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香港內科醫學院



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SYNAPSE



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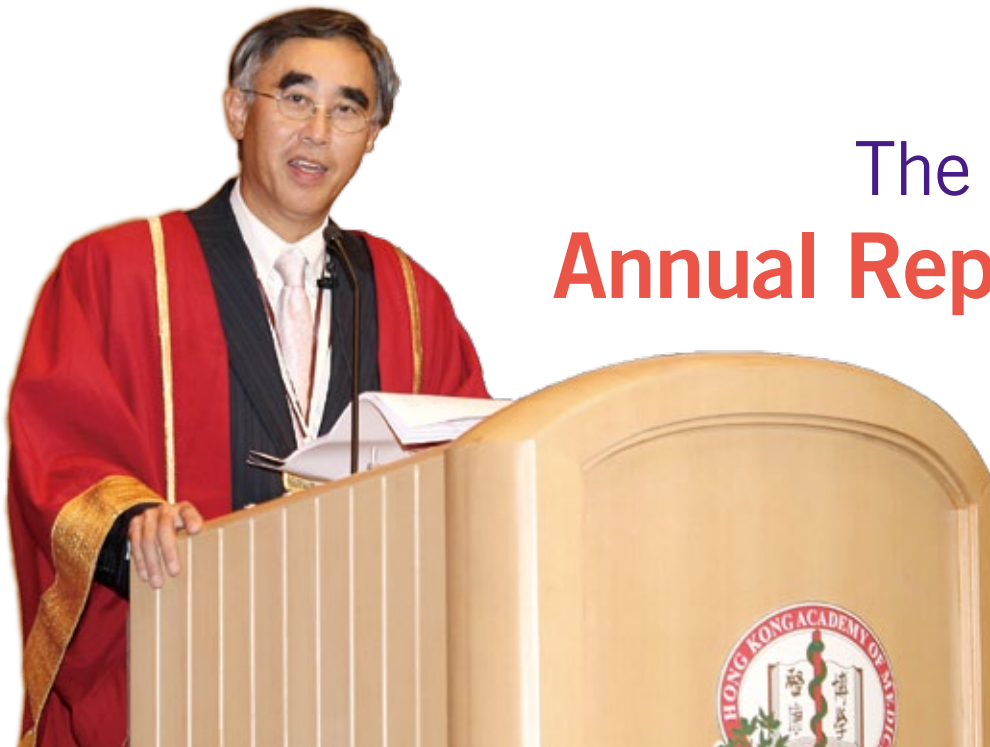
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The President's Annual Report 2010

KN Lai
President, HKCP

In the year of the Tiger 2010, the Hong Kong SAR sustained peaceful progress in her politics. With a vigilant and attentive approach, our medical community successfully smothered the threat of Swine flu. At times of crisis, our profession always proves its quality, alertness and readiness.

This is my last annual report since elected to the Office in 2004. I appreciate greatly the support from the Council and I would like to thank all Fellows and Members for having given me the opportunity and honor to serve you. While our College continues to flourish with fellowship exceeding 1,350, we must not be complacent as we have noticed less applications for physician training over the last two to three years. Physician training is demanding both in time and skill. Nowadays, most specialties in Hospital Authorities hospitals can adopt a five-day week arrangement as they have few emergency admissions but this is not the case in Medicine. All medical units admit emergency patients seven days a week and 52 weeks a year. Not only longer

and busier working hours, the promotion prospect in Medicine is less despite our devoted and relatively stable workforce. We must proactively address these issues in order to maintain our attraction to the fresh medical graduates. I sincerely hope the incoming President will discuss thoroughly with the Hospital Authority on these issues. Any Department of Medicine with less than appropriate manpower and resources can compromise the service in the hospital within a short time. The new Chief Executive of the Hospital Authority should be aware of this. Meanwhile, our College maintains strong academic and collegiate links with overseas physician colleges in London, Edinburgh, Glasgow, Australasia, Malaysia and Singapore. Our interaction with physician societies in China remains active directly through the College and indirectly through our specialty societies. Our College continues to improve our computerization system in training and examination matters allowing paper documentation to be conducted from the desktop computer using the Web.

This Annual Report outlines the various events and achievements of all the College Committees that deserve the attention of our Members and Fellows. My heartiest gratitude and appreciation goes to all Chairmen, Members of the Committee, the Boards and the Secretariat for having done such a magnificent job. Briefly, I would like to highlight some of the important changes.

Education and Accreditation Committee

Under the very capable Chairmanship of Dr. Loretta Yam, the committee further improved the examination format, scoring system, remedial training program, and written guideline of the dissertation thesis. Several new developments in training were established in the last 12 months.

1. To raise awareness about clinical risk among our trainees and improve clinical management, the College collaborated with the Hospital Authority to develop a Self Learning Tool

(SLT). In essence, SLT is an educational e-learning tool which tests Basic and Advanced Internal Medicine (AIM) trainees using clinical scenarios in the form of multiple choice questions with scenario development and appropriate explanations. These questions are administered through a tailor-made software and information technology system hosted online by the Hospital Authority. The SLT is expected to be applied to all three years of Basic Physician Training.

2. In accordance with the training structure stated in the *Guidelines on Postgraduate Training in Internal Medicine, Fourth Edition, July 2007*, it is mandatory for Palliative Medicine and Rehabilitation to be trained concurrently with AIM and AIM or Geriatric Medicine respectively. It therefore follows that trainees who pass the Exit Assessment in Palliative Medicine or Rehabilitation as the first specialty cannot be accredited in the respective specialty until they have passed the Exit Assessment in AIM or Geriatric Medicine.
3. The College was satisfied that there are now sufficient numbers of Fellows and Trainers in Medical Oncology to merit Specialty Board status, such that the specialty can become independent from the Specialty Board in Haematology and Haematological Oncology. The Specialty of Medical Oncology thus became an independent Specialty Board with effect from April 2010.
4. The Specialty boards had conducted annual assessment for 260 trainees and exit

assessment for another 106 candidates.

5. The current CME/CPD cycle will end on 31 December 2010. The College decided to continue to adopt the current "Principles and Guidelines on CME/CPD 2008" and "CME/CPD Operational Guidelines 2008" for the new CME/CPD cycle to commence from 1 January 2011.

National and International Liaison Committee

Under the dedicated Chairmanship of Professor W.K. Lam, the committee continued to liaise with national and international professional bodies in Medicine on matters of mutual interest, including postgraduate training, professional examinations, scientific and academic interaction and continuous professional development in the practice of Internal Medicine.

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

Dr Neil Dewhurst, Consultant Cardiologist and General Physician, Perth Royal Infirmary, and Honorary Senior Lecturer in Medicine, University of Dundee, is the new President of the Edinburgh College with effect from 1 March 2010.

Mr. Ian WR Anderson, has been elected as the President of the Glasgow College for three years.

Sir Richard Thompson KCVO DM FRCP has been elected as the new President of the London College.

Professor John Kolbe, Professor

of Medicine at the University of Auckland, has been elected President of the Royal Australasian College of Physicians in May 2010. Dr Jennifer Alexander, CEO of the RACP, visited the College Chamber on September 3, 2010.

Examination Committee

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

A new format of station 5 was commenced in the October 2009 PACES examination. Candidates were required to undertake a focused history and targeted examination pertinent to the presenting problem.

The College has proposed to the MRCP(UK) Central Office to invite UK PACES examiners to deliver lectures on Stations 1 and 3 on a Training Day, to be held on the Saturday after one of the two PACES examinations. The first training day is scheduled for March 2011.

Scientific Committee

The Scientific Committee under the chairmanship of Professor Y.L. Kwong organized a Scientific Meeting of Hong Kong College of Physicians on October 9-10, 2010 with over 450 participants.

The Gerald Choa Memorial Lecture was delivered by Professor T.F. Fok. Hon Chief Justice Geoffrey Ma gave the AJS McFadzean Oration.



Research Committee

The Research Committee under the chairmanship of Professor K.S. Wong selected four young investigators for Distinguished Research Paper Award. All were invited to present their papers in the Annual Scientific Meeting of the College in October 2010, with a medal award for the best presenter.

Membership Committee

Under the chairmanship of Dr. Patrick Li, 44 applicants were proposed for Membership and 54 applicants for Fellowship as of 31 August 2010.

Professional and General Affairs Committee

The Committee under the chairmanship of Dr. C.P. Wong continued to handle issues related to professional and

general medical affairs this year. A career talk was delivered to medical students of the University of Hong Kong in November 2009. Our College also drafted a position paper to the Food and Health Bureau on a consultation paper entitled: "Introduction of the concept of advance directives in Hong Kong".

Synapse

Synapse under the editorship of Dr. C. Kng continued its important role of fostering communication between the College and its Fellows, Members and trainees. Updated statistics on the number of Higher Physician Trainees in all Medical Specialties in Hong Kong were published regularly as a reference for trainees deciding on their career pathway.

During the past year, Synapse was greatly privileged to interview Professor Leishi Li and Professor

Sir Neil Douglas as profile doctors who have contributed vastly to medicine in China and in the United Kingdom.

Administration and Finance Committee

We are grateful to our Hon Treasurer for his very shrewd book-keeping such that the College remains in a healthy state financially.

Finally no word of appreciation or thanks can express my gratitude to the two Vice-Presidents, Chairpersons of different committees, College Council members, and the previous Presidents for their invaluable support and advice. My final vote of thanks goes to all the very hardworking secretaries of the College who have maintained our engine running smoothly.





The President's Address at the Fellowship Conferment Ceremony 2010

KN Lai
President, HKCP

Today is a great day for the College. Seventy-five physicians will be admitted to the Fellowship and another 54 to our Membership, following their success in qualifying examinations. Let me extend the College's congratulation to the new members and fellows. This is my last presidential speech after six years in office. In the previous five years' conferment ceremonies, I spoke about different issues including the virtue of naiveness, the clinician-scientist career path, the media, medical ethics and health reform. On this occasion, I will address the issue of human resource management or the skill of leadership. Now that you have achieved your training goals and become a specialist or will be admitted for specialist training, I can envisage, in the not distant future, you will progress as a leader of your field, be it a division or department head, or even a chief of service or an academician – what the layman or your colleagues call 'The Boss'. The word "Boss" originated in North America around 1640-1650 and was derived from Dutch word – baas

master, which meant a foreman on a ship. From the Oxford and Cambridge dictionaries, a boss is a person in charge of workers or an organization; someone in control of a group or situations; and someone who tells others what to do, gives orders, makes decisions and exerts authority. In simple terms, one expects the boss who is a manager with outstanding leadership and experience, and will be willing to take up and share the responsibility including criticism and blame. Not infrequently, this may not always be true, especially in public sectors with tenured as well as appointed positions. In such circumstances, a manager may be chosen or appointed just by being obedient or willing to compromise, and even worse, simply the person is not bright enough and pose less threat to the administration above.

I must admit that I have been lucky in working under excellent bosses in Australia, United Kingdom and Hong Kong. After practicing medicine for 35 years, I have just begun to have some vague ideas about who

is a good boss and what are the differences between a leader and a boss? Let me first address the issue of a good boss versus a lousy manager. Paradoxically, one may not recognize a good manager while working under him or her. More frequently, one only appreciates retrospectively how good the boss was when working under the next incoming management. Then, what is the quality of a good manager? Just as said by Lao Tzu in his Principle of Ethics: "A leader is best when people barely know he exists, not so good when people obey and acclaim him, worse when they despise him. But of a good leader who talks little when his work is done, his aim fulfilled, they will say: We did it ourselves." A lousy manager lacks confidence and demands loyalty. Some even say laugh heartily at all the jokes your boss tells as it maybe a test of loyalty. What a pity?

Robert Townsend, an Afro-American writer once said: "A good manager doesn't try to eliminate conflict; he tries to keep it from wasting the energies of his people. If you're the boss and your people fight you openly



when they think that you are wrong -- that's healthy." Let me rephrase it neatly, a real leader faces the music, even when he doesn't like the tune.

Before moving to the issue of leadership, let me spell out the four basic prerequisites or qualities of a competent manager in our medical profession. First, there is active involvement and personal participation. In other words, who that has not served cannot command. Example: SARS in year 2003. Second, only ask your team to deliver if you, yourself, can perform. Example: A university academic sought approval from his departmental head for promotion application. This chairman asked: "What is your achievement? Have you published in the New England of Medicine or Lancet?" This department chairman has neither published in these journals and his or her achievement at similar stage of promotion was finishing a MD degree -- nowadays, a minimal requirement for a junior faculty appointment. President Dwight Eisenhower put this succinctly: "You do not lead by hitting people over the head — that's assault, not leadership" The third quality is courtesy. Example: "Punishment of the Casualty Chief in the Caritas Medical Center event. Max De Pree, founder the Max De Pree Center for Leadership, wrote in his book: Leadership is an Art said: "The first responsibility of a leader is to define reality. The last is to say thank you. In between, the leader is a servant." And he further added: "Leaders don't inflict pain — they share pain." The last quality is team spirit and modesty. A good leader takes a little more than his share of the blame, a little less than his share of the credit.

Now I like to address the difference between a true leader and a boss by using a few quotes. Russell Ewing, a 19th century British journalist said: "A boss creates fear, a leader confidence. A boss fixes blame, a leader corrects mistakes. A boss knows all, a leader asks questions. A boss makes work drudgery, a leader makes it interesting. A boss is interested in himself or herself, a

leader is interested in the group." Similarly, Gordon Selfridge, an American magnate famous for his saying "The customer is always right" wrote in his book, *The Romance of Commerce* and I quote: "The boss drives people; the leader coaches them. The boss depends upon authority; the leader on good will. The boss inspires fear; the leader inspires enthusiasm. The boss says "I"; the leader, "We." The boss fixes the blame for the breakdown; the leader fixes the breakdown. The boss knows how it is done; the leader shows how. The boss says "Go"; the leader says "Let's go!" Along similar lines, President Theodore Roosevelt said: "People ask the difference between a leader and a boss. The leader works in the open, and the boss in covert." President Dwight Eisenhower also said: "Leadership is

the art of getting someone else to do something you want done because he wants to do it."

Finally, let me address the issue of power or authority. People often equate leadership with power and this is not always true. As the proverb says, "Power lasts ten years; influence not more than a hundred." We must realize that leadership is the wise use of power. Power is the capacity to translate intention into reality and sustain it. Again, President Eisenhower once remarked: "Pull the string, and it will follow wherever you wish. Push it, and it will go nowhere at all". Kar Neng LAI, your President and an amateur golfer only now realizes after playing the game for 15 years that "Power is like a golfswing, hit harder from above and the shorter the drive".



Now after hearing my annotation of the qualities of a good leader and a decent manager, please formulate your own opinion and set your own standard should you be promoted to such a position. With the structural training program supervised by the College, you should form a formidable force to provide good management of our healthcare system and its human resources. Please remember you should always observe the courtesy of respecting your patients and colleagues. There is no point reminding others that

you are the boss unless your team wholeheartedly endorses you.

Finally, let me finish by blessing you with a saying from the late President John Fitzgerald Kennedy in his 1960 election: "It is time for a new generation of leadership, to cope with new problems and new opportunities. For there is a new world to be won."

With this, I will say goodbye and wish you every success in your future career and a very pleasant evening.

Thank you.

A good leader takes a little more than his share of the blame, a little less than his share of the credit.

The 15th AJS McFadzean Oration 2010

The Search for the Right Balance: A Question of Judgment

The Honourable Chief Justice Geoffrey Ma



Mr President, Distinguished Doctors and Guests, Ladies and Gentlemen, I am grateful to the College and much honoured to be invited to deliver this, the 15th McFadzean Oration. This Oration – like the Harveian Oration in London – is a venerable institution. Many distinguished speakers have preceded me. I am humbled to be invited to follow them.

It is part of human nature to think in terms of absolutes and that only absolutes represent the truth. We would like to believe that absolute answers to all questions exist, just simply waiting to be discovered. Through the ages, religions the world over and philosophies as plentiful as there are different nationalities,

have put their doctrines in terms of absolutes: deviations, much less contradictions here are non-existent. Science promulgates absolutes as an end in itself: water becomes a gas at 100 Celsius, a solid at 0 Celsius, etc. Medicine in terms of science also and rightly points to the existence of absolutes. There is a historical basis for this: from Galen (the physician of Marcus Aurelius and his son, Commodus) and his discovery of the function of organs, to the great anatomical discoveries of the Flemish physician, Vesalius, in the early sixteenth century, through the birth of modern day medicine in the work of Vesalius' grand pupil William Harvey in the seventeenth century discovering for the first time how blood circulated

in the human body, and to the work of Jenner, Pasteur, Fleming not forgetting Crick and Watson. Incidentally, it is appropriate to mention William Harvey in the context of this Oration : Professor McFadzean was a specialist in haematology at Glasgow University prior to his arriving in Hong Kong in 1948.

I readily concede as an argument that absolutes do exist, at least until the next absolute is discovered. But the existence of absolutes does not justify an approach to life in terms of absolutes, that there is only one answer to problems that we encounter daily. Most of the time, life and our professional work are not like that at all.

Life is often not about absolutes



or even the truth but arriving at the right balance. In the practice of medicine, one can perhaps easily identify extremely difficult decisions that have to be made: the extent to which treatment should be advised for a seriously, even terminally, ill patient; how far any course of treatment is determined by the costs involved, and so the list of situations goes on.

Furthermore, when one is discussing difficult decisions to be made, we are of course talking most of the time about matters of judgment. My premise is that the exercise of a judgment almost invariably involves a question of balance.

Where an exercise of judgment takes place, the decision maker will have to balance between perhaps a number of choices that can each be entirely reasonable and plausible, yet which are diametrically opposed to one another in their result. This is the world where both black and white can be reasonable solutions to a problem. There are no absolutes here. How is the decision maker to choose, what principles help him choose and does truth play a part at all? All these questions arise in the exercise of judgment.

I have no doubt at all that as doctors, you have all had to make difficult decisions and exercise your judgment when there were presented to you two or more alternative solutions, each reasonable but which can yield dramatically different results. I have already referred to one: the decision to advise whether or not to continue giving treatment to a seriously or terminally ill patient. A number of reasonable answers may present themselves, some result in life (or a longer life), while others may result in the termination of life.

I am not so bold or rash, and certainly not wise enough, to offer an answer to the dilemma just

posed, but I do know that, however difficult the decision, one has to be made. It is not an option to refuse to make that decision because, while passing the buck may at times be possible, sooner or later you will have to face the challenge head on and make that decision yourself. When the ultimate responsibility falls on you, you do not look the other way. Being wrong is better than not taking responsibility at all.

I am not qualified to speak about medical decisions or indeed what ought to be a doctor's approach. I am more confident discussing the law in this context. Here, there are indeed few absolutes. Many decisions of judges (all in some way or another affecting the lives of those who are before us) require

My premise is that the exercise of a judgment almost invariably involves a question of balance.

the striking of a right balance between rival (but reasonable) contentions. Sometimes, the difference between decisions at different levels of court can be as fine as a different balance being struck. Let me try to illustrate this.

It is in relation to human rights where we see perhaps the most common area of the law where a critical balancing exercise can take place.

The Basic Law and the Bill of Rights (contained in the Hong Kong Bill of Rights Ordinance Cap. 383) give Hong Kong people substantial and significant rights and liberties. The courts have time and again reiterated that such rights and liberties are to be given a wide, purposive and generous

interpretation. Nevertheless, at times, a difficult balancing of rival interests has challenged the courts.

Some rights are regarded as inviolable: no one is to be subjected to torture or to cruel, inhumane or degrading treatment or punishment (Article 3 of the Bill of Rights), no one is to be held in slavery (Article 4 of the Bill of Rights), the right to be presumed innocent until proven guilty of a criminal offence (Article 11 of the Bill of Rights).

Yet, there are other rights set out in the Bill of Rights which contain in-built limits, limits which call for a difficult and delicate balancing exercise by the courts. Article 16 of the Bill of Rights guarantees the freedom of opinion and expression, but that same article states that this freedom maybe subject to restrictions which are "necessary" for the respect of the rights or reputation of others (for example here, libel laws) or for the protection of national security, of public order, of public health or morals.

In one of the earliest decisions on the freedom of opinion and expression, the courts (right up to the Court of Final Appeal) were faced with a citizen's wish to exercise this freedom (he was protesting against the lack of democracy in the Mainland) by defacing the national flag. Defacing the flag is a criminal offence. The defence was that the offence breached the freedom of expression and therefore, constitutionally, had to be struck down. He relied on decisions of the US Supreme Court in which legislation criminalizing desecration of the American flag was struck down as breaching this freedom.

The Court of Final Appeal, in a unanimous decision, held in favour of the Government. It was recognized that while the freedom of expression was to be given a

wide interpretation and effect, there was a counter argument (which won the day for the Government) that at that stage of Hong Kong's development (1999, soon after the resumption of the exercise of sovereignty in 1997), societal and community interests lay in the protection of the national flag as a unique symbol of the Hong Kong SAR.

Some may perhaps argue that this was an obvious result. In my view, far from it. The Court of Final Appeal was faced with effectively a difficult balancing exercise, especially given the established approach of the courts to construe rights and liberties widely, and, correspondingly, to read restrictions on such rights narrowly. It is perhaps of some note that at the Court of Appeal level, which is one level below the Court of Final Appeal, the Government had lost. This demonstrates the difficulties of having to balance competing, but entirely reasonable, points of views. Even in the United States, those Supreme Court decisions which struck down laws criminalizing the desecration of the US flag, were not unanimous but were 5 to 4 decisions. Sometimes, the difference between a result one way or the other, can be as fine as that: 2 entirely reasonable and plausible points of view, yet diametrically opposed results.

Away from human rights and into the area of medicine, we also see balances having to be struck. For example, in legislation, a balance is struck between, on the one hand, the obvious benefits of organ transplants or reproductive technology and, on the other, the commercial exploitation of this:- see Cap. 465¹ and 561².

Another piece of legislation affecting the medical profession which again highlights the difficulties that may arise in balancing interests is the limitation statute (in Hong Kong, this is the Limitation Ordinance Cap. 347).

Many of you will know that where medical negligence is alleged by a patient, the limitation period is 3 years. This cut off point balances the rights of the patient to have a reasonable time within which to prepare and mount a claim for negligence against the interests, first, of the doctor properly to defend himself and secondly, of the court in adjudicating on stale cases. The 3 years run from the date of the injury or from the date the patient first knew of significant injury (for example the effects of a drug causing latent damage), whichever is later.

The determination by a court of the point when an injury is known to be significant can be said at times to involve a balancing of different interests. Take a real case that faced the English courts (*Dobbie v Medway Health Authority* [1994] 1 WLR 1234). In this case, a woman had had her breast surgically removed. She had been advised by the surgeon that there was a malignant tumor. 15 years later, she discovered that there was in fact no tumor; the surgeon had not even tested for it. In the English Court of Appeal, it

was held she was time-barred: the significant injury was said to be the removal of her breast and this had taken place some 15 years earlier. This result has always seemed to me to be unfair: the poor woman had no means of knowing that a wrong had been committed until 15 years after the operation. The significant injury was not simply the removal of her breast, but the removal of a *healthy* breast. The current analysis of that case is along these lines and this analysis seems to me to be right. There is of course a difficult balance to be struck between the doctor's position (defending a case an extremely lengthy period after the operation) and the patient's predicament of not having known the truth until that same period had elapsed. There is no easy answer to these conflicting, yet rational, arguments. Perhaps the answer ultimately lies in the exercise of commonsense and an underlying sense of justice.

Even in the area of medicine, we see the relevance at times of human rights, and the balancing exercise that has to be undertaken. A few years ago



References

1. **Human Organ Transplant Ordinance Cap. 465**
 1. Organ transplant can save lives. But there is a balance to be struck between commercial exploitation and this benefit.
 2. Commercial exploitation is prohibited : s. 4.
 3. Limits as donors : must be genetically related (s. 5(1)(i)) or a spouse of 3 years or more (s. 5(1)(ii)).
 4. Donor must also be 18 years old (s.5(4)(b)(i)) or 16 if married (s.5(4)(b)(ii)).
2. **Human Reproductive Technology Ordinance Cap. 561**
 1. **Balance** : To enable childless couples to have children but also to prevent commercial exploitation.
 2. The need of a licence : s. 13.
 3. Cannot commercially exploit surrogacy arrangements.



(in *Kwok Hay Kwong v Medical Council of Hong Kong* [2008] 3 HKLRD 524), the Court of Appeal in Hong Kong had to consider the limits to the freedom of expression belonging to doctors to advertise their services. This can be a very difficult balancing exercise indeed: on the one hand, the public interest in enabling doctors to inform members of the public of available medical services so that informed choices can be made; on the other, a rival public interest against excessive and perhaps even undignified forms of advertising, worse still dubious information being provided to the public. What is or is not acceptable is a matter for the profession's governing body (The Medical Council) to determine and I recognize at once the difficulties of adjudicating between diametrically opposed positions in which the proponents each fervently believe in the correctness of their own arguments.

I mentioned at the outset the necessity of making decisions, however difficult the balancing process may involve and however fine the dividing line between competing interests. In the law, we are guided by notions of justice, the respect for the dignity of the individual in the enforcement of fundamental rights and liberties, commonsense and experience.

It is with much diffidence that I venture to suggest that in arriving at difficult decisions, the guides are perhaps similar for doctors. One ultimately goes back to basics:-

1. Learn from your own experience and the experience of others. I have earlier mentioned the great medical scientists – Galen, Vesalius, Harvey, Jenner, Pasteur, Fleming, Crick and Watson – there are many more around you, many in this room. Wisdom consists in part of knowing that there are others wiser than you, from whom you can learn.

If what we do in life echoes in eternity, wisdom requires us to listen to those echoes. The reverse of this coin is that one should not hesitate to share one's experience and knowledge. The Hippocratic Oath (in its original form) stated a requirement that “by precept, lecture, and every mode of instruction, I will impart a knowledge of the Art [of medicine] to my own sons, and those of my teachers.” The Oath of Hippocrates (a Greek physician born in about 460 B.C.) used to be required to be taken by many doctors after graduating from medical school, but obviously now contains a number of requirements which are outdated (for example, the

Wisdom consists in part of knowing that there are others wiser than you, from whom you can learn.

bar on abortion). However, it contains many more facets which, I believe, are still relevant; indeed it is still required to be taken by some medical schools albeit in a more modern form.

2. Use your commonsense. We all have it; it is just that some people try to suppress it for some reason. Using your commonsense requires confidence in your own abilities. Do not underestimate yourself.
3. If you always bear in mind just why you are here in the first place, in other words your mission, you will then have realized the importance of the dignity and rights of the patient. This is not new.

Again, the Hippocratic Oath assists in that part that urges a doctor to “use my power to help the sick to the best of my ability and judgment”. In the 13th AJS McFadzean Oration in 2008, Dr York Chow said this (and I cannot put it better):-

“Medical care is a professional service provided by people: people with knowledge, expertise and experience. More importantly, it relies on professionals who possess strong compassion, and high standards of honesty and morality.... Let us treasure those values and principles, and continue to develop young doctors to be capable, caring, conscientious and confident professionals. Let them enjoy the trust and respect of our citizens.”

4. The dignity and rights of the individual pervade every aspect of society, and rightly so. These rights are not to be sacrificed even if at times against the majority view or, perhaps more accurately, what is regarded as the view of the majority, unless powerful and compelling arguments prevail. When one read recently about the medical experiments carried out on Guatemalans back in the 1940s, the reaction is one of shock. Competing arguments no doubt existed there, but most right thinking people would regard this episode with utter abhorrence.

Lastly a sense of balance requires wisdom, but wisdom can only come from hard work and study. I wish you all wisdom in all that you do and in every difficult decision that you will all no doubt face in the future. It is impossible to please everyone all the time when you have to make an important decision. That (pleasing everyone) is not the obligation. The obligation is to do your best and to do it wisely.

ANNUAL SCIENTIFIC MEETING (9-10 OCTOBER 2010)

The theme of the meeting was “Novel therapeutics in medical practice” with updates in advances relevant to current medical practice, particularly in cardiology and oncology. New treatment approaches to hepatitis C, diabetes, autoimmune rheumatic diseases and myeloid neoplasms were covered during the two days of lectures. The Gerald Choa Memorial Lecture was delivered by Professor Fok Tai Fai who shared with the audience valuable lessons learned from the history of neonatology.

The second day of the meeting featured the outstanding scientific achievements of local researchers. Recipients of the Best Thesis Award and the Distinguished Research Paper Award for Young Investigators 2010 presented their papers. The prestigious Sir David Todd Lecture was presented by Professor Tse Hung Fat on his exciting stem cell research in cardiology. As in the previous year, the annual scientific meeting owed its success to Professor Kwong Yok Lam and the organizing committee.



PROF KAO JIA-HORNG FROM TAIWAN SPOKE ON NOVEL APPROACHES TO HEPATITIS C TREATMENT



PROFESSOR RICHARD YU WITH LECTURERS FOR THE CANCER SYMPOSIUM – DR JANICE TSANG, DR CONRAD LEE AND PROF WINNIE YEO



PROF CM YU, BOTH CHAIRMAN AND SPEAKER FOR THE NOVEL THERAPEUTICS SESSION IN CARDIOLOGY.



A WARM HANDSHAKE AS PROF R YU PRESENTED THE 2010 GERALD CHOA MEMORIAL LECTURE MEDAL TO PROF TF FOK.



COUNCIL MEMBERS APPRECIATIVE OF PROF JOSEPH SUNG'S MANY CONTRIBUTIONS AND LONG SERVICE TO THE HKCP



PROF CS LAU ON NOVEL THERAPEUTICS IN RHEUMATOLOGY



NEW HKCP ANNUAL FELLOWSHIP SUBSCRIPTION FOR 2011

The College has recently reviewed the annual Fellowship subscription. At our recent Council Meeting, the Council noted that the Fellowship subscription has not been revised since 2008. With the complexity of the College, the running cost of our Secretariat is increasing. As a result, the Council decided to increase the annual Fellowship subscription from HK\$1,200.00 to HK\$1,500.00 from the year 2011 onwards. The Membership subscription will remain unchanged at HK\$800.00. At the same time, the training fees for Basic Physician Training and Higher Physician Training remain unchanged at HK\$3,000.00 and HK\$6,000.00 respectively for the whole training period. Please note that our current subscription is still relatively low compared with that of other Academy Colleges. Thank you for your understanding and continued support to the College.

23RD ANNUAL GENERAL MEETING, 12TH CONGREGATION AND 24TH COLLEGE DINNER

At the AGM held on the 9 October 2010, Professor KN Lai delivered his last report as he stepped down from serving as President of our College since 2004. He summarised the work and achievements of the College's various subcommittees in the past year and reported on maintaining strong academic ties with physician colleges, both nationally and internationally. The ceremony proceeded with the conferral of Fellowships and Memberships to 70 doctors, efficiently coordinated by the public orator, Professor Philip Li and officiated by a distinguished platform party.

Two stalwart Councillors retired from their duties in their HKCP Council after many years of devoted service and noteworthy contributions to the College. Prof WK Lam served as Vice President from 2004 – 2010. Prior to that, he was Chairman of the Examination Committee for 12 years and Chairman of National and International Liaison Committee for 11 years. His precise coordination of the MRCP examinations in Hong Kong was widely admired by both UK and local examiners. Prof Joseph Sung chaired the Scientific Committee from 1998 to 2003 and laid the foundation for the Annual Scientific Meeting in 1998. The Council extends heartfelt appreciation for their devoted service.

The annual dinner concluded the first day of the meeting. Over a feast of fine food and wine, honourable guests, fellows and members enjoyed fellowship with new and old friends. The highlight of the evening was the AJS McFadzean Oration. The audience enjoyed an eloquent and thought provoking speech by The Hon Chief Justice Geoffrey Ma on the matter of exercising judgement in the face of difficult decisions posed to both doctors and judges alike.



HKCP
Celebrates **25** YEARS
of extraordinary achievements

The Hong Kong College of Physicians will be celebrating its 25th anniversary this year. Founded in December 1986, our College has grown hugely and now has an impressive membership of a total of 1377 Fellows, 329 Members, 391 trainees. Indeed, we have many achievements we are proud of celebrating on our Silver Jubilee anniversary. A special committee will organize celebrations and a commemorative publication to mark this grand occasion.

The highlight will be the Annual College Dinner scheduled for **8 October 2011**. May we invite you to record this event in your diary now.

Save the date!

THE FELLOWSHIP CONFERRAL CEREMONY AND ANNUAL COLLEGE DINNER 2010



PROF JOSEPH SUNG AND PROF WK LAM RECEIVED THE HKCP PLAQUE FROM THE PRESIDENT AS A TOKEN OF APPRECIATION FOR THEIR LONG SERVICE TO THE COUNCIL



PROF SIR DAVID TODD AND THE HON CHIEF JUSTICE GEOFFREY MA WHO DELIVERED THE AJS MCFADZEAN ORATION



PROFESSORS KN LAI AND WK LAM SHARING A LAUGH WITH BROTHERS HON CHIEF JUSTICE GEOFFREY MA AND DR JOHN MA AT THE ANNUAL DINNER.



THE PRESIDENTIAL PHOTO: DR PATRICK LI, THE NEWLY ELECTED PRESIDENT, TOGETHER WITH THE PAST PRESIDENTS OF THE COLLEGE, PROF RICHARD YU (1998-2004), PROF SIR DAVID TODD (1986-1992), PROF TK CHAN (1992-1998) AND PROF KN LAI (2004-2010)



PRESIDENT KN LAI WITH THE OFFICIATING PLATFORM PARTY AT THE 12TH CONGREGATION FOR NEW FELLOWS



FROM LEFT TO RIGHT: DR PATRICK LI, PROF V CHAN, PROF J SUNG, PROF R YU, PROF SIR DAVID TODD, PROF TK CHAN, PROF KN LAI, PROF WK LAM, PROF P LI & DR L YAM



The HKCP Council 2010-2011

President	<i>Dr Li Chung Ki Patrick</i>
Vice-Presidents	<i>Prof Matthew Ng Dr Yam Yin Chun Loretta</i>
Honorary Secretary	<i>Prof Li Kam Tao, Philip</i>
Honorary Treasurer	<i>Dr Tse Tak Fu</i>
Council Members	<i>Prof Chan Tak Cheung, Anthony Dr Chan Wai Man Johnny Dr Kng Poey Lyn, Carolyn Prof Kwong Yok Lam Dr Lai Sik To, Thomas Prof Lau Chak Sing Dr Leung Man Fuk, Edward Dr Li Chun Sang Dr Tong Kwok Lung, Matthew Dr Tse Man Wah, Doris Dr Wong Chun Por Prof Wong Ka Sing, Lawrence Prof Yu Cheuk Man</i>
Co-opted Council Members	<i>Prof Chan Ka Leung Dr Tsoi Tak Hong</i>
Founding President	<i>Prof Sir David Todd</i>
Past President	<i>Prof Lai Kar Neng</i>
Senior Advisor	<i>Prof Yu Yue Hong Richard</i>

The Council appointed the following Chairmen of various Committees:

National and International Liaison Committee

Prof Matthew Ng

Education and Accreditation Committee

Dr Loretta Yam

Professional and General Affairs Committee

Dr CP Wong

Scientific Committee

Prof YL Kwong

Membership Committee

Dr CS Li

Examination Committee

Prof CS Lau

Administration and Finance Committee

Dr TF Tse

Working Group in Traditional Chinese Medicine

Dr TF Tse

Research Committee

Prof Lawrence Wong

Synapse

Dr Carolyn Kng

Distinguished Research Paper Award for Young Investigators 2010

The following doctors received the awards at the Annual Scientific Meeting.



Dr Bik Ling Man

Department of Medicine & Geriatrics, Tuen Mun Hospital

Dr Chung Wah Siu

Department of Medicine, Queen Mary Hospital

Dr Grace Lai Hung Wong

Department of Medicine & Therapeutics, Prince of Wales Hospital

Dr Vincent Wong

Department of Medicine & Therapeutics, Prince of Wales Hospital

LESION PATTERNS AND STROKE MECHANISMS IN CONCURRENT ATHEROSCLEROSIS OF INTRACRANIAL AND EXTRACRANIAL VESSELS.

INTRAVENOUS DILTIAZEM IS SUPERIOR TO INTRAVENOUS AMIODARONE OR DIGOXIN FOR ACHIEVING VENTRICULAR RATE CONTROL IN PATIENTS WITH ACUTE UNCOMPLICATED ATRIAL FIBRILLATION.

HIGH INCIDENCE OF MORTALITY AND RECURRENT BLEEDING IN PATIENTS WITH HELICOBACTER PYLORI-NEGATIVE IDIOPATHIC BLEEDING ULCERS.

CLINICAL SCORING SYSTEM TO PREDICT HEPATOCELLULAR CARCINOMA IN CHRONIC HEPATITIS B CARRIERS.

Man BL. Fu YP. Chan YY.
Lam W. Hui AC. Leung WH.
Mok V. Wong KS.

Siu CW. Lau CP. Lee WL.
Lam KF. Tse HF.

Wong GL. Wong VW. Chan Y.
Ching JY. Au K. Hui AJ. Lai LH.
Chow DK. Siu DK. Lui YN. Wu
JC. To KF. Hung LC. Chan HL.
Sung JJ. Chan FK.

Wong VW. Chan SL. Mo F.
Chan TC. Loong HH. Wong GL.
Lui YY. Chan AT. Sung JJ. Yeo W.
Chan HL. Mok TS.

Stroke. 40(10):3211-5, 2009 Oct.

Critical Care Medicine.
37(7):2174-9, 2009 Jul.

Gastroenterology.
137(2):525-31, 2009 Aug.

Gastroenterology.
137(2):525-31, 2009 Aug.



Sir David Todd Lecture

New Era of Regenerative Medicine for Cardiovascular Diseases



Hung Fat Tse

Department of Medicine
University of Hong Kong

The increasing life expectancy in many parts of the world has led to an epidemiologic transition in the leading causes of death from infectious diseases and acute illness to chronic illness, especially cardiovascular diseases. Despite the recent advances in medical and surgical therapies, a large number of patients with cardiovascular diseases remain severely symptomatic with poor clinical outcomes. Many currently untreatable cardiovascular disorders arise from disease process due to significantly loss of cardiomyocytes that do not otherwise regenerate. As a result, stem cell and gene therapy has been explored as potential treatment to limit the progression of diseases or to regenerate damaged heart in patients with different cardiovascular diseases.

Stem cell therapy was conceptualized more than a decade ago in the treatment of acute myocardial infarction.¹⁻³ Based on the initial encouraging results in the experimental studies,⁴ we have initiated the first human clinical study in 2001 on the use of novel catheter-based intramyocardial transplantation of bone marrow (BM) stem cells for treatment of chronic myocardial ischemia in patients with severe coronary artery disease not amenable to conventional medical or surgical therapies.⁵ Long-term follow-up^{6,7} in this initial cohort of patients suggested that intramyocardial BM stem cell transplantation was a safe and feasible treatment option in this group of patients. In 2006, we performed the first Prospective RandOmized controlled Trial on the use of direct Endomyocardial implantation of BM Cells for

Treatment of severe Coronary Artery Diseases (PROTECT-CAD trial).⁸ In this study, we have demonstrated that BM cells injection were associated with improvement in exercise time, functional class, left ventricular ejection fraction and wall thickening over the target region by 6 months.⁸ On cardiac magnetic resonance imaging, myocardial perfusion and flow reserve were improved over the target region, suggesting the enhancement of neovascularization after bone marrow transplantation.⁹ Indeed, numerous clinical studies in recent years from other centers have also confirmed that BM cells transplantation can improve symptoms and cardiac function, and limit infarct size and adverse ventricular remodeling in patients with acute myocardial infarction, chronic myocardial ischemia and congestive heart failure.¹⁰

Despite the promising initial clinical results, the beneficial effects are at best modest, and several major issues, such as the optimal timing, cell types and mode of delivery need to be addressed in the ongoing clinical trials. Furthermore, additional strategies should also be developed to improve the efficacy of cell-based therapy for cardiovascular diseases. One of the important obstacle for cardiac regeneration with stem cell therapy is the ability to replace any major loss of cardiomyocytes after the initial insult. For instance, more than 1 billion of cardiomyocytes died after an acute myocardial infarction. Currently, adult stem cells, such as BM, skeletal myoblast and mesenchymal stem cells (MSC) are the most common cell source for cardiac regeneration in clinical trials as they have no risks of

immune rejection with autologous transplantation, non-tumour forming, and have no ethical obstacle.¹¹ However, they are restricted in their renewal and differentiation potential to become functional cardiomyocytes. In contrast, human pluripotent stem cells, such as embryonic stem cells (ESCs) can propagate indefinitely while maintaining their normal karyotypes and pluripotency to differentiate into all cell types, including functioning cardiomyocytes.^{12,13} We have demonstrated that transplantation of functional cardiomyocytes derived from these pluripotent stem cells could improve left ventricular function and prevent adverse ventricular remodeling after myocardial infarction.¹⁴ However, the immature phenotypes, such as calcium handling and electrophysiological properties in those cardiomyocytes derived from ESC was associated with development of fatal ventricular tachyarrhythmias.¹⁵⁻¹⁷ Therefore, new techniques to drive cardiac differentiation and maturation, such as gene modification¹⁸ could ultimately enable the application of these human pluripotent stem cells to regenerate damaged myocardium.

Recently, the generation of human induced pluripotent stem (iPS) cells, via reprogramming of somatic cells has circumvented some of the potential technological, social and ethical issue related to ESC.¹⁹ Conceptually, iPS cell technology should provide an unlimited supply of even specified cells, not limited to cardiomyocyte, but also hepatocytes, beta-cells and neurons etc for tailored made patients-specific cell-based therapy for treatment of various human diseases, and to



develop human cell based platform for drugs screening. Indeed, we have successfully derived functional MSC from human iPS cells, and demonstrated that iPS-derived MSC was superior to BM-MS in enhancement of neovascularization in ischemic limb.²⁰ Furthermore, we have also established patient-specific human iPS platform for modeling of different human diseases, such as premature aging due to laminopathy.²¹

Finally, gene based therapy may also play a role in cardiac regeneration. We have previously demonstrated that over-expression of bioengineering pacemaker gene via somatic gene transfer in heart could initiating cardiac rhythm, and thus act as biological pacemaker.²²⁻²⁴ This therapeutic approach may potentially avoid or act as hybrid therapy to reduce the dependence of electronic pacemaker in patients with cardiac arrhythmias. In summary, it is anticipate that regenerative medicine will play an ever more prominent role in the new era of modern cardiovascular therapies; however, significant challenges must be overcome before that promise is realized.

References:

1. Tse HF, Lee PY, Lau CP. Bone Marrow Cell Transplantation for Myocardial Regeneration and Therapeutic Angiogenesis. In Laham R, Balm DS (eds): *Angiogenesis and Direct Myocardial Revascularization*. Totowa, NJ: Humana Press Inc., pp. 261-281, 2005.
2. Tse HF, Yiu KH, Lau CP. Bone marrow stem cell therapy for myocardial angiogenesis. *Curr Vasc Pharmacol* 2007;5:103-112.
3. Tse HF, Lau CP. Therapeutic angiogenesis with bone marrow derived stem cells. *J Cardiovasc Pharmacol Ther.* 2007;12:89-97.
4. Tse HF, Siu CW, Zhu SG, Liao S, Zhang QY, Lai WH, Kwong YL, Nicholls J, Lau CP. Paracrine effects of direct intramyocardial implantation of bone marrow derived cells for enhancement of neovascularization in chronic ischemic myocardium. *Eur J Heart Fail.* 2007;9:747-53.
5. Tse HF, Kwong YL, Lo G, Ho CL, Chan JFK, Yeung DW, Lau CP. Angiogenesis in ischemic myocardium by intramyocardial autologous bone marrow mononuclear cell implantation. *Lancet.* 2003; 361: 47-9.
6. Tse HF, Thambar S, Kwong YL, Rowlings P, Bellamy G, McCrohon J, Bastian B, Chen WH, Chan JFK, Lo G, Ho CL, Lau CP. Safety of catheter-based intramyocardial autologous bone marrow cells implantation for therapeutic angiogenesis. *Am J Cardiol.* 2006; 98: 60-2.
7. Tse HF, Kwong YL, Chan JFK, Lo G, Ho CL, Parker A, Hauser T, Lau CP. Comparative evaluation of long-term clinical efficacy with catheter-based percutaneous intramyocardial autologous bone marrow cells implantation versus laser myocardial revascularization in patients with severe coronary artery disease. *Am Heart J.* 2007;154:982.e1-6.
8. Tse HF, Thambar S, Kwong YL, Rowlings P, Bellamy G, McCrohon J, Thomas P, Bastian B, Chan JFK, Lo G, Ho CL, Chan WS, Kwong RY, Parker A, Hauser T, Chan J, Fong YT, Lau CP. Prospective randomized trial of direct endomyocardial implantation of bone marrow cells for treatment of severe coronary artery diseases (PROTECT-CAD trial). *Eur Heart J.* 2007; 28: 2998-3005.
9. Chan WS, Kwong YL, Kwong RY, Lau CP, Tse HF. Therapeutic angiogenesis with direct endomyocardial implantation of autologous bone marrow cells in patients with severe coronary artery diseases: Insight from cardiac magnetic resonance imaging. *J Cardiovasc Magn Reson.* 2010;12:6.
10. Siu CW, Liao SY, Liu Y, Lian Q, Tse HF. Stem cells for myocardial repair. *Thromb Haemost.* 2010 Mar 29;104(1). [Epub ahead of print]
11. Lian Q, Chow Y, Esteban MA, Pei D, Tse HF. Future perspective of induced pluripotent stem cell for diagnosis, drug screening and treatment of human diseases. *Thromb Haemost.* (in press).
12. Moore JC, Fu J, Chan YC, Lin D, Tran H, Tse HF, Li RA. Distinct cardiogenic preferences of two human embryonic stem cell (hESC) lines are imprinted in their proteomes in the pluripotent state. *Biochem Biophys Res Commun.* 2008; 372:553-8.
13. Moore JC, Tsang SY, Rushing SN, Lin D, Tse HF, Chan CW, Li RA. Functional consequences of overexpressing the gap junction Cx43 in the cardiogenic potential of pluripotent human embryonic stem cells. *Biochem Biophys Res Commun.* 2008;377:46-51.
14. Au KW, Liao SY, Lee YK, Lai WH, Ng MK, Chan YC, Yip MC, Ho CY, Wu EX, Li RA, Siu CW, Tse HF. Effects of iron oxide nanoparticles on cardiac differentiation of embryonic stem cells. *Biochem Biophys Res Commun.* 2009;379:898-903.
15. Wang K, Xue T, Tsang SY, Huizen RV, Wong CW, Lai KW, Ye Z, Cheng L, Au KW, Zhang J, Li GR, Lau CP, Tse HF, Li RA. Electrophysiological properties of pluripotent human and mouse embryonic stem cells. *Stem Cells.* 2005; 23: 1526-34.
16. Lieu DK, Liu J, Siu CW, Mc Nerney GP, Abu-Khalil A, Huser T, Tse HF, Li RA. Absence of transverse tubules contributes to non-uniform Ca2+ wavefronts in mouse and human embryonic stem cell-derived cardiomyocytes. *Stem Cell Dev* 2009;18:1493-500.
17. Liao SY, Liu Y, Siu CW, Lai WH, Wu Y, Yip P, Wu Y, Wu EX, Lau CP, Li RA, Tse HF. Proarrhythmic risk of transplantation of embryonic stem cell derived cardiomyocyte in infarcted myocardium. *Heart Rhythm* (in press).
18. Ng KM, Lee YK, Lai WH, Fung ML, Siu CW, Li RA, Tse HF. Exogenous expression of HIF-1 promotes cardiac differentiation of embryonic stem cells. *J Moll Cell Cardiol* 2010;48:1129-37.
19. Lian Q, Chow Y, Esteban MA, Pei D, Tse HF. Future perspective of induced pluripotent stem cell for diagnosis, drug screening and treatment of human diseases. *Thromb Haemost.* (in press).
20. Lian Q, Zhang Y, Zhang J, Zhang HK, Wu X, Zhang Y, Lam FY, Kang S, Xia JC, Lai WH, Au KW, Chow YY, Siu CW, Lee CN, Tse HF. Functional mesenchymal stem cells derived from human induced pluripotent stem cells attenuate limb ischemia in mice. *Circulation* 2010;121:1113-23.
21. Liu B, Wang J, Chan KM, Tjia WM, Deng W, Guan X, Huang J, Li KM, Chan JD, Pei D, Pendas A, Lopez-Otin C, Tse HF, Hutchison C, Chen J, Cao Y, Cheah KSE, Tryggvason K, Zhou Z. Genomic instability in laminopathy-based premature aging. *Nat Med.* 2005; 11: 780-85.
22. Tse HF, Xue T, Lau CP, Siu CW, Wang K, Zhang QY, Tomaselli GF, Akar FG, Li RA. Bioartificial sinus node constructed via in vivo gene transfer of an engineered pacemaker HCN channel reduces the dependence on electronic pacemaker in a sick sinus syndrome model. *Circulation.* 2006; 114: 1000-11.
23. Xue T, Siu CW, Lieu DK, Lau CP, Tse HF, Li RA. Mechanistic role of If revealed by induction of ventricular automaticity by somatic gene transfer of gating-engineered pacemaker (HCN) channels. *Circulation.* 2007; 115:1839-50.
24. Chan YH, Siu CW, Chan YH, Lau YV, Lau CP, Li RA, Tse HF. Synergistic effects of inward rectifier (IK1) and pacemaker (If) currents on the induction of bioengineered cardiac automaticity. *J Cardiovas Electrophysiol* 2009; 20:1048-54.

Best Thesis Award Gold Award Winner

Good collateral circulation predicts better outcome in patients with intracranial large artery occlusive diseases

By Alexander Yuk Lun LAU

Department of Medicine and Therapeutics
Prince of Wales Hospital



DR ALEXANDER LAU, DR VINCENT MOK (SUPERVISOR) AND PROF KN LAI

Background

Collateral circulation via circle of Willis (COW) and leptomeningeal anastomosis preserves perfusion and stabilizes cerebral blood flow, and is an important outcome predictor of revascularization in acute occlusion and symptomatic carotid stenosis. Its role in the prevalent intracranial large artery occlusive disease (ILAD) has not been explored. This study aimed to assess the antegrade and collateral circulation status in patients with symptomatic ILAD and to correlate with the stroke severity, neurological recovery, and recurrence risk. The stroke topography was assessed to elucidate its pathogenesis.

Methods

This is a retrospective study of patients who had ischemic stroke related to ILAD (intracranial ICA, MCA, BA) and underwent MRI brain and digital subtraction angiography (DSA). The angiograms were assessed by the Thrombolysis in Cerebral Infarction (TICI) grading for antegrade flow, and the American Society of Interventional and Therapeutic Neuroradiology/Society of Interventional Radiology (ASITN/SIR) grading for collateral flow. MRA was used to assess the COW. Composite *circulation score* and *global circulation score* were derived to incorporate antegrade, collateral, and COW status. Outcome measures included the National Institute of Health Stroke Scale (NIHSS) for index stroke severity, functional independence at 3-months, and recurrent stroke or transient ischemic attack (TIA) in 12-months. Stroke topography was assessed according to vascular territories into perforator, pial, borderzone, and territorial infarcts using published templates.

Results

79 patients were analyzed. The majority (n=56, 71%) had MCA stenosis and mild stroke (median NIHSS 3). 44 (58%) patients had good antegrade flow (TICI grade 2b and 3), 66 (89%) patients had good collateral flow (ASITN/SIR grade 2-4), and 55 (70%) patients had complete COW; corresponding to 65 (88%) patients with good circulation score and 65 (88%) patients with good global circulation score. Patients with good circulation score had less severe index stroke (NIHSS 3±2 versus 3±4, p=0.038), better stroke recovery with functional independence at 3-months (94% versus 6%, p=0.035), and less recurrent stroke or TIA in 12-months (91% versus 9%, p=0.073). Good *circulation score* (OR 13.9, 95% CI 1.37-142.4, p=0.026), and complete COW (OR 15.3, CI 2.50-93.83, p=0.003) predicted functional independence. In the stroke topography analysis, borderzone (n=41, 52%) and pial (n=28, 35%) infarcts were the commonest and corresponded to

more severe stroke (NIHSS 3±3 versus 3±2, p=0.029, and NIHSS 3.5±2 versus 3±2, p=0.028, respectively). High-grade (>70%) stenosis predicted multiple infarcts (OR 6.4, CI 1.20-34.30, p=0.03), and diabetes predicted pial infarcts (OR 4.9, CI 1.54-15.75, p=0.007).

Conclusion

In patients with symptomatic ILAD, composite circulation assessment by incorporating the leptomeningeal collateral and COW flow status provides more comprehensive prognostication. Better prognosis can be anticipated in patients with compromised antegrade flow but compensated by good collateral circulation. Pial, borderzone, and multiple infarcts are unfavorable stroke topography, suggesting that impaired washout of thromboemboli in hypoperfused region is important in the stroke pathogenesis.

Best Thesis Award Silver Award Winner

Tests used in the subtype classification and outcome of treatment in primary aldosteronism

By Benjamin Yick Toa AU YEUNG
Department of Medicine
Queen Elizabeth Hospital

Objective

The aim of this dissertation is to review the evidence base for the need to differentiate between APA and BAH, and the evidence base for the tests used for this purpose.

Methods

Literature search as well as a retrospective analysis of the experience in our centre are performed.

Results

The difference in prognostic implications between APA and BAH is uncertain. Medical therapy of APA appears to be less effective in terms of cardiovascular outcome



DR BENJAMIN AU YEUNG, DR CHIU MING NG (SUPERVISOR) AND PROF KN LAI

Background

Clinical guidelines state that it is important to differentiate between the different subtypes of primary aldosteronism (PA), notably between unilateral adenoma (APA) and bilateral hyperplasia (BAH). Treatment recommendations for these two subtypes differ. Adrenal venous sampling (AVS) is considered the reference standard for this purpose, though imaging studies can also be helpful.

than surgical therapy. Whether surgical therapy for BAH is a viable option awaits future exploration. For the time being, it is still worthwhile to differentiate between unilateral and bilateral disease in view of the difference in treatment recommendations.

For differentiation, imaging studies and posture stimulation test both have good positive predictive value for APA. AVS is helpful when these two tests are negative, or show discordant results. AVS can lead to false lateralization in 10% of cases. A cut-off lateralization ratio of > 3:1 should suffice for diagnosing APA. A contralateral ratio of <1 is also very useful. It is a difficult

procedure, and failure to cannulate the adrenal veins, especially the right adrenal vein, can occur in 25 to 50%. However, suboptimal cannulation can also produce useful data, and blood samples should always be obtained from the nearest site.

Conclusion

The need for differentiating APA and BAH should be further studied. Diagnosis of PA subtypes should depend on a combination of imaging and biochemical studies.

Best Thesis Award **Bronze Award Winner**

A prospective study on the significance of quality of life measurement and clinical factors in prediction of survival in Chinese patients with hepatocellular carcinoma

By Leung LI
Department of Clinical Oncology
Prince of Wales Hospital

Methods

Two hundred and three patients with newly diagnosed HCC were prospectively recruited. Treatment included surgery, loco-ablative therapies, transarterial therapies, chemotherapies, sorafenib and best supportive care as determined by clinicians. Patients' baseline QOL assessment, clinical factors, staging and treatment were analysed to identify independent factors for survival in Cox proportional hazards regression model. The correlations between QOL and stage of HCC and severity of cirrhosis were analysed by Wilcoxon rank-sum test.

Results

Median overall survival of the 203 HCC patients (79% hepatitis B) was 8.1 months (95% CI 6.2-



DR LEUNG LI, PROF WINNIE YEO (SUPERVISOR) AND PROF KN LAI

Background

Quality of life (QOL) assessment with EORTC QLQ-C30 questionnaire was reported to be prognostically significant in patients with hepatocellular carcinoma (HCC). The HCC-specific QOL EORTC QLQ-HCC18 may have a better reflection of QOL in HCC patients with chronic liver disease. The potential mechanisms of QOL being prognostic for survival were investigated. Various staging systems were developed in different populations, however, differences in etiological pattern and prognosis between Chinese and Caucasian HCC patients were noted. The objectives of this study were 1) to evaluate the prognostic significance of EORTC QLQ-HCC18 module, 2) to validate the prognostic value of EORTC QLQ-C30 module, 3) to assess correlation between QOL and the stage of HCC and severity of cirrhosis, and 4) to find the best HCC staging systems for Chinese HCC patients.

9.6 months). 1) In combined multivariate analysis, independent poor prognostic factors for survival among QLQ-HCC18 were worse scores in HCC18 fatigue domain (HR 1.146; $p=0.0042$) and nutrition domain (HR 1.137; $p=0.0244$). 2) of the QLQ-C30, no factor was identified as independent prognostic factor. 3) There were significant correlations between worse QOL scores in C30/HCC18 and advanced cirrhosis, as well as advanced stages in Chinese University Prognostic Index (CUPI), Okuda, the American Joint Committee on Cancer Tumor Node Metastasis (AJCC TNM), Cancer of the Liver Italian Program (CLIP). 4) In Chinese HCC patients, CUPI ($p=0.0037$) and Okuda (0.0019) were significantly superior among various staging systems.

Conclusions

This study was the first to report the significant prognostic value of EORTC QLQ-HCC18 module in HCC patients. The combined multivariate analysis was unable to confirm previous report on EORTC QLQ-C30's prognostic significance. Worse QOL scores correlated significantly with advanced cirrhosis and advanced HCC stage. CUPI and Okuda had significantly better prognostic value in Chinese HCC patients.

Distinguished Awards for Our Fellows

Hearty congratulations to our Fellows and Honorary Fellows who have received prestigious awards in 2010 for their outstanding contributions.



PROFESSOR
RICHARD YU YUE-HONG

Silver Bauhinia Star (SBS)

Professor Yu is awarded the SBS in recognition of his distinguished public and community service, particularly his significant contribution to the health care sector and the development of nephrology in Hong Kong. He is also a staunch supporter of research and education on emerging infectious diseases.



**DR THE HONOURABLE
EDWARD LEONG CHE-HUNG**

Grand Bauhinia Medal (GBM)

Dr Leong is awarded the GBM in recognition of his distinguished public and community service, particularly his significant contribution as a Member of the Executive Council and his dedication to the development of the medical profession in Hong Kong. With his extensive professional expertise, Dr Leong has provided valuable advice in the formulation of medical services and health care policies. During his tenure as Chairman of the Hospital Authority, he led the organisation to implement initiatives to improve the quality of patient care. He also played a pivotal role in championing the legislation and establishing the regulatory regime for human reproductive technology activities. In his capacity as the Chairman of the Elderly Commission, he has successfully introduced innovative programmes to benefit the elderly and address their long-term care needs.



DR LEO WONG KWAI-KUEN

Bronze Bauhinia Star (BBS)

Dr Wong is awarded the BBS for his achievements in photographic art and his exemplary efforts in promoting the development of photographic art in Hong Kong, the Mainland and overseas.

Professor Kar Neng Lai

Our immediate Past President, Professor Kar Neng LAI, Yu Chiu Kwong Chair of Medicine, HKU, received the following honors given by the Asian-Pacific Society of Nephrology at Seoul in June 2010. They are the Priscilla Kincaid-Smith Award for outstanding contribution to science in nephrology from the Asian-Pacific Region and the Ross Bailey Lecture Award for outstanding scientific achievement.



Dr Chew Chin Hin (Honorary Fellow, HKCP)

Dr Chew received the Mastership of the American College of Physicians at a convocation ceremony in Toronto, Canada for his contributions to the development of clinical medicine, medical education, research and medical ethics in Singapore. The Mastership has been given to fewer than 700 doctors worldwide since 1923.

Meeting with the CEO, Royal Australasian College of Physicians

Dr Jennifer Alexander, CEO of the Royal Australasian College of Physicians, met our College President, on 3 September 2010 at the College Chamber to discuss matters of mutual interest. Prof Philip Li, Hon Secretary, Dr Patrick Li (President-elect) and Dr Matthew Tong also joined the discussion. Dr Alexander gave a College tie to our President as a gift. Our College hosted a dinner in her honour at the Hong Kong Golf Club on the same evening.





Pass Rates for the Joint HKCPIE/MRCP(UK) PACES examination

October 2001	36/72 = 50%
February 2002	34/74 = 46%
October 2002	29/72 = 40%
February 2003	30/69 = 43%
October 2003	27/59 = 46%
March 2004	39/64 = 61%
October 2004	26/69 = 38%
March 2005	35/75 = 47%
October 2005	28/75 = 37%
March 2006	36/75 = 48%
October 2006	16/73 = 22%
March 2007	44/74 = 59%
June 2007	44/74 = 59%
October 2007	36/55 = 65%
March 2008	36/74 = 49%
October 2008	29/65 = 45%
February 2009	39/75 = 52%
October 2009	24/72 = 33%
March 2010	33/75 = 44%
October 2010	40/74 = 54%

Pass List for the October PACES 2010 Examinations

Au Chi Kit	Au Chi Sum
Au Ho Yan Toni	Chan Chi Pan
Chan Chung On	Chan Kam Wa
Chan Koon Ming	Chan Shuk Ying
Chan Wai Lun Larry	Chan Yu Hong
Cheung Sze Wan Peggy	Cheung Wing Sze Emily
Chu Yim Pui	Fan Sin Ying
Fong Ho Fai Daniel	Fong Man Chi
Ho Yim Ha	Huang Shan Shan
Ip Muk Fai	Kwok Wing Hang Dorothy
Kwong Kin Keung	Lai Tin Lok
Lau On Cheung	Lau Yue Leung Joulen
Lee Ching Man Margaret	Li John Wing
Li Shi Piu Carlton	Mui Chun Yue
Shek Lam Hin	Sin Chung Wah
Sze Yee Yan	Tong Yee Hong Terence
Tsang Cheuk Hang	Tsang Kai Fung
Wong Chi Kin	Wong Ho Nam
Wong Lok Yan Ivy	Yeung Pui Yu
Yu Wen Zhen	Yung Sai Kwong

TRAINING



Please note below the important announcements relevant to trainees and trainers.

Dual Specialty Training

The College noted that there has been a trend for trainees to give up AIM training after achieving specialist status in the first specialty. The College considers that practice in Internal Medicine and its specialties require broad-based training, and accreditation in a single subspecialty is not broad enough in terms of knowledge. As a result, the College has decided that, with immediate effect from 28 October 2010, all future Higher Physician trainees entering dual training programs must choose AIM or Geriatric Medicine as one of the broad-based specialties in addition to one subspecialty.

Deferment of HPT training

All HPT trainees who wish to defer their training in a specialty will only have their previous training accredited

at a later date if they had already taken the first Annual Assessment in that specialty.

Termination or change of HPT Training Program

The scenarios below serve to remind trainees the importance of informing College prior to any change in the nature of their training programs.

Scenario 1

Doctor A was originally registered for dual training in Specialties I and II in Training Institution P. Some time later Doctor A left Training Institution P and transferred to another Training Institution Q, which is not a Training Centre for Specialties I and II. Doctor A **did not inform** the College about his transfer and proceeded to register to train in Specialty III.

Scenario 2

Doctor B was originally registered for dual training in Specialties I and II in Training Institution M. Some time later Doctor B left Training Institution M and transferred to another Training Institution N, which is not a Training Centre for Specialties I and II. Doctor B **informed** the College that he wished to terminate his training in Specialties I and II and applied to train in Specialty III.

Council's decision regarding Scenario 1 and 2

At the 224th Meeting of 18 May 2010, the Council noted that many trainees as in Scenario 1 did not inform the College when they decided to terminate their originally registered HPT training programs. The Council therefore decided that, if such HPT trainees wished to rejoin the College's training programs in the same or another specialty, a new payment of the HPT training fee of HK\$6,000.00 will be imposed. Therefore, Doctor A in Scenario 1 will be charged a new HPT training fee of HK\$6,000.00 to register to be a trainee in Specialty III.

However, in Scenario 2, Doctor B will not be required to pay any additional fees when he/she registers to be an HPT trainee in Specialty III.

Default of College Membership – Process for Re-application

Scenario

Doctor C completed his BPT training in June 2003. Doctor C subsequently left Training Institution J in December 2003 and started private practice in January 2004. Doctor C has never applied for College Membership. In January 2008, Doctor C was recruited into Training Institution K and expressed his wish to commence his HPT training in Specialties I and II. The College Secretariat found that Doctor C was not a College Member and informed him to apply for admission. After submission of Membership application, Doctor C registered as HPT trainee in Specialties I and II. Doctor C was admitted as College Member in June 2008.

Council's decision regarding above Scenario

At its 224th Meeting of 18 May 2010, the Council decided that HPT trainees who are not College members and not working in any training institutions as reported by their trainers and Specialty Boards will be removed from the Trainees' Lists of the respective Boards. If such trainees wish to rejoin the HPT training program at a later date, they must first apply for College Membership. **The first year's membership fees for such trainees will be double the total sum of annual membership subscriptions counting from the year when they first became eligible to be College Members to the year of application.**

In the above Scenario, Doctor C has terminated the training program for more than three years. In accordance

with the Council's decision on 29 January 2008, his application to be HPT again should be approved by both the Education and Accreditation Committee and Council before Doctor C can apply for College Membership. His first year's membership fee would be HK\$8,000.00, being the total annual membership fee of HK\$800 x (2008 – 2003) years x 2.

Membership is required before Annual Assessment

In accordance with the *Guidelines on Postgraduate Training in Internal Medicine, fourth edition, July 2007*, page 27, "After completing three years of accredited Basic Physician Training and passing the Intermediate examination, the Trainee should report, through his/her Program Director, to the Basic Physician Board for certification of training completion. The Trainee should then apply to be admitted as Member of the Hong Kong College of Physicians before proceeding to Higher Physician Training in one or more specialty in Internal Medicine".

At its 224th Meeting of 18 May 2010, the Council reiterated that **HPT trainees must be College Members before undertaking Annual Assessment.** Trainees who have not completed membership application after their first Annual Assessment will not be allowed to continue to take Annual Assessment in the registered specialties.

BPT and HPT Attendance at the HKCP Annual Scientific Meeting

The College noted that many BPT and HPT trainees had attended the Annual Scientific Meeting by signing the attendance sheets and leaving the venue immediately afterwards. In order to emphasize the importance of attending the Meeting, the Council decided that the **Annual Assessment will include some questions based on topics delivered at the Annual Scientific Meeting.**

HPT dissertations - Study design, medical statistics and research methodology

The Council noted that a number of trainees had demonstrated **knowledge deficiency in the use of statistical methods and research methodology** in their dissertations. Trainees are advised to obtain such information from books and the internet and tutorials will not be organised by the College. All Specialty Boards have been reminded to ensure their Trainees are updated on this aspect of training.



Professor Zhong Nan-Shan

John MacKay



PROF ZHONG WITH DR JOHN MACKAY AT THE FRCPE SIGNING OF THE ROLL CEREMONY HELD IN HONG KONG IN 2009

Professor Zhong Nan-shan was born in Nanjing in 1936. Both his parents were doctors, his father a famous paediatrician.

When he was three months old his parents left Nanjing, just before the Japanese took the city in 1937.

His schooling took place in areas outside the Japanese area of control, but he recalls one time when he was walking with his family in a park, and watched a Japanese plane bomb their house, destroying it completely.

At Beijing University he developed an interest in athletics. In the first Chinese National Games he won the 400 meter hurdles in a time that is still a student record.

After graduation in 1960 he worked as an assistant biochemistry lecturer at Beijing University.

1966 saw the start of the Cultural

Revolution. Soon he was sent to work in kitchens and as a labourer near the Great Wall in Hebei province. His wife was sent to rural Guangdong and their young child was given into the care of his grandmother.

During the Cultural Revolution the medical system was in disarray. When it was over there was a need to make good the ten years of lost medical advancement.

Deng Xiao Ping ordered that leading doctors be sent abroad for further training. Under this scheme, in 1979 Prof. Zhong was sent to Edinburgh University to work with Professor Flenley, Professor of Respiratory Disease at the City Hospital, the successor to the famous Professor Sir John Crofton.

He completed a second year of studies in London in St. Bartholomew's Hospital.

He remembers those days as being most rewarding but also hard, in that his funding from China amounted to only GBP6 per month.

On his return to China Professor Zhong was appointed to the Guanzhou Institute of Respiratory Disease. In the following years he published numerous papers on original research. Here it was that in 2003 he earned national and international fame for his leadership in combating the SARS epidemic.

The first patient he saw in December 2002 alerted him to the unusual features of this atypical pneumonia; the decreased compliance of the lungs and the dramatic improvement after administration of steroids. He emphasised that steroids had to be given in the right dosage to the right patient at the right time.

Under this regime he had only two patients who suffered the side effect of aseptic necrosis of the hip, a lower incidence than elsewhere.

The illness and deaths of colleagues working with him on SARS patients was a great sadness. But he was proud that none stepped back from the front line.

Professor Zhong's insistence that SARS was a viral infection was vindicated when the corona virus was identified as the culprit.

His leadership was rewarded when he was appointed President of the Chinese Medical Association.

Research is still proceeding on the corona virus carrier rates in civet cats, carriers of the disease. He has shown that civet cats farmed in south China for eating had a high carrier rate, whereas wild civet cats in the north had a very low rate.

In 2008 The Lancet published Prof. Zhong's PEACE study that showed that carbocisteine given to COPD patients during acute exacerbations, was as effective as standard treatment with steroid and beta-agonist bronchodilators, and importantly was affordable to poor people.



PROF ZHONG AND PROF NEIL DOUGLAS

Currently, Dr Zhong is the Head of Guangzhou Institute of Respiratory Diseases, Chief Committee Member of Society of Respirology to Chinese Medicine Association, Medical Tutor of Smoking and Health WHO, Vice-director of Dept. of Medicine and Healthcare, Chinese Academy of Engineering, Vice chairman of Guangdong Society of Scientific Technology, Chairman of Guangzhou Society of Scientific Technology, Committee Member of the 8th and 9th Chinese

People's Political Consultative Congress and a Representative of the 15th CCPC.

It is fitting that in 2009 Professor Zhong Nan-shan should receive an Honorary Fellowship from Edinburgh University, where he first learned the techniques to do original research and developed confidence in his own abilities. Abilities that he has put to such good use over the years, most spectacularly during the SARS epidemic.



PROF ZHONG RECEIVED THE HONORARY FELLOWSHIP IN 2004