SYNAPSE

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Sapientia et Humanitas

Spring Blossoms

Professor Richard YH Yu

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SYNAPSE

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The Gerald Choa Memorial Lecture 2009

MEDICAL ETHICS

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The Chinese University of Hong Kong
Honorary Professor, Li Ka Shing Faculty of Medicine,
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President, Honoured guests, Fellows of the Hong Kong College of Physicians, Ladies and Gentlemen, I am highly honoured and delighted to be invited by the Hong Kong College of Physicians to deliver the Gerald Choa Memorial Lecture.

Professor Choa was my teacher when I was a medical student at the University of Hong Kong from 1952-1958. He was also my boss when he was appointed the Director of Medical and Health Services from 1970 to 1977 by the Hong Kong Government. I worked under him at the Headquarters of the Medical and Health Department at the Lee Gardens, Hysan Avenue in Causeway Bay.

The title of my presentation will be in two parts. Bearing in mind that my presentation is under the name of Gerald Choa Memorial Lecture, I would like, to begin with, make a presentation about my personal involvement with Professor Choa when he was the Director of Medical and Health Services. The second part of my presentation will be on "Medical Ethics — its new challenges in the 21st century."

Working with Professor Gerald Choa

Vietnamese Refugees in Hong Kong

Screening Vietnamese Refugees

Looking back, one of the most memorable events when working with Professor Choa was during the mid-1970s when Hong Kong began to face the influx of Vietnamese refugees. On one day morning when we were having a Christmas party at the Headquarters of the former Medical and Health Department, without any advanced notice, Professor Choa suddenly asked me to go to the Government Secretariat to attend an urgent meeting. The meeting was concerned with emergency arrangement of screening the refugees from Vietnam, who were kept in a refugee ship floating at high sea off the Poi Tai Island, once the permission for landing was received from London. The purpose of screening was to make sure that the refugees would not bring dangerous infectious diseases into Hong Kong, since Vietnam was a hyper-endemic area for plague and other dangerous infectious diseases.

Professor Choa with Professor McFadzean

The only way to screen the refugees was to mobilize the Auxiliary Medical Service (AMS), but I had no authority to do so. So I sought the permission of Professor Choa who was the Controller of AMS. Professor Choa immediately authorized me to call out the AMS for emergency duty.

As the refugee ship was floating at high sea off the Poi Tai Island, I had to call the Auxiliary Air Force to use the helicopter to bring members of the AMS to the refugee ship.

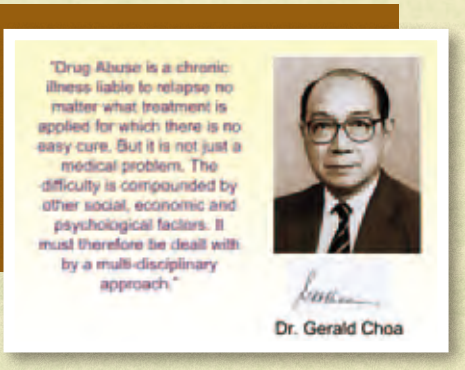
Arriving by helicopter

The AMS team led by Professer SH Lee

When the refugee ship was allowed to enter into Hong Kong the next day, the refugees were unloaded at the Kwai Chung Container Terminal. From there they were taken to the Princess Margaret Hospital and were screened again before they were sent to the refugee camps at Chi Man Wan. From then onwards, the Medical and Health Department had to shoulder a heavy responsibility of providing medical care to many thousands of refugees in the refugee camps and took great efforts in preventing the spread of infectious diseases from the camps to the local people. (The Chief Staff Officer of AMS and his senior staff are present at this lecture room, I would like to pay tribute to the members of AMS who responded so well to this emergency call for duties. Going back the medical history further, the Auxiliary Medical Service was established more than 55 years ago. It was established by Government with the task to augment the medical and health services in times of emergency. Throughout the past years especially during the cholera epidemic in the 1960s, members of the AMS have provided a dedicated, loyal and essential supporting service to assist the regular health care services in Hong Kong. During the cholera epidemic, they operated a territory-wide cholera vaccination programme by manning the inoculation centres on the streets, in the market places and ferry terminals. They operated the Quarantine Centre at the Chatham Road for the isolation of contacts of cholera cases. Without the invaluable contributions of Members of this essential service, the regular medical and health care force will no doubt be in a much more difficult situation to tackle the medical emergencies. Could the AMS Members please stand up ? Let us give them a big applause.)

Action Committee Against Narcotics (ACAN)

Professor Choa was chairman of ACAN (1985-1992)



Professor Choa with Professer McFadzean

The second memorable event was on the fight against narcotics. In 1965, the Government set up an Action Committee Against Narcotic (ACAN) to advise the Government on all aspects of anti-narcotics strategies. Professor Choa was the Chairman of ACAN from 1985 to 1992.

In a publication dated 2000 to commemorate the 35th Anniversary of the Action Committee Against Narcotics, Professor Choa had stated and I quote: "Drug abuse is a chronic illness liable to relapse no matter what treatment is applied for which there is no easy cure. But it is not just a medical problem. The difficulty is compounded by other social, economic and psychological factors. It must therefore be dealt with by a multi-disciplinary approach," unquote. With the increasing problem of drug abuse among the youth today, it was quite right for Professor Choa to emphasize the importance of a multi-disciplinary approach to tackle the problem of drug abuse in Hong Kong.

Methadone Clinic

One of the major achievements in the treatment and rehabilitation of drug abuse was the establishment of a

methadone maintenance and substitution programme for the heroin drug addicts. In the year 1976, there was a serious shortage of drugs in the illicit market and there was an unprecedented upsurge in the prices of heroin. This resulted in a sudden rise of crimes on the streets thus seriously affecting the security of the community. The Government had no alternative but to launch the methadone maintenance programme on a territory-wide basis so as to provide an alternative form of substitution therapy for the drug dependent persons.

Professor Choa was instrumental in opening a total of 21 methadone clinics within a short period of about three weeks in 1976. During this period of emergency, I had the opportunity of assisting Professor Choa in organizing the service programme. Again, we were grateful to members of the AMS who responded to our call and took part in the services delivery of methadone at all these clinics.

To-day, the methadone substitution and maintenance programme in Hong Kong not only proved effective in assisting drug dependent persons to sustain their employment and social life. It also helps the society to reduce the incidence of drug abuse, drug-related deaths and the spread of blood-borne diseases, notably HIV/AIDS. The benefit of the programme has been well accepted by other countries and areas including Mainland China and Taiwan.

I am fortunate to be able to follow the foot-steps of Professor Choa in the area of anti-narcotics work. When I became the Chairman of ACAN from 1999 to 2002, I set up a Working Group to conduct a review of the Methadone Treatment Programme. As a result of this review, further improvements have been made in enhancing counseling and referral services and in forming support groups for patients and their families as well as services for the young and for women patients' families.

Recently, I had the opportunity of visiting the first methadone clinic at High Street Sai Ying Pun. I was so impressed to see that after a period of over 30 years, members of the AMS are still faithfully and loyally serving the methadone clinics.

Development of Medical and Health Services

Another memorable event of working with Professor Choa was his invaluable contributions to the development of medical and health services in Hong Kong in the 1970s-1980s. In the immediate post-war years, faced with an influx of returning residents and refugees, the priority of the Government medical services was on control and prevention of communicable diseases. Progress in developing Government facilities for in-patients and out-patients was slow.

The Medical Development Advisory Committee, a new body, was given the task this year to advise the Government on what programmes of improvement and expansion would be appropriate over the next 10 years in the circumstances of Hong Kong. This picture shows the Committee in session. Reading from left to right: Mr. Tai Kuen, Dr. Li Shu-pui, Sister (Dr.) M. Aquinas, Dr. G. H. Choa (Vice Chairman), Dr. Sir Albert Rodrigues (Chairman), Mr. R. H. Lobo, Mr. Li Fook-wo, Mr. S. F. Bailey, Mr. D. G. Jeaffreson, and Mr. P. B. Williams.

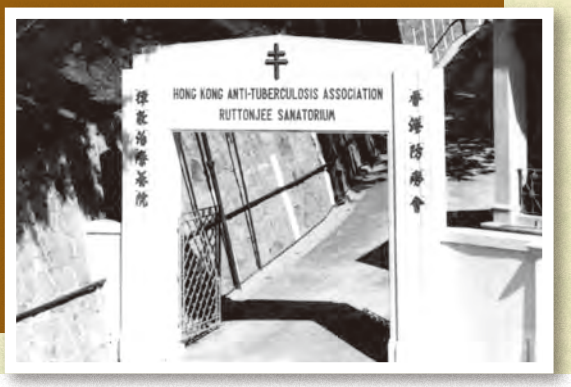
Following the publication of the White Paper on the Further Development of Medical and Health Services in Hong Kong in 1974, the Government set up a Medical Development Advisory Committee (MDAC) to oversee the implementation of the further development of medical and health services in Hong Kong. Professor Choa was the Vice-Chairman of the Committee. I was assisting Professor Choa in implementing the development programme.

Under the distinguished leadership of Professor Choa, considerable development of additional facilities and services for in-patients and out-patients was achieved. The number of hospital beds was increased steadily from 17,034 in 1974 to 25,059 in 1989, with bed population rates rising from 3.89 to 4.35 per 1,000 people. The number of general out-patient clinics has also grown from 44 to 54 to provide a better coverage of primary medical care to new towns.

In developing medical and health services in Hong Kong, the voluntary and charitable organizations have played a crucial part in providing the much needed hospital care to the people in Hong Kong.

I would like to take this opportunity to mention an organization, the Hong Kong Tuberculosis, Chest and Heart Diseases Association, which celebrated its 60th Anniversary last year in providing hospitals care to people suffering from tuberculosis. Tuberculosis has been a great menace of infectious disease in Hong Kong, especially immediately after the end of the Pacific War. Professor Choa was President of the Association from 1970 to 1976.

Doctors of the older generation in Hong Kong will no doubt remember Sister Acquinas and Sister Gabriel who taught us tuberculosis at the former Ruttonjee Sanatorium in Wan Chai. Over the past years, The Hong Kong Tuberculosis Association had considerably been benefited by the dedication and devotion of the Catholic Sisters from St. Columban Mission of Ireland in providing quality care and love to the patients. Over the past years, the Association has expended its services to the community considerably. The name of the Association has changed from an Association on Tuberculosis to an Association on Tuberculosis, Chest and Heart Diseases. The Association not only provides treatment services for patients but also services on health promotion and prevention of diseases, Chinese medicine and dental services. The old Ruttonjee



Sanatorium has been totally redeveloped into a modern general Ruttonjee Hospital. The success of the Association in meeting the changing needs of the community owed considerably to the invaluable contributions of the public–spirited individuals notably members of the Ruttonjee family who donated generously to the Association for building new facilities and devoted so much of their time in serving the Association.

In executing his duties as Director of Medical and Health Services, I had observed that Professor Choa had displayed justice, fair and honesty and patient-centered care in the delivery of medical and health services.

Medical Ethics

What is Ethics?

I now turn to the second part of my presentation — Medical Ethics. What is ethics? It is a set of philosophical beliefs and practices concerned with questions of justice, fairness, equity, rights, allocation of resources and costs. Professional ethics is the study of human actions, whether they are right or wrong, good or bad, worth doing or worth preventing. Although medical graduates nowadays no longer take the Hippocratic Oath on graduation from medical schools, we are still required under the Code of Professional Conduct of the Medical Council of Hong Kong to observe the International Code of Medical Ethics.

The International Code of Medical Ethics set out the duties of physicians in general, duties of physicians to patients and duties of physicians to colleagues. In essence the International Code is based on the following values in medical ethics: Beneficial (A practitioner should act in the best interest of the patient; Non-Maleficence (Actions intended not to harm or bring harm to the patient and others); Autonomy (Patient has the right to refuse or choose his treatment); Justice (Fair or Just to the wider community in terms of the distribution of scarce health resources, and the decision who gets what treatment); Dignity (Patient has right to dignity) and Truthfulness and Honesty (The concept of informed consent).

Challenges in the Fulfillment of Ethical Rules

In the 21st century, there are many challenges in the fulfillment of the ethical rules.

First, let us look at it from the Health Providers perspectives. In the areas of Hospitals: — Hospitals in the past are remarkably resistant to change both structurally and culturally. Hospitals have been described as "palaces of medical power". The concept of patients' right was difficult to promote. To-day the hospitals are facing the problems of containing cost, and many environmental factors including population aging resulting in more chronic non-communicable diseases, changing pattern of disease and rapid technological change. Furthermore, the changing hospital configuration, changing staff expectation and changing patients' attitude and the availability of alternative medicine put greater pressure for change in hospitals. In the allocation of scarce resources, we have to consider who will be responsible for the decision making and how the resources are to be allocated. Is it by disease category or by geographical regions?

In the area of public health, it is concerned with ethics because not only that we have to explain the occurrence of disease to the public but also have to take action to ameliorate it. We are also concerned with the integrative goals requiring the commitment of the whole population to take control measures to guard against the threat of death and disease. Formerly, ethics was discussed in terms of individual choice and personal morality but nowadays ethical issues have to be examined in terms of legislative, regulatory and judicial implications.

For example, during the SARS epidemic in 2003, the global public health response to control the disease included the surveillance of the disease, isolation and quarantine of patients and contacts, tracing of contacts and the provision of travel advice or restriction.

While we have a duty to protect the public's health, we also have to bear in mind the individual rights to privacy, liberty and freedom of movement.

The ethical issues that have been encountered during the SARS epidemic were the questions of what limits on privacy were justified by surveillance, contact investigations and the intervention measures? And what limits on liberty are justified by isolation or quarantine designed to separate the healthy from the infected or exposed? Further, what restriction of movement and economic liberty were justified by travel advisories to and from areas with SARS?

During the recent human swine influenza (H1N1) epidemic, the same ethical issue was raised again — whether it was justified ethically to keep the contacts in quarantine in a hotel for seven days?

One of the principles in the application of public health measures and the protection of human right is to recognize that the Government has the responsibility to implement effective health protection measures to guard its citizens against the health hazards and that only as last resort can human rights be interfered with to achieve a public health goal. So this time Government has acted promptly by changing its strategy in the course of the outbreak of human swine influenza from the Confinement Phase to Mitigation Phase w.i.f. 18 June 2009, once the epidemiology of the disease was better understood. The difference between the two phases was that in the Confinement Phase the application of quarantine and isolation measures was intended to hold off community outbreak as long as possible. With effect from 16 June 2009, this strategy was replaced by a less restrictive mitigation strategy, which requires patients with symptoms to attend designated out-patient clinics for treatment only. Quarantine and tracing of contacts were no longer required. The objective was to reduce spread in the community and to minimize the burden to society.

Second, from the public and patients perspective, there is increasing pressure for recognition of patients rights, the rights of being involved in policy making in healthcare and the rights for equal access to health care. In Hong Kong, apart from the statutory boards and councils in handling patients' complaints, there are other avenues to which complaints on medical issues can also be made. These include the various independent authorities such as the Ombudsman, the ICAC, the Legislative Council, Equal Opportunity Commission, Consumer Council and District Councils. Furthermore, the media, the Legal Aid Department provide avenues for the patients to address their complaints. If necessary, the Government can appoint Independent Ad Hoc Committee to undertake the investigation on issues of public health importance such as the SARS Expert Committee. The Harvard Report on Health Care Reform has indicated that the complaint system in handling public complaints on medical care is not transparent enough. We therefore have to ensure that justice is not only done but also seen to be done.

The SARS Expert Committee

Third, from the professionals' perspective, we are seeing many new issues in medical ethics. They include organ transplant, management of patients with AIDS, in vitro fertilization and embryo transplantation, the use of computers in medicine and the use of animals in bio-medical research (BIO-ETHICS), as well as increasing pressure for the relaxation of control on medical advertising. Recently, we have read from a newspaper that an advocate for euthanasia from Australia has called Hong Kong's laws against assisted suicide inhumane.

In a publication of the Medical Council in August this year, it is noted that the number of disciplinary cases handled by the Medical Council has been on the increase over the past 5 years. The common complaints are "Disregard of professional responsibility to patients", "practice promotion" and "issuing misleading, false medical certificates".

"The term misconduct in a professional respect" is not defined in the Medical Registration Ordinance but has been interpreted by the Court of Appeal as conduct falling short of the standards expected among registered medical practitioners. It includes not only conduct involving dishonesty or moral turpitude, but also any act, whether by commission or omission, which has fallen below the standards of conduct which is expected of members of the Profession. It also includes any act which is reasonably regarded as disgraceful, dishonourable or unethical by medical practitioners of good repute and competency.

Future Trend of Ethical Issues in Health Care

What will be the future trend in ethical issues in health care in Hong Kong and how should we meet the new challenges? Our future is rooted in our past and is predictable from the present. In the past, our health care has been under close scrutiny. There have been increasing demands from consumers for better quality of care, and increasing complaints from consumers on lack of transparency in responding to complaints. There have been progressive weakening of professional status, and increasing competition among health care providers.

Although there have been many issues on medical ethics in the past, the present time offers us new opportunities in responding to these challenges. The Hospital Authority in looking forward to the challenges ahead has made its pledges that the HA in the year 2011 will operate a modern health system of quality, financially sustainable, a top employer with good leadership, a substantial change in care outside hospital and an open and accountable organization.

There will be closer relationship between HA and private sector. HA will continue to serve as a facilitator

to ensure that no one should be denied of health services because of lack of means. Financing of health care will be focusing on the gap between what is available and what will be needed. The emphasis in future is patient-centered care, putting people on top of the agenda.

On 20 September last month, the Hospital Authority (HA) launched a New Service Culture. The ceremony was officiated by the Minister of Health, Professor Chen Zhu from China and the Secretary for Food and Health, Dr. York Chow. The Chairman of the HA, Mr. Anthony Wu said and I quote "the old Vision, Mission and Values (VMU) of the HA were devised some 18 years ago. With the progression of society and changing community expectations towards HA, we need to refresh a new service culture and consolidate it in our daily work to meet the needs of patients today" unquote.

The new Vision of the HA is "Healthy People, Happy Staff, Trusted by the Community'. The new Mission is "helping people stay healthy" (與民攜手，保健安康). The Chief Executive of HA, Mr. Shane Solomon elaborated and I quote "the new Vision is to balance the interests of people, staff and the community. While helping people, we want to make our staff happy and earn the trust of the community" unquote. We wish the HA greater success in introducing this "people first" philosophy.

The Government in its consultation document of "Building a Healthy Tomorrow" has indicated that Government will continue to take up the responsibility of protecting public health, provide accident and emergency services in public hospitals, take care of the low income groups and the under-privileged, provide tertiary levels of hospital services of high cost and high technology and continue to be responsible for education and training of medical, nursing and other health care professionals.

For the future we should strengthen education and training of doctors, nurses and allied healthcare professionals in legal and ethical aspects of health care. (I often advise medical students in university when they first start the medical course that it is not difficult to study medicine provided they have "three hearts". (1) Commitment (决心) — Medicine is a long course and involves a great variety of subjects. So you must have commitment in yourself to ensure that your work is satisfactorily completed. (2) Perseverance (恆心) — Medical science changes very rapidly. So you must continue to keep yourself up-to-date through continuing medical education throughout your life. (3) Tender loving care — (愛心) Although doctors are very busy in their work, it will be a great comfort to the patients and their families if we spend a little time to explain to the patients and families and talk to them about the medical conditions of the patients, this will give them a great relief and comfort facing the medical problem and avoid a lot of misunderstandings that often arise as a result of inadequate communications.) We should promote public education on the responsibility of the patients in seeking advice from the professionals. We need to introduce continuing professional education to all healthcare professionals on legal and ethical issues arising from advances in medical science and technology. We need to involve patients and public in planning for health care. We should have more transparency and information data on fees and charges in healthcare. The communication between the Boards and Councils and the healthcare professionals on ethical issues and on standard and quality of services should continue to be strengthened in order to cater for the changing needs.

Our future is rooted in our past and is predictable from the present

Conclusion

In conclusion, I would like to say as a healthcare profession, we have a duty to do great good in fulfilling the roles of a 5-star doctor as advocated by WHO, which is: a good health care provider, a good health promoter, a good health manager, a good community leader and a good advocate in supporting collective action for sustained improvement in people's health. In essence, it is leadership from the profession in building a good standard of practice, partnership among the profession in developing a strong team of professional staff to provide quality care, and community involvement to secure the public's trust, and to foster a culture of partnership for health.

The Hong Kong College of Physicians has been playing a leading role in promoting quality health care and in education, training of our physicians. With the continuing support of the Fellows of the College and the leadership of the Council, I have every confidence that the College will make great achievements in meeting the new challenges and in fulfilling our roles as a responsible profession to provide quality care to the people of Hong Kong. Thank you again for the invitation to this memorable occasion, I wish the College greater success in the years to come. Thank you.

Medical Professionalism, Leadership and Regulation

Professor Dame Carol Black
Past President, Royal College of Physicians, London

Thank you for this opportunity to explore the idea of the regulatory environment shaping medical professionalism and professional leadership in the UK. I shall look at how that environment influences ways in which doctors and our professional institutions think and behave.

Until quite recently the role of doctors in people's lives, in the community and in national life, and the skills, duties and responsibilities that merited the standing of doctors, were largely unquestioned by the public. It was axiomatic that the profession knew best how to deal with illness and disease. It was sanctioned by experience. Although there were discontented voices the Government that established the National Health Service 61 years ago – and successive Governments – were largely content to leave the profession to do what the profession thought it right to do.

That is no longer the case. Singular events alongside relentless change in our society have generated debate and actions that have greatly influenced both the regulation and the ethos of healthcare professions. The chief impact has been on medicine. Social and political factors, together with the achievements and promise of medical science, are reshaping attitudes and expectations – of governments, the public and of doctors.

The relationship between doctors and society generally, the doctor-patient relationship and the environments in which doctors undertake their training and their practice have all changed. They have changed rather quickly – within a generation. Increasing opportunities and demands for healthcare, advances in medical science, a drive to improve performance with the best use of resources, and a consumerist voice, have all brought pressures for reform. The patients' vision of good medical care includes quick access to reliable advice, effective treatment delivered by trusted professionals, comprehensive and clear information, involvement in decisions and respect for preferences, support for self-care and continuity of care with smooth transitions.

A willingness to question traditional values and behaviour throughout our society has also greatly

Editor's note : This lecture was delivered to medical students and medical officers on 2 December 2009 at Prince of Wales Hospital, Hong Kong.

Professor Dame Carol Black is currently the National Director for Health and Work in the United Kingdom, President of the British Lung Foundation, and Pro-Chancellor at the University of Bristol. In 2002 she was President of the Royal College of Physicians; a post she stepped down from in July 2006. She has recently stepped down as Chairman of the Academy of Medical Royal Colleges. In 2002 Dame Carol was awarded the CBE for her work on systemic sclerosis and in 2005 she was awarded the DBE for her services to medicine.

influenced the life and work and experience of doctors. Deference has almost vanished and authority that was signified by past achievement has to be re-earned and demonstrated. Knowledge that Medicine once exclusively possessed is now accessible to all. Doctors are held increasingly to account – rightly, to our patients as we have always been, but now also in respect of other actions that once lay within the domains of professional judgement. The exercise of clinical judgement is constrained by organizations such as the National Institute for Health and Clinical Excellence according to criteria of clinical and cost effectiveness[1].

Undoubtedly these changes have brought progress, with benefit for patients and for the public good. But care must be taken that there are not insidious consequences too. There is evidence that in different ways these changes can sometimes jeopardise the quality of care that patients trust their doctors to give, and the changes can have a detrimental effect on the confidence, morale and professional fulfillment of doctors.

There has been continuing discussion about regulation in modern society and no less intense discussion about professionalism. Regulation and professionalism explore many shared concerns. But they come from different directions, often with different emphases. The aims of reform and its regulatory instruments – improvement of service and care for patients, with the best use of resources – are difficult to achieve without the fullest engagement of clinicians and their committed leadership. For all these reasons medical leadership is now a vital element of professionalism.

Medical Professionalism

During the past decade, throughout the English-speaking world there have been a number of inquiries into the nature of medical professionalism.

In the UK the Royal College of Physicians of London assembled a working party whose membership extended far beyond the College. The working party began its task with the assumption that at the heart of good medical care is a set of values, attitude and behaviours called "medical professionalism". The aim was to discover what is understood by the concept of medical professionalism today, to formulate a description that could command wide recognition and support, and to make recommendation that we believed would help shape a new medical professionalism as a valued force in the life of our society in the UK[2].

Our recommendations were for a new, strengthened form of medical professionalism, valid for this time, to maintain trust and confidence in doctors and their part in our system of healthcare. We gave renewed emphasis to qualities that must endure, discarded those that have become outdated, and brought in new aspects that recognise the extended responsibilities of doctors today.

We defined medicine as a vocation in which a doctor's knowledge, clinical skills, and judgement are put to the service of protecting and restoring human well-being. This purpose is realised through a partnership between patient and doctor, one based on mutual respect, individual responsibility - and appropriate accountability. We reaffirmed the commitment to integrity, compassion, altruism, continuous improvement and excellence, and working in partnership with members of the wider healthcare team.

Our report was not for the profession and its institutions alone. The recommendations called for responsible engagement, drawing in a well-informed public alongside the medical profession, together with the national agencies that have an essential part in bringing about the steps necessary.

Medical professionalism today incurs many other duties and responsibilities. They are to do with responsibilities to the institutions in which doctors work; and, more widely, the system within which healthcare is provided. This corporate responsibility, calling for leadership and partnership with others, has not been a strong feature of the professional ethos hitherto. It was given great emphasis in our report. Much action is now being taken to eliminate this shortcoming.

Other responsibilities for a modern doctor might include encouraging justice in healthcare provision, functioning as public health professionals to reduce the burden of chronic disease, practising medicine with a deep awareness of the social determinants of health, and facilitating the introduction of new systems of care.

The RCP report was in several ways a radical departure from what had gone on before, showing a determination to draw the profession more closely into true partnerships with every element of our society involved in healthcare and its provision.

Leadership

A few words on what I understand by the much used term "leadership" and, in particular, leadership within the context of medical professionalism.

We seek many attributes in clinical leaders. Not only must clinicians be among the leaders of change, they must also exercise stewardship for quality and safety, and be protectors of quality and safety at the level of patient care.

The influence of clinicians in shaping organisations rests on their commitment to strategic aims and their underlying professional ethos. To this they should bring added value by a professional understanding of:

- the functions, facilities, working, organisation and delivery of an effective service
- the nature of team working, skill needs
- clinical networks and care pathways
- care across organisational and professional boundaries
- distribution of professional responsibilities in service delivery
- requirements and mechanisms of clinical governance
- the need to align clinical and financial responsibilities.

Thus, clinical leaders should be able to bring a whole-system view and an understanding of the way in which evey part of a joined-up system acts to serve patients and the service.

Clinical training and traditions can make the notion of clinical leadership counterintuitive for many doctors, the conventional view being that doctors and nurses should look after patients while managers look after organization. Let me mention two recent initiatives designed to change this view. First the Academy of Medical Royal Colleges and the NHS Institute for Innovation and Improvement have developed a Medical Leadership Competency Framework and Curriculum which have been approved for inclusion in the undergraduate and postgraduate curricula[3]. Secondly, in partnership with The Royal College of Physicians in partnership with Birkbeck College and The London School of Hygiene and Tropical Medicine, is delivering a leadership programme specifically designed to meet the needs of doctors in any specialty[4]. The aim is to anable medical professionals to attain senior levels of leadership and management.

Regulation

I should like to share a broader understanding of the term "regulation". Regulation can signify any measure or intervention carried out by government, or on behalf of government or some other statutory body, that seeks to change the behaviour of individuals or groups; and to monitor those changes, and to act where it thinks necessary.

From 1858 onwards the state exerted influence on the medical profession in the UK. Formal regulation was first established
by Act of Parliament in 1858. This established what became the General Medical Council - the GMC. That body, comprising members of the profession, undertook administration of the Act. Indeed, regulation was self-regulation and, despite powerful voices that wished otherwise, it remained so until quite recently[5].

The Medical Act has been updated by Parliament on many occasions. The Act covers the statutory purpose of the GMC, its governance, its responsibilities in relation to the medical education and registration of doctors and for giving guidance to doctors on matters of professional conduct, performance and ethics. The Act also sets out the GMC's powers and responsibilities for dealing with doctors whose fitness to practice might be impaired. As a consequence of continuing changes, medical regulation has moved from self-regulation to a regulation system in partnership with the public, professionally led.

However, regulation can be very wide-ranging, more extensive, and less sharply defined than that undertaken by the statutory professional regulatory body. In the United Kingdom it also lies, for example, in central and

local priorities, contracts of employment, authoritative guidance from professional bodies such as the medical Royal Colleges, out of the findings of inspecting bodies such as our Care Quality Commission – and formerly the Healthcare Commission - and authoritative recommendations from bodies such as the National Institute for Health and Clinical Excellence. The last is an independent organisation responsible for providing national guidance on promoting good health and preventing and treating ill health, though its agenda are set by government.

The professional bodies, the Medical Royal Colleges and specialist societies also retain major roles in standard setting and in measuring clinical performance, and have a central role in continuing professional development. But they no longer have the primacy of earlier times – instead they have become partners in a larger enterprise. The interaction of each of these modes of regulation with the professional ethos is, perhaps, no less important than the interaction of individual doctors with their statutory regulatory bodies.

Giving life to professional values

Statements about professional values, about attitudes, behaviours, conduct, are just that – they are statements. They can be developed into codes of conduct but remain descriptive, aspirational. That is also true of the admirable statement by the GMC, Good Medical Practice, delivered under the banner "*Regulating doctors, ensuring good medical practice*"[6]. The need is to build sound structures and functions to give practical expression to these values. Indeed, it is the observance and demonstration of the tenets of professionalism that trust is kept. And a crucial test is that patients be confident that their doctors are not merely competent but aspire to excellence, and that they are safe. Regulation is a means of affirming professionalism.

In the past most attention has been given to the important task of detecting bad doctors. There has been much less emphasis on supporting, quality assuring and improving the practice of the vast majority of doctors who already perform to an acceptable standard. That is the background to another major reform now being implemented in the UK - revalidation[7]. This is a system to enable each doctor to have fitness to practise reviewed every five years, and their licence to practise renewed only if they satisfy the requirements of that review.

Chief among the principles are that revalidation in the United Kingdom should support doctors in meeting their personal and professional commitment to sustaining and developing their skills. Revalidation should focus on raising standards generally, supporting aspirations to excellence, a hallmark of medical professionalism. Revalidation most certainly should not simply be a means of identifying those who fall short, and moreover, it should have remediation and rehabilitation as essential elements of the process for the very few who struggle to reach the required standards.

The drive of the profession to adopt revalidation affirms the assurance of medicine in the United Kingdom. It has rekindled the fire of medical professionalism. Doctors are confident that their work will answer the additional scrutiny that revalidation brings and they will welcome the opportunity to demonstrate their quality.

These reforms have mirrored a greater emphasis in the NHS on the quality and safety of care. There is now a legal duty of quality for all NHS organisations, clear national standards, with comprehensive local clinical governance arrangements. These changes are reinforced by a system of independent inspection against standards in hospitals and primary care services. There is a national patient safety programme to promote and share learning from adverse events. Medical regulators have come to be positioned within the wider domain of quality assurance – they are not an element apart.

What forces support or obstruct professionalism?

The values of medical professionalism and those of society, and the aims of government to improve the quality and safety and the clinical and cost-effectiveness of care, are not dissimilar. They should reinforce each other. I have no doubt at all that developments in professional education and training in the wake of regulatory reform will enhance the new professionalism and its impact.

However, problems arise when political or managerial differences about the policies adopted or the manner

of implementation run counter to the values of professionalism. Their resolution demands candid constructive dialogue based on respect and trust. Both have been severely tested in recent times. It is essential that Government, in its zeal for reform, acknowledge the ethos of our medical professional institutions and the goals to which that professionalism is directed. All those most closely involved in policy making, development and implementation must demonstrate trust in clinicians. This means more than willingness to share openly in their deliberations and decision-making processes; it means entrusting clinicians with both the authority and responsibility to implement change.

As I suggested earlier, among the behaviours and relationships signifying professionalism are leadership – clinical leadership – and stewardship – protection of quality and safety at the level of patient care. The Healthcare Commission, the independent body (now succeeded by the Care Quality Commission) charged until recently with inspecting hospitals and primary care services, has recognized that clinicians are also "the main agents of improvement". Such stewardship and the leadership that gives it force are at the core of a clinician's role. For the profession this means taking on responsibility for initiating such change as it believes fit and in the best interests of patients and populations.

Finally, I am moved to ask – optimistically – "Can regulation influence professional behaviour to such a degree that it can be applied with a lighter touch; for example where institutional, peer pressure and personal commitment rekindle responsible self-regulation – a form of earned autonomy?" I dare to believe so.

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Professor Yu & Professor Black

A Physician's Odyssey: Recollections and Reflections

Chin Hin Chew
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Past Master, Academy of Medicine
Singapore

Allow me to thank you Mr President and your Council for asking me to deliver the 5th College of Physicians Lecture. Your President has suggested that with over 50 years of association with Medicine, the title be "In the Service of the Medical Profession". With his permission I have re-phrased the title to "A Physician's Odyssey: Recollections and Reflections".

Prologue

Older Fellows know of my abiding interest and preoccupation in Medical Education. The very title "doctor" from the Latin "docere" means to teach and implies a responsibility for all doctors to share knowledge and impart information. This mission was recognised by the Founders of our Academy in 1957 namely to advance the Art and Science of Medicine, to sustain and foster Postgraduate Medical Education, now also included in the mission and objectives of our College. Thus, our predecessors in the Academy and Fellows of our sister Colleges of Physicians in Britain always insisted they be known as "Doctors" regardless of their professional or professorial standing.[1,2]

Pre-War, The 30s and Syonan Years

My introduction to Medicine some 70 years ago was as a young lad at Singapore General Hospital (SGH) growing up in the doctors' quarters at Outram Road before the outbreak of the 2nd World War. My late father, Dr Benjamin Chew, was a physician under the Chief of Medicine, Dr V Landor, with Gordon Ransome as a fellow colleague. He had graduated with Drs Benjamin Sheares and Ernest Monteiro in 1929 (Figs. 1 & 2). I still remember wandering in the wards of Norris and Bowyer Blocks and the clinical laboratory not far from our home. Malaria and tuberculosis

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Editor's note :

This article is written by Dr Chew Chin Hin who is an Honorary Fellow of the Hong Kong College of Physicians. Dr Chew graduated from the University of Hong Kong in 1955. He did his surgical internship at the Queen Mary Hospital, Hong Kong before returning to Singapore where he undertook his physician training, and rapidly rose through the ranks. He was Master of the Academy of Medicine, Singapore in 1973 and held the post of Deputy Director of Medical Services, Singapore until his retirement in 1991. Dr Chew is a key figure responsible for the close ties enjoyed between Hong Kong and Singaporean physicians. He delivered the 1st Gerald Choa Memorial Lecture at our Annual Scientific Meeting in 2002.

We are grateful to Dr Chew for granting Synapse permission to publish his speech which presents the historical development of medicine, teaching and standards of training in our region. It stresses the values of our profession, and the relentless pursuit of raising standards of care. This lecture was delivered on 5 July 2008 at the College of Physicians 5th Annual Scientific Meeting in Singapore and published in the Annals, Academy of Medicine, November 2008;Vol37, No.11.

Fig. 1. SGH in the 30s.

Fig. 2. LMS 1929.

Fig. 3. Memorial plaque at COMB.

(TB) were scourges. A young technician assisting my father showed me old-fashioned microscope specimens of acid-fast bacilli (AFB) and malaria parasites. He was Ong Soon Lim who continued to serve SGH some 30 years before retiring. These visits occurred in the late evenings and I was impressed by the dedication of the doctors, nurses and laboratory assistants.

Many here have not experienced the horrendous effects of war that engulfed Singapore. I recall seeing the numerous bodies haphazardly placed on the grass slopes outside the overfilled mortuary following the first wave of bombs directly hitting nearby Chinatown and a few missing us by hardly 100 yards on the morning of 8 December 1941. Even on the day before Singapore's surrender on 14th February 1942, we saw the 11 bodies, broken and battered by Japanese shells, of our dear medical students in the open field near the College of Medicine Building (COMB) (Fig. 3).[3,4]

In the first Tan Tock Seng Hospital (TTSH) Oration, I recounted that SGH was occupied by the Japanese military.[3] The whole staff with over 500 patients had to move at short notice in a long convoy of ambulances and trucks to Yio Chu Kang, now the old Woodbridge Hospital. Nine months later the same group moved from Yio Chu Kang (named Miyako Byoin by the Japanese) to TTSH (Hakuai Byoin). But this time it was a welcome move. TTSH with its central location meant that many more people could avail themselves of medical facilities and for the staff, better living conditions. TTSH with Kandang Kerbau Hospital (KKH) became the main general hospitals for the local civilian population.

Even so, conditions remained grim and harsh. TB, dysentery, malaria and other dreadful diseases were widespread. Medical supplies became scarce and staff did their best to eke out the available stocks, working long hours relying

much on good nursing and scrupulous use of available drugs. Experiences of death, dreadful diseases, scarce resources and hardship brought doctors and staff much closer together as one big family in an amazing *esprit de corp*. Five years ago, in 2003, this same spirit of courage, camaraderie and sacrifice was replicated when Singapore was struck by the severe acute respiratory syndrome (SARS) virus without warning with TTSH bearing the brunt. Alex Chao, a dearly loved Fellow of the Academy, with a few other healthcare workers sadly lost their lives and many others afflicted with the deadly infection (Fig. 4).[3,5]

During the occupation, hospitals were administered and manned entirely by local doctors and nurses. Medical education formally ceased but they became practical centres where doctors discussed their patients and they taught and learned daily by the bedside and meeting rooms. The three and a half years under the most trying conditions gave local teams tremendous opportunity to assume full responsibility for the medical services. Benjamin Chew was the first Singapore physician to administer live-saving penicillin in August 1945 (Fig. 5). His patient was fellow physician Clarence Smith who had a lung abscess.

During this period, I made a personal decision to follow in my father's footsteps to study medicine. The cruel effects of war coupled with his example and of his colleagues' selfless service and compassion for their fellow men underlie the noble character of our profession.

Early Years of Clinical Medicine: Hong Kong, Singapore and Britain

The next important milestone was formal introduction to medicine in 1949. It was a happy moment when I was accepted as a medical student by the University of Hong Kong. Singapore and Hong Kong were both British colonies and their medical schools followed similar and well established traditional Commonwealth patterns. Standards were stringent and consistently high. The Professor of Medicine, AJS McFadzean, was the counterpart

Fig. 4. Alex Chao with Drs B Chew and CH Low, TTSH.

Fig. 5. Dr Benjamin Chew, Head Medicine TTSH 1942-1945 with the family's residence.

of Gordon Ransome (Figs. 6 and 7). Both subscribed to the Oslerian doctrine and ethics, which were inculcated early in their teaching. Both were committed physicians and teachers. Singapore and Hong Kong often shared external examiners. My 6 years in Hong Kong was hard going with medical studies and sporting activities especially hockey and cricket but nevertheless satisfying and with Anna, my wife to be, happy and rewarding (Fig. 8).[6,7]

I returned to Singapore in 1956 and stepped into the wards of Professor Ransome in SGH and commenced my 6 months as house physician.[3] Anna was posted to the casualty and outpatient services at SGH under Dr Colin Marcus.

Much has been written and said of Sir Gordon Ransome. He was indeed a superb clinician – kind and gracious – treating every patient regardless of station with the same thoroughness. Above all he was humble in all ways, prepared to learn from others including lowly housemen, giving credit magnanimously when due, ready to admit his mistakes and frailty (Fig. 9).[8] While he was not the best of administrators this was made up by TJ Danaraj, his senior lecturer, who later planned the Medical School in Kuala Lumpur. With Seah Cheng Siang, Evelyn Hanam and PK Wong amongst others, care of patients was of first importance, records were meticulously kept, and training of doctors and medical students was thorough despite having no formal basic

Fig. 6. Sir David Todd with predecessor Alex and Mrs McFadzean

Fig. 8. MBBS, Hong Kong (1949-1955).

Fig. 7. CCH with Sir Gordon Ransome at his retirement, 1975.

Fig. 9. University Department of Medicine, SGH 1959 with Sir Stanley Davidson PRCPE.

and advanced training programmes as we now do. We were a good team. With Cheng Siang, my immediate mentor, I learnt their clinical methods and inherited much of their teachings and values. Later, when I was a trainee preparing to proceed to Britain for the membership examinations, he ensured his trainees were not only competent but also knowledgeable before proceeding overseas. I will always remember with gratitude when he undertook our active night calls while we who were studying went only on passive duties.[9]

Having completed the statutory year of housemenship, I returned to TTSH in 1957. I was warmly received by the Medical Superintendent and Senior Physician, Clarence Smith. The senior doctors introduced to me were most cordial and warm, especially Yeoh Seang Aun, my supervisor. Seang Aun was to play a special role in influencing my career, as he knew of my special interest in medicine and medical education. He had always been supportive of my plans.

With the support of Cheng Siang, Seang Aun and Gordon Ransome, I proceeded to Edinburgh in late 1959 arriving in the cold winter for the Internal Medicine course at the Royal Infirmary. This was followed in 1960 for the Chest diploma in Cardiff and again in Edinburgh for the Clinical Medicine course.

Professors Sir John Crofton, Sir Derrick Dunlop and their colleagues were our teachers and examiners in Edinburgh. They were friendly, committed to their work and somehow had a special affinity for Singapore postgraduates. Life was austere but the sincerity and friendliness of the Scots made our stay in Edinburgh most pleasant. Many became our lifelong friends contributing much to our postgraduate education training and research.

There were a number of postgrads from Singapore, Malaya and Hong Kong, often gathering weekly in one another's homes for study, revision and discussion; later with our wives for fellowship and supper – truly in the Hippocratic tradition of supporting fellow brethren doctors in friendship and camaraderie. Among this group were BY Tan and PK Wong from Singapore, BK Khoo of Malaya, and CH Ip of Hong Kong.

Practice of Medicine in the Civil Service: TTSH and Ministry of Health (MOH)

In January 1961, Anna and I left Edinburgh over land and sea through the Suez Canal after examinations and studies in Scotland and Wales for Singapore. I found myself again under Seang Aun, now the senior Head of Medicine, TTSH. Anna was made medical officer in charge of the Kallang outpatient clinic at Mountbatten Road. My family and I moved into 15 Akyab Road (Fig. 10). This was our home for 31 years, moving out only after my formal retirement as a civil servant.[3]

TTSH had become a centre for treatment of TB although it had also patients with lung cancers, chronic bronchitis and emphysema (many addicted to opium). TB was a formidable problem with over 5000 new cases annually. Although we had potent chemotherapy of streptomycin, PAS and isoniazid, collapse therapy was still practised. Drug resistance and relapses were common.

With the sympathetic encouragement of our medical superintendent, HF Jackson and other physicians, it became a matter of time before we saw medical students in the wards. By 1963, we had converted a ward for acute general medicine, followed shortly by another two. I was appointed

Fig. 10. TTSH Doctors' Residence at Akyab Road with teaching wards behind.

consultant and had Sitoe Kum Fatt and Chia Boon Lock managing these wards. Boon Lock is today an eminent Emeritus Professor and doyen cardiologist, still teaching and learning, a true example of a lifelong educationist and academician. Amongst our first house physicians was Chen Ai Ju, later my successor in MOH and Director of Medical Services. Others joining our medical units were J Abdullah, Loong Si Chin, Boey Mee Leng, Aileen Wee, and later Susan Quek, Ann Chan, Tan Kim Ping, Chee Yam Cheng and many more as established posts progressively increased.

Fig. 11. Department of Medicine IV with IWB Grant of Edinburgh.

In 1964, the medical units were reorganised by the recently appointed medical superintendent, Andrew Chew. Hence, Medical Unit IV was formed with me as Foundation Head assisted by SK Lee. With subsequent promotions and transfers, YY Ong became my Senior Registrar in 1973 and Consultant in 1977 (Fig. 11). He, Tan Tiong Har and later Teo Seng Kee played a tremendous role in teaching, training and research and we were a good team. Yong Yau was to cover my duties frequently in the late 70s following administrative changes in the MOH and TTSH when I was officiating and later designated Medical Director in 1979. With this change, PH Feng succeeded me as Head and his position was taken over by Yong Yau who became Seah Cheng Siang's deputy at SGH. Further changes were to take place in MOH and in 1981, I was appointed at short notice Deputy Director of Medical Services (DDMS) overseeing hospital services and in my place came Moses Tay and shortly after Ng Kwok Choy. My association with the hospital remained close not only because of our residence within the grounds but my continued involvement in research through the Ministry's TB Research committee, Anna's work at the control unit, seeing to my patients and attending ward rounds and conferences when permitted. I was much heartened to be conferred the title of Emeritus Consultant in 1998.[3]

A main preoccupation at the Ministry was the future planning and development not only of TTSH but also plans for other hospitals and specialist centres. These have now materialised with National University Hospital (NUH), the new Woodbridge, Changi General and KK Womens' and Children's Hospital (KKWCH) and the centres we see today at Outram and TTSH campuses. A corresponding preoccupation at the Ministry was manpower planning including selection and postings of trainees and specialists. Chee Yam Cheng was of immense help as Director of Manpower. I had recruited him when he was president of the doctors' union (SMDPOA) and brought him over to the right side of MOH's establishment. He continues to be ever faithful, continues to be a physician at TTSH and succeeded me in the MRCP Policy Committee of the UK Colleges.

Some memorable events at MOH included leading the Singapore delegation to WHO World Health Assembly meetings in Geneva and Regional meetings in Manila in the 80s.

In 1994 (post retirement), it was most gratifying to be asked by the Minister for Health to chair the newly established National Medical Ethics Committee. Some of the Committee's early recommendation led to the passage of the Advance Medical Directive Act[4] in 1996 and the formal teaching and establishing a chair of Medical Ethics in our Medical School.

Progress in TB Control and Research

Control measures against TB had greatly improved. Statistical and epidemiological data were now better appreciated with the establishment of the TB Control Unit, chemotherapy regimens strengthened and more efficiently delivered following successful drug trials in the 50s by the British Medical Research

Council (BMRC) with streptomycin, PAS and isoniazid (INH). This work was extended by a group of our friends in Edinburgh led by John Crofton (Fig. 12). Similar treatment policies and methods were adopted at TTSH.[10] Sir John whom I had the pleasure of knowing as teacher, examiner and friend also became a lifelong friend of the hospital and the Academy, visiting Singapore as President of RCPE in 1976 and made an Honorary Fellow in 1978.

Further improvements in delivery of acceptable regimes under routine treatment conditions were necessary. This led to the formation of the TTSH TB Research committee with Yeoh Seang Aun as Chairman. Other members included Wong Hin Sun, James Supramaniam, William Chan, S Devi and myself. This was elevated in 1966 to a Ministry of Health committee when we commenced joint studies and trials with the BMRC led by Wallace Fox (Fig. 13). Other returning chest specialists from the UK and Australasia soon joined us. They were Poh Soo Chuan, Ng Yook Khim, Ng Kwok Choy, SK Lee, Ong Yong Yau, Tan Tiong Har, Teo Seng Kee and others with David Macfadyen as a WHO representative.

In early 70s, our collaborative studies with BMRC showed that fully supervised treatment with streptomycin and isoniazid given twice a week was highly effective and more acceptable than the daily regimen. The mid-70s saw the advent of rifampicin and our several studies showed the tremendous value of *full supervision* and intermittent therapy. Indeed these studies paved the way for short course regimens of 6 months. They also offered operational advantages: a decrease in utilisation of treatment services with shorter duration and substantial economic savings.[11]

As Chairman of this research committee and DDMS in charge of hospitals, I had the privilege to preside over the 1986 World Conference of Tuberculosis and Respiratory Diseases held in Singapore. The guest of honour was Dr Wee Kim Wee, President of Singapore (Figs. 14 and 15). Our committee presented several landmark papers on short course regimens under full

Fig. 12. Conferment of Hon. FAMS on Sir John Crofton, 1978.

Fig. 13. MOH TB Research Committee with Wallace Fox.

Fig. 14. World Chest Conference in Singapore, 1986.

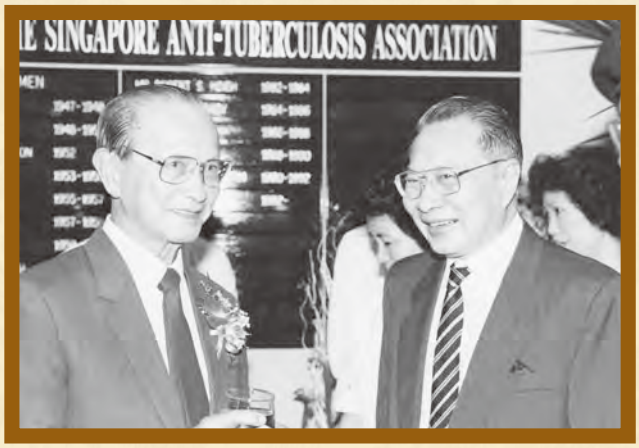

Fig. 15. President Wee Kim Wee, Patron of Academy of Medicine, Singapore and SATA.

supervision with excellent results at this and other conferences. These are relevant even today and WHO has now termed the programme as DOT (Directly Observed Treatment) for treatment of TB patients. These studies were also published widely in the *Lancet, British Medical Journal, Tubercle and American Review of Respiratory Diseases.*[12]

With the rapid decline of TB and with the disciplines of chest and internal medicine and diagnostic radiology well established, the stage was set in the late 60s for the transformation of TTSH into a general hospital. By the 70s, it became the second largest general hospital. In the 80s, with increasing specialisation, it also had numerous specialist departments and centres, noted for its strength in many disciplines. Infectious Diseases and the Communicable Disease Centre became part of the TTSH family.[3]

Medical Organisations, Associations and Academic Institutions

Sir William Osler, the father of modern Medicine, was an organisational and educational man. He understood that organisations impart a sense of belonging, promote fellowship and hoped counter self-centredness and contentiousness. He advised his medical brethren to be involved actively in organisations. While in Oxford, he had founded the Association of Physicians of Great Britain and Ireland. He had also been an active fellow of the Royal College of Physicians, London. In our context and in our time, these are our national medical organisations like our Academy and its Colleges, Singapore Medical Council (SMC), Singapore Medical Association and our Specialist Societies.

In Singapore, formal postgraduate education became more organised only with the founding of the Academy of Medicine in 1957 and the Committee of Postgraduate Medical Studies in 1961, formed as a result of Academy's carefully prepared memorandum sent to the Ministry of Health and the University. The pace of sending our doctors abroad for specialist training had been painfully slow by the colonial government. The Academy's principal objectives were to advance the art and science of medicine, to maintain and promote the highest standards of professional practice and a high code of ethical conduct. With such a mission and knowing of my keen interest in medical education, it was only natural for Seang Aun, my chief in 1963, to invite me for membership. I was elected to council a few years later and Master in 1973 and have been closely associated with this body and its developments (Fig. 16).[1]

Patterned on the Royal Colleges in Britain and the Commonwealth but unlike these Colleges, which are responsible for individual disciplines, the Academy embraces all specialties. This was also the period when Singapore became more politically independent (Table 1). In the

Fig. 16. Visit of first Patron President BH Sheares, 1975 to Academy of Medicine, Singapore.

Table 1. Postgraduate Institutions in 50s and 60s

1957	Academy of Medicine
1961	Committee of Postgraduate Medical Studies
1970	School of Postgraduate Medical Studies, M Med qualification
Pre-1959	Singapore, a Crown Colony
1959	Singapore, self-governing State
1963	Singapore in independent Malaysia
1965	Singapore an independent Republic

Fig. 17. Some Past Masters at the Academy in College of Medicine Building in the 80s.

Fig. 18. The Governing Board School of Postgraduate Medical Studies (DGMS).

early years, regular courses were organised for candidates preparing for examinations of the Royal Colleges. The Academy had always felt that Singapore should have its own professional qualifications of internationally recognised standards (Fig. 17). Many memoranda on this matter and on specialist training, certification and registration had been sent to the Ministry and the University but progress was slow. On October 8, 1967 Deputy Prime Minister Toh Chin Chye delivered a speech when he censured the Medical Faculty for not making progress in this area. The response by the Academy was immediate when Council saw the report in the Straits Times. A letter was sent to him indicating that the Academy existed for the advancement of medical specialisation and establishment of higher professional qualifications and requested for a meeting. He promptly agreed and we met over morning coffee at the City Hall on 4 November. Dr Toh suggested that a committee be formed under the chairmanship of the Master with representatives from the Faculty and the Singapore Medical Association and that the recommendations be sent to the Ministry of Health and University. Soon after, Dr Toh was appointed Vice Chancellor and accepted the recommendations of the committee. The recommendations were "that higher qualifications in various clinical specialties be awarded by the University and the School of Postgraduate Medical Studies be reconstituted to enable the Academy to participate as equal partners in the training programmes and examinations". A new statute for the School also provided for it to function under an independent Board. Thus, this meeting on 4 November was not only historically significant in regard to our new degrees of Master of Medicine established in 1970 but allowing the Academy to participate as equal partners on the Board of which I had been closely associated almost since the beginning, initially as a Board member, then Deputy Director and now Honorary Advisor.[1,8]

From the outset, we stressed that standards obtained must be stringent and examinations be of the order no less than that required for corresponding qualifications of Britain and Australasia. The Board also laid stress on high standards of training before candidates could sit. This was ensured by a selection committee and this principle of trainee selection continues to this day (Fig 18).

I had earlier stated that to establish these objectives, it was vitally important to cultivate close friendships and links with these Colleges if we were to have international recognition of our examinations. From its inception, external examiners were appointed from the Royal Colleges in Australasia and Britain for our Master of Medicine (MMed) examinations. Some even sent their Presidents. They have regularly attested to the high standard of these examinations. Recognition and reciprocities were accorded early. By 1986, the Royal College of Surgeons of Edinburgh, the Academy and the Postgraduate School had joint examinations in MMed Surgery with FRCS (Edin) (Fig. 19).

Fig. 19a. (FRCS) MRCS Edin/M Med Surg, 1986.

Fig. 19b. Edinburgh meeting of Presidents in 1994 leading to MRCP (UK)/M Med Int Med and Paediatrics.

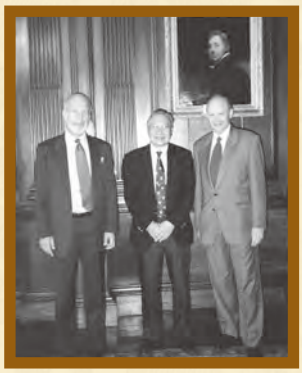

Fig. 20. CCH with David London, Registrar and Lord Turnberg PRCP, Hon FAMS at the London College.

Fig. 21. SAB 2001-2004.

Fig. 22. SAB 2004-2007.

In June 1994, the President Royal College of Physicians of Edinburgh, Dr Anthony Toft, invited his fellow UK Presidents and Presidents of some overseas colleges and academies to Edinburgh to discuss specialist standards including reciprocity and joint examinations. I was privileged to represent the Academy and the School. This with another personal meeting with the Presidents of the London and Hong Kong Colleges [Lord Turnberg (Fig. 20) and Sir David Todd] led to the first joint MMed/MRCP examinations for adult and paediatric medicine in 1995. In recent years, the Royal College of Paediatrics and Child Health continued the same arrangements with regard to paediatric medicine.[8,13,14]

Specialist Standards, Certification and Registration

With the progress of specialisation, it was recognised that our local MMed and its equivalent qualifications did not denote the completion but the beginning of advanced specialist training of a further 3 to 4 years. In 1975, a standing committee on specialist certification was formed which led to the institution of the Academy's Roll of Specialists. The committee and its specialist boards also laid criteria for basic and advanced training in accredited units of our hospitals. It was further recognised the need to conduct formal exit assessment by teams of both local and external assessors. In this regard, the FAMS has since 1987 been the registrable qualification by the SMC for successful completion of specialist training.

With fast moving developments in the 90s, the Medical Registration Act was revised in 1997, providing for the establishment of the Specialist Accreditation Board (SAB) assisted by the Joint Committee of Specialist Training (JCST) and Specialist Training Committees (STCs). The Chairman is the Director of Medical Services with the Master, Director, DGMS and the President of

Medical Council as ex-officio members (Figs. 21 and 22). This inclusive tripartite representation comprising the Ministry, the Academy and the Medical School has been the hallmark of our specialist boards, training and examination committees: so important in our relatively small community of our small island nation. It has indeed been a privilege to serve on the Academy's committees, the SMC, the protem committee of SAB, the SAB since its formation until 2007, the JCST and the STCs. The Act also provided for the establishment of a Specialist Register which succeeded the Academy's Roll of Specialists.

Our College of Physicians was established officially in August 2004. This followed an Extraordinary meeting of the Academy on 27 March 2004 under the chairmanship of Master K Satku with 95 Fellows attending. They gave resounding support to the special resolution to amend the Academy's Memorandum and Articles of Association (M&A). This enabled the Academy to form 6 Colleges, autonomous yet within the Academy's family including ours. Master Satku in introducing the resolution declared "the formation of Colleges will stimulate and allow for an enhanced role for the various specialties in Training, Examination and Continuing Professional Development".[15] I was greatly heartened, honoured but humbled when the College through our first President Lim Shih Hui conferred on me in 2005 the Honorary Fellowship which I shall always cherish (Fig. 23);[14] similarly with the Fellowship conferred by the Hong Kong College a few years earlier.

Fig. 23. Conferment of Honorary Fellowship by President Lim Shih Hui, 2005.

Epilogue

In closing, let me commend to our fellows 3 longenduring quotations that have guided me in this odyssey:

First, our Medical School's alumni motto "not to be ministered unto but to minister" or to paraphrase this we are here to serve our fellow men and patients with care and compassion.

Second, "integrity without knowledge is weak and useless, knowledge without integrity is dangerous and dreadful" so wrote Dr Johnson and needs no elaboration.

Third, "the practice of Medicine is an art, *not* a trade; a calling *not* a business, a calling in which your heart will be exercised equally with your head" by Sir William Osler.

Medicine and its practice environment have changed tremendously but these ethical principles remain fundamental and timeless. As long as we hold true to the mission and spirit of ministering to the sick, to continue as an anchor in postgraduate and continuing medical education and professional development, to teach and support our brethren colleagues and peers and collaborate actively with SAB, JCST, their specialist and assessment committees, I am convinced our College will continue to flourish going forth from strength to strength and will long endure.

Acknowledgements

My Brethren Colleagues & Fellows for their unwavering support, my Scribes: Ms Yong Bee Choon, Ms Eileen Chew-Harrop and the Medical and Healthcare fraternity.

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The Council wishes to congratulate Fellows who have received awards in the recent few months.

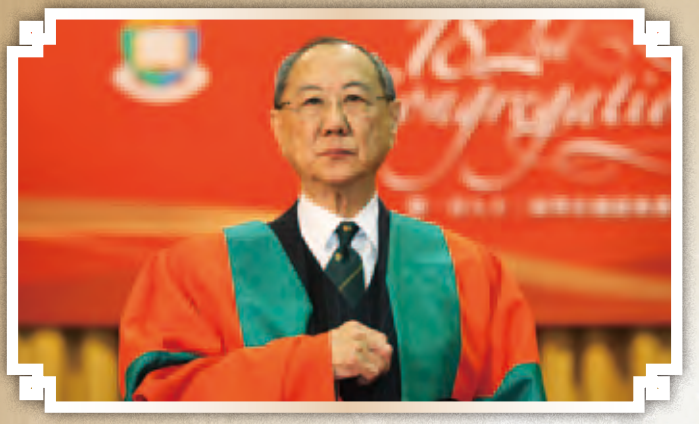
Leading the honours is our Past President, Professor Richard Yu, who was among the five individuals bestowed the highest accolade by the University of Hong Kong with the conferment of the degree of Doctor of Social Sciences, honoris causa by the Dr the Honourable Donald Tsang Yam Kuen, Chancellor. This award is in recognition of Professor Yu's distinguished service and commitment to the University, the Hong Kong community, and to academia. The Citation was delivered by the Public Orator, Professor Michael R. M. Wilkinson who has kindly granted permission to include the citation in Synapse.

We would also like to offer hearty congratulations to Fellows who were newly elected to sister Colleges in the United Kingdom this year.

Citation for Honorary Degree, Doctor of Social Sciences, University of Hong Kong

(182nd Congregation, 11 March 2010)

Professor Michael R. M. Wilkinson
Public Orator, 182nd Congregation
Barrister, Faculty of Law, University of Hong Kong



Professor Richard Yue Hong YU
Doctor of Social Sciences

Our final honorary graduand this evening is Professor Richard YH Yu, another most illustrious alumnus of this University who comes from a family of illustrious alumni. His father, who lived to the ripe old age of 102, graduated from our Medical School in 1929. He and his wife raised four sons all of whom followed in their father's footsteps becoming doctors. Richard was the second son and graduated form HKU with an MBBS degree in 1958. With disarming frankness Richard revealed to me that he failed in Medicine in his final examinations, only passing at a second attempt. He says that this upsetting experience, far from deterring him in his career, incited him to work even harder to show to himself and the world that he was as good as, if not better than, his fellow students. Looking back on his time as a student, he says that the guidance and example that he received from his teachers such as Professor McFadzean, of whom all students were in awe, Gerald Choa, who was a rather stern but impressive figure, and David Todd, a lifelong friend, stimulated his interest, not only in medicine, but also in the arts, and convinced him that life was full of challenges and had to be lived to the full.

He completed his clinical training at Queen Mary Hospital and then, encouraged by Gerald Choa, took the unusual step of undertaking postgraduate research at the University College Hospital in

London, from which he obtained his doctorate in 1966. Returning to Hong Kong he entered upon an academic career in our Faculty of Medicine and his research on blood pressure in patients with renal failure or following renal transplants led to the award to him of an MD degree by this University in 1972.

In 1973 Richard, burning with a desire to introduce improvements in medical care, decided to enter private practice, although he continued to teach at HKU as an Honorary Clinical Lecturer and subsequently as an Honorary Clinical Associate Professor.

As a medical practitioner Richard specialized in nephrology and made enormous improvements both in respect of patient care and in the provision of medical treatment. But perhaps his greatest contribution has been by way of public service to the medical profession. Again he attributes his desire to better the profession and its delivery of service to the community to the early training and professional standards set by his teachers. In 1985, with the change of sovereignty on the horizon, Richard joined distinguished colleagues who included Professors David Todd, TK Chan, Gerald Choa and Dr EK Yeoh to found the Hong Kong College of Physicians, which was to assume responsibility for medical education and training in Hong Kong. He was the Founding Honorary Secretary of the College from 1986 until 1995, its Vice-President for Education from 1993 until 1995 and then its President from 1998 until 2004. During this time he was very much involved in ensuring that our qualifications were recognized overseas and that the close links that had been forged between our profession and those in the United Kingdom and Australia were maintained and indeed further strengthened. He also oversaw the development of comprehensive training courses and fair and transparent accreditation procedures. At present he is the Chairman of the Higher Physician Training Committee, leading a revision exercise to implement changes in the annual and exit Examination for Higher Physician Trainees.

Another major contribution to public service has been Richard's involvement in ensuring that proper compensation is paid to pneumoconiosis sufferers. With the support and encouragement of our Council Chairman, Dr CH Leong, he served for 10 years on the Pneumoconiosis Board, acting as Chairman of the Rehabilitation Committee for the last 5 years of that period and several important improvements can be attributed to his efforts. First, the digging of caisons by hand was outlawed, this being a major cause of pneumoconiosis in Hong Kong. Secondly, he was instrumental in bringing about an amendment to the law introducing an improved system of compensation whereby sufferers received compensation, not by way of a one-off payment, but payable throughout the period of continued suffering. Thirdly, he developed rehabilitation facilities for 2,000 sufferers so that they could receive consistent and one-stop treatment at three Hong Kong hospitals, Ruttonjee Hospital, Shatin Hospital and Haven of Hope Hospital, where excellent respiratory rehabilitation services are now provided.

For his signal contribution to healthcare and public service Richard has received a host of accolades. He is a Fellow of the College of Physicians in Hong Kong, the Royal Colleges of Physicians in UK and Australia and of the Academies of Medicine of Hong Kong and Singapore. He served as a member of the Hospital Governing Committee of the Ruttonjee and Tang Shiu Kin Hospitals from 1992 until 2002 and the Queen Mary and Tsan Yuk Hospitals since 2003.

Despite his onerous public duties Richard never neglected his alma mater. He himself donated an Endowed Professorship (the Yu Professorship in Nephrology) and has been instrumental in arranging two more Endowed Professorships, one in honour of his father. He is currently an Honorary Professor in the Department of Medicine at HKU and of the Department of Medicine and Therapeutics at the Chinese University of Hong Kong.

Just as the Hong Kong College of Physicians continues to benefit from Richard's wise counsel, so indeed does Hong Kong society as a whole as he persists in his lifelong quest to raise the quality of medical education, hospital services and the medical sector overall. When asked about his philosophy of life, Richard replied that he has always been driven by challenges, usually self-imposed. First there was the academic challenge, then the professional challenge and finally the challenge of public service. He says that his success in meeting these challenges can be traced back to his failing that one segment of his examinations back in 1958. We should all be grateful that he failed that examination.

Mr Chancellor, it is my honour and privilege to present to you Professor Richard YH Yu for the degree of Doctor of Social Sciences, *honoris causa*.

Newly Elected Fellows of the Royal College of Physicians, London

Elected in 2010

Members of the College

Dr HO Chung Man James

Dr HON Hing Tong Patricia

Dr KNG Poey Lyn Carolyn

Dr LAU Ip Tin

Dr LEE Yuk Tong

Dr LEUNG Yu Hung

Dr LI Fu Keung

Dr NG Fook Hong

Dr TSO Po Yiu

Distinguished doctors, not Members of the College

Dr LEONG Che Hung

Prof ZHONG Nanshan

Fellows and Members of other College of Physicians

Prof PEIRIS Joseph Sriyal Malik

Newly Elected Fellows of the Royal College of Physicians, Edinburgh

Elected from March 2009 to January 2010

Dr CHAN Kin Yip John

Dr CHIU Alexander

Dr CHOI Kin Wing

Dr HO Tze Kwan Carmen

Dr HO Chung Man James

Dr HUI Pun Edwin

Dr HUNG Hiu Gong

Dr LAM Chiu Wah

Dr LO Kwun Man

Dr TSANG Kin Keung

Dr CHEUNG Tak Cheong

Dr FONG Chung Yan Gardian

Dr TSE Wai Choi Eric

Newly Elected Fellows of the Royal College of Physicians, Glasgow

Elected in 2010

Dr CHAN On On Annie

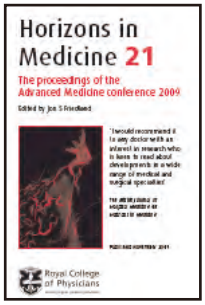
Dr CHAU Mo Chee Elaine

For Your Calendar

Our Annual Scientific Meeting will be held on 9 and 10 October 2010 at the Hong Kong Academy of Medicine. Please do mark your diary.

Notice from the Royal College of Physicians, London

Based on the popular Advanced Medicine Conference held at the Royal College of Physicians, the Horizons in Medicine series provides physicians of all backgrounds and levels with an invaluable insight into these exciting times in the field of medicine and an opportunity to broaden their knowledge of other specialties.



For more information refer to http://www.rcplondon.ac.uk/pubs/brochure.aspx?e=293

Obituaries

On December 30, 2009, **Professor Arthur Colville Kennedy** CBE, MD, FRCP(Lond), FRCPE, FRCP(Glas), FRCPI, FRSE, FACP(Hon.), FRACP(Hon.) passed away peacefully in the St Margaret of Scotland Hospice accompanied by his beloved wife, Nancy.

Professor Kennedy was the Muirhead Professor of Medicine, Glasgow University and served as the President, Royal College of Physicians and Surgeons of Glasgow in 1986-1988. Besides supervising many nephrology fellows from Hong Kong spending their sabbatical training at the Glasgow Royal Infirmary, Professor Kennedy also gave invaluable advice in the establishment of our College.

On March 16, 2010, **Professor Lei-shi LI**, MD, PhD, Fellow of the National Academy of Engineering, (Hon) FHKCP passed away in Nanjing, China.

Professor Li was the Emeritus Chairman of the Research Institute of Nephrology and Dean of the Nanjing University Clinical School of Medicine. In 1978 he established the new medical subspecialty of kidney disease, separate from general medicine, and founded the modern era of nephrology in China. He was the founder of the Chinese Society of Nephrology, one of the key founders of the Asian-Pacific Society of Nephrology, the first Chinese Council Member for the International Society of Nephrology, Adjunct Professor of Medicine of Brown Medical School, Honorary Fellow of the Hong Kong College of Physicians and Member of the Standing Committee of the Chinese National Academy of Science and Engineering. Professor Li fostered numerous academic collaborations between Hong Kong and China.

MRCP Examination Dates for 2011

Joint HKCPIE/ MRCP(UK) Part I examination 2011	Joint HKCPIE/ MRCP(UK) Part II (Written) examination 2011	PACES examination dates for 2011
18 January 2011 (Tuesday) 20 September 2011 (Tuesday)	6 –7 April 2011 27 – 28 July 2011 23 – 24 November 2011	21 – 25 February 2011 17 – 21 October 2011

Examination Results

Pass rates for the Joint HKCPIE/MRCP(UK) Part I examination for the years 2002-2010

	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%)
Sep 09	47	28 (60%)
Jan 10	45	28 (62%)

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%)
8 & 9 Apr 09	32	25 (78%)
29 & 30 Jul 09	50	43 (86%)
25 & 26 Nov 09	12	7 (58%)

Joint HKCPIE/MRCP(UK) PACES examination

October 2001	36/72 = 50%	October 2006	16/73 = 22%
February 2002	34/74 = 46%	March 2007	44/74 = 59%
October 2002	29/72 = 40%	June 2007	44/74 = 59%
February 2003	30/69 = 43%	October 2007	36/55 = 65%
October 2003	27/59 = 46%	March 2008	36/74 = 49%
March 2004	39/64 = 61%	October 2008	29/65 = 45%
October 2004	26/69 = 38%	February 2009	39/75 = 52%
March 2005	35/75 = 47%	October 2009	24/72 = 33%
October 2005	28/75 = 37%	March 2010	33/75 = 44%
March 2006	36/75 = 48%		

Pass List of Joint HKCPIE/MRCP(UK) Examination - March 2010

Chan Hiu Mang	**Chan Chi Hey Heyson**	**Chan Ting**
Chang Carlin	**Che Pey Sze Patricia**	**Cheng Jen Ngai**
Cheung Sai Wah	**Choy Shin Man**	**Ho Chup Hei**
Ismail Moamina	**Kong Chun Cheong**	**Kung Ka Yee**
Kwan Pui Yuen Lorraine	**Lam Chi Yeung**	**Lau Ngan Ming**
Lee Tsz Heung	**Lee Wai Chung Kirsty**	**Leung Chi Hung Czarina**
Li Wing Man Christie	**Lin Oi Yee**	**Lui Hoi Ki**
Ma Kit Kwan	**Ng Sin Ngai**	**Poon Yin**
Ting Chung Yi	**Tsang Chun Fung Sunny**	**Tsang Hoi Lun Helen**
Wong Ka Fai	**Wong Wai Mui**	**Wong Cheuk Lik**
Wong Chi Yan	**Wong Pik Wa Carrie**	**Yung Chi Yui**

Writing Case Reports for AIM Assessment

Reflective writing, No plagiarism

Dr. KS Chan
Examination Coordinator, Specialty Board in AIM

Reflective writing

It is a requirement for Higher Physician Trainees (HPT) in Advanced Internal Medicine (AIM) to submit two case reports for each annual assessment.

1. The objective of this requirement is to assess the learning of the HPTs from clinical practices during their training period. The key points of learning in writing these case reports are stipulated in the "Guidelines for Candidates on Writing Case Report for AIM Annual Assessment" [1], including:
   - Logical approach to a problem
   - Critical thinking on logic employed
   - Critical analysis of data available
   - Knowledge of contents of the quoted literature
   - Appraisal of the published literature relevant to the case
2. When writing up the case report, in practical terms, the HPT is going through a reflective learning process of what one could learn from the patient so as to add to the existing knowledge.
3. Therefore, a case report is:
   - A study of the patient with the disease; not just the disease itself.
   - A search for information and answers for questions arising from the specific clinical care process; not a direct copying of ready made topic review.
   - A product of reasoning and integration of information; not merely one generated from copy and paste.

No plagiarism

What is plagiarism? According to World Association of Medical Editors, "Plagiarism is the use of others' published and unpublished ideas or words (or other intellectual property) without attribution or permission, and presenting them as new and original rather than derived from an existing source. The intent and effect of plagiarism is to mislead the reader as to the contributions of the plagiarizer. This applies whether the ideas or words are taken from abstracts, research grant applications, Institutional Review Board applications, or unpublished or published manuscripts in any publication format (print or electronic)."[2]

1. Direct copying of contents, tables, diagrams and pictures from original articles or literature in writing of case report is strictly forbidden. Various academic institutions have websites to address plagiarism [3], and there are plagiarism exercises available on-line [4].
2. The World Association of Medical Editors considered "Plagiarism is scientific misconduct"[2].
3. The Hong Kong College of Physicians considers plagiarism a serious professional misconduct. Plagiarism will lead to serious consequences. Any candidate who is found to commit plagiarism will be suspended from the clinical viva of that AIM Annual Assessment, and may be subjected to PERMANENT exclusion from sitting for the future AIM Annual Assessment.

References:

1. Guidelines for Candidates on Writing Case Report for AIM Annual Assessment. Available at http://www.hkcp.org/docs/TrainingGuidelines/CaseReport/F-AIM-Annual-CaseReport-GuidelinesforWriting.pdf accessed on 12 February 2010
2. World Association of Medical Editors. WAME publication ethics policies for medical journals 2008. Available at http://www.wame.org/resources/publication-ethics-policies-for-medical-journals#plagiarism accessed on 12 February 2010
3. David Gardner, Plagiarism and How to Avoid It. English center, University of Hong Kong. Available at http://ec.hku.hk/plagiarism/introduction.htm accessed on 12 February 2010
4. Avoiding plagiarism exercise. Cardiff University (Wales). Available at https://ilrb.cf.ac.uk/plagiarism/exercise/index.html accessed on 12 February 2010

The AIM Corner

Moon-sing Lai
Chairman, Specialty Board in AIM

Guidelines for Candidates on Writing Case Report for AIM Annual Assessment

1. Objectives of case report is part of training of candidates on:
   - 1.1 Logical approach to a problem
   - 1.2 Critical thinking on logic employed
   - 1.3 Critical analysis of data available
   - 1.4 Knowledge of contents of the quoted literature
   - 1.5 Appraisal of the published literature relevant to the case
2. Assessment is based on:
   - 2.1 Clarity and logic of presentation of case
   - 2.2 Demonstration of critical review of relevant literature
   - 2.3 Independent thinking and analyses
   - 2.4 Discussion RELEVANT to the case
3. Case report with the following conditions are REJECTED
   - 3.1 Text of < 1000 or >2000 words
   - 3.2 Tables or figures used > 2
   - 3.3 References > 10
   - 3.4 Closely related to the other specialty(ies) of the candidate

   IMPORTANT: Candidate has the responsibility to ensure all requirements are met before submitting the case reports. Failure of the candidate to comply will lead to rejection of Case Reports and subsequent inability to proceed to Annual Assessment.
4. Direct copying of contents, tables, diagrams and pictures from original articles or literature is considered to be plagiarism and is strictly forbidden. Plagiarism will lead to serious consequence including **PERMANENT** exclusion from sitting the Annual Assessment.
5. Candidate should write the case report in the following Format. Marks will be deducted for failure to do so.
   - 5.1 Use complete sentences and paragraphs. Point form of presentation is not allowed.
   - 5.2 Use standardized or acceptable abbreviations e.g. RFT, with the full term specified when they first appear in the case reports.
   - 5.3 Use generic name of drugs e.g. propanolol, rather than trade name, e.g Inderal®
   - 5.4 References should be relevant and up-to-date. They should be retrievable through e-KG or the internet. A copy of the reference(s) should be submitted if they cannot be retrieved from the internet. All reference should be quoted in the same format as that of Hong Kong Medical Journal

     e.g. "Yuen YP, Lai CK, Poon WT, Ng SW, Chan AY, Mak TW. Adulteration of over-the-counter slimming products with pharmaceutical analogues – an emerging threat. Hong Kong Med J 2007;13:216-20"
6. Case reports on rare medical diseases with uncommon presentations are discouraged. Instead, case reports should be on
   - 6.1 Common medical problems with common presentations
   - 6.2 Uncommon medical problems with common presentations
   - 6.3 Common medical problems with atypical presentations

Guidelines for Examiners on Marking Case Report for AIM Annual Assessment

1. Objectives of case report is part of training of candidates on:
   - 1.1 Logical approach to a problem
   - 1.2 Critical thinking on logic employed
   - 1.3 Critical analysis of data available
   - 1.4 Knowledge of contents of the quoted literature
   - 1.5 Appraisal of the published literature relevant to the case
2. Assessment is based on:
   - 2.1 Clarity and logic of presentation of case
   - 2.2 Demonstration of critical review of RELEVANT literature
   - 2.3 Independent thinking and analyses
   - 2.4 Discussion RELEVANT to the case
3. Case report with the following conditions should be REJECTED. The candidates would not be allowed to proceed to the Annual Assessment.
   - 3.1 Text of < 1000 or > 2000 words
   - 3.2 Tables or figures used > 2
   - 3.3 References > 10
   - 3.4 Closely related to the other specialty(ies) of the candidate
4. Direct copying of contents, tables, diagrams and pictures from original articles or literature is considered to be plagiarism and is strictly forbidden. Plagiarism will lead to serious consequence including **PERMANENT** exclusion from sitting the Annual Assessment.
5. Candidate should write the case report in the following Format. Marks should be deducted for failure to do so
   - 5.1 Use complete sentences and paragraphs. Point form of presentation is not allowed
   - 5.2 Use standardized or acceptable abbreviations e.g. RFT, with the full term specified when they first appear in the case reports
   - 5.3 Use generic name of drugs e.g. propanolol, rather than trade name, e.g. Inderal®
   - 5.4 References must be relevant and up-to-date. They should be retrievable through e-KG or the internet. A copy of the reference(s) should be submitted if they cannot be retrieved from the internet. All reference should be quoted in the same format as that of Hong Kong Medical Journal
6. Case reports on rare medical diseases with uncommon presentations are discouraged. Instead, case reports should be on
   - 6.1 Common medical problems with common presentations
   - 6.2 Uncommon medical problems with common presentations
   - 6.3 Common medical problems with atypical presentations
7. Reasons must be given for a score of failure (≤4) in case reports, or when the score is "exceptionally good" (≥9). All cases reports, marked or unmarked, should be returned by reviewers to the AIM Annual Assessment Coordinator at least two weeks before the Annual Assessment day.

Statistics on No. of Trainees in all Specialties

Updated in March 2010

SPECIALTY	TRAINEES TOTAL (PP/DH/HA/ OTHERS)	TRAINEES							
		HONG KONG EAST CLUSTER			HONG KONG WEST CLUSTER			
		PYNEH	RH	TWEH	FYKH	GH	QMH	TWH
		YEAR			YEAR			
CARDIOLOGY	34	1—I 4 2—I 3—II 4 *4*	1 2 2—I 3 4—I *2*	1 0 2 3 4 *0*	1 0 2 3 4 *0*	1 0 2 3 4 *4*	1—II 6 2 3—IV 4 *5*	1 0 2 3 4 *0*
CLINICAL PHARMACOLOGY & THERAPEUTICS	1	1 0 2 3 4 *0*	1 0 2 3 4 *0*	1 0 2 3 4 *0*	1 0 2 3 4 *0*	1 0 2 3 4 *0*	1 0 2 3 4 *1*	1 0 2 3 4 *0*
CRITICAL CARE MEDICINE	13	1—II 3 2 3—I 4 *2*	1 0 2 3 4 *0*	1 0 2 3 4 *0*	1 0 2 3 4 *0*	1 0 2 3 4 *0*	1 2 2—II 3 4 *3*	1 0 2 3 4 *0*
DERMATOLOGY & VENEREOLOGY	11	1 0 2 3 4 *0*	1 0 2 3 4 *0*	1 0 2 3 4 *0*	1 0 2 3 4 *0*	1 0 2 3 4 *0*	1 1 2—I 3 4 *1*	1 0 2 3 4 *0*
ENDOCRINOLOGY, DIABETES & METABOLISM	19	1 1 2—I 3 4 *0*	1—I 1 2 3 4 *2*	1 0 2 3 4 *3*	1 0 2 3 4 *0*	1 0 2 3 4 *0*	1—I 2 2—I 3 4 *5*	1 0 2 3 4 *0*
GASTROENTEROLOGY & HEPATOLOGY	31	1 4 2—II 3—II 4 *7*	1 1 2 3—I 4 *1*	1 0 2 3 4 *0*	1 0 2 3 4 *0*	1 0 2 3 4 *0*	1 1 2 3—I 4 *5*	1 0 2 3 4 *1*
GERIATRIC MEDICINE	12	1—I 1 2 3 4 *6*	1 0 2 3 4 *11*	1 0 2 3 4 *4*	1 0 2 3 4 *3*	1—I 1 2 3 4 *0*	1 2 2—I 3—I 4 *2*	1 0 2 3 4 *0*
HAEM/HAEM ONCOLOGY	13	1 2 2—I 3—I 4 *3*	1 0 2 3 4 *0*	1 0 2 3 4 *0*	1 0 2 3 4 *0*	1 0 2 3 4 *0*	1 1 2 3—I 4 *7*	1 0 2 3 4 *0*
IMMUNOLOGY & ALLERGY	0	1 0 2 3 4 *0*	1 0 2 3 4 *0*	1 0 2 3 4 *0*	1 0 2 3 4 *0*	1 0 2 3 4 *0*	1 0 2 3 4 *0*	1 0 2 3 4 *0*
INFECTIOUS DISEASE	8	1 1 2—I 3 4 *0*	1 0 2 3 4 *0*	1 0 2 3 4 *0*	1 0 2 3 4 *0*	1 0 2 3 4 *0*	1 1 2 3—I 4 *0*	1 0 2 3 4 *0*
INTERNAL MEDICINE	241	1—III 20 2—IX 3—VI 4—II *33*	1—I 5 2—I 3—II 4—I *16*	1 1 2 3 4—I *10*	1 0 2 3 4 *1*	1—I 2 2 3 4—I *4*	1—IV 34 2—XIII 3—XII 4—V *45*	1 0 2 3 4 *6*
MEDICAL ONCOLOGY	4	1 1 2 3—I 4 *0*	1 0 2 3 4 *0*	1 0 2 3 4 *0*	1 0 2 3 4 *0*	1 0 2 3 4 *0*	1 2 2—II 3 4 *2*	1 0 2 3 4 *0*
NEPHROLOGY	14	1 0 2 3 4 *4*	1 0 2 3 4 *0*	1 0 2 3 4 *0*	1 0 2 3 4 *0*	1 0 2 3 4 *0*	1 2 2—I 3—I 4 *7*	1 0 2 3 4 *2*
NEUROLOGY	20	1 1 2—I 3 4 *3*	1 1 2 3—I 4 *2*	1 1 2 3 4 *0*	1 0 2 3 4 *0*	1 0 2 3 4 *0*	1 1 2 3—I 4 *5*	1 0 2 3 4 *0*
PALLIATIVE MEDICINE	8	1 0 2 3 4 *0*	1 0 2 3 4 *1*	1 0 2 3 4 *0*	1 0 2 3 4 *0*	1 1 2 3 4—I *1*	1—I 2 2—I 3 4 *0*	1 0 2 3 4 *0*
REHABILITATION	3	1 0 2 3 4 *0*	1 0 2 3 4 *2*	1 0 2 3 4 *4*	1 0 2 3 4 *1*	1 0 2 3 4 *0*	1 2 2—II 3 4 *1*	1 0 2 3 4 *3*
RESPIRATORY MEDICINE	20	1 0 2 3 4 *3*	1 0 2 3 4 *6*	1 0 2 3 4 *0*	1 0 2 3 4 *0*	1 0 2 3 4 *7*	1 2 2 3—II 4 *5*	1 0 2 3 4 *0*
RHEUMATOLOGY	16	1—I 3 2—II 3 4 *1*	1 0 2 3 4 *1*	1 0 2 3 4 *1*	1 0 2 3 4 *0*	1 0 2 3 4 *0*	1 3 2—II 3—I 4 *3*	1 0 2 3 4 *0*

		TRAINEES										
		KOWLOON CENTRAL CLUSTR		KOWLOON EAST CLUSTER			KOWLOON WEST CLUSTER					
SPECIALTY	TRAINEES TOTAL (PP/DH/HA/ OTHERS)	KH	QEH	HOHH	TKOH	UCH	CMC	KWH	OLMH	PMH	WTSH	YCH
		YEAR		YEAR			YEAR					
CARDIOLOGY	34	1 0 2 3 4 ***0***	1—II 5 2—I 3—I 4—I ***8***	1 0 2 3 4 ***0***	1—I 1 2 3 4 ***2***	1 1 2 3—I 4 ***2***	1 1 2 3 4—I ***1***	1 2 2—I 3—I 4 ***0***	1 0 2 3 4 ***1***	1—I 3 2 3—II 4 ***6***	1 0 2 3 4 ***0***	1 0 2 3 4 ***3***
CLINICAL PHARMACOLOGY & THERAPEUTICS	1	1 0 2 3 4 ***0***	1 0 2 3 4 ***0***	1 0 2 3 4 ***0***	1 0 2 3 4 ***0***	1 0 2 3 4 ***0***	1 0 2 3 4 ***0***	1 0 2 3 4 ***0***	1 0 2 3 4 ***0***	1 0 2 3 4 ***0***	1 0 2 3 4 ***0***	1 0 2 3 4 ***0***
CRITICAL CARE MEDICINE	13	1 0 2 3 4 ***0***	1—I 1 2 3 4 ***5***	1 0 2 3 4 ***0***	1 1 2—I 3 4 ***2***	1 0 2 3 4 ***4***	1 1 2—I 3 4 ***3***	1 1 2 3—I 4 ***3***	1 0 2 3 4 ***0***	1 2 2 3—II 4 ***3***	1 0 2 3 4 ***0***	1 0 2 3 4 ***0***
DERMATOLOGY & VENEREOLOGY	11	1 0 2 3 4 ***0***	1 0 2 3 4 ***0***	1 0 2 3 4 ***0***	1 0 2 3 4 ***0***	1 0 2 3 4 ***0***	1 0 2 3 4 ***0***	1 0 2 3 4 ***0***	1 0 2 3 4 ***0***	1 0 2 3 4 ***0***	1 0 2 3 4 ***0***	1 0 2 3 4 ***0***
ENDOCRINOLOGY, DIABETES & METABOLISM	19	1 0 2 3 4 ***0***	1 2 2—I 3—I 4 ***4***	1 0 2 3 4 ***0***	1 1 2—I 3 4 ***2***	1—I 1 2 3 4 ***3***	1 1 2—I 3 4 ***2***	1 2 2 3 4—II ***3***	1 2 2—I 3 4—I ***2***	1 0 2 3 4 ***5***	1 0 2 3 4 ***0***	1 0 2 3 4 ***2***
GASTROENTEROLOGY & HEPATOLOGY	31	1 0 2 3 4 ***0***	1—I 3 2 3—II 4 ***5***	1—I 1 2 3 4 ***0***	1 0 2 3 4 ***3***	1 1 2 3—I 4 ***2***	1—I 3 2—I 3—I 4 ***4***	1—II 3 2 3 4—I ***3***	1 1 2 3—I 4 ***0***	1 3 2—II 3—I 4 ***5***	1 1 2 3 4—I ***0***	1 1 2 3—I 4 ***5***
GERIATRIC MEDICINE	12	1 0 2 3 4 ***3***	1 2 2 3—II ***2*** 4	1 0 2 3 4 ***5***	1 0 2 3 4 ***1***	1 2 2 3 4—II ***7***	1 0 2 3 4 ***7***	1 0 2 3 4 ***8***	1 0 2 3 4 ***1***	1 1 2 3 4—I ***11***	1 1 2 3 4—I ***3***	1 0 2 3 4 ***5***
HAEM/HAEM ONCOLOGY	13	1 0 2 3 4 ***0***	1—II 5 2—II 3—I 4 ***2***	1 0 2 3 4 ***0***	1 1 2 3—I 4 ***1***	1 1 2—I 3 4 ***1***	1 0 2 3 4 ***0***	1 0 2 3 4 ***0***	1 0 2 3 4 ***0***	1 1 2—I 3 4 ***3***	1 0 2 3 4 ***0***	1 0 2 3 4 ***0***
IMMUNOLOGY & ALLERGY	0	1 0 2 3 4 ***0***	1 0 2 3 4 ***0***	1 0 2 3 4 ***0***	1 0 2 3 4 ***0***	1 0 2 3 4 ***0***	1 0 2 3 4 ***0***	1 0 2 3 4 ***0***	1 0 2 3 4 ***0***	1 0 2 3 4 ***0***	1 0 2 3 4 ***0***	1 0 2 3 4 ***0***
INFECTIOUS DISEASE	8	1 0 2 3 4 ***0***	1 2 2—II 3 4 ***2***	1 0 2 3 4 ***0***	1 0 2 3 4 ***0***	1 0 2 3 4 ***1***	1 0 2 3 4 ***0***	1 0 2 3 4 ***0***	1 0 2 3 4 ***0***	1 2 2—I 3—I 4 ***3***	1 0 2 3 4 ***0***	1 0 2 3 4 ***0***
INTERNAL MEDICINE	241	1 0 2 3 4 ***4***	1–VIII *31* 2–VIII 3—X 4–V *46*	1—II 3 2 3—I 4 ***5***	1—I 7 2—III 3—I 4—II *14*	1—I *10* 2—II 3—IV 4—III *33*	1—II *11* 2—IV 3—III 4—II *22*	1—III *12* 2—III 3—II 4—IV *29*	1 4 2—II 3—I 4—I ***3***	1—III *18* 2—V 3—VII 4—III *46*	1 2 2 3 4—II ***3***	1 5 2—II 3—III 4 *20*
MEDICAL ONCOLOGY	4	1 0 2 3 4 ***0***	1 0 2 3 4 ***1***	1 0 2 3 4 ***0***	1 0 2 3 4 ***0***	1 0 2 3 4 ***0***	1 0 2 3 4 ***0***	1 0 2 3 4 ***0***	1 0 2 3 4 ***0***	1 0 2 3 4 ***1***	1 0 2 3 4 ***0***	1 0 2 3 4 ***0***
NEPHROLOGY	14	1 0 2 3 4 ***0***	1—I 2 2 3—I 4 ***7***	1 0 2 3 4 ***0***	1 0 2 3 4 ***1***	1 0 2 3 4 ***4***	1 0 2 3 4 ***1***	1 2 2—I 3 4—I ***5***	1 0 2 3 4 ***0***	1—II 2 2 3 4 ***7***	1 0 2 3 4 ***0***	1 0 2 3 4 ***2***
NEUROLOGY	20	1 0 2 3 4 ***0***	1 2 2—II 3 4 ***5***	1 0 2 3 4 ***0***	1 0 2 3 4 ***1***	1 2 2 3 4—II ***3***	1—I 1 2 3 4 ***1***	1 1 2 3 4—I ***3***	1 0 2 3 4 ***0***	1 0 2 3 4 ***2***	1 0 2 3 4 ***0***	1 1 2 3 4—I ***0***
PALLIATIVE MEDICINE	8	1 0 2 3 4 ***0***	1 0 2 3 4 ***0***	1 1 2 3—I 4 ***2***	1 0 2 3 4 ***0***	1 1 2 3—I 4 ***1***	1 1 2 3—I 4 ***2***	1 0 2 3 4 ***0***	1 0 2 3 4 ***1***	1 0 2 3 4 ***0***	1 0 2 3 4 ***0***	1 0 2 3 4 ***0***
REHABILITATION	3	1 0 2 3 4 ***7***	1 0 2 3 4 ***0***	1 0 2 3 4 ***1***	1 0 2 3 4 ***0***	1 0 2 3 4 ***1***	1 0 2 3 4 ***1***	1 0 2 3 4 ***0***	1 0 2 3 4 ***0***	1 0 2 3 4 ***1***	1 0 2 3 4 ***4***	1 0 2 3 4 ***0***
RESPIRATORY MEDICINE	20	1 0 2 3 4 ***6***	1 1 2 3—I 4 ***6***	1—I 1 2 3 4 ***5***	1 1 2—I 3 4 ***2***	1 2 2—I 3—I 4 ***3***	1 1 2—I 3 4 ***5***	1—I 2 2 3—I 4 ***3***	1 1 2—I 3 4 ***0***	1 1 2—I 3 4 ***4***	1 0 2 3 4 ***3***	1 2 2 3—II 4 ***1***
RHEUMATOLOGY	16	1 0 2 3 4 ***0***	1—I 2 2 3—I 4 ***2***	1 0 2 3 4 ***0***	1 0 2 3 4 ***0***	1 1 2 3 4—I ***2***	1 2 2 3—I 4—I ***1***	1 1 2—I 3 4 ***1***	1 0 2 3 4 ***0***	1 1 2 3—I 4 ***1***	1 0 2 3 4 ***0***	1 1 2—I 3 4 ***1***

		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	34	1 1 2 3—I 4 ***2***	1 2 2 3—II 4 ***2***	1 1 2 3—I 4 ***5***	1 0 2 3 4 ***0***	1 0 2 3 4 ***0***	1 0 2 3 4 ***1***	1 5 2 3—III 4—II ***4***
CLINICAL PHARMACOLOGY & THERAPEUTICS	1	1 0 2 3 4 ***0***	1 0 2 3 4 ***0***	1 1 2 3—I 4 ***3***	1 0 2 3 4 ***0***	1 0 2 3 4 ***0***	1 0 2 3 4 ***0***	1 0 2 3 4 ***0***
CRITICAL CARE MEDICINE	13	1 0 2 3 4 ***2***	1 1 2 3 4—I ***3***	1 0 2 3 4 ***1***	1 0 2 3 4 ***0***	1 0 2 3 4 ***0***	1 0 2 3 4 ***0***	1 1 2 3—I 4 ***2***
DERMATOLOGY & VENEREOLOGY	11	1 0 2 3 4 ***0***	1 0 2 3 4 ***0***	1 1 2 3—I 4 ***0***	1 0 2 3 4 ***0***	1 0 2 3 4 ***0***	1 0 2 3 4 ***0***	1 0 2 3 4 ***0***
ENDOCRINOLOGY, DIABETES & METABOLISM	19	1 0 2 3 4 ***0***	1—I 3 2 3—I 4—I ***1***	1—I 1 2 3 4 ***7***	1 0 2 3 4 ***0***	1 0 2 3 4 ***0***	1 0 2 3 4 ***0***	1 4 2—I 3—II 4—I ***2***
GASTROENTEROLOGY & HEPATOLOGY	31	1 0 2 3 4 ***2***	1—I 2 2 3—I 4 ***2***	1 2 2—I 3—I 4 ***4***	1 0 2 3 4 ***0***	1 0 2 3 4 ***0***	1 0 2 3 4 ***1***	1—I 4 2—III 3 4 ***3***
GERIATRIC MEDICINE	12	1 0 2 3 4 ***1***	1 0 2 3 4 ***1***	1 0 2 3 4 ***4***	1—II 2 2 3 4 ***6***	1 0 2 3 4 ***2***	1 0 2 3 4 ***0***	1 0 2 3 4 ***11***
HAEM/HAEM ONCOLOGY	13	1 0 2 3 4 ***0***	1 0 2 3 4 ***0***	1 1 2 3 4—I ***3***	1 0 2 3 4 ***0***	1 0 2 3 4 ***0***	1 0 2 3 4 ***0***	1 1 2 3—I 4 ***5***
IMMUNOLOGY & ALLERGY	0	1 0 2 3 4 ***0***	1 0 2 3 4 ***0***	1 0 2 3 4 ***0***	1 0 2 3 4 ***0***	1 0 2 3 4 ***0***	1 0 2 3 4 ***0***	1 0 2 3 4 ***0***
INFECTIOUS DISEASE	8	1—I 1 2 3 4 ***1***	1 1 2 3—I 4 ***0***	1 1 2 3—I 4 ***1***	1 0 2 3 4 ***0***	1 0 2 3 4 ***0***	1 0 2 3 4 ***0***	1 0 2 3 4 ***2***
INTERNAL MEDICINE	241	1—II 7 2—III 3—I 4—I ***13***	1—III 12 2 3—VI 4—III ***13***	1—III 15 2—IV 3—IV 4—IV ***42***	1—II 4 2 3—II 4 ***5***	1—I 1 2 3 4 ***3***	1 0 2 3 4 ***5***	1—IV 29 2—VI 3–VIII 4—XI ***40***
MEDICAL ONCOLOGY	4	1 0 2 3 4 ***0***	1 0 2 3 4 ***0***	1 1 2 3—I 4 ***9***	1 0 2 3 4 ***0***	1 0 2 3 4 ***0***	1 0 2 3 4 ***0***	1 0 2 3 4 ***0***
NEPHROLOGY	14	1 3 2—III 3 4 ***2***	1 0 2 3 4 ***1***	1 2 2—II 3 4 ***4***	1 0 2 3 4 ***0***	1 0 2 3 4 ***0***	1 0 2 3 4 ***0***	1 1 2 3 4—I ***5***
NEUROLOGY	20	1—I 1 2 3 4 ***1***	1 0 2 3 4 ***2***	1—II 3 2 3—I 4 ***5***	1 1 2 3—I 4 ***0***	1 0 2 3 4 ***0***	1 0 2 3 4 ***0***	1—I 4 2—I 3—I 4—I ***3***
PALLIATIVE MEDICINE	8	1 0 2 3 4 ***0***	1 0 2 3 4 ***0***	1 0 2 3 4 ***0***	1 1 2 3—I 4 ***1***	1 0 2 3 4 ***0***	1 0 2 3 4 ***0***	1 0 2 3 4 ***0***
REHABILITATION	3	1 0 2 3 4 ***0***	1 0 2 3 4 ***0***	1 0 2 3 4 ***1***	1 0 2 3 4 ***0***	1 0 2 3 4 ***1***	1 0 2 3 4 ***1***	1 1 2—I 3 4 ***3***
RESPIRATORY MEDICINE	20	1 0 2 3 4 ***3***	1—I 2 2 3—I 4 ***2***	1 0 2 3 4 ***3***	1—I 1 2 3 4 ***0***	1—I 1 2 3 4 ***1***	1 0 2 3 4 ***0***	1—I 2 2 3—I 4 ***4***
RHEUMATOLOGY	16	1 0 2 3 4 ***1***	1 0 2 3 4 ***0***	1 1 2—I 3 4 ***3***	1 0 2 3 4 ***0***	1 0 2 3 4 ***1***	1 0 2 3 4 ***0***	1—I 1 2 3 4 ***1***

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

SPECIALTY	TRAINEES TOTAL (PP/DH/HA/OTHERS)	TRAINEES
		DH
DERMATOLOGY & VENEREOLOGY	11	1—II 9 2—II 3—II 4—III ***11***
IMMUNOLOGY & ALLERGY	0	1 0 2 3 4 ***1***
INFECTIOUS DISEASE	8	1 0 2 3 4 ***1***
INTERNAL MEDICINE	241	1 3 2—II 3 4—I ***0***
NEUROLOGY	20	1 1 2—I 3 4 ***0***
RESPIRATORY MEDICINE	20	1 1 2 3 4—I ***7***

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

Statistics on No. of Fellows in all Specialties
Updated in March 2010

		FELLOWS									
		HONG KONG EAST CLUSTER				HONG KONG WEST CLUSTER					HONG KONG EAST + WEST CLUSTER
SPECIALTY	FELLOWS TOTAL (PP/DH/HA/OTHERS)	PYNEH	RH	TWEH	Subtotal	FYKH	GH	QMH	TWH	Subtotal	
CARDIOLOGY	191	7	4	0	**11**	0	5	11	0	**16**	**27**
CLINICAL PHARMACOLOGY & THERAPEUTICS	7	0	0	0	**0**	0	0	2	0	**2**	**2**
CRITICAL CARE MEDICINE	67	10	0	0	**10**	0	0	7	0	**7**	**17**
DERMATOLOGY & VENEREOLOGY	83	0	0	0	**0**	0	0	1	0	**1**	**1**
ENDOCRINOLOGY, DIABETES & METABOLISM	80	4	2	3	**9**	0	0	8	0	**8**	**17**
GASTROENTEROLOGY & HEPATOLOGY	133	7	1	0	**8**	0	0	10	1	**11**	**19**
GERIATRIC MEDICINE	163	7	12	4	**23**	3	0	4	1	**8**	**31**
HAEM/HAEM ONCOLOGY	46	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	30	1	0	0	**1**	0	0	2	0	**2**	**3**
INTERNAL MEDICINE	1009	47	26	10	**83**	3	9	73	7	**92**	**175**
MEDICAL ONCOLOGY	37	0	0	0	**0**	0	0	8	0	**8**	**8**
NEPHROLOGY	107	6	1	0	**7**	0	0	7	2	**9**	**16**
NEUROLOGY	81	5	2	0	**7**	0	0	8	1	**9**	**16**
PALLIATIVE MEDICINE	18	0	2	0	**2**	0	1	0	0	**1**	**3**
REHABILITATION	47	0	3	5	**8**	1	0	1	3	**5**	**13**
RESPIRATORY MEDICINE	157	8	9	2	**19**	0	8	10	0	**18**	**37**
RHEUMATOLOGY	54	2	2	1	**5**	1	0	4	1	**5**	**10**

		FELLOWS														
		KOWLOON CENTRAL CLUSTER			KOWLOON EAST CLUSTER				KOWLOON WEST CLUSTER							KOWLOON CENTRAL + EAST + WEST CLUSTER
SPECIALTY	FELLOWS TOTAL (PP/DH/HA/ OTHERS)	KH	QEH	Subtotal	HOHH	TKOH	UCH	Subtotal	CMC	KWH	OLMH	PMH	WTSH	YCH	Subtotal	
CARDIOLOGY	191	0	11	**11**	0	1	6	**7**	1	5	1	9	0	3	**19**	**37**
CLINICAL PHARMACOLOGY & THERAPEUTICS	7	0	0	**0**	0	0	0	**0**	0	0	0	0	0	0	**0**	**0**
CRITICAL CARE MEDICINE	67	0	6	**6**	0	3	6	**9**	5	5	0	5	0	0	**15**	**30**
DERMATOLOGY & VENEREOLOGY	83	0	0	**0**	0	0	0	**0**	0	0	0	0	0	0	**0**	**0**
ENDOCRINOLOGY, DIABETES & METABOLISM	80	0	6	**6**	0	2	4	**6**	2	3	2	6	0	2	**15**	**27**
GASTROENTEROLOGY & HEPATOLOGY	133	0	8	**8**	0	3	4	**7**	5	4	0	6	0	6	**21**	**36**
GERIATRIC MEDICINE	163	6	3	**9**	7	1	12	**20**	8	11	2	15	4	6	**46**	**75**
HAEM/HAEM ONCOLOGY	46	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	30	0	3	**3**	0	0	1	**1**	0	1	0	4	0	1	**6**	**10**
INTERNAL MEDICINE	1009	6	61	**67**	9	16	47	**72**	31	39	8	57	7	25	**167**	**306**
MEDICAL ONCOLOGY	37	0	2	**2**	0	0	0	**0**	0	0	0	1	0	0	**1**	**3**
NEPHROLOGY	107	0	8	**8**	2	2	5	**9**	2	6	1	7	0	2	18	**35**
NEUROLOGY	81	0	6	**6**	0	1	4	**5**	1	3	1	2	3	1	**11**	**22**
PALLIATIVE MEDICINE	18	0	0	**0**	4	0	2	**6**	3	0	1	0	1	0	**5**	**11**
REHABILITATION	47	10	0	**10**	2	0	2	**4**	1	1	0	2	4	0	**8**	**22**
RESPIRATORY MEDICINE	157	6	7	**13**	5	3	5	**13**	6	6	0	4	6	2	**24**	**50**
RHEUMATOLOGY	54	2	4	**6**	0	1	3	**4**	1	2	1	1	0	1	**6**	**16**

		FELLOWS									
		NEW TERRITORIES EAST CLUSTER						NEW TERRITORIES WEST CLUSTER			NEW TERRITORIES EAST + WEST CLUSTER
SPECIALTY	FELLOWS TOTAL (PP/DH/HA/ OTHERS)	AHNH	NDH	PWH	SH	TPH	Subtotal	POH	TMH	Subtotal	
CARDIOLOGY	191	4	6	10	0	0	**20**	1	8	**9**	**29**
CLINICAL PHARMACOLOGY & THERAPEUTICS	7	0	0	5	0	0	**5**	0	0	**0**	**5**
CRITICAL CARE MEDICINE	67	3	3	2	0	0	**8**	0	3	**3**	**11**
DERMATOLOGY & VENEREOLOGY	83	0	0	2	0	0	**2**	0	0	**0**	**2**
ENDOCRINOLOGY, DIABETES & METABOLISM	80	1	2	13	1	0	**17**	0	3	**3**	**20**
GASTROENTEROLOGY & HEPATOLOGY	133	2	5	9	0	0	**16**	1	8	**9**	**25**
GERIATRIC MEDICINE	163	1	1	5	7	3	**17**	0	13	**13**	**30**
HAEM/HAEM ONCOLOGY	46	0	0	4	0	0	**4**	0	6	**6**	**10**
IMMUNOLOGY & ALLERGY	6	0	0	0	0	0	**0**	0	0	**0**	**0**
INFECTIOUS DISEASE	30	1	0	3	0	0	**4**	0	4	**4**	**8**
INTERNAL MEDICINE	1009	20	24	67	10	6	**127**	5	61	**66**	**193**
MEDICAL ONCOLOGY	37	0	0	16	0	0	**16**	0	0	**0**	**16**
NEPHROLOGY	107	3	1	6	0	0	**10**	1	7	**8**	**18**
NEUROLOGY	81	2	2	6	2	0	**12**	0	4	**4**	**16**
PALLIATIVE MEDICINE	18	0	0	0	1	0	**1**	0	1	**1**	**2**
REHABILITATION	47	0	1	2	1	1	**5**	0	5	**5**	**10**
RESPIRATORY MEDICINE	157	3	6	9	1	1	**20**	1	7	**8**	**28**
RHEUMATOLOGY	54	3	1	4	0	2	**10**	0	3	**3**	**13**

Professor Sir Neil Douglas

John MacKay

Professor Sir Neil Douglas graduated MB ChB (Edin) in 1973 with Distinction in Medicine and Therapeutics, and Surgery, and achieved further distinction with an MD (Edin) in 1983. He trained in the Royal Infirmary, Edinburgh and as MRC Travelling Fellow in the Cardiovascular Pulmonary Research Laboratory, University of Colorado, Denver, ascending rapidly the professional ladder to become Professor of Respiratory and Sleep Medicine, University of Edinburgh in 1995.

His contribution to respiratory and sleep medicine is phenomenal. He was Founding Chairman of the British Sleep Society (1988-89) and the British Sleep Foundation (1997 - 2001), and has been/is Associate Editor of Sleep, and Editorial Board member of American Journal of Respiratory & Critical Care Medicine, Respiratory Research, and Sleep Medicine Reviews.

Sir Neil has published over 220 original papers including in the New England Journal of Medicine, Lancet, Journal of Applied Physiology, Annals of Internal Medicine, Archives of Internal Medicine, American Journal of Respiratory and Critical Care Medicine, Thorax, and over 200 books, reviews and chapters.

His many studies in the diagnosis, pathogenesis and the science and practice of continuous positive airway pressure (CPAP) treatment in obstructive sleep apnoea-hypopnoea syndrome over the past quarter of a century, stand tall as landmarks in the unravelling of this complicated multidisciplinary syndrome. He is a hotly sought after speaker at major national and international respiratory or sleep medicine conferences. He organised and hosted the 6th International Symposium on Sleep and Breathing in 1997.

Sir Neil is a born leader. In the early pre-registration years 1970 - 73, he was President of the British Medical Students Association, Chairman of the Edinburgh Medical Students' Council, and Senior President of the Royal Medical Society.

After registration, he served in various capacities on National Health Service and Scottish National Committees. He was Chairman of the South Lothian Medical Junior Staff Group, Director of Scottish National Sleep Centre, Chairman of the Specialty Advisory Group in Respiratory Medicine for Lothian, Chairman of Academy of Medical Royal Colleges in Scotland and Chairman of Scottish Joint Consultants Committee.

He has now served the Royal College of Physicians of Edinburgh for 30 years starting from membership of Collegiate Member's Committee in 1979. He then became Director of Continuing Medical Education and Dean (Head of Education and Training). He proceeded to become Vice-President (2000-03}, and now President of RCPE since 2004.

When he retires from the Presidency in March 2010, he will have been the longest serving President of the Royal College of Physicians of Edinburgh in the past 250 years!

Sir Neil's tremendous contributions to the science and training of medicine are widely recognised nationally and internationally. He was awarded DSc (Edin) in 2003 and Hon MD (St Andrews) in 2007. He is FRCP (Edin and Lond). He has been awarded Honorary or ad eundem Fellowships of all major Academies and (Royal) Colleges of Physicians, all over the world, including Glasgow, Ireland, Australia, America, Singapore and South Africa, and Royal College of Surgeons of Edinburgh. He was knighted in Jan 2009 for his tremendous contributions and service to medicine.

The information above was taken from the citation at the ceremony in October 2009 when he received

Professor KN Lai presented the Honorary Fellowship certificate to Professor Douglas in October 2009

the Honorary Fellowship of the Hong Kong College of Physicians.

Three days later Sir Neil and his wife Sue spent a morning with my wife and I, enjoying a break from academic business to walk in the wilds of Sai Kung and enjoy a sea-food lunch on the Sai Kung waterfront. From conversation then and by letter subsequently Sir Neil provided some personal background to his distinguished career.

His father, Donald, was a first generation doctor, Professor of Surgery at St. Andrews – later Dundee – University, Dean of Medicine at Dundee, President of the Royal College of Surgeons of Edinburgh and Surgeon to the Queen in Scotland. He was knighted in 1972: a role model difficult to live up to.

His wife Sue has no less than five generations of doctors before her, and is senior partner in a GP practice in Edinburgh. They have a son and a daughter both of whom are doctors and both in training, one in England and the other is Scotland.

Sir Neil was educated at Dundee High School, Glenalmond College, St Andrews University for pre-clinical studies and Edinburgh University for clinical studies. He trained in Respiratory Medicine in Edinburgh, with a year in Denver, Colorado as a Medical Research Council Travelling Fellow.

"My early academic career was influenced by David Flenley an energetic and challenging Professor of Respiratory Medicine (He had succeeded Professor Sir John Crofton), who first supported my work on breathing during sleep. He was a great generator of ideas, some of which worked! My clinical mentors were two National Health Service respiratory consultants of the old school – Andrew Douglas (no relation) and Norman Horne. Both were excellent clinicians who would take enormous pains with patients and were entirely patient focussed decades before that became a mantra.

My research has mostly been clinical and based around the diagnosis and treatment of the sleep apnoea/hypopnoea syndrome. The most satisfying aspect has been producing the evidence base required, in terms of benefits of therapy on symptoms, blood pressure and performance, to persuade healthcare systems around the world to fund clinical services for sleep apnoea.

I have been very lucky to be President of the Edinburgh College and have enjoyed it immensely. My only major disappointment was failing to persuade others in advance of the Medical Training Application Service (MTAS) crisis that more training posts needed to be included in the pool. Had I succeeded many trainees could have been spared a great deal of anxiety.

I am a great admirer of Hong Kong medicine. You have set high standards both in undergraduate and postgraduate training and also in clinical practice. The response to SARS was immensely impressive both in terms of clinical care and the speed and rigour with which world leading clinical and basic research was conducted and published.

My immediate goal in chairing the UK Academy of Medical Royal Colleges is to try to get the Royal Colleges in the UK to speak with one voice and to avoid the weakness of division which has been common. I am keen to improve the training experience for young doctors, to open experience of UK training for high quality oversees trainees and ensure good training programmes for doctors in medical management.

I preserve my weekends carefully for relaxation and family, usually by escaping to my cottage in the Perthshire countryside for hill-walking, sailing and gardening. I also enjoy skiing and fishing although not often enough"

I think a walk in Sai Kung must have been exactly the right tonic for Sir Neil Douglas after a week of concentrated academia.

Sai Kung (Hong Kong) in October 2009

A pre-dinner inspection at the fish tanks

Sheung Yiu Folk Museun From Left to Right: Dr. Judith MacKay, Dr. John MacKay, Professor Neil Douglas, Mrs Douglas