SYNAPSE

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Hanami

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SYNAPSE

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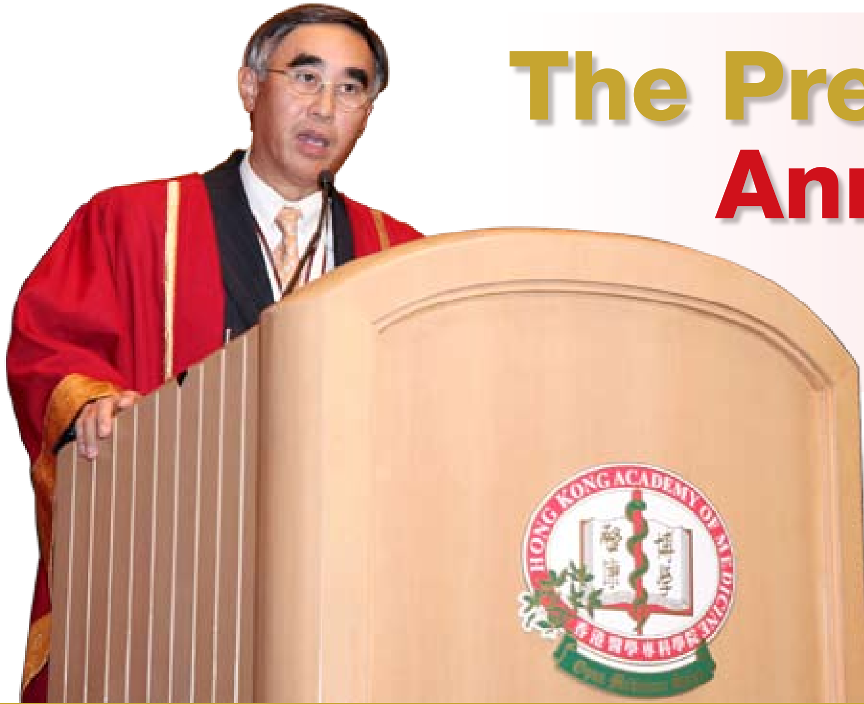

The President´s Annual Report 2009

KN Lai
President, HKCP

After a peaceful year of the Rat 2008, Hong Kong SAR is facing another major threat of Swine flu in the year of the Ox 2009. Our medical profession, as in the past, has put up a devoted and highly professional performance to battle this new virus with a vigilant and attentive approach. At the time of crisis, our profession always prove its quality, alertness and readiness.

This is my fifth annual report since elected to the Presidency in 2004. I appreciate greatly of the support from the Council and I would like to thank all Fellows and Members for having given me the opportunity and honor to serve you. Our College continues to maintain a strong academic link and collegiate friendship with overseas physician colleges in London, Edinburgh, Glasgow, Australasia, Malaysia and Singapore. At the same time, we are increasingly engaged in interaction with physician societies in China with reference to the structural training. The National Medical Examination Center in Beijing has explored arrangements to attend the clinical examination of the Joint Intermediate Qualification of HKCP/MRCP (UK) Examination. On the local front, our College continues to improve our computerization system in training and examination matters allowing paper documentation be conducted from the desktop computer using the Web.

This Annual Report outlines the various events and achievement of all the College Committees that deserve the attention of our Members and Fellows. 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 further 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 has been collaborating with HA to develop an Affirmatory Proficiency Test (APT) – Self Learning Tool (SLT) for basic physician trainees, to raise awareness of trainees about clinical risks with improving the view to clinical management. A Steering Committee has also been established and 79 specialists in various specialties have been recruited to set questions, with a vetting group to vet a question pool of 200 questions. The SLT is expected to be applied to all three years of Basic Physician Training in the coming year.
2. The Specialty boards had conduction annual assessment for 266 trainees and exit assessment for another 122 candidates.
3. The new CME/CPD cycle has started from 1 January 2008 and will last till 31 December 2010. The revised version of the CME/CPD Operational Guidelines has been uploaded to the College website and published in Synapse.
4. The statistics on the pass and failure rates of Exit Assessments in 1997-2009 have been sent to all Specialty Boards regularly, so that they can review the training programs of hospitals with relatively lower passing rates.

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.

The Royal College of Physicians of Edinburgh will hold a Roll Signing Ceremony on 9 October 2009 in Hong Kong. Prof Sir Neil Douglas, President of the Edinburgh College and new Chair of the Academy of Medical Royal Colleges in United Kingdom, will be conferred an Honorary Fellowship of the HKCP in recognition of his outstanding contributions to medicine at the 11th Congregation of the College on 10 October 2009.

Examination Committee

Annually, two written Part I, three written Part II, and two clinical PACES examination are now held in Hong Kong. The local PACES examination centers have increased to ten. Prof Matthew Ng (the Chairman) is serving the MRCP(UK) Part I Examining Board as HK representative while Prof KN Lai is the HK representative at the MRCP (UK) Part II Examining Board and Policy Board.

A new format of station 5 will be used commencing in the October PACES 2009. Candidates will be required to undertake a focused history and targeted examination pertinent to the presenting problem. A pilot demonstration was held in February 2009. A training session was held in September 2009 for trainers, examiners and trainees so that they could be more familiar to the new format.

Scientific Committee

The Scientific Committee under the chairmanship of Professor Y.L. Kwong had organized a Scientific Meeting of Hong Kong College of Physicians on October 11-12, 2008 with over 450 participants.

The Gerald Choa Memorial Lecture was delivered by Professor S.P. Lee. Dr. York Chow gave the AJS McFadzean Oration entitled: "Hong Kong as a Medical Hub: Fantasy or Reality?"

Research Committee

The Research Committee under the chairmanship of Professor K.S. Wong had selected three young investigators for Distinguished Research Paper Award. All are invited to present their papers in the Annual Scientific Meeting of the College in October 2009, with a medal to award to the best presenter.

Membership Committee

Under the chairmanship of Dr. Patrick Li, 69 applicants were proposed for Membership and 49 applicants for Fellowship as of 31 August 2009.

Professional and General Affairs Committee

The Committee under the chairmanship of Dr. C.P. Wong continues to handle issues related to professional and general medical affairs this year. A career talk was delivered to medical students of the University of Hong Kong in November 2008. The aim of the talk was to let the medical students know more about different specialty Colleges in Hong Kong. Our College also gave advice to the Private Hospitals Association on a common format for informed consent.

SYNAPSE

SYNAPSE under the editorship of Dr. C. Kng 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.

During the past year, Synapse was greatly privileged to interview Lord Leslie Turnberg and Dr. Judith Mackay as profile doctors who have contributed vastly to medicine in Hong Kong.

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 at the Fellowship Conferment Ceremony 2009

Reform is needed for healthcare in Hong Kong

KN Lai
President, HKCP

Today is a great day for the College. Sixty-seven physicians will be admitted to the Fellowship and another eighty-six to our Membership, following their success in qualifying examinations. Let me extend the College's congratulation to the new members and fellows. Now that you have achieved your training goals and become a specialist or will be admitted for specialist training, it may be time for you to seriously analyze and critically explore the healthcare in Hong Kong – a system that you will work in the next thirty years or more. You may ask what I think of the healthcare in Hong Kong after three decades of service. First, I must admit that this is amongst the best in the world irrespective of what the politicians or media say. It is highly efficient and cost-effective. We have a high life expectancy of 82 years, ranked second in the world compared with number 36 for the United Kingdom and 50 for the United States, and the low infant mortality rate of 2.9 deaths per thousand live births, again ranked fourth in the world compared with 22 for the United Kingdom and 33 for the United States. Most importantly, the public only pays $100 per day for hospital admission that covers major surgery and even a computerized tomographic scan within hours after admission. Other than a few exceptionally wealthy oil-producing states, healthcare provision in Hong Kong is unique and highly economical. Then, what is the problem of the healthcare system in Hong Kong and why reforms have been proposed? There are three: First, the public does not realize or try not to acknowledge our system is extremely efficient and cost-effective. Second, everyone avoids the cost issue of our system. Lastly, interested groups including the patients, non-government organizations, and medical schools try to play down the issue of the financial sustainability of our system.

Let us examine some of the statistics obtained from World Health Organization and our own government. I will compare those of Hong Kong with three countries namely United States, United Kingdom and Canada before I touch on the fourth one – Singapore. Governments of the United States, United Kingdom and Canada spend equivalents of US$ 7,300, 2,800 and 3,700 yearly per capita

on healthcare while HKSAR spends only $650. Mine you; the percentages of government revenue spent on healthcare for these countries are 16, 8.4 and 10% respectively while our government spends no less than 15% of its revenue on healthcare. This is, not at all, miserly but we do have a very low tax rate and revenue income. Yet the key performance indicators of our local health system are better than these three wealthy developed countries. In 1989, public spending on healthcare for Hong Kong was 1.7% of gross domestic product (GDP) and this figure increased to 2.5% in 1996. What happens in the year 2008? Although the absolute amount has increased but the percentage has plummeted to 1.4%, meaning spending on healthcare falls behind the economic growth of Hong Kong in the last decade measured by the GDP. Nevertheless, the government spends no less than 15% of its income revenue – a figure greater that that of UK and Canada. Simply, our healthcare budget cannot catch up with the demand. In the three countries mentioned above, patients also pay part of the health cost through insurance, 54% in United States, 30% in Canada and 13% in United Kingdom.

Where comes the demand? First is the ageing of the general population, which is not preventable. The second is the shift of patients from private to public section especially for in-patient service and those with chronic illnesses. In the in-patient service, public section has taken its share from 85% in the 1990 to 95% in 2008. The general public and the politicians may not realize or choose to neglect that what ever charges of $100 for in-patient or $65 for out-patient covers no more than one-tenth of the actual cost. At the turn of the last century, the Hospital Authority even put up the slogan of zero waiting time for specialist outpatient and hospital admission through accident and emergency department. Unfortunately, the cost of healthcare was rarely considered and the reality of demand and supply was ignored and neglected. What a similarity between this and the 1957 China's Great Leap Forward. The latter led to famine in 1960 and the former results in the crisis of financial sustainability of our healthcare service. Even for a commercial society like Hong Kong, I doubt whether the public health service should strive for a mammoth-size market share.

In 2002, Dr. Gwen Taylor in his article in the Journal: Perspectives on Business and Economics published by the Lehigh University in Pennsylvania, addressed the shortage of doctor in Hong Kong. Let me quote: “A shortage of doctors in the public sector also threatens efficiency and quality of care. The Hospital Authority has only 60 doctors per 100,000 citizens, making it difficult to serve the multitudes of patients who come teeming into public hospitals. Combining both the public and the private sectors, the city still only provides 142 doctors per 100,000 people, totaling about 9,500 doctors in all. By contrast, in 1998 the United States, United Kingdom, and China had 288, 176, and 160 doctors per 100,000 people, respectively.” You may ask what is for the year 2008. The United States, United Kingdom, and Canada have 240, 250 and 210 doctors per 100,000 citizens while Hong Kong has increased to 170 doctors per 100,000 citizens. The two universities are lobbying to double the number of medical students to improve the public service. With such proposal, the number of academic staff will naturally be increased. The question is will this improve the teaching and service? With more staff, better academic output – maybe. Teaching and service – it is up to the student and the patients to judge. The major issue is can the Hospital Authority provide adequate financial commitment for training more resident doctors. My memory is still fresh with the change of doctors' contract in 1997 when the Hospital Authority's budget was in deficit. The training program of the College and the Academy had to be modified as there was no guarantee of minimum training for six years. To double the intake of medical student will only repeat the history of 1997 that

most of our responsible doctor and supervisor will not wish to experience once more. Just then, I mentioned the public section has only 60 doctors per 100,000 citizens while Hong Kong has 142 per 100,000 citizens. Where are those remaining sixty percent? These are in private practice that Hong Kong should fully utilize their ability, knowledge and experience. In the past, such wealth was not tapped by our local healthcare system simply due to discrete compartmentation of the public and private medical service. The service provided between the public and private section was so skewed and the costing is so distorted that we will not solve our problem even if our total doctor to general population ratio becomes higher than that of the United States.

One of the fundamental blocks that could condemn us to failure is the total lack of the concept of healthcare costing in most Hong Kong citizens. Somehow, our public has mutated to believe that general outpatient only costs $65 per visit and in-patient service costing $100 per night. The truth is it costs the Hong Kong government a minimum of $500 and $2500 respectively to provide such service. In some cases, the costing of general out-patient clinic is more expensive with the public service than the private practitioner. If the Hong Kong public still prefers or insists to treat the illusion as truth, our healthcare system will collapse and more medical incident will occur. It is a ticking time-bomb for the government budget. And it is unsustainable for Hong Kong.

How can we prevent this from happening? Only by reform, reform and reform. Reform is not a luxury, but a necessity. Like the old Chinese saying: "Increase the source of income and decrease the wastage in expenditure" but in a sensible and rational manner. Let me first address the latter - expenditure. The disease spectrum and treatment regime have drastically changed over the last three decades. We should and we must emphases on prevention than concentrating in treating the complications. Take an example of the diabetic tsunami that may affect 10% of the general population. If we are going to spend ten million dollars to monitor the eyes of 5000 patients in the clinic, we should first target to prevent diabetic patient from developing any complications during the initial diagnosis of the illness. Prevention is always better than cure. Here a comprehensive family medicine or a general internal medicine program at the upstream to prevent these complications is important and most rewarding rather than spending large sum of money in managing the downstream complications. In Hong Kong, often prevention is inadequate and neglected. The Hospital Authority should concentrate in in-hospital service and management of chronic illnesses. General outpatient service should be franchised to family physician in practice that could be more cost-efficient. Many a time, in the public institutions, utilization of hospital facilities is still compartmental. Not infrequent, elderly patients have to stay on camp-bed while there are empty beds in other ward under another department. All specialties must prepare to re-engineer their practice. For example, the geriatricians are actively shifting from geriatric ward to out-reach service for early action and hence preventing admission. Procedures as day case in now practiced in many specialties. We can no longer shy away from the issue of patient's advance directive. We must practice evidence-based medicine and be prepared to stand firm irrespective of any noise from the media as in the recent incident of activated recombinant Factor 7 (Novo-7). The pharmaceutical company producing Novo-7 never lists traumatic bleeding as its indication. Instead, complications of cerebrovascular accident and myocardial infarction are clearly stated. Even question in specialist qualification examination in the United Kingdom addresses that recombinant activated Factor 7 is not for treatment traumatic bleeding or disseminated intravascular coagulation. Mega-analysis in Canada fails to show its benefit in traumatic bleeding. An international multicenter

control trial named CONTROL initiated by the pharmaceutical company itself stopped the trial in 2008 after three years as the study was underpowered to demonstrate any primary endpoint. The finding is published this year in the journal, Clinical Trials. Why can't we stand firm on the medical evidence of this drug but instead yield because of the false emphasis of cost or the melodramatic story from the media? Finally, the cost of medico-legal litigation must be capped as in other countries.

Now I have to move on the most sensitive issue of "increasing income". Here I will like to draw the experience of Singapore – a city state similar to Hong Kong with equally excellent record in healthcare proviso. Singapore has only 140 doctors per 100,000 citizens compared to 170 in Hong Kong. The government spends 1% of its GDP in healthcare compared to 1.4% in Hong Kong. Eighty percent of acute and hospital care is provided by government restructured institutions; family physicians provide 70% of ambulatory access care but only look after 35% of the chronic disease condition. The major difference from Hong Kong is, other than personal income tax, 6% of monthly wage goes into the Medisave account which is a compulsory savings scheme to pay for certain medical expenses. This percentage will be raised up to 9% depending on income and adjusted with age. This account is kept at the Central Provident Fund that earns interest at 4%, not 0.25% from our bank. If Medisave is not used at death (i.e. after paying for last episode of hospitalization), the remainder goes to spouse/family as per the deceased's will. Government does not receive it. If a member of the family needs more Medisave money than he has in his own personal account, any family member can use his/her account to top up for the person in need. This is voluntary transfer from one personal account to another. The money collected for Medisave amounts to 2% of GDP such that the nation's total health spending adds up to 3%. The good or "bad" aspect of this scheme is co-payment by the government and the citizen. Every citizen will be more conscious of his/her health as the health cost partly comes from one's own saving. There are better family ties and good health is rewarded with saving for the future. Again, the extra 6% of Medisave could be painful but our Singaporean friends have done it.

Now, back to Hong Kong. Are we going to swallow a bitter pill of health reform that works or continue to take a sugar-coated candy bar that worsens our health? When it comes to the cost of our healthcare, then, the status quo is unsustainable. But let there be no doubt – the cost of inaction is greater. If we fail to act or reform, cost will climb higher, benefits will erode quicker, standard of service will deteriorate faster, and disappointment or dissatisfaction will escalate further. To say it as plainly as I can, healthcare reform is the single most important thing we can do for Hong Kong's long-term fiscal health. That is a fact.

Richard Hooker, an influential theologian at the reign of Elizabeth I had put it nicely: "Change is not made without inconvenience, even from worse to better". John Wooden, a famous American baseball player and coach once said: "Failure is not fatal, but failure to change might be." A hundred years ago in China, the famous reformist Tan Situng (譚嗣同) who was executed after the failure of the Hundred Days' Reform supported by the Emperor Guangxu said:

"變法則民智，變法則民富，
變法則民強，變法則民生。"

I believe the reform of our healthcare system and its financing is inevitable. Only with adequate reform, you will appreciate and contribute in your career as a doctor for our society. With this, I wish you every success in your future career and a very pleasant evening.

The 14th AJS McFadzean Oration 2009

Governance in Hong Kong: Strengths, Contexts and Challenges

Anthony B.L. Cheung, GBS, JP
President, The Hong Kong Institute of Education
Non-Official Member, HKSAR Executive Council

Introduction

Today's topic is the "Governance of Hong Kong". It is not just about the government, but how government relates to political institutions, society and the economy at large to achieve "governability". Academics would define "effective governance" as the ability of the state to get things done in pursuance of state-defined objectives and goals.

Let me start by looking at Hong Kong's situation using a SWOT analysis and international benchmarking.

SWOT analysis of Hong Kong

Strengths:

- Institutional vibrancy (such as freedom, rule of law, clean government, meritocratic civil service, free market), as well as our 'English' legacy
- Highly rated by World Bank in 'Governance'
- As international financial centre and transport hub
- The 'One country two systems' framework as guaranteed by Basic Law

Weaknesses:

- In need of economic restructuring: we have reached a bottleneck in our development
- Constitutional defects which are weakening government leadership
- Identity crisis: such as self-doubt; too Hong Kong-centred?
- Not really *in* China: Staying at periphery of mainland China
- Basic Law may also become a straitjacket to what we can do

Opportunities:

- The rapid rise of China
- Hong Kong's potential economic role in Greater Pearl River Delta Region *if* it is well integrated with the mainland
- Freedoms under 'one country two systems'
- Hong Kong as China's global city

Threats:

- Globalization and rise of competition in the region
- Hong Kong's edge as an "English" city and part of Western World is diminishing?
- Political uneasiness and conflicts

- Concern about *'mainlandization'* and losing *Hongkongness*
- One-way dependence on the mainland China might erode Hong Kong's comparative advantage
- Overspill impact of China's problems: domestic and international

Hong Kong as an East Asian little dragon

Hong Kong's economic rise as an East Asian little dragon during the 1980s – 90s was a result of –

- China's failure during 1950s – 70s,
- The City's geo-political and geo-economic situation,
- Its *English* institutions – rule of law, civil service system,
- Its economic pragmatism ("positive non-interventionism"), and
- Its bureaucratic executive-led polity

By the early 1980s, when the Future of Hong Kong beyond 1997 was negotiated between China and Britain, the success model of Hong Kong had become something to be preserved under the "one country two systems" formula.

International benchmarking

Nowadays, even though the local media have been painting a negative picture of government performance and the competence of officials, Hong Kong has been doing very well internationally, despite the lack of democracy. The World Bank's 2008 governance indicators show that the SAR stands at the top of the list in terms of political stability (86.1 out of 100), government effectiveness (95.3), regulatory quality (100), rule of law (90.9) and control of corruption (94.2). Its only drawback is in 'voice and accountability', but with a score of 60.6 (much higher than Singapore's 35.1) it is still on a par with the new Asian democracies like South Korea (at 65.4) and Taiwan (at 68.8).

World Bank's Governance Indicators 2008

	Voice and Accountability	Political Stability	Regulatory Quality	Rule of Law	Control of Corruption	Government Effectiveness
HK	**60.6**	**86.1**	**100**	**90.9**	**94.2**	**95.3**
China	5.8	33.5	46.4	45	41.1	63.5
Japan	76	79.4	86.5	89.5	85.5	89.1
Korea	65.4	59.8	72.9	74.2	69.6	86.3
Singapore	35.1	96.2	99.5	93.8	99.5	100
Taiwan	68.8	71.8	81.6	73.7	72.9	79.1
OECD (average)	90.6	81.9	91.2	90.2	90.2	88.7

(percentile ranks 0-100)

Why has governance become a problem?

The pre-1997 transitional thinking was to minimize the extent of change (political, economic, social) in the interest of continuity and stability, which was captured by the slogan "50 Years no change".

The political design underlying Hong Kong's Basic Law was originally supposed to continue the previous logic of administration: namely the executive-led principle; government by bureaucrats (with civil servants continuing to hold ministerial posts); administrative absorption of politics (through a large web of advisory and consultative bodies); and limited role for political parties and for popular elections.

Despite such desire to have minimal change, Hong Kong has been experiencing continuous political transformation since the 1980s, with the introduction of legislative elections and the emergence of political parties and elected politicians. On top of various systemic problems which I will elaborate later, Hong Kong has also suffered from an identity crisis. Its political trajectory has come to a stage where a culture of distrust is building up and being reinforced.

Changes in Policy Environment: Old architecture, new actors and contexts

On the surface there was supposed to be 'no change' in Hong Kong's policymaking architecture after the handover. In practice, however, the actors now occupying that inherited architecture, their interests and thinking, and both the internal and external habitats, had all undergone subtle but significant changes.

During the colonial era, the system was bureaucrats-led, dominated by the elite Administrative Officers (AOs). With the rise of elected politicians, parties and civil society activism, and with the new ministerial system of political appointments since July 2002, the bureaucratic monopoly of policymaking powers has been broken.

The policy habitat has moved from a relatively orderly to a more unstable and crowding environment. In the colonial past, we had a relatively more submissive, acquiescent society, politically under-mobilized and less articulate. Nowadays, there is crowding because of the increase in political/policy actors, higher mobilization, and greater demand for participation; this has resulted in a more complex society and a more differentiated polity. In terms of constitutional design, the government centre may appear strong, however in policy practice, the centre has become increasingly vulnerable to various political and administrative challenges.

The colonial system was government by consultation – known invariably as 'government by discussion', and 'the administrative absorption of politics'. Consultation through advisory bodies was used as means to achieve policy legitimacy. After the handover, the SAR government has to increasingly go for political negotiations – with legislators, parties and principal business and labour organizations, you name it – in order to secure enough support to and legitimacy for its policies. The influence of the mass media, academic and public commentators, and public opinion polls, has been on the rise, more so because of the government's lack of electoral mandate.

The colonial government did not adhere to any political ideology. It was administratively pragmatic, economically conservative and fiscally limited, as represented by the saying; *"if it's not broken, why fix it?"*. Being non-ideological, the bureaucratic elites had expanded welfare and public services, not out of pursuit of any clearly defined value preferences or ideological convictions, but for the sake of doing something good that government could afford as public finances improved, and coping with changing public expectations and circumstances – such as active urban and New Town planning, and the launch of ambitious social policy blueprints. The ascendancy of electoral politics, political negotiations and popular demands since the handover has coerced the SAR government into discarding the traditional boundaries of non-intervention. Nowadays there are more conflicts over values and goals. The population expects frequent "handouts" from the government.

Several 'systemic' problems of government can be detected.

Problem 1: Institutional incompatibilities

Since 1997, Hong Kong has been suffering from one legitimacy crisis after another. The infallibility of the administrative state—long held responsible for Hong Kong's success story in the final decades of British colonial rule – has been largely eroded. Most academic literature pointed to a decline in the government's capacity to lead and govern. Professor Ian Scott, for example, summed up the SAR's early crisis as "the disarticulation of Hong Kong's post-handover political system", with the following defects:

> "[T]he relationships between the executive, the legislature and the bureaucracy today are uncoordinated, poorly developed, fractious and sometimes dysfunctional ... [W]ith a system which is neither parliamentary fish nor presidential fowl, the executive, the bureaucracy and the legislature (which is divided within itself) each pursue their own agendas, punctuated by occasional skirmishes on the boundaries of their domains and by subterranean campaigns to extend their jurisdictions"[1]

Under British rule, the population could acquiesce to colonial governance for want of a better alternative (and returning to Chinese communist rule was not considered an alternative for many who had escaped to Hong Kong as either political or economic refugees from mainland China). An enlightened but efficient form of authoritarian government was thus politically tolerated. Such a colonial logic no longer works after 1997 when the general public expects the government to be accountable and responsive under the principle of self-administration (港人治港). In the absence of universal suffrage in electing the Chief Executive and Legco, it was difficult to gain enough political trust from the public through the inherited institutions of governance.

The formal power configuration under the Basic Law has displayed increasing incompatibility with the actual interplay of powers and expectations among various political players and institutions. Instead of having a government with unchallenged executive power, as exemplified in the heydays of colonial rule, the SAR government is now constrained in both formulating and implementing policy. All of the major institutional actors feel inhibited from performing their roles effectively, making the political system essentially *'disabled'*.

Problem 2: Managing differentiated polity and social cleavages

Hong Kong is subject to more values-ladden community mobilizations and class politics unleashed by the rapid politicization of the policy scene. The emergence of new non-institutional cleavages grounded in value-oriented interests has imposed greater demand on the limited political and policy capacity of the SAR government. New cleavages have come from:

- the clash of values between government and the more vocal, assertive and value-oriented professional middle-classes, as seen in environmental, heritage protection, democracy, and core values issues;
- the concern about government-business relations, which the public, including some professionals and small-and-medium enterprises, are watching with suspicion for fear of 'government-business collusion' in the transfer of advantages; and
- the rise of 'national interest' as a variable in policymaking, as observed in the Article 23 saga in 2002-03 over national security legislation.

Besides, the more active and differentiated polity has called for more government interventions, especially amidst economic uncertainties in the aftermath of the 1997-98 Asian economic turmoil, and again under the current global financial tsunami.

The traditional form of government based on bureaucratic domination and administration cooptation is no longer conducive to managing a complex society with conflicting interests and cleavage in values. There is the need to reform

1. Scott, Ian (2000) "The Disarticulation of Hong Kong's Post-Handover Political System", *The China Journal* , No. 43, January, p. 29.

institutions and their *modus operandi* so as to improve the relationships between the political executive and bureaucracy, between the executive and legislature, between government and opposition, and within the wider scene, between government and society and government and business. A new institutional logic has to be found to help forge policy consensus and agreement amidst rising and diverse expectations and conflicts of interests and values.

Problem 3: Futile efforts in reinvention hybrid administrative state

After 1 July 2003, Beijing's policy towards Hong Kong had focused on re-imposing political order and restoring executive power. Chief Executive Donald Tsang had hoped to build a strong and efficient government: "government by political bureaucrats". However, in the absence of institutional means to link up the executive and legislature, the overall system has remained disjointed. As new civil society activism emerges and escalates, the traditional form of "absorption politics" based on the co-optation of business and professional elites has proved insufficient to carry the public view and confer policy legitimacy. The Chief Executive does not enjoy any firm support from any political party. The absence of democratic election has deprived him of the opportunity to get a clear political mandate to govern.

Problem 4: Crisis of trust

People growing up in pre-1997 period of boom had generally taken HK-style capitalism for granted – that is: low tax and yet good welfare; small government and yet firm leadership; undemocratic government and yet a highly liberal market where everyone could make good money. After the handover, the belief in the 'Hong Kong miracle' had largely evaporated as economic difficulties and then government failure crept in. The crisis of social cohesion was a combined result of an economic crisis of production and a political crisis of representation.

The window of political opportunity for policymaking is narrowing. People have become all the more cynical. Meanwhile, the lack of democratic progress since 1997 has also induced a form of 'democracy by substitutes' – like protests, media monitoring, judicial reviews, and the politics of opinion polls. Yet both Legco, political parties, and the media (the fourth power) are also suffering from declining credibility. All political institutions have weakened credibility with the exception of the Judiciary. We are trapped in a political system with no winners.

As the quagmire resulting from the unresolved constitutional debate drags on, the lack of trust by the community in government persists. The social capital so necessary for policy capacity is hard to come by. While trust has yet to be fully nurtured, the level of distrust continues to rise, creating such a gap that may ultimately be too large to be filled by the day-to-day practice of governance and politics.

Problem 5: The identity crisis

The first identity crisis came with the 1989 Tiananmen crackdown on the pro-democracy movement in mainland China. Reunification has led to local worries about a contraction of the city's political sphere vis-à-vis the mainland, as the perceived unavoidable convergence of two different political structures could one day curb the articulation and development of local identities. Despite attempts for assimilation with the national culture and identity, the resistance to surrendering the local identity has remained strong and visible in the political, cultural and discursive arenas.

Historically, the Hong Kong identity had grown out of being different from, and superior to, mainland China. In a sense, the Sino-British negotiations of the 1980s were about preserving Hong Kong's different system vis-à-vis China's mainstream. After 1997, such a Hong Kong identity has been called into question. Instead of leading China's economic development, Hong Kong has now turned around to the mainland for economic support.

The public uproar over Article 23 legislation in 2003 and the subsequent social mobilizations for constitutional reform have rekindled the Hong Kong identity debates. The issue of identity now takes centre stage in local politics,

as exemplified in the new waves of political aspirations for democracy and autonomy, and for the preservation of Hong Kong's 'core values'.

Post 2003, apart from pro-democracy demands, there have also been a surge in pro-heritage sentiments and a nostalgia for the past, described as 'collective memory', that is not entirely cultural but indicative of an underlying political assertiveness for a locally-rooted Hong Kong identity. This new concern for identities can be compared to what Charles Taylor, a sociologist, called 'the politics of recognition'[2]. It marks the rise of a new politics of identity.

Hong Kong is at a crossroads of its future. It faces two fundamental challenges.

Challenge I – Rethinking the Hong Kong model and paradigm shift

The Hong Kong SAR Basic Law was drafted in the 1980s not only with the intention to keep Hong Kong's model of executive-led government intact, but also to preserve a unique kind of capitalism that is underpinned, which was thought responsible for the city's boom under British colonial rule. The keywords of such Hong Kong-style capitalism were "small government" and "positive non-interventionism". Without committing government to any particular ideology, Hong Kong seemed able to champion an administrative state that was highly successful in delivering continuous economic growth, social mobility, and extensive public services supported by fiscal surplus, despite a narrow tax base.

This development model, however, has proved increasingly hard to sustain after 1997. The political environment has changed, as explained above. The 'executive-led' notion has to be understood within the new context. As more new actors come onto stage, the accommodation of interests becomes a more complex process. Government has to respond to increasing demands from various sectors for assistance, intervention and regulation across policy areas. New political and economic factors have induced government to become more interventionist.

More critically, rapid globalization has brought about a new international economic environment which no long favours small-scale export-dependent economies like Hong Kong. The Asian financial crisis which occurred almost immediately after the handover in 1997 was the dividing line. The rise of the mainland Chinese economy has raised the fundamental question: *Is there still a role for Hong Kong? Will Hong Kong become 'marginalized'?* During the 1960s – 70s, Hong Kong's growth had benefited from China's misfortune and domestic turmoils. Now and into the future, Hong Kong has to map its developmental path within the context of a fast-growing Chinese economy. In other words, our mindset has to move from "中國不好, 香港好" to "中國好, 香港才好". This necessitates economic rethinking and restructuring, in which government has to play an important steering role. A political economy characterized by an executive-led bureaucratic polity, positive non-interventionism and fiscally-driven reforms no longer suffices. There is a need for the Hong Kong development model to adopt a paradigm shift.

Need for paradigm shift

From	To
➢ Executive-led	➢ Executive-led within the context of executive-legislative co-responsibility and checks and balance ➢ Socially-embedded government
➢ Positive non-interventionism	➢ Proactive government; "enabling" government
➢ Small government	➢ Effective government
➢ Fiscally-driven policy change	➢ Values-driven policy change

Challenge II – Governing amid global uncertainties

The need for economic restructuring in light of globalization requires strategically-directed government actions. Government has to invest more in education, training and infrastructure development; it also has to respond to calls for a better regulatory environment. Hong Kong's position as the premier financial, shipping and trading centre needs to be strengthened. Government is now talking about grooming 6 priority industries of strength. These are: testing and certification; medical services;

2. C. Taylor (1992) *Multiculturalism* and the *"Politics of Recognition"*, Princeton; Princeton University Press.

innovation and technology; cultural and creative industries; environmental industry; and educational services.

Although far from government picking the winners, the steering role of the SAR government in economic development is becoming more prominent. A steering government, however, needs legitimacy, innovative thinking, and strong linkages with society and industry. Given the constraints imposed by the political system on its policymaking and legislative capacity, while it may aspire to be proactive, the SAR government may not posses enough political power, strategic capacity and the right administrative tools for effective intervention. People are still too skeptical of bureaucratic planning. Because of the slow pace of democratization the political climate tends to be suspicious of government intentions and policies, thereby creating a "Catch 22" situation.

A related fundamental issue is: *How should future government policy be reoriented towards managing market failure?* The hard reality of life under globalization is that economic fluctuations are equally globalized, so that no country or city is free from external risks. It is easy to say that government should refrain from interfering with the market, but when the crunch comes, no government is immune from intervention because both the political and economic costs of non-intervention are too high to ignore. The ultimate question is whether government is fully prepared and well equipped, and has the resources to undertake intervention.

A major difference lies between good and bad intervention. A governing philosophy firmly grounded in non-intervention is arguably not susceptible to grooming the capacity for good intervention. Still the contentions between government intervention and non-intervention have remained strong. Hence, when Chief Executive Donald Tsang remarked at the end of an economic summit in September 2006 that positive non-interventionism was no longer a relevant factor in government policy nowadays, though "big market, small government" would remain an overriding principle, he immediately caused a big row in society, inviting severe criticisms from both free-market ideologues and some opposition politicians who questioned a more interventionist government without public mandate.

Conclusion

To conclude, all the signs are that it is time that Hong Kong has a more thorough reflection of the role of government in a more turbulent global economy. We need a government that is efficient, effective and able to lead and steer. That cannot come about unless the fundamental constitutional and political quagmire is sorted out. We cannot just look to the colonial past for wisdom.

Annual Scientific Meeting

This year's meeting was held on 10-11 October 2009 and the theme was "Infections in Internal Medicine", with sessions on fungal infections, infections encountered in oncology and emerging infections. The Gerald Choa Memorial Lecture on Medical Ethics was given by Professor Lee Shiu Hung.

On the second day of the meeting, presentations included the Best Thesis Award and the Distinguished Research Paper Awards for Young Investigators 2009. The prestigious Sir David Todd Lecture was delivered by Professor Benjamin Wong on the prevention of gastric cancer. Professor Sir Neil Douglas shared the training program for physicians in the United Kingdom with a particular focus on infectious disease. This year's annual scientific meeting was attended by 400 doctors and owed its success to Professor Kwong Yok Lam and the organizing committee consisting of Professor Anthony Chan, Dr ST Lai, Dr Kathryn Tan, Dr Matthew Tong, Dr Kenneth Tsang, Dr TH Tsoi and Professor CM Yu.

Prof KN Lai with winners and their supervisors for the 2009 Best Thesis Awards. From left to right: Prof Lai, Dr Chan Hay Nun, Dr Dominic Yeung, Dr Liza Ong, Prof Karen Lam, Dr Chan Kwok Ying, Dr Michael Sham

Prof YL Kwong, Chairman of the Organising Committee for the ASM 2009 also delivered the lecture on invasive fungal infections. From left to right: Prof YL Kwong, Dr PL Ho and Dr Vincent Cheng

Prof Rosie Young listening attentively

Prof Lam chaired the lecture delivered by Prof Sir Neil Douglas

Question time by Dr Tsang Man Wo

Visiting the exhibits at coffee break

22nd Annual General Meeting, 11th Congregation and 23rd College Dinner

At the AGM held on the 10 October 2009, 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 ceremony proceeded with the conferral of Fellowships and Memberships to 88 doctors, officiated by a distinguished platform party. The order of proceedings was smoothly conducted by the public orator, Professor Philip Li.

The 2009 dinner and ceremony introduced new changes by the HKCP Council who endeavoured to make this occasion fittingly grand and memorable for our Fellows and Members.

Most notably, the congregation venue was changed from the Lim Por Yen Lecture Theatre to the Run Run Shaw Hall, the same site as the annual college dinner which followed the ceremony. The larger space accommodated a new backdrop designed for photo-taking opportunities. This was enthusiastically welcomed by Fellows and Members who took turns to be photographed with their family members. An on-site colour printer kept our wonderful secretariat staff busy printing out almost a hundred photographs, which were framed in a specially designed College card for doctors to take home the same night. Fourty-five congregation gowns were additionally tailored for all new Fellows to wear the entire evening without a need to share, unlike in previous years. The evening turned out to be a resounding success, thanks to the meticulous supervision of Professor Philip Li and the secretariat team.

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 Anthony BL Cheung. He addressed the audience on governance in Hong Kong and the challenges ahead for our government. Following the tradition of AJS McFadzean orations in previous years, we were treated to a stimulating lecture outside the realms of medicine and a crash course in politics!

The Fellowship Conferral Ceremony and Annual College Dinner 2009

The HKCP Council with the official Platform Party

Prof KN Lai confers the Honorary Fellowship to Prof Sir Neil Douglas

Distinguished guests. From left to right: Dr MF Leung, Prof WK Lam, Prof Cheung, Ms Evelyn Ng, Prof R Young, Lady Sue Douglas, Prof Sir Neil Douglas, Prof KN Lai, Prof SH Lee, Prof P Li

From left to right: Prof WK Lam, Prof KN Lai, Ms Evelyn Ng, Prof Anthony Cheung, Father John Russell, S.J., Dr Diana Siu, Prof Philip Li

Prof SC Tso, first editor of Synapse (December 1991) with Council and Synapse editorial board members.
From left to right: Dr MF Leung, Dr John Mackay, Prof Judith Mackay, Dr ST Lai, Prof Tso, Dr Johnny Chan, Dr Doris Tse and Dr Carolyn Kng

The Secretariat Team.
From left to right: Sara, Karis, Rachel, Natalie, Cecilia, Gloria, Elaine, Lydia, Dorothy, Susanna and Christine

What's new at the 2009 annual dinner and conferral ceremony

Fellows posing in front of the new backdrop

Both conferral ceremony and dinner were held at the Run Run Shaw Hall

Photos of Fellows (including our youngest guest) are framed in nicely designed cards bearing the College emblem

The HKCP Council 2009-2010

President	*Prof Lai Kar Neng*
Vice-Presidents	*Prof Lam Wah Kit* *Dr Yam Yin Chun, Loretta*
Honorary Secretary	*Prof Li Kam Tao, Philip*
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Synapse – *Dr Kng Poey Lyn, Carolyn*

SIR DAVID TODD LECTURE

Prevention of Gastric Cancer: a Global Challenge

Benjamin Chun Yu WONG
Department of Medicine, The University of Hong Kong

Distinguished Research Paper Award for Young Investigators 2009

The following doctors received the awards on behalf of their research teams at the Annual Scientific Meeting.

Lee Pui Wai Alex

Department of Medicine & Therapeutics, PWH

Mechanisms of Recurrent Functional Mitral Regurgitation After Mitral Valve Repair in Non-ischemic Dilated Cardiomyopathy: The Importance of Distal Anterior Leaflet Tethering

Lee APW, Acker M, Kubo SH, Bolling SF, Park SW, Bruce CJ, Oh JK

Circulation. 2009;119:pp.2606-2614.

Chan Lam Stephen

Department of Clinical Oncology, PWH

A new utility of an old marker: Serial alpha-fetoprotein measurement in predicting radiological response and survival of patients with hepatocellular carcinomas undergoing systemic chemotherapy

Chan SL, Mo FKF, Johnson PJ, Hui EP, Ma BBY, Ho WM, Lam KC, Chan ATC, Mok TSK, Yeo W

Journal of Clinical Oncology. 2009;Vol 27,No 3,pp. 446-452.

Tam Lai Shan

Department of Medicine & Therapeutics, PWH

Subclinical Carotid Atherosclerosis in Patients with Psoriatic Arthritis

Tam LS, Shang Q, Li EK, Tomlinson B, Chu TTW, Li M, Leung YY, Kwok LW, Wong KC, Li TK, Yu T, Zhu YE, Kun EW, Yip G, Yu CM

Arthritis Care & Research. 2009,Vol 59,Issue 9,pp. 1322-1331.

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

Professor KN Lai and Professor Sir Neil Douglas,PRCP(Edinburgh) officiated at the Signing of the Roll ceremony on the 9 October 2009 for 22 new Fellows from Hong Kong. In addition, the event was graced by the presence of Professor Zhong Nanshan who signed the Roll and enjoyed the magnificent dinner. The ceremony was aptly conducted at the Edinburgh Room, Hong Kong Club. It has been three years since Professor Sir Douglas last officiated at the admissions ceremony in Hong Kong on 13 May, 2006. He will soon be retiring from office and he took the opportunity to inform us that Hong Kong has the largest number of Fellows belonging to the Edinburgh college outside of the United Kingdom. Professor Lai's speech reminded us of the close links and friendships between the Edinburgh and Hong Kong Colleges throughout the years. Over fifty Fellows and guests enjoyed the dinner at the Hong Kong Club. Indeed, the speeches, fine dining and wine inspired a convivial evening of wonderful conversations, creative verse and the revelation of yet other interesting connections between Edinburgh and Hong Kong. To salute this event, Professor Judith Mackay penned the poem below.

Fellows signing the roll

Prof Zhong being congratulated by Master of the ceremony, Prof Philip Li

Prof KY Yuen

Dr Doris Tse

A Dinner Challenge

On the occasion of a challenge by Fellows at the Hong Kong dinner on 9 October 2009 hosted by the Royal College of Physicians of Edinburgh, Professor Judith Mackay wrote this overnight poem on "porridge" (with apologies to William Topaz McGonagall).

Porridge and The Scots

Porridge is made of oatmeal
Which the Scots do favour
It is very inexpensive
So is a money-saver

And oatmeal is in haggis
Giving it some flavour
Other nations cannot stomach it
And give the dish a waiver

Porridge was food for Scotland's poor
Few would disagree
And around the world in China
It was the same for con-gee

Many Scots in history
(Apart from eating **por-ridge**)
Set sail for foreign parts
Seeking the world to bridge

This bridge with friends in China
Is clothed in a tartan to admire
Mixing the red and gold of the Chinese flag
With Scotland's blue and white saltire

A thin green line through the tartan runs
Commemorating a link
With Edinburgh's Botanical Gardens
And to that, whisky we'll drink!

Judith Longstaff Mackay

Professor Mackay with the Chinese tartan scarf

Address to Fellows of the Royal College of Physicians (Edinburgh) at the Signing of the Roll Admissions ceremony

KN Lai
President, HKCP

Prof KN Lai and Prof Sir Neil Douglas exchanging college plaques

Sir Neil, Lady Douglas, Professor Zhong, Mrs. Zhong, Professor Young, Professor Yu, Fellows of the Royal College of Physicians of Edinburgh, honorable guests, ladies and gentlemen.

On behalf of the Hong Kong College of Physicians, I welcome you to the signing of the roll ceremony of the Edinburgh College. Signing of the roll is an important tradition of the College where every fellow signs his or her name personally on the historic roll. This is the fourth occasion that the Edinburgh College has conducted the ceremony in Hong Kong, the last time being three years ago.

Medicine in Hong Kong has long affiliations with Edinburgh, even earlier than with London or Glasgow. Let me give you four historic names to illustrate my point. In 1847, 163 years ago, Reverend Steve Brown of the Morrison Education Society brought three young men from Hong Kong to the United States. The most well known person is Mr. Yung Wang who was the first Chinese graduate of the Yale University. In 1881, he was responsible for the program of sending 120 young Chinese students to the US for high school and university education during the modernization reform movement of the Qing Dynasty. One of the three young men who went to the US with Reverend Brown in 1847, Huang Kuan (Wong Foon), left the States and chose to study Medicine at the Edinburgh University instead. He graduated in 1857 and returned to practise medicine in Canton and Hong Kong. He was quoted as the best surgeon east of the Suez Canal in the late 19th Century. In September 2007, the first minister of Scotland, Alex Salmond unveiled a statute of Dr. Huang Kuan at the Edinburgh University, the first Chinese graduate of an European University. Later, Dr. Huang encouraged another young man from Hong Kong to read medicine at the Aberdeen University. His name is Ho Kai, (later Sir Ho Kai). In memory of his wife, Sir Ho Kai donated and built the Alice Ho Miu Ling Nethersole Hospital in Hong Kong. Sir Ho Kai also pioneered the building of the first airport in Hong Kong – the Kai Tak Airport that we used until 1997. The Alice Ho Miu Ling Nethersole Hospital was the teaching hospital of the Hong Kong College of Medicine for Chinese. It was established in 1887 with Dr. Sun Yat-sen as one of the two first graduates. The College was

founded by three clinicians, Dr. D. Gerlach, Sir Patrick Manson and Sir James Cantlie. Sir Patrick and Sir James, the first and second Deans respectively, were Scottish physicians who graduated from the Aberdeen University. They later founded the London School of Hygiene and Tropical Medicine. Sir Patrick was known for his work in filariasis and schistosomiasis. The new species he discovered was named after him as Schistosoma mansoni. Sir James, a surgeon by training, was interested in leprosy and later established ambulance services during World War I. He also saved Dr. Sun Yat-sen from his kidnap by the Embassy of the Qin Dynasty in London. Of course, the Hong Kong College of Medicine for Chinese later formed part of the University of Hong Kong in 1911. Today, there is still a building in the medical faculty called the Patrick Manson Building. Ever since then, the bondage of medical societies between Edinburgh and Hong Kong has grown stronger and stronger.

So much for history, I hope you have an enjoyable evening and a wonderful memory of this Edinburgh College roll signing ceremony, in the Edinburgh Room, at the Edinburgh Place in Hong Kong.

Prof Philip Li served as master of ceremony

Prof KN Lai, Prof Sir Neil Douglas and Prof Zhong Nanshan with HKCP council members

SIR DAVID TODD LECTURE

Prevention of Gastric Cancer: a Global Challenge

Benjamin Chun Yu WONG
Department of Medicine
The University of Hong Kong

Gastric cancer remains a top global health care issue and 75% of new cases come from Asian countries. The disease, like most cancers are caused by a variety of host and environmental factors. We have tried different approaches in preventing this top killer in China.

There is a strong association between *Helicobacter pylori (H. pylori)* and gastric cancer. Gastric cancer developed in chronic *H. pylori* carriers including those with a normal baseline endoscopy and histology. Those with baseline precancerous gastric lesions like intestinal metaplasia or dysplasia were at a significantly higher risk.

We designed a population based intervention study in Fujian, PR China to examine the effect of treatment of *H. pylori* and the risk of developing gastric cancer. In our prospective randomized placebo controlled study, after a follow-up of 7.5 years, the overall gastric cancer incidence was reduced by 37% after eradication of *H. pylori* as compared to placebo (P=0.33)[1]. In the subgroup of patients with absence of baseline precancerous lesions, there is a significant reduction in the incidence of gastric cancer (P=0.016). However, in the subgroup with existing precancerous lesions, there is no effect of treatment on the incidence of gastric cancer. Hence we have confirmed a protective effect for eradication of *H. pylori* in low risk individuals, meaning those without precancerous gastric lesions. From our study and others, we believe that the unique feature for gastric cancer is that intestinal metaplasia represents a 'point of no return'. In subjects with precancerous lesions, the protective effect of *H. pylori* eradication was minimal. Hence the management of these high risk patients remains a clinical challenge.

Epidemiological evidences suggest that chronic use of aspirin and nonsteroidal anti-inflammatory drugs (NSAIDs) is associated with a reduced risk of gastrointestinal cancers, with the strongest effect seen in gastric cancer. This is reviewed in our recent meta-analysis [2]. The precancerous gastric lesions and gastric cancers over-expressed cyclooxygenase (COX)-2, a target of NSAID. This over-expression is associated with *Helicobacter pylori* infection, but also may be due to exposure to carcinogens. Our early data suggested that targeted inhibition of COX, especially the COX-2 isoenzyme, can lead to growth inhibition and apoptosis of gastric cancer [3-6]. Various mechanisms including COX-dependent and COX-independent pathways have been identified, including activator protein-1 [7] and NF-kappa B [8]. Animal xenograft models confirmed the tumour suppressing effect of COX-2 inhibitors.

Taking these encouraging laboratory data, we designed another population based intervention study in Shandong, PR China to examine the effect of celecoxib, a specific COX-2 inhibitor already in clinical use, in treatment of subjects with gastric precancerous lesions. This randomized double blind placebo controlled study showed that the proportion of regression for precancerous gastric lesions was significantly higher in the celecoxib group than in placebo (OR=1.55, 95% CI, 1.03-2.34), similar to the effect of anti-*H. pylori* treatment. No significant difference in the proportion of regression was found in the group with combined (celecoxib and anti-*H. pylori*) treatment compared with placebo. [9] Celecoxib provides marginal benefit to these high risk patients.

The COX-independent anti-tumour effect of celecoxib acts through apoptosis-related mechanisms. We have shown promising results in searching for new targets in the Inhibitor of Apoptosis Protein (IAP) family. In particular we have shown that inhibition of survivin activity can prevent tumour formation and reduce the

size of existing tumours in vivo [10]. We have generated an adeno-associated virus gene therapy model against survivin which is efficient and safe [11]. The other target of interest is XAF1, another member of the family. We have demonstrated various regulatory mechanisms that allow our extension into therapeutic use [12-14]. Hopefully we can extend these laboratory findings into clinical trials soon.

In conclusion, gastric cancer remains a global challenge. Early eradication of *H. pylori* is a good strategy for low risk subjects. For high risk subjects with precancerous lesions, more research is needed in future.

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Best Thesis Award

Gold Award Winner

Quality of life in Chinese patients with advanced gynecological cancers and its clinical correlates

By ***Kwok Ying CHAN***

Palliative Medical Unit, Grantham Hospital

Study Design

The study adopted a cross-sectional design and the dated was collected from 3 July 2008 to 9 February 2009. A consecutive series of Chinese advanced gynecology cancer patients who had been admitted to the palliative medical unit of the Grantham Hospital during the above said period were recruited. The patients with advanced gynecology cancer were in palliative phase. The types of advanced gynecology cancer included cancers of ovary, uterus or cervix with stage 3 or 4 disease as shown by radiological investigations. The McGill Quality of Life Questionnaire-Hong Kong version (MQOL-HK) has been adopted to measure the quality of life (QOL) among the subjects. The Hospital Anxiety and Depression Scale (HADS) and the Lubben Social Network Scale (LSNS) were used to measure the anxiety and depressive symptoms and the extent of social support of the patients respectively. The Psychosocial Adjustment to Illness Scale (PAIS) sexual subscale was used to assess the sexual relationship and dysfunction.

Results

A total of 30 patients with advanced gynecology cancer were interviewed. Three patients were excluded because of significant cognitive impairment, poor physical condition and language barrier respectively. Twenty seven eligible patients were recruited and all of them had completed the questionnaires. The mean score of MQOL-HK was 4.69 +1.93. Among the subscales, the physical domain has the lowest mean score of 4.10 (SD=2.12 range: 0-7) while the support domain yielded the highest of 5.35 (SD=2.21). Sexual domain of MQOL-HK was significantly compromised compared with previous studies using the same scale for patients in palliative stage other than advanced gynecological cancers. Using the HADS-Depression (Dep) scale> 10 as a screening cut-off point, significant depressive symptoms were common (59 %) in this group of patients. There was a statistically significant positive correlation found between age and LSNS with the mean total score of MQOL-HK ($r= 0.71$, $p< 0.05$ and $r=0.50$, $p< 0.05$ respectively). HADS-dep scores was negatively correlated with the mean total score of MQOL-HK ($r= -0.57$, $p<0.05$). After multiple regression on the mean total score of MQOL-HK, age and HADS-Dep remained statistically significant and these two factors together account for 94.5 % of the total variance of MQOL-HK.

Conclusion

Patients with advanced gynecology cancer had a relatively poor QOL compared with previous local studies using MQOL-HK in palliative care. Among different domains of MQOL-HK, all the domains were low especially the physical one. Depressive symptoms were common in this group of patients. Age and depressive symptoms were the most important independent factors for QOL in this group of patients.

Implications

The results of this study draw the attention of palliative care workers to the depressed advanced gynecology cancer patients in the palliative care unit. The results help the physicians to identify the group of patients that is particularly vulnerable to depression by identifying its clinical correlates. It was found that depressive symptoms significantly affect a patient's QOL. A correct identification and subsequent treatment of depressive symptoms is the first step towards improving the quality of care in in advanced gynecology cancer patients. By using HADS as a screening tool, it helps to identify more depressed cases who need specialist care. To this end, it is important for the palliative care workers to aware of the depressive symptoms in advanced gynecology cancer patients and to know the way to handle; therefore, more training in this aspect is warranted.

Best Thesis Award

Silver Award Winner

Role of Two Novel Adipokines in the Prediction of Coronary Atherosclerosis

By **Liza Ho Yun ONG**

Department of Medicine, Queen Mary Hospital

Background and aims

The adipose tissue was traditionally thought to be merely an energy store. However, it is now increasingly recognized that the adipose tissue is metabolically active and can be considered as an endocrine organ with the production of adipokines. Animal studies suggest that these adipokines such as adipocyte fatty-acid binding protein (A-FABP) and epidermal-fatty acid binding protein (E-FABP) may play vital roles in the regulation of body weight and energy metabolism. It is well established that obesity increases cardiovascular risks and therefore, there is growing interest in exploring the role of these adipokines in the prediction of obesity-related cardiovascular risk. This study aimed to investigate the association of A-FABP/E-FABP with cardio-metabolic risk factors and coronary atherosclerosis in humans.

Subjects and methods

Subjects were recruited from the Hong Kong Cardiovascular Risk Factor Prevalence Study. 644 non-diabetic individuals had since been invited for prospective follow-up at 2, 5 and 10 years from baseline to assess for the development of various cardiovascular risk factors. At 10 years, multi-detector computed tomography (MDCT) was also performed for the assessment of coronary atherosclerosis, as estimated by coronary artery calcium score. Baseline serum A-FABP and E-FABP levels were measured with enzyme-linked immunosorbant assay (ELISA).

Results and conclusion

A total of 407 subjects were included in this study. Serum A-FABP was positively correlated with the adverse cardio-metabolic risk factors. In multinomial regression analysis which included sex, age, smoking status, metabolic syndrome and LDL-cholesterol, A-FABP was found to be a significant independent baseline parameter predictive of coronary atherosclerosis, together with sex and age ($p = 0.015$). In contrast, E-FABP was not found to be a significant predictive factor when it replaced A-FABP in the same model ($p = 0.720$). This study has shown that A-FABP is a novel biomarker associated with adverse cardio-metabolic risk profile and coronary atherosclerosis.

Best Thesis Award

Bronze Award Winner

Survival and Molecular Responses of Chinese Adults with Chronic Phase Chronic Myeloid Leukemia Treated with Imatinib Mesylate in Hong Kong

By ***Hay Nun CHAN***

Department of Medicine & Geriatrics, Tuen Mun Hospital

Background:

Imatinib, a selective inhibitor of the BCR-ABL tyrosine kinase, is remarkably effective in treating newly diagnosed patients with chronic myeloid leukemia (CML) in chronic phase. We determined the efficacy and safety of imatinib treatment in Chinese patients with chronic phase CML.

Methods

Records from 31 Chinese patients who were diagnosed to have CML in chronic phase between January 1998 to June 2008, treated with imatinib, were analyzed retrospectively. Patients were evaluated for overall and progression free survival, hematologic responses, molecular responses and toxic effects.

Results

The median follow-up was 43 months. The estimated 3-year overall survival and progression free survival were 95.2% and 92.9%. The 12-month cumulative rate of complete hematologic response was 100%. The estimated 12-month and 36-month cumulative rate of major molecular response (MMR) were 18.4% and 52.4%. None of the patients who achieved MMR had disease progression. Early 1-log transcript reduction at 6 months was identified to be an independent predictor of MMR (p=0.029). Rate of grade 3 or 4 hematologic toxicities was 38.7%. Two (6.4%) patients required permanent imatinib discontinuation because of drug-related adverse events.

Conclusion

Imatinib was found to be highly effective in treating Chinese CML patients in chronic phase. Early 1-log transcript reduction at 6 months was found to be an independent predictor of major molecular response. Rates of Grade 3 or 4 hematologic adverse events were not significantly higher among Chinese patients.

- Founder and Deputy President, Chinese Society of Nephrology (1980-1985)
- Vice-President, Chinese Society of Internal Medicine (1985 to 1995)
- Councillor, Chinese Medical Association (since 1986)

Awards

- National Science and Technology Progress Award, China
- Elected Academician and on Governing Board, Chinese Academy of Engineering.
- Honorary Fellowship, International Society of Nephrology in 2003
- Honorary Fellowship, Hong Kong College of Physicians, 2000

An Interview with Professor Li Lei-Shi

John Mackay
Translated by Tak Fu Tse

Acknowledged as one of the most distinguished nephrologists in China, and one of the founders of the Chinese Society of Nephrology, Professor Li Lei-Shi has contributed to the development of modern nephrology in China.

Thanks to his studies on the role of Chinese herbs in the treatment of glomerular disease, diabetic nephropathy and chronic renal failure, immunosuppressive treatment in lupus nephritis, and the technique of continuous blood purification, he has been honored with the China National Science and Technology Progress Award for six times.

Professor Li has authored 13 books and published over 700 papers, with particular focus on the clinical and basic research of glomerular disease. Professor Li has played an important role in national and international kidney societies. He was a member of the council of the Asian Pacific Society of Nephrology and of the council of the International Society of Nephrology, and won the Honorary Fellowship by International Society of Nephrology in 2003. Elected member of the Governing Board of the Chinese Academy of Engineering, Professor Li has been honored with the highest academic title and honor, and named a life tenure in China.

Editor : *What inspired you to pursue a career in medicine? Your brother is a famous surgeon. Were your parents also healthcare professionals?*

Prof Li : All my brothers studied medicine. Everything happened by chance. It started with our poor financial condition. My father was an English teacher in a high school. I was only ten years old when he passed away. I barely made Form 2 with the financial support of my relatives and some kind of scholarship. After that, I had to quit school to make a living. If I had my choice, I really would like to study engineering. However, at that time, the government only offered free tuition and free boarding in a few national medical schools and colleges for training teachers. So in order to make a living, I applied with the same qualification and was successfully admitted into the then National Zhong Zheng Medical College. Although Li Jieshou was 2 years my senior, we had always been in the same class and in the same high school. He was also admitted into Zhong Zheng Medical School, now known as Medical College of Nanchang University in order to get free food and lodging.

我家兄弟都學醫，完全是偶然。主要是因為當時家境貧寒，我的父親是一位中學英文教員，他病故時我才十歲，依靠親戚的幫助和獎學金我勉強讀到了高中二年級，之後便輟學了。在社會上打工糊口，按照我自己的意願，我很想讀工科，但是當時政府規定只有少數國立的醫學院及師範學院才是免費的，而且供食宿，為了解決生活的問題，我以同等學歷考上了當時的國立中正醫學院，主要的目的是為了“謀生”。黎介壽雖然比我大兩歲，但中學時期我們始終同校同班，他也和我一樣為了找一個食宿之地而考入中正醫學院。

Editor : *Where did you grow up?*

Prof Li : I was born in Changsha, Hunan province but I moved with my parents to Shanghai before I was one so my childhood was spent in Shanghai and Hangzhou. After my father passed away, we moved back to Changsha and I spent all my high school and university life in Hunan and Jiangxi in areas which were not occupied by the Japanese. That was a period of hard wandering life, and it allowed me to recognise the social responsibility of intellectuals to the desolate and backward Chinese people in agony.

我出生在湖南長沙，但不到一歲我就隨父母親遷居上海，我的童年是在上海、杭州渡過的。父親去世後，又遷回湖南，當時家境十分困難，整個中學及大學生涯都是在湖南、江西，在未被日本人佔領的區域內渡過的，這是一段顛沛流離的生活，也讓我意識到了作為中國的知識分子對當時貧窮落後的苦難中國人民應擔負的社會責任。

Editor : *Could you reflect on your fondest memories of your medical school days ?*

Prof Li : I spent my first 3 years in the Medical School (1943-1945) as a fugitive medical student, moving from the northern part of Jiangxi to the southern part, and then to Fujian Changding, just to avoid the attacks from the Japanese army. In three school years, we moved 4 times. The journey was 1000 miles and the only means of transportation for a student was by foot, pushing a wheelbarrow on which stood a new model Zeiss microscope, which I guarded dearly for I treasured it as valuable as my own life. Although the fugitive's life was very tough both physically and spiritually, it was an active period in the arena of learning and studying. All the professors, at that time, were either trained in the States, or from famous northern universities like Peking Union Medical College. Our classmates came from everywhere, all of them being from Japanese occupied areas or fled from overseas occupied areas like Hong Kong and Singapore. Many different dialects were spoken at the same time. Professors (many were foreigners) all taught in English. There were no teaching manuals. Every night, all students would gather under an oil lamp to rearrange their notes and to read outdated foreign medical journals. Although life was very hard and even bowl of plain noodles was considered a kind of luxury, we cared for each other and studied hard.

我的醫學院的前三年（1943～1945)過的是流亡大學生的生活，從江西北部到南部，又往返到福建長汀，為了避免日軍的襲擊，三個學年中校址搬遷了四次，行程逾千里，學生基本是步行，推著獨輪車，上面放著每個學生各自保管，視以為命的一架新式Zeiss顯微鏡，這段流離顛沛的生活在物質上十分艱苦，然而在學習精神上都是異常的亢奮。當時的師資大多數是從美國學成歸來的教授，或是協和醫學院停辦後從北邊來的老師，同學則是來自四面八方。都是從各個淪陷區或是從香港、新加坡等地從海外敵佔區撤退下來的學生，不同的鄉音滙集在一起，老師（包括少數外籍）都是用英語授課，沒有教材，每天晚上大家滙集在豉油燈下，重新整理自己的筆記，閱讀從圖書館借來已經陳舊過期的英文專刊，儘管生活十分艱苦，一碗“陽春麵”就被

認為是“美餐”，但是大家都互相關心、刻苦的學習。

這三年給我留下了難以磨滅的烙印，也為日後我在事業上的執著追求，不畏艱難撒下了種子。

Editor : *Where did you undertake your postgraduate training?*

Prof Li : From 1948 July to 1949 June, I interned at the Central Hospital of Nanjing, the biggest Medical University hospital directly under the Department of Health of the Central government then. After finishing my internship, I stayed at the Central Hospital to receive three more years of resident training.

1948年7月～1949年6月我在南京中央醫院(Central Hospital，當時中央政府衛生署直轄的最大的教學醫院)完成Intern的學習，之後留在中央醫院接受三年內科的Residentship。

我沒有接受過腎臟病的專業訓練。

Editor : *What inspired you to pioneer research in nephrology and tropical medicine in China?*

Tripterygium wilfordii 雷公藤

Prof Li : From 1952, I was assigned to assist a Professor who had recently returned from the United States, specializing in infectious diseases and that was the beginning of my era of 20 years in infectious diseases. At that time, New China was just established and the emphasis of the Medical and Health services was to prevent and treat infectious diseases that endangered people's lives: such as Malaria, and amoebiasis. There was a slogan on eliminating all blood sucking parasites (direction of Mao). In the whole country, the campaign on preventing and treating the blood sucking parasites was started. This became the emphasis of the utmost important issue amongst all health problems. As one of the pioneers in this field, I worked really hard. At that time, my working condition was not bad at all (according to the standard of the 50s), there was a special laboratory, clinical ward, and camping facility for prevention and treatment purposes. We also did a lot of good work.

During the 10 years of the Cultural Revolution, I had to stop all work on infectious diseases. As a proletariat academic, I was stripped of all my working rights and was assigned to become a laborer (including very basic health care work). During this period, I came into contact with a lot of patients suffering from kidney diseases. There were no nephrologists at that time, no dialysis, no transplant. There were really no physicians and only few medicines were available. Uraemic patients were like cancer patients, just waiting to come to the end of life. I took compassion with them but there was nothing that I could do. So, I decided to learn more about kidney diseases. Even though I was burdened with the label of Category Black Five, I secretly studied foreign journals and TCM literature on treatment of nephritis, and started with the basics. Slowly, I fell in love with kidney diseases. In 1975, when Mr. Deng Xiaoping became the leader, I was reinstated to my former post. I was informed that I could apply to rebuild my laboratory. I declined my senior's offer but asked instead for 2 tons of Leigongteng for research and for clinical studies (because, by that time, I already realized that this herb had potential hope for treating nephritis).

我從1952年始按照醫院上級的安排去為一位剛從美國學成歸來的熱帶病學專家當助手，從此開始了我將近20年的熱帶病學生涯。當時新中國成立不久，國家衛生事業重點是防治嚴重危害人民健康的熱帶病。諸如瘧疾、絲蟲病等，特別提出一定要消滅血吸蟲病的口號（毛澤東的指示）。在全國掀起了一個防治血吸蟲病的運動，成為衛生工作的重點。我作為最早投入這一防治工作的醫務人員之一，努力地工作，當時的工作條件相當不錯（按50年代水平），有專門的實驗室、病房和野外防治基地，我們也取得了很多成績。十年文革讓我中斷了熱帶病的工作，作為資產階級學術權威我被剝奪了

一切工作權利，下放去勞動（包括去醫院做基礎醫療工作），在這個時期我接觸了大量腎臟病患者，當時沒有腎臟病專科醫生，沒有透析，沒有移植，是名副其實的"缺醫少藥"，尿毒症病人就像惡性腫瘤一樣在等待死亡。我非常同情他們，但又愛莫能助，我下決心要讓自己多懂點腎臟病。從這個時候起，雖然還是一個"黑五類"的身份，我偷偷地閱讀國外雜誌及中醫治療腎炎的書籍，從最基本的學起，逐步地我愛上了"腎臟病"。1975年，鄧小平上台，恢復我的職務，通知我要撥款重建"實驗室"，我謝絕了上級的好意，我要求給我採購兩噸雷公藤供臨床及研究應用（因為這時，我已感覺到雷公藤在治療腎炎方面的潛在希望）。

Editor : *Which of your many scientific discoveries are you most proud of ?*

Prof Li : In my 60 years of medical research and applications, I have treaded on many areas. However there were only 2 discoveries which I considered to be particularly meaningful, and resulted in significant contribution to the Chinese Medical and Health industry. The first is the "Discovery of Leigongteng for treatment of Nephritis". From observing the effects of this herb through clinical and research studies, we proved its effectiveness on nephritis, particularly in eliminating proteinuria. Also, it was inexpensive, with very little side effects. That was why it was more popular than steroids and immunosuppressants among doctors and patients. After the study paper was published in 1980, the use of this herb was promoted all over the country. With 30 years of relentless research and studies, more than millions of patients have been treated and it is now ranked a "National basic drug". The second discovery was "Manufacture of antigen of the liver blood sucking parasites". It all happened in 1955, when the country wanted to survey the prevalence of blood sucking parasites along among the 300 million residents of the Chang Jiang district. The international test for this was the antigen skin test. The antigen must be made from the parasite but it was technically very complicated. To manufacture sufficient antigen for 300 million people, even if we engaged all the technicians involved in the field in the country, it would take 3 years to complete. I used extraordinary effort to discover that infected liver cells from rabbits could be used to manufacture antigen and could produce identical results as the original antigen. The procedure was simple and the results were good. In 3 months, sufficient antigen was provided for the survey for 300 million to be completed. A huge problem was solved for that time. These 2 pieces of work may not contain very advanced technology, but allowed us to see the meaning of the work that we had done.

在60年的醫療科研實踐，我雖然探索了不少領域，其中只有二件事情我覺得特別有意義，對中國的醫藥衛生事業作出了直接的貢獻。第一件事是關於"發現雷公藤治療腎炎的作用"。我們從臨床及實驗研究證實了這種草藥治療腎炎的效應，特別是消除蛋白尿的作用，而且它價格低，副作用少，遠比激素及其他免疫抑制劑得到廣大醫生和患者歡迎。文章在1980年發表後迅速在國內推廣，經過30年的實踐和不斷的研究，數以百計的病人接受了治療，如今已被認定為"國定基本藥物"。第二件事是"血吸蟲肝臟蟲卵抗原的制備"，事情發生在1955年，當時國家要在長江流域3億人口中進行血吸蟲病的篩選普查，國際上通用的最簡便方法是抗原"皮內實驗（antigen skintest）"，所需要的抗原必須是由吸血成蟲制備，但是技術上複雜，即使全國從事血防的科技人員全力以赴也要三年才能完成3億人所需要的抗原，我經過艱辛的努力，發現以感染血吸蟲的家兔肝臟（含大量蟲卵）制作的抗原與成蟲抗原有相同的效果，手續簡便，效果好，費用少，三個月內就為全國血吸蟲病的普查，提供了足夠的抗原，解決了當時的一大難題。這二項工作的科學技術含量不一定比其他的項目高深，但卻讓我直觀地看到我們所做工作的意義。

Editor : *You initiated the use of herbal medicine for the treatment of glomerular diseases. At your institution, is this concurrently offered with Western medical remedies?*

Prof Li : We are accustomed to using western medicine as the basis of our treatment, while we use TCM as an adjuvant. Of course, all these TCM are now produced in either tablet or capsule form and no longer in Tang form. Like Leigongteng tablet, Dahuang Acid tablet, Dahuang su tablet etc. are all now westernized in form.

我們習慣以現代西藥作為治療的主要藥物，同時輔以中成藥，當然所有這些藥物都已經做成片劑或丸

劑而不再用湯劑（組份藥或複方），像雷公藤多甙片、大黃酸片、大黃素片等都已經西藥化。

Editor : *You hold numerous eminent positions in administrative, clinical and academic medicine at a national level. What is the greatest challenge you have faced?*

Prof Li : In China today, the biggest stress for a good doctor is that you cannot satisfy the vast number of patients who demand your service and hope that you can cure them. As one person, I certainly cannot meet these demands, I still use my greatest effort to nurture the new generation, hoping that they will become good doctors, to satisfy the demands of the vast number of patients. Nurturing qualified doctors is the biggest challenge for China today.

在目前的中國，一個好醫生所面臨的最大壓力是有太多的病人需要你，希望你為他進行治療，我本人顯然無法去滿足所有這些要求，我始終用最大的努去培養年輕一代，希望他們能夠成為好醫生，去滿足巨大數量病人的要求，培養合格的醫生是中國目前最重要的問題。

Editor : *Have there been any major influences that have shaped your career?*

Prof Li : In my life, I have met numerous setbacks (especially in the first 30 years as a medical doctor). For example, in 1958, I discovered that the TCM herb Lilu could cure blood sucking parasites. Although I could prove that it was effective, it was toxic to the optic nerve and could not be used clinically. For this, I lost five whole years and had to bear the criticisms of others. In the ten years of Cultural Revolution, I was hit hard, my laboratories were destroyed and my team disbanded, and I became the target of attack. Although I felt humiliated and suppressed, I became strengthened in my perseverance and mission. During the Cultural Revolution, I worked as a front line resident doctor for seven years. I was assigned to work and to rotate in seven specialties in the Medical department, reminiscent of my days as an intern 20 years ago. This type of “returning to the oven to train” work reinforced my clinical ability, and enabled me to gather a lot of clinical experience during my lst 30 years of medical practice. When Cultural Revolution ended, I was already 51 years old and it was then that I changed my specialty to become a Nephrologist, and began to build the first modern Nephrology specialty.

我一生曾經遭受過許多挫折（特別是當醫生的前30年），例如：1958年我曾經發現中藥（黎蘆）治療血吸蟲病的療效，雖然證明藥物有效，但卻有視神經毒性，無法應用，為此我浪費了整整5年時間，同時遭受人們的指責。十年“文革”我被打倒，實驗室和研究隊伍被徹底摧毀和解散，我成了勞動改造的對象，雖然所有這些都讓我感到屈辱和壓抑，但也磨練了我的意志和毅力。在文革期間，我有七年時間從事一個低級住院醫生的生活，被安排去大內科七個專業輪流地工作，就像從新回到20年前的實習醫生狀態。這種“回爐訓練”式的工作，對我的臨床處理能力有很大的提高，也為我人生中後30年的行醫積累了很好的臨床工作經驗。文革結束以後我已經51歲，也就在這個時候，我正式轉行為“腎臟病醫生”，建設中國第一個現代腎臟病專科。

Editor : *How do you encourage your students to pursue medical research ?*

Prof Li : All my students know that I believe that only strict teachers can breed outstanding students. So Strictness is my code. Some of my students who are friendly with me ridicule me and said that they grew up with scolding. I truly believe that in the modern Chinese academia, insufficient stringency is a problem. Of course, to ask young people born in the 80s to share our commitment to social responsibility is very difficult. Yet, I often tell them this: in China where we have 1.3 billion people, whatever advances we make in medical research, even if it is only a small step, it will benefit a lot of patients, so there is no reason not to take that step.

我的學生都知道我相信“嚴師出高徒”的古訓、嚴學當頭。有些和我相處長的學生甚至開玩笑地說，他們是“在罵聲中成長”。我始終認為在當代中國的學術界，“嚴謹不足”是大問題。

當然，要使80後的年青人和我們這一代一樣有強烈的社會責任感是很困難的，但是，我常常告誡他們，在13億人的中國，我們在醫學研究中所取得的

成就，哪怕是細微的進步，都會給廣大病人帶來巨大的福祉，我們沒有理由讓自己停步不前。

Editor : *Are any of your children doctors ?*

Prof Li : My three children study Mathematics, Physics, and Chemistry respectively, but none of them wanted to be a doctor. Perhaps I as an example make them feel in their hearts that a doctor's professional life is very hard and he knows not how to enjoy life.

我的三個子女分別學習數（學）、（物）理、化（學），但沒有一個想當醫生。也許以我為例證，在他們的心目中，醫生的職業“很辛苦，但不會享受人生”。

Editor : *What do you do to relax ?*

Prof Li : I have very little free time. Before I was 70, I routinely jogged slowly every morning for half an hour, and often listened to classical music, but rarely watched TV. Now I am old. In recent 6 to 7 years, every winter, I would go to Sanya in Hainan island for a holiday. During this period, my children would all come back. With the whole family staying together, enjoying the sun, the beach and the sea is my greatest pleasure.

我的業餘時間很少，70歲以前每天早上慢跑半小時是常規，平時也聽聽古典音樂，難得看電視。如今老了，這六、七年來，每年冬天去海南島三亞度假，孩子們都回來了，享受陽光、沙灘和海水是我最大的樂趣。

Supplementary information of interest from Prof Philip KT Li

“In 1949, while working in Nanjing, Prof Li Lei-Shi had the opportunity to go with many of his colleagues to Taiwan. He chose to stay in Nanjing with the incoming regime. He has a long history of contacts with Hong Kong, having visited many times as a distinguished lecturer, and has published a paper on research carried out jointly with Professor KN Lai. In return, he has invited Prof Philip Li and others from Hong Kong as Visiting Lecturers to contribute to the annual Nanjing Forums on Nephritis, and on Blood Purification.”

Prof Li Lei-Shi was conferred the Honorary Fellowship of the Hong Kong College of Physicians in 2000 by Professor Richard Yu.