health issues. Topics have included health, sexual behaviour, cancer, cardiovascular disease, and oral health. She has also written extensively in journals and lectured at conferences in many countries.

In the early days, working in tobacco control in Asia was a lonely job, with no career structure and certainly no pay. Few, if any, countries had even a single person working full-time on tobacco control. She also faced the formidable opposition of the trans-national tobacco companies, who identified Asia as their future. There has now been a sea-change in attitudes, activities and grant funding, for example from the Bloomberg Initiative, enabling hundreds of job opportunities in tobacco control, which were simply not there beforehand.

In 2006, she was appointed Project Coordinator, for the launch of the World Lung Foundation component of the Bloomberg Initiative to Reduce Tobacco Use in low and middle-income countries. With the project successfully up and running her designation is now Senior Policy Advisor.

Awards have come from many sources. One of her most treasured awards came from the Tobacco Industry itself which named her in its trade magazine as 'one of the three most dangerous people in the world'.

Awards honouring her career in public health include:

- The USA Surgeon General's Medallion, presented by Dr C. Everett Koop in 1989, for 'outstanding leadership efforts in the international smoking and health movement'.
- The Chinese National Medal Award, presented in 1991 by the Minister of Health, for 'your help with smoking control in China.'
- The first Luther Terry Award for Outstanding Individual Leadership, at the 11th World Conference on Tobacco or Health in Chicago, USA in 2000.
- A Royal award: Commander of the Most Admirable Order of Direkgunabhorn, Thailand, presented on behalf of the King of Thailand in 2000.
- The Silver Bauhinia Star from the Hong Kong government in 2006, for "her distinguished public and community service, particularly her long dedication to the campaign on tobacco control and her contribution to the promotion of the well-being and advancement of women in Hong Kong."
- In 2006 she was selected by Time Magazine as one of 60 Asian Heroes from the previous 60 years, and by Time magazine a year later as one of the 2007 "Time 100 World's Most Influential People who shape our world."

- In 2008, Queen Elizabeth presented her with the OBE in Buckingham Palace.
- This year, 2009, she was awarded the British Medical Journal Group's first 'Lifetime Achievement Award' from an international field of 42 competitors. The result of the world-wide vote was announced at a glittering dinner in London on 2nd April. She is very appreciative of the massive support she received from Hong Kong. Professor Mackay particularly treasures this award because it marks not only the recognition by her peers of the value of her work, but is also an endorsement of the importance of public health, prevention, global health issues and tobacco control.

Despite her many commitments, she still has time to look after her own health and wellbeing. She has been playing golf off and on since childhood, enjoys swimming, walking in the Sai Kung countryside, and relaxing in her garden. She has been practicing Tai Chi for the last three years, and particularly loves brandishing the sword!

Her two sons are happily married and established in their careers, one a doctor and the other an environmentalist; both live in UK, a good reason for summer holidays with them and the grandchildren.

At a time when many people might be thinking of easing up, Judith Mackay is as busy as ever with conferences at which to speak, books to write, media interviews and international travel. What drives her dedication is the knowledge of the harm done by tobacco use, the disgraceful behaviour of the tobacco industry, and the knowledge that solutions are known, but have yet to be applied effectively and globally.

She is pleased at recent tobacco control legislation and tobacco tax increases in Hong Kong, but there still remains much to be done – a never ending battle. She often quotes Sun Tzu's "Art of War", written in the 6<sup>th</sup> century B.C., because this classic work on military strategy, tactics, logistics and espionage has great relevance to today's tobacco war. She takes heart from Sun Tzu's belief that victory will eventually be achieved for a "just and noble" cause.