HONG KONG COLLEGE OF PHYSICIANS
香港內科醫學院
Sapientia et Humanitas

SYNAPSE

AUGUST 2011

RESTRICTED TO MEMBERS ONLY

Photographer
Professor Richard YH Yu

SYNAPSE

CONTENTS

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The HKCP celebrates its 25th anniversary this year. To mark this grand occasion, the College will hold the Silver Jubilee Dinner on the 8th October 2011, where we will be joined by distinguished guests from near and far. A unique publication entitled 'Sapientia et Humanitas; A History of Medicine in Hong Kong' chronicles 25 years of history and achievements of the HKCP, and custom designed commemorative pins will be distributed free to our fellows and guests.

The Annual Scientific Meeting will be held on 8-9 October 2011 with the theme "Degenerative disease' at the Hong Kong Academy of Medicine Building. Symposiums will feature prominent speakers, notably Professor Zhong Nanshan. The AJS McFadzean oration will be delivered by Professor Sir Ian Gilmore and the Gerald Choa Memorial Lecture by Professor Joseph Sung.

Annual Scientific Meeting (8-9 October 2011)

Theme: Degenerative disease

Highlights

Sir David Todd Lecture

Distinguished Research Paper Award for Young Investigators 2011

Best Thesis Award

Gerald Choa Memorial Lecture

AJS McFadzean Oration

Symposiums include

Cardiovascular and metabolic diseases

(Chairman: Prof YY Lam)

1. **Hypertension – a cardiovascular endemic**	Prof Bernard Cheung
2. **Peripheral arterial disease: nothing peripheral about this artery disease**	Prof Bryan Yan
3. **Advances in the management of the cardiometabolic risk factors**	Prof Ronald Ma

Immunology and Infection

(Chairman: Prof WK Lam)

1. **Treatment option for severe influenza**	Prof Kwok-Yung Yuen
2. **Autoimmune diseases in the elderly**	Dr Temy MY Mok
3. **Title pending**	Prof Nanshan Zhong

Neurology

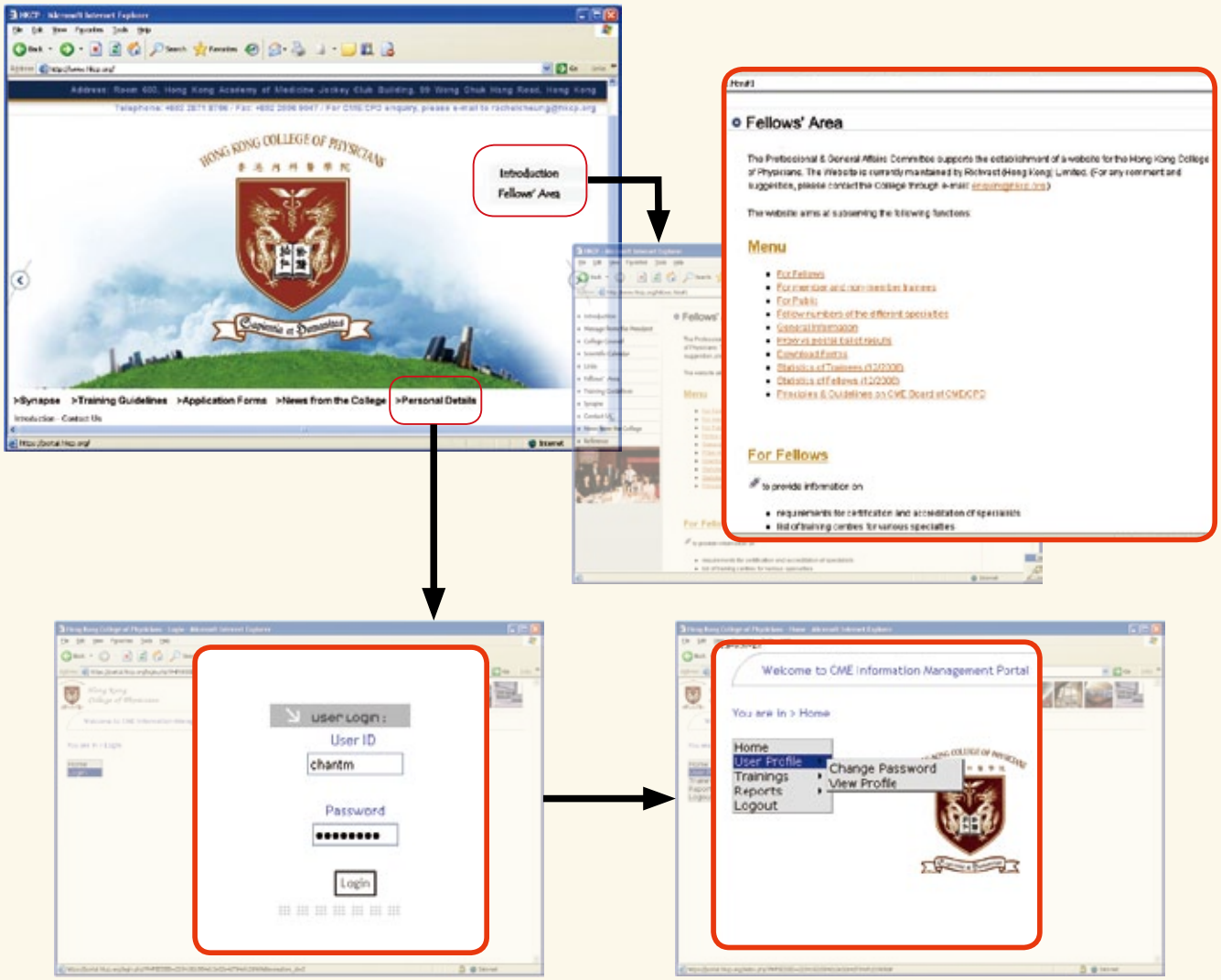
(Chairman: Dr TH Tsoi)

1. **Neurodegenerative diseases: what can we learn from the pathogenic processes?**	Dr Jonas Yeung
2. **Disease progress modification in Parkinson's disease: is it possible?**	Prof SL Ho
3. **Dementia, is it preventable?**	Prof Vincent Mok

A Guide to the HKCP Website and Information Management Portal

www.hkcp.org

The HKCP is committed to ensuring all Fellows and Members have access to our website. To serve 396 Fellows, 328 Members and 383 Trainees, the College has employed the latest information technology to provide efficient management of training-documentation and administrative functions. At the website, you can easily navigate updated training guidelines, news and publications.

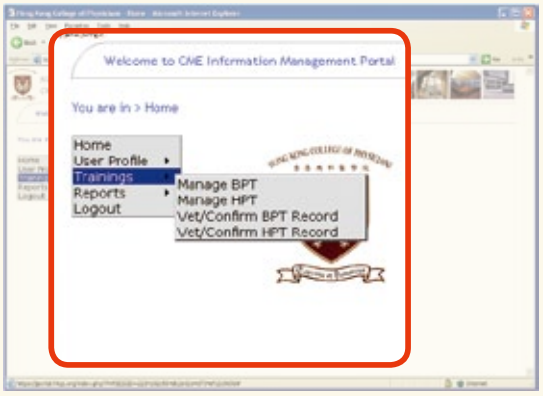


As a further step forward, the HKCP Portal System was developed in 2004 by Richvast (Hong Kong) Limited, who was engaged as the solution provider responsible for the Portal System and its support functions, which include website maintenance, electronic certificate, email and trainee and fellow registries. This ensures that all College-related data is managed centrally, securely, and reliably in the College Secretariat office.

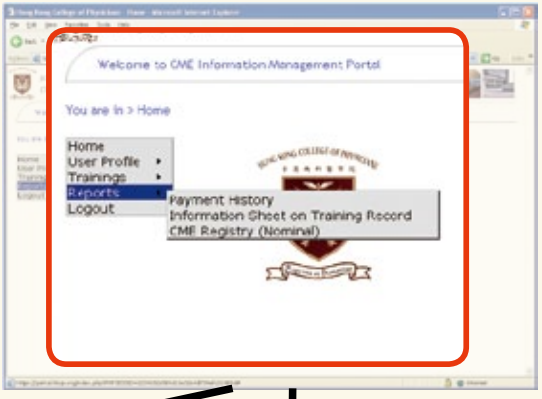
How to Access the HKCP Portal

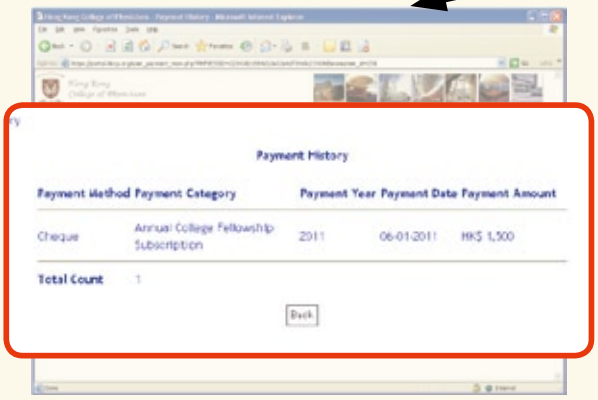
Getting connected to the Portal is easy. Click on 'Personal Details' circled in the cartoon above. A unique login identity and password provides all Fellows and trainees access to update their personal details, training records, view their payment history and CME status on the Portal System. If you have misplaced your login identity and password, please send an email to enquiry@hkcp.org. Our secretariat will promptly issue you with your login identity and new password. Thereafter, you may access User Profile to change your password. The Portal allows Trainees to update their training records, which can be vetted by Trainers. Payment for the current year will be recorded if received. CME details such as dates of current CME cycle and accumulated points can be checked.

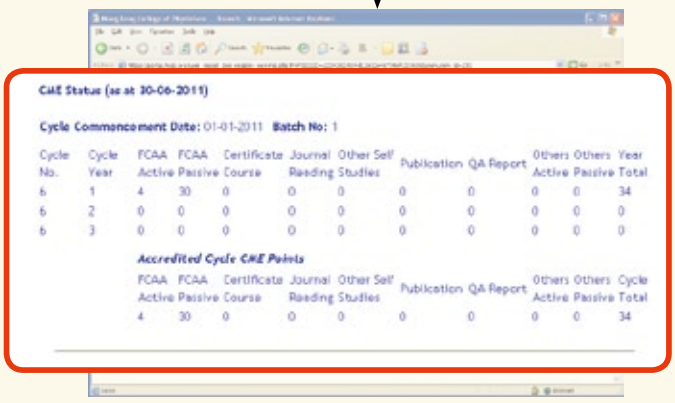
Training



Reports







Specialty Update in Nephrology

Management of Chronic Renal Failure in Diabetes

Cheuk-Chun SZETO
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The Chinese University of Hong Kong

Diabetic nephropathy with chronic kidney disease (CKD) is one of the most prevalent microvascular complications of diabetes. It is the leading cause of end-stage renal disease (ESRD), accounting for around 50% of incident cases in Hong Kong. However, it is important to realize besides the traditional diabetic nephropathy, diabetic patients are at risk of many other kidney problems (Table 1). This review will discuss several special issues related to the management of diabetic patient with CKD. Unless specified otherwise, we should focus on type 2 diabetes, which accounts for over 90% of the diabetic population.

Table 1. Kidney Problems in Diabetic Patients, Other Than Diabetic Nephropathy

- renal artery stenosis
- electrolyte disorders
  - hypoaldosteronism / type IV RTA
  - osmotic diuresis
- papillary necrosis*
- neurogenic bladder*
- (predisposition to) contrast nephropathy
- pyelonephritis
  - bacterial / fungal
  - emphysematous, xanthogranulomatous

*may lead to obstructive uropathy

Diabetic control

The "Clinical Practice Guidelines and Clinical Practice Recommendations for Diabetes and Chronic Kidney Disease" from the NKF-KDOQI have endorsed the American Diabetes Association (ADA) Standards of Medical Care in Diabetes recommendation of hemoglobin A1c (HbA1c) goal of <7% for patients with CKD[1]. However, this target is not achieved in a substantial proportion of patients. For example, the USRDS 2008 data show that 63% patients with stages 1-2, and 46% patients with stages 3-4 CKD had HbA1c levels above 7%[2].

Benefits of intensive control of hyperglycemia on prevention of microvascular complications, including diabetic nephropathy, is generally accepted in types 2 diabetes. For example, the 10-year follow-up study of patients with type 2 diabetes in UKPDS demonstrated remarkable risk reduction for microvascular end points and, to a lesser extent, for myocardial infarction by intensive glycemic control (with target HbA1c 7%) as compared to conventional treatment (with target HbA1c 7.9%[3]. However, more recent studies (for example, the ACCORD study) that targeted even lower HbA1c goals (below 6–6.5%), failed to show cardiovascular disease risk reduction with more intensive glycemic control regimens[4]. More importantly, hypoglycemia and inadvertent weight gain were much more common in the group that received intensive treatment.

Why should there be a discrepancy in the result of these mega-trials? At least three reasons likely contribute. First, the UKPDS trial focused on low risk cases with newly diagnosed diabetes, while the ACCORD trial recruited high risk subjects with prolonged diabetes. Secondary, the UKPDS trial actually targeted a less intensive goal than the ACCORD study. In fact, the intensive group in the UKPDS trial had roughly the same achieved HbA1c as the standard care group of the ACCORD study. Thirdly, the UKPDS trial had much longer duration of follow up than the ACCORD study (15 years and 3.5 years, respectively). The conclusion that one could draw at the moment is simple: It is important to liberalize HbA1c target in high risk groups and those with greater risk of hypoglycemia (for example, patients with CKD).

Assessment of diabetic control

Inaccuracy in the relationship between HbA1c and average plasma glucose levels may hinder good glycemic control in diabetic patients with CKD. The HbA1c assay *per se* can have inherent biases that lead to either higher or lower HbA1c levels for a given degree of glycemia in CKD compared to the general population. Reduced red cell lifespan, hemolysis, and anemia tend to falsely decrease the HbA1c value. For example, a recent study showed that in diabetic patients on dialysis, HbA1c level is around 1% lower for the same degree of mean serum glucose than diabetic

patients without nephropathy, while glycated albumin levels reflect more accurately the mean serum glucose level[5]. Conversely, misleadingly high total HbA1 (not HbA1c) values may be produced by acidosis and carbamylation of hemoglobin, although this bias is less common with the current high performance lipid chromatograph (HPLC) method.

On this aspect, the NKF-KDOQI Guideline recommends that assessment of glycemic control in diabetes and CKD, even at advanced stages, should follow the standards of care set by the ADA[1]. Due to the complexity of interpreting HbA1c levels in patients with advanced CKD, self-monitoring of blood glucose assumes particular importance for assessment of glycemic control. Traditionally, the approach is to monitor pre-meal and bedtime blood glucose levels by finger prick testing. However, postprandial testing may be particularly helpful in patients with autonomic neuropathy and gastroparesis, which are common in patients with advanced CKD.

Anti-diabetic drugs

A few drug classes for treatment of hyperglycemia can be used in patients with advanced CKD. The major concern in the setting of impaired kidney function is increased incidence of hypoglycemia due to decreased drug clearance, drug interactions, and impaired kidney gluconeogenesis[6].

Insulin is generally recommended for diabetic patients with substantial renal insufficiency, even though they are not insulin-dependent by the traditional definition. However, insulin requirements change with reduction of kidney function. As a result of loss of kidney mass, the amount of gluconeogenesis carried out is reduced. At the same time, the half-life of insulin is prolonged because about one-third of its degradation is by the kidney. In general, the dosage of insulin should be individually adjusted according to insulin sensitivity, frequency and severity of hypoglycemia, and presence of co-morbidities that additionally increase hypoglycemic risk.

Among the sulfonylurea class of insulin secretagogues, the preferred agent in CKD patients is glipizide and gliclazide because hepatic metabolism is the major route of elimination of these drugs. Biguanides (i.e. metformin) and alpha-glucosidase inhibitors (e.g. acarbose) are not recommended in patients with serum creatinine above 177 µmol/l (2 mg/dL). The thiazolidinedione class of drugs (e.g. pioglitazone) does not require dose adjustment for reduced kidney function because they are metabolized in the liver. However, they should be prescribed with special precautions in patients with heart failure, nephrotic syndrome, advanced CKD, or liver disease, because of the high frequency of fluid retention and worsening edema. It should be noted that the American Heart Association (AHA) and ADA have jointly recommended that thiazolidinedione should be avoided in those with New York Association class III or /IV congestive heart failure[7].

As to other new anti-diabetic agents, repaglinide is the preferred agent in the metaglinide class of insulin secretagogues, and no dose adjustment is needed for creatinine clearance ≥ 20 ml//min. Sitagliptin is an oral dipeptidyl peptidase-4 (DPP-4) inhibitor that requires dose reduction for reduced kidney function. Exenatide is an analog of glucagon-like-peptide-1 (GLP-1); it enhances pancreatic insulin secretion. Although doses of this agent do not require adjustment for reduced kidney function, risk of hypoglycemia in patients with advanced CKD is increased. Furthermore, both sitagliptin and exenatide slow gastric emptying and suppress appetite; they should be avoided in patients with known gastroparesis.

Due to the complexity of interpreting HbA1c levels in patients with advanced CKD, self-monitoring of blood glucose assumes particular importance for assessment of glycemic control

Blood pressure control

Hypertension is a critical risk factor for progression of CKD in both diabetic and non-diabetic patients. It is also one of the most prevalent co-morbidities in CKD. Unlike other therapeutic targets, there is very little dispute in the treatment of high blood pressure because treatment of hypertension is a well-established tactic to slow progression of diabetic kidney disease. The NKF-KDOQI Guideline recommends target BP <130/80 mmHg in diabetic patients with CKD stages 1 to 4[1]. The preferred agents are angiotensin-converting enzyme (ACE) inhibitors or angiotensin receptor blockers (ARB), usually in combination with a diuretic. Since salt and volume overload is common in patients with diabetic kidney disease, dietary sodium intake should be restricted within 2.3 g/day. Generally, keeping the blood pressure on target requires multiple anti-hypertensive agents.

A few practical issues should be noted for the use of ACE inhibitor and ARB in CKD patients. First, transient worsening of renal function is very common following the initiation of therapy. The Royal College of Physicians of London recommends that serum creatinine should be checked 2 weeks after starting the treatment and after subsequent increase in dose[8]. If serum creatinine level increases by over 20%, or there is a fall in estimated glomerular filtration rate (GFR) by over 15%, treatment should be stopped and evaluation for renal artery stenosis should be

considered. On the same matter, the European guidelines and National Kidney Foundation (NKF) expert opinion both state that one can tolerate a rise in creatinine up to 30%.

Another common problem is: What is the upper limit of serum creatinine below which one could start ACE inhibitor or ARB treatment? There is no good clinical trial on diabetic nephropathy in this respect. For non-diabetic CKD, Hou et al[9] showed that benazepril, an ACE inhibitor, conferred substantial renal benefits in patients with pre-treatment serum creatinine below 442 µmol/l. There seems no reason that the result could not be related to diabetic patients.

On the other hand, when a CKD patient is already taking ACE inhibitor or ARB, and the renal function continues to deteriorate, there is minimal, if any, renal benefit to stop the treatment. In general, despite progressive worsening of renal function, ACE inhibitor or ARB could be continued unless there is resistant hyperkalemia despite vigorous attempts to control the serum potassium level (such as low potassium diet, loop diuretics, and oral sodium bicarbonate supplement).

Lipid control

Typically, patients with diabetic kidney disease have low levels of high-density lipoprotein cholesterol (HDL-C), high triglyceride levels, and average low-density lipoprotein (LDL-C) levels, but the LDL particles are smaller, denser, and probably more atherogenic. The NKF-KDOQI "Clinical Practice Guidelines for Management of Dyslipidemia in Diabetes and CKD" recommend treatment of LDL-C in CKD stages 1 to 4 with a statin if the level is higher than 100 mg/dL (2.6 mmol/l)[1]. As for other populations at high cardiovascular risk, targeting the LDL-C to below 70 mg/dL (1.8 mmol/l) should be considered as the therapeutic target.

It is important, however, to appreciate that the recommendation for stage 4 CKD was by extrapolation of data on earlier stages of CKD. In addition, these recommendations were based on secondary, subgroup, or post-hoc analyses of a few major clinical trials (including the West of Scotland Coronary Prevention Study, the Cholesterol and Recurrent Events, and the Pravastatin Pooling Project[10-12]), all of which provide evidence for use of statins in diabetes patients with stages 1 to 3 CKD. On the contrary, there are direct clinical trial data regarding statin treatment for diabetic patients on hemodialysis: to-date, two major trials have demonstrated no benefit on major cardiovascular events or death. The 4D study used atorvastatin and actually showed increased risk of fatal ischemic stroke[13]. The diabetes subset of the more recent AURORA trial also confirmed no benefit of rosuvastatin on cardiovascular events or death[14].

Hypertension is a critical risk factor for progression of CKD

More recently, the Study of Heart and Renal Protection (SHARP), which is the largest-ever statin trial in renal patients announced the result[15]. In this study, 9438 CKD patients were randomized to simvastatin plus ezetimibe treatment or placebo. Over nearly 5 years of follow-up, there was a 16.5% overall risk reduction in the primary atherosclerotic end point. More importantly, subgroup analysis found a higher effect size in predialysis than in dialysis CKD patients, with a risk reduction of 20% and 10%, respectively. In the dialysis cohort alone, the risk reduction was actually not statistically significant, which is in accordance with the 4D and AURORA trials. Taken together, available evidence indicates that lipid-lowering therapy does offer cardiovascular protection, at least in CKD classes lower than 5.

Anemia

Anemia is a common complication and occurs earlier in patients with diabetic nephropathy than in nondiabetic individuals with comparable renal function. For example, the Kidney Early Evaluation Program found that in CKD patients with diabetes, anemia prevalence at the stages 1, 2, 3 and 4 CKD were 8.7%, 7.5%, 22.2%, and 52.4%, respectively, as compared to 6.9%, 5.0%, 7.9%, and 50.0%, respectively in patients without diabetes[16].

There are many reasons for the high prevalence of anemia in diabetic CKD patients: chronic kidney disease per se, presence of chronic inflammation, malabsorption of hematinics, direct effects of advanced glycation end products, abnormal red blood cell membrane, and adverse effects of ACE inhibitor or ARB treatment. The most important reason, however, appears to be diabetes-related chronic hyperglycemia, which lead to a hypoxic environment in the renal interstitium, resulting in impaired production of erythropoietin by the peritubular fibroblasts and subsequent anemia. For example, Symeonidis et al[17] showed that inappropriately low serum erythropoietin level is a uniform feature in patients with type 2 diabetes mellitus, which may represent a constitutive blunted response to anemia or an altered metabolic rate of erythropoietin, the latter is probably a result of abnormal glycosylation of the cytokine.

Anemia does not only affect patients' quality of life; it amplifies risks of major complications in the setting of diabetic kidney disease. Notably, anemia is an independent contributor to the pathogenesis and progression of other diabetes-related complications (especially left ventricular hypertrophy). In CKD patients with diabetes mellitus, correction of anemia improves quality of life and might delay the progression of diabetic complications. Therefore, routine screening for anemia is recommended, and treatment with

recombinant human erythropoietin should be considered for anemic patients. Until definitive evidence is available for the optimal target hemoglobin levels, treatment should aim to achieve hemoglobin level of 10 to 12 g/dL.

Mineral bone disease

Diabetic patients often have underlying bone and mineral disease that are further exacerbated once CKD ensues. For traditional renal osteodystrophy, adynamic bone disease predominates over hyperparathyroidism, which is distinctly uncommon in diabetic patients with ESRD. Since insulin is a co-factor for parathyroid hormone secretion and bone turn-over, adynamic bone disease may reflect insulin lack or resistance within the parathyroid glands and bone.

Vitamin D deficiency has recently emerged as an important issue within the spectrum of bone and mineral disease in CKD. Across the spectrum of CKD stages, several studies have demonstrated that 25-hydroxy and 1, 25-dihydroxy vitamin D levels are more likely to be low in patients with diabetes or who are female. There are several mechanisms of vitamin D deficiency in patients with diabetic kidney disease. Uremia impairs production of cholecalciferol from 7-dehydrocholesterol by UVB light radiation. In addition, CKD *per se* reduces the formation of $1,25\text{-}(OH)_2D3$ due to profound tubulointerstitial injury and early loss of 1α-hydroxylase activity. Furthermore, hyperglycemia down-regulates the vitamin D receptor. It is important to note that in addition to the effect on bone and calcium, vitamin D deficiency may in turn accelerate renal function decline in diabetic nephropathy, and vitamin D supplement may be an important therapeutic consideration.

A number of other factors also contribute to the bone and mineral disease in patients with diabetic kidney disease. Poorly-controlled diabetes is associated with hypercalciuria, which predisposes to bone loss. Besides osteoporosis, patients with diabetic kidney disease have increased risk of fall and fracture because of poor vision (due to retinopathy) and peripheral neuropathy. In addition, glitazone has recently been reported to be associated with accelerated loss of bone mineral density.

Conclusions

Management of patients with diabetes and CKD is often a complicated and tedious matter. Physicians need to remind themselves not to be narrow minded because multiple therapeutic targets are often necessary at the same time. There is good evidence of having a tight glycemic control, although the benefit must be balanced against the risk of hypoglycemia, especially in patients with multiple comorbidities and poor kidney function. Blood pressure control is absolute necessary. Most patients actually require multiple anti-hypertensive agents to achieve the blood pressure target. For the majority of patients, ACE inhibitor or ARB should be continued as long as possible despite progressive worsening of kidney function. There is now evidence for the treatment of hypercholesterolemia, at least for pre-dialysis CKD patients. Anemia is common and worth to screen for, because recombinant human erythropoietin treatment is usually effective. Bone and mineral disease is also common. Because adynamic bone disease and vitamin D deficiency are common, one must not try to over-suppress the parathyroid hormone level, and vitamin D supplement should be considered early in the course of CKD.

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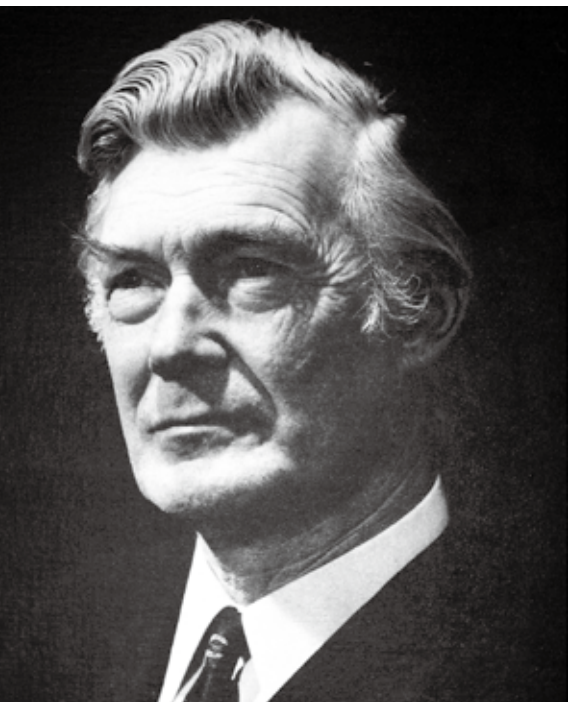

Professor John Vallance-Owen

MA. MD (Cantab), FRCP, FRCPI, FRCPath

Professor John Vallance-Owen, ('JVO' to his friends), was the Foundation Professor and Chairman of the Department of Medicine, Chinese University of Hong Kong. His education started with school in Bangor in his native Wales, continued at Epsom College, Surrey, from where he won the De Havilland Scholarship to St. John's College, Cambridge at the beginning of the Second World War. From Cambridge he won an Open Entrance Scholarship to The London Hospital. At the London Hospital he won the Dressers' prize in Clinical Medicine and Anderson Prize in Clinical Surgery, and the Letheby Prize in Chemical Pathology.

Dr. Vallance-Owen's first House job starting in July 1946 under Dr. Donald Hunter. Remarkably, he passed his MRCP examination only three months after qualifying and before the end of this first job! The next five years were spent at The London Hospital, under some distinguished clinicians, Sir Henry Souttar who did the first successful mitral valvulotomy in 1925, Sir John Parkinson of the Wolf Parkinson White Syndrome, and culminating in the position of Medical First Assistant to Sir Horace Evans, Physician to Queen Mary (wife of King George V).

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

In 1955 he was a Rockefeller Travelling Fellow at the University of Pennsylvania, Philadelphia. He returned to England and moved north to Durham taking up the appointment of Consultant Physician and Senior Lecturer, then Reader, in Medicine at the University of Newcastle upon Tyne. JVO continued his research on Diabetes. When he moved to Durham, he was joined by a young lecturer specialised in nephrology from Hammersmith, Dr. David Kerr, who later became the Professor of Medicine in Newcastle and subsequently the Dean of the Royal Postgraduate Medical School of London at the Hammersmith. In 1966 JVO became Consultant Physician and Professor and Chairman of the Department of Medicine at The Queen's University of Belfast. In 1981 he was, in addition, appointed Director of Medical Services of Malta, and organiser of medical teaching, positions he had to relinquish in 1983 when he took up the position of Professor of Medicine at the new Chinese University of Hong Kong.

In 1983, when the late Professor Gerald Choa, Dean of the Faculty of Medicine of the new Chinese University Medical School, was looking for an academic of distinction to be the Foundation Professor and Chairman of the Department of Medicine, he was advised by the late Professor Sir Melville Arnott to invite Professor Vallance-Owen, then aged 63 and at the peak of a distinguished career. JVO was courageous to take up the new challenge.

The first batch of 60 medical students was admitted in 1981. By 1983, the medical school buildings had not been completed: only the Li Choh Ming Basic Sciences Building at the main campus had been ready in time in 1981. The clinical teaching was outsourced to the United Christian Hospital in Kwun Tong, and the Kowloon Hospital in Kowloon in 1983-1984, until the Prince of Wales Hospital facilities were completed in 1984. Another problem was the recruitment of senior academics of a suitable calibre. So JVO recruited from overseas, young academics of distinction from Australia, New Zealand and UK. The Department of Medicine started with six academic staffs (including JVO) in late 1984. As foundation Professor and Chairman of the Department of Medicine, Professor Vallance-Owen chaired a number of committees at Senate and Faculty level, and especially those related to the interface between the University and Medical and Health Department. He also took up the appointment of Associate Dean in 1984. He was also supportive of the establishment of the Hong Kong College of Physicians in 1986.

The culmination of these efforts was the graduation of the first group of students in 1986, their M.B., Ch.B. degrees being recognised by the General Medical Council of UK, a recognition that JVO had had to fight for – one of his proudest achievements. For the next two years Professor Vallance-Owen presided over the further development of the Medical School, leaving it in 1988 with the satisfaction of knowing that it had grown into an institution deserving of the highest respect. He was succeeded by Professor Gary Nicholls.

On his return to England, Professor Vallance-Owen took up appointments as Visiting Professor at the Royal Postgraduate Medical School, Hammersmith Hospital, teaching General Medicine; as Adviser on Clinical Complaints for the North (later also the South) Thames Regional Health Authority; and as Consulting Physician at the London Independent Hospital. He retired from his medical career in 2004, aged 84.

Since his retirement, Professor Vallance Owen and his wife, Renee, lived comfortably in a pleasant village, Great Shelford, just outside Cambridge. They have four children and eleven grandchildren.

On July 23, 2011, Professor John Vallance-Owen sadly passed away at the Addenbrooke's Hospital. JVO will always be remembered for his contribution in establishing the Medical School of the Chinese University of Hong Kong and the founding of the Hong Kong College of Physicians.

Professor K.N. Lai
July 27, 2011

(This obituary is written based on Dr. John Mackay's Profile Doctor column published in Synapse March 2008 issue)

Examination Dates

MRCP Part I

17 January 2012 (Tuesday)

11 September 2012 (Tuesday)

MRCP Part II (Written)

28 & 29 March 2012

12 & 13 December 2012

PACES dates for 2012

13 – 17 February 2012

15 – 19 October 2012

Pass Rates for the MRCP(UK) Part I examination for the years 2002 – 2011 as follows

	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%)
Sept 08	47	32 (68%)
Jan 09	59	47 (80%)
Sept 09	47	28 (60%)
Jan 10	45	28 (62%)
Sept 10	62	39 (63%)
Jan 11	44	23 (52%)

Pass Rates for PACES examinations for the past 10 years

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%
February 2011	23/66 = 35%

Pass List for the February PACES 2011

Chan Chun Ngai

Cheng Hok Fai

Cheung Ka Shing

Cheung Yuk Man

Chung Wing Shan

Ho Kai Tin

Kwok Chun Lee

Kwok Ka Ming

Lau Kui Kai Gary

Lee Chi Yan

Lee Chun Yin Jonan

Mak Kwok Shing

Ng Kei Yan Andrew

Ng Kit Chung

Ni Michael Yuxuan

Pong Vincent

Siu Chun Yue

Tai Wai Ching

Teng Kar Yee Sophia

Tse Sau Mei

Wong Sai Ho

Yau Tse Ling

Yeung Pui Ning Pauline

Assessment requirement for Higher Physician Training (HPT)

Loretta Yam
Chairman, Education and Accreditation Committee

At the 234th Council Meeting of 29 March 2011, the Council endorsed the following assessment requirement for HPT trainees:

Specific to Trainees in AIM in Single or Dual Specialty Training

- Change from two Annual Assessments to one "Interim Assessment" during HPT
- Two Case Reports are to be submitted for "Interim Assessment"
- Completion of all requirements from the AIM Board regarding the Self Learning Tool (SLT), a web-based interactive training modules jointly developed by the College and Hospital Authority. The SLT consists of clinical scenarios involving different subspecialties with the aim of identifying and preventing risk in clinical decision making and ultimately improvement in clinical management.
- *NOTE: Since Geriatric Medicine is regarded as AIM for the elderly, Trainees may opt to substitute Geriatric Medicine for AIM as the broad-based specialty in Dual Specialty Training. Under such circumstances, Geriatric Medicine trainees should also complete SLT before proceeding to Interim and Exit Assessment in the specialty*

Specific to Trainees in Specialties other than AIM

- Change from two Annual Assessments to one "Interim Assessment" during HPT
- At Interim Assessment, individual Specialty Boards may require, but will not award formal scores to, documented evidence of continuing training activities including attendance or case presentation at inter-hospital or society meetings, or portfolios of cases seen.
- The submission of Case Reports is not required for Interim Assessment.

Applicable to ALL HPT specialties

1. At least 12 months' training in each specialty is required before attempting Interim Assessment in that specialty
2. As far as possible, trainees should undergo Interim Assessment of the two specialties at least six months apart.
3. Trainees who fail at Interim Assessment must repeat the Assessment after six months.
4. A pass in Interim Assessment is a mandatory requirement for application to undergo Exit Assessment.
5. Interim Assessment in a specialty must be passed at least 12 calendar months before Exit Assessment in that specialty
6. Other requirements related to Exit Assessment in the respective specialties, including submission of dissertations, continue to apply.

Implementation Schedule

The new Assessment format is applicable to all trainees commencing HPT training from July 2011

Special Consideration

Because of the current manpower shortage, the College has decided to offer two options to HPT Trainees who have not yet attempted First Annual Assessment in any specialty by 30 April 2011:

1. To proceed with First Annual Assessment in May-June 2011, followed by Second Annual Assessment and Exit Assessment in the respective specialties*; OR
2. To proceed to Interim Assessment under the new Assessment format in the respective specialties from November-December 2011 onwards.

** Trainees who have successfully passed OR attempted but failed the First Annual Assessment in any specialty are required to undergo Second Annual Assessment before undergoing the Exit Assessment in that specialty.*

Statistics on No. of Trainees in all Specialties

Updated in April 2011

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	31	1—I 5 2—I 3—I 4—II ***4***	1 1 2 3—I 4 ***2***	1 0 2 3 4 ***0***	1 0 2 3 4 ***0***	1 0 2 3 4 ***4***	1—II 4 2 3—II 4 ***5***	1 0 2 3 4 ***0***
CLINICAL PHARMACOLOGY & THERAPEUTICS	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***
CRITICAL CARE MEDICINE	15	1 3 2—II 3 4—I ***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 3—II 4—I ***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 3—I 4 ***1***	1 0 2 3 4 ***0***
ENDOCRINOLOGY, DIABETES & METABOLISM	19	1 1 2 3—I 4 ***2***	1 1 2—I 3 4 ***1***	1 0 2 3 4 ***3***	1 0 2 3 4 ***0***	1 0 2 3 4 ***0***	1—I 3 2—I 3—I 4 ***4***	1 0 2 3 4 ***0***
GASTROENTEROLOGY & HEPATOLOGY	24	1 2 2 3—II 4 ***7***	1 1 2 3 4—I ***1***	1 0 2 3 4 ***0***	1 0 2 3 4 ***0***	1 0 2 3 4 ***0***	1—I 1 2 3 4 ***4***	1 0 2 3 4 ***1***
GERIATRIC MEDICINE	11	1 0 2 3 4 ***6***	1 0 2 3 4 ***11***	1 0 2 3 4 ***4***	1 0 2 3 4 ***3***	1 1 2—I 3 4 ***0***	1 1 2 3—I 4 ***4***	1 0 2 3 4 ***1***
HAEM/HAEM ONCOLOGY	13	1 1 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—II 2 2 3 4 ***6***	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	6	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 1 2 3 4—I ***1***	1 0 2 3 4 ***0***
INTERNAL MEDICINE	224	1—II 22 2—V 3—X 4—V ***35***	1 4 2—I 3—I 4—II ***12***	1 0 2 3 4 ***10***	1 1 2 3—I 4 ***1***	1 1 2—I 3 4 ***3***	1—VII 35 2—IV 3—XII 4—XII ***47***	1 0 2 3 4 ***8***
MEDICAL ONCOLOGY	5	1 1 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 2 2 3—II 4 ***2***	1 0 2 3 4 ***0***
NEPHROLOGY	15	1 1 2—I 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—I 2 2 3—I 4 ***6***	1 0 2 3 4 ***3***
NEUROLOGY	14	1 1 2 3—I 4 ***4***	1 1 2 3 4—I ***2***	1 0 2 3 4 ***0***	1 0 2 3 4 ***0***	1 0 2 3 4 ***0***	1 0 2 3 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 0 2 3 4 ***1***	1 2 2—I 3—I 4 ***0***	1 0 2 3 4 ***0***
REHABILITATION	6	1 0 2 3 4 ***0***	1 0 2 3 4 ***2***	1 0 2 3 4 ***4***	1 1 2 3—I 4 ***1***	1 0 2 3 4 ***0***	1 1 2 3—I 4 ***0***	1 0 2 3 4 ***4***
RESPIRATORY MEDICINE	20	1—I 2 2 3—I 4 ***4***	1 0 2 3 4 ***4***	1 0 2 3 4 ***0***	1 0 2 3 4 ***0***	1 0 2 3 4 ***7***	1 1 2 3 4—I ***6***	1 0 2 3 4 ***0***
RHEUMATOLOGY	14	1 3 2—I 3—II 4 ***2***	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 2 2 3—II 4 ***2***	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	31	1 0 2 3 4 ***0***	1 4 2—II 3—I 4—I ***8***	1 0 2 3 4 ***0***	1 1 2—I 3 4 ***2***	1 0 2 3 4 ***2***	1—I 1 2 3 4 ***1***	1 4 2—III 3 4—I ***0***	1 0 2 3 4 ***0***	1 2 2—II 3 4 ***5***	1 0 2 3 4 ***0***	1 1 2 3—I 4 ***3***
CLINICAL PHARMACOLOGY & THERAPEUTICS	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***
CRITICAL CARE MEDICINE	15	1 0 2 3 4 ***0***	1—I 3 2—II 3 4 ***3***	1 0 2 3 4 ***0***	1 1 2 3—I 4 ***2***	1 0 2 3 4 ***4***	1—I 2 2 3—I 4 ***4***	1 1 2 3 4—I ***3***	1 0 2 3 4 ***0***	1 1 2 3 4—I ***4***	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 1 2 3—I 4 ***6***	1 0 2 3 4 ***0***	1 1 2 3—I 4 ***3***	1 1 2—I 3 4 ***3***	1 1 2 3—I 4 ***2***	1 0 2 3 4 ***3***	1 1 2 3—I 4 ***2***	1 0 2 3 4 ***4***	1 0 2 3 4 ***0***	1—II 2 2 3 4 ***1***
GASTROENTEROLOGY & HEPATOLOGY	24	1 0 2 3 4 ***0***	1 1 2—I 3 4 ***6***	1 0 2 3 4 ***0***	1 0 2 3 4 ***1***	1 1 2—I 3 4 ***2***	1 2 2—I 3—I 4 ***4***	1 2 2—II 3 4 ***3***	1 1 2 3 4—I ***0***	1—II 5 2 3—II 4—I ***4***	1 0 2 3 4 ***0***	1 0 2 3 4 ***5***
GERIATRIC MEDICINE	11	1—I 1 2 3 4 ***4***	1 1 2 3 4—I ***2***	1 0 2 3 4 ***6***	1 0 2 3 4 ***2***	1 1 2 3—I 4 ***7***	1 1 2—I 3 4 ***7***	1 0 2 3 4 ***9***	1 0 2 3 4 ***1***	1 0 2 3 4 ***13***	1 0 2 3 4 ***3***	1 0 2 3 4 ***6***
HAEM/HAEM ONCOLOGY	13	1 0 2 3 4 ***0***	1 4 2—II 3—II 4 ***2***	1 0 2 3 4 ***0***	1 1 2 3 4—I ***1***	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 ***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	6	1 0 2 3 4 ***0***	1 2 2 3—II 4 ***2***	1 0 2 3 4 ***0***	1 0 2 3 4 ***0***	1 0 2 3 4 ***1***	1—I 1 2 3 4 ***0***	1 0 2 3 4 ***0***	1 0 2 3 4 ***0***	1 1 2 3—I 4 ***4***	1 0 2 3 4 ***0***	1 0 2 3 4 ***0***
INTERNAL MEDICINE	224	1 1 2—I 3 4 ***3***	1-III *29* 2-VIII 3-VIII 4-X *46*	1 1 2—I 3 4 ***7***	1 5 2—I 3—III 4—I *14*	1—I *8* 2—II 3—II 4—III *34*	1—IV *13* 2—III 3—IV 4—II *24*	1 *10* 2—VI 3—II 4—II *35*	1—I 4 2 3—II 4—I ***4***	1—III *18* 2—IV 3—V 4—VI *47*	1 0 2 3 4 ***3***	1—II 7 2—I 3—II 4—II *20*
MEDICAL ONCOLOGY	5	1 0 2 3 4 ***0***	1—I 1 2 3 4 ***1***	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 ***1***	1 0 2 3 4 ***0***	1 0 2 3 4 ***0***
NEPHROLOGY	15	1 0 2 3 4 ***0***	1 2 2—I 3 4—I ***7***	1 0 2 3 4 ***0***	1 0 2 3 4 ***1***	1 0 2 3 4 ***4***	1—I 1 2 3 4 ***2***	1 1 2 3—I 4 ***5***	1 0 2 3 4 ***0***	1 2 2—II 3 4 ***7***	1 0 2 3 4 ***0***	1 0 2 3 4 ***2***
NEUROLOGY	14	1 0 2 3 4 ***0***	1—I 3 2 3—II 4 ***5***	1 0 2 3 4 ***0***	1 0 2 3 4 ***2***	1 0 2 3 4 ***2***	1 1 2—I 3 4 ***1***	1 0 2 3 4 ***3***	1 0 2 3 4 ***0***	1—I 1 2 3 4 ***2***	1 0 2 3 4 ***1***	1 0 2 3 4 ***0***
PALLIATIVE MEDICINE	8	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 1 2 3 4—I ***1***	1 1 2 3 4—I ***2***	1 0 2 3 4 ***0***	1—I 1 2 3 4 ***1***	1 0 2 3 4 ***0***	1 0 2 3 4 ***0***	1 0 2 3 4 ***0***
REHABILITATION	6	1—I 2 2—I 3 4 ***7***	1 0 2 3 4 ***0***	1 0 2 3 4 ***2***	1 0 2 3 4 ***0***	1 1 2 3—I 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 0 2 3 4 ***6***	1 1 2—I 3 4 ***4***	1—I 2 2 3—I 4 ***2***	1—I 2 2 3—I 4 ***3***	1 1 2 3—I 4 ***3***	1 0 2 3 4 ***2***	1 1 2 3—I 4 ***0***	1 1 2 3—I 4 ***4***	1 0 2 3 4 ***2***	1 3 2—I 3 4—II ***1***
RHEUMATOLOGY	14	1 0 2 3 4 ***0***	1 1 2—I 3 4 ***2***	1 0 2 3 4 ***0***	1 0 2 3 4 ***1***	1 0 2 3 4 ***1***	1 1 2 3 4—I ***1***	1 2 2—I 3—I 4 ***1***	1 0 2 3 4 ***0***	1 1 2 3 4—I ***1***	1 0 2 3 4 ***0***	1 1 2 3—I 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	31	1 1 2 3 4—I ***2***	1 4 2—I 3—I 4—II ***2***	1 0 2 3 4 ***5***	1—I 1 2 3 4 ***0***	1 0 2 3 4 ***0***	1—I 1 2 3 4 ***1***	1 1 2 3 4—I ***4***
CLINICAL PHARMACOLOGY & THERAPEUTICS	0	1 0 2 3 4 ***0***	1 0 2 3 4 ***0***	1 0 2 3 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	15	1 0 2 3 4 ***3***	1 0 2 3 4 ***2***	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 4—I ***1***
DERMATOLOGY & VENEREOLOGY	11	1 0 2 3 4 ***0***	1 0 2 3 4 ***0***	1 1 2 3 4—I ***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 ***1***	1 2 2—I 3 4—I ***2***	1—II 3 2—I 3 4 ***8***	1 0 2 3 4 ***0***	1 0 2 3 4 ***0***	1 0 2 3 4 ***0***	1 2 2 3—I 4—I ***3***
GASTROENTEROLOGY & HEPATOLOGY	24	1—I 1 2 3 4 ***1***	1 1 2—I 3 4 ***2***	1—I 2 2 3—I 4 ***4***	1 0 2 3 4 ***0***	1 0 2 3 4 ***0***	1 0 2 3 4 ***1***	1 4 2—I 3—III 4 ***4***
GERIATRIC MEDICINE	11	1 0 2 3 4 ***1***	1 0 2 3 4 ***1***	1 0 2 3 4 ***4***	1 2 2—II 3 4 ***6***	1 0 2 3 4 ***3***	1 0 2 3 4 ***1***	1 2 2—II 3 4 ***9***
HAEM/HAEM ONCOLOGY	13	1 0 2 3 4 ***0***	1 0 2 3 4 ***0***	1 1 2 3 4—I ***4***	1 0 2 3 4 ***0***	1 0 2 3 4 ***0***	1 0 2 3 4 ***0***	1 2 2—I 3 4—I ***4***
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	6	1 0 2 3 4 ***1***	1 0 2 3 4 ***0***	1 0 2 3 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 ***2***
INTERNAL MEDICINE	222	1—I 5 2 3—III 4—I ***12***	1 11 2—V 3—I 4—V ***14***	1—III 15 2—IV 3—IV 4—IV ***46***	1—I 4 2—II 3 4—I ***5***	1—I 2 2—I 3 4 ***5***	1—I 1 2 3 4 ***7***	1—II 25 2—IX 3–VI 4–VIII ***40***
MEDICAL ONCOLOGY	5	1 0 2 3 4 ***0***	1 0 2 3 4 ***0***	1—I 1 2 3 4 ***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***
NEPHROLOGY	15	1 3 2 3—III 4 ***3***	1 0 2 3 4 ***1***	1 2 2 3—II 4 ***5***	1 0 2 3 4 ***0***	1 0 2 3 4 ***0***	1 0 2 3 4 ***0***	1 1 2—I 3 4 ***5***
NEUROLOGY	14	1 0 2 3 4 ***1***	1 1 2—I 3 4 ***1***	1 2 2—II 3 4 ***5***	1 0 2 3 4 ***0***	1—I 1 2 3 4 ***0***	1 0 2 3 4 ***0***	1 3 2—I 3—I 4—I ***2***
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 4—I ***1***	1 0 2 3 4 ***0***	1 0 2 3 4 ***0***	1 0 2 3 4 ***0***
REHABILITATION	6	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 ***1***	1 0 2 3 4 ***0***	1 1 2 3—I 4 ***3***
RESPIRATORY MEDICINE	20	1 0 2 3 4 ***3***	1 2 2—I 3 4—I ***3***	1 0 2 3 4 ***3***	1 0 2 3 4 ***0***	1 1 2—I 3 4 ***1***	1 0 2 3 4 ***0***	1—I 3 2—II 3 4 ***3***
RHEUMATOLOGY	14	1 0 2 3 4 ***1***	1 0 2 3 4 ***0***	1 1 2 3—I 4 ***3***	1 0 2 3 4 ***0***	1 0 2 3 4 ***1***	1 0 2 3 4 ***0***	1—I 2 2—I 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—I 9 2—IV 3—III 4—I ***9***
IMMUNOLOGY & ALLERGY	0	1 0 2 3 4 ***1***
INFECTIOUS DISEASE	6	1 0 2 3 4 ***1***
INTERNAL MEDICINE	222	1 3 2—II 3 4—I ***0***
RESPIRATORY MEDICINE	20	1 1 2—I 3 4 ***8***

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

Statistics on No. of Fellows in all Specialties
Updated in April 2011

		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	203	6	5	0	**11**	0	6	13	0	**19**	**30**
CLINICAL PHARMACOLOGY & THERAPEUTICS	8	0	0	0	**0**	0	0	2	0	**2**	**2**
CRITICAL CARE MEDICINE	71	10	0	0	**10**	0	0	8	0	**8**	**18**
DERMATOLOGY & VENEREOLOGY	87	0	0	0	**0**	0	0	1	0	**1**	**1**
ENDOCRINOLOGY, DIABETES & METABOLISM	84	5	1	3	**9**	0	0	6	0	**6**	**15**
GASTROENTEROLOGY & HEPATOLOGY	146	8	1	0	**9**	0	0	11	1	**12**	**21**
GERIATRIC MEDICINE	166	6	12	4	**22**	3	0	5	0	**8**	**30**
HAEM/HAEM ONCOLOGY	48	2	0	0	**2**	0	0	9	0	**9**	**11**
IMMUNOLOGY & ALLERGY	6	0	0	0	**0**	0	0	1	0	**1**	**1**
INFECTIOUS DISEASE	31	1	0	0	**1**	0	0	2	0	**2**	**3**
INTERNAL MEDICINE	1052	47	23	11	**81**	3	11	73	8	**95**	**176**
MEDICAL ONCOLOGY	39	0	0	0	**0**	0	0	7	0	**7**	**7**
NEPHROLOGY	108	6	0	0	**6**	0	0	7	3	**10**	**16**
NEUROLOGY	91	5	3	0	**8**	0	0	10	2	**12**	**20**
PALLIATIVE MEDICINE	18	0	1	0	**1**	0	1	0	0	**1**	**2**
REHABILITATION	49	0	3	5	**8**	1	0	0	4	**5**	**13**
RESPIRATORY MEDICINE	162	8	7	2	**17**	0	9	10	0	**19**	**36**
RHEUMATOLOGY	57	2	2	1	**5**	1	0	5	0	**6**	**11**

		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	203	0	12	**12**	0	1	7	**8**	1	5	0	10	0	3	**19**	**39**
CLINICAL PHARMACOLOGY & THERAPEUTICS	8	0	0	**0**	0	0	0	**0**	0	0	0	0	0	0	**0**	**0**
CRITICAL CARE MEDICINE	71	0	5	**5**	0	3	6	**9**	5	6	0	5	0	0	**16**	**30**
DERMATOLOGY & VENEREOLOGY	87	0	0	**0**	0	0	0	**0**	0	0	0	0	0	0	**0**	**0**
ENDOCRINOLOGY, DIABETES & METABOLISM	84	0	7	**7**	0	3	5	**8**	2	4	2	5	0	1	**14**	**29**
GASTROENTEROLOGY & HEPATOLOGY	146	0	10	**10**	0	2	4	**6**	6	5	1	5	1	8	**26**	**42**
GERIATRIC MEDICINE	166	5	4	**9**	7	1	12	**20**	7	11	2	16	6	6	**48**	**77**
HAEM/HAEM ONCOLOGY	48	0	5	**5**	0	1	2	**3**	0	0	0	4	0	0	**4**	**12**
IMMUNOLOGY & ALLERGY	6	0	0	**0**	0	0	0	**0**	0	0	0	0	0	0	**0**	**0**
INFECTIOUS DISEASE	31	0	3	**3**	0	0	1	**1**	0	1	0	4	0	1	**6**	**10**
INTERNAL MEDICINE	1052	6	64	**70**	11	17	50	**78**	31	40	8	55	7	23	**164**	**312**
MEDICAL ONCOLOGY	39	0	2	**2**	0	0	0	**0**	0	0	0	1	0	0	**1**	**3**
NEPHROLOGY	108	0	7	**7**	2	2	4	**8**	2	6	1	7	0	2	**18**	**33**
NEUROLOGY	91	0	6	**6**	0	1	5	**6**	1	4	1	2	1	2	**11**	**23**
PALLIATIVE MEDICINE	18	0	0	**0**	4	0	2	**6**	4	0	1	0	1	0	**6**	**12**
REHABILITATION	49	9	0	**9**	3	0	2	**5**	1	1	0	2	4	0	**8**	**22**
RESPIRATORY MEDICINE	162	6	8	**14**	5	3	5	**13**	6	6	1	4	4	1	**22**	**49**
RHEUMATOLOGY	57	2	5	**7**	0	1	3	**4**	1	2	0	2	0	1	**6**	**17**

		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	203	2	5	13	0	0	**20**	1	8	**9**	**29**
CLINICAL PHARMACOLOGY & THERAPEUTICS	8	0	0	6	0	0	**6**	0	0	**0**	**6**
CRITICAL CARE MEDICINE	71	3	4	1	0	0	**8**	0	3	**3**	**11**
DERMATOLOGY & VENEREOLOGY	87	0	0	2	0	0	**2**	0	0	**0**	**2**
ENDOCRINOLOGY, DIABETES & METABOLISM	84	1	3	13	0	0	**17**	0	3	**3**	**20**
GASTROENTEROLOGY & HEPATOLOGY	146	1	5	8	0	0	**14**	1	9	**10**	**24**
GERIATRIC MEDICINE	166	1	1	6	7	3	**18**	1	12	**13**	**31**
HAEM/HAEM ONCOLOGY	48	0	0	6	0	0	**6**	0	5	**5**	**11**
IMMUNOLOGY & ALLERGY	6	0	0	0	0	0	**0**	0	0	**0**	**0**
INFECTIOUS DISEASE	31	2	0	3	0	0	**5**	0	4	**4**	**9**
INTERNAL MEDICINE	1052	19	23	70	10	6	**128**	7	65	**72**	**200**
MEDICAL ONCOLOGY	39	0	0	17	0	0	**17**	0	0	**0**	**17**
NEPHROLOGY	108	4	1	6	0	0	**11**	1	7	8	**19**
NEUROLOGY	91	2	1	7	3	0	**13**	2	4	**6**	**19**
PALLIATIVE MEDICINE	18	0	0	0	1	0	**1**	0	1	**1**	**2**
REHABILITATION	49	0	1	2	1	1	**5**	0	6	**6**	**11**
RESPIRATORY MEDICINE	162	3	6	8	1	1	**19**	1	7	**8**	**27**
RHEUMATOLOGY	57	3	0	4	0	2	**9**	1	3	**4**	**13**

Professor Kar Neng LAI

John MacKay

HEAD, DEPARTMENT OF MEDICINE,
UNIVERSITY OF HONG KONG, 2004 - 2007

Anyone with a CV of eighty-two pages, and counting, has to be a busy person. When asked to reveal how he has accomplished so much in his medical career, so far of 35 years, Professor Lai explained that there has been a combination of factors, amounting to efficient time management.

At meetings he fixes on the essential factors presented in the briefing papers, not getting distracted by minor details, cutting down meeting times from the four hours to one hour. When working on a scientific manuscript he can stay focussed for extended periods, and recalls having written a paper in one day finishing at 4am.

Where had this ability and work ethic come from? His grandfather had been born in Hong Kong and graduated from Queen's College in 1913. He had a long career in Guandung latterly becoming Postal Master of Guandung Province. During the Japanese occupation he and his family lived in northern Guandung. KN's parents were born in China. His father was a Civil Engineer and his mother a teacher. In 1950 they came to Hong Kong where they were both teachers. His father's siblings moved to Taiwan.

KN was born in Hong Kong, went to Diocesan Boys School for his Primary and Secondary education, then on to Hong Kong University to read Medicine. That last step was not preordained. He had acceptances and scholarships also from Columbia University to read Engineering, and from the California Institute of Technology, Caltech, in Pasadena, California, to read Aerospace engineering. He chose medicine after advice that foreign engineering graduates might have difficulty in getting jobs in the USA.

At Hong Kong University he excelled academically being awarded the C.P.Fong Gold Medal for Medicine, a Distinction in Medicine and the award for the Outstanding Graduate of the Year in 1975.

LECTURER IN UNIVERSITY OF HONG KONG, YEAR 1977

He must have continued to impress as a house offer at the Queen Mary Hospital because after one year Professor David Todd appointed the young Doctor Lai as a Lecturer in Medicine at Hong Kong University. In the next three years he developed an interest in Nephrology while working under Dr. Andrew Hua.

In 1979 he elected to leave the University to undertake further training in Australia, in Nephrology, first in Adelaide then in Sydney, returning to Hong Kong in 1982, with an MRCP and with an Australian passport.

After working as an SMO for six month periods at first the Tung Wah Eastern Hospital and then the Nethersole Hospital, KN was appointed by Professor John Vallance-Owen to a lectureship at the newly-opened Medical School of the Chinese University of Hong Kong. The Medical School was so new that when On Call he had to sleep in a converted shipping container.

In 1982 he was awarded an MD from Hong Kong University for his thesis 'Observations of the left ventricular function of uraemic patients.

Promotions followed, to Senior Lecturer in 1985 and Reader in 1989.

With the Readership came a Wellcome Fellowship to go to Cambridge University to join the Medical Research Council (MRC) as Honorary First Clinical Assistant to Regius Professor of Physic Sir Keith Peters (an appointment initiated by King Henry VIII in 1540), and Dr. Martin Lockwood. During this year he passed his MRCPath (Clinical Immunology).

In Cambridge he carried out original research on systemic vasculitis leading to several publications. After one year of purely laboratory work he elected to return to Hong Kong to rejoin his wife, Diana and their young children. He was happy to return to clinical work, and more research. Two years later he was flattered when the Department of Medicine in Cambridge made an approach inviting him back again, which he declined.

In 1992 he was appointed Chair Professor of Medicine at the Chinese University of Hong Kong along with the titles of Director of the Clinical Immunology Unit and the Renal Unit, a position he held for the next five years. In 1995 he was awarded a Doctor of Science from Hong Kong University for his research work in nephrology.

In 1997 he was appointed to the Chair Professor of Medicine and Nephrology at HKU, a position that he holds today, along with the titles of Director of the Combined Renal Unit, Queen Mary Hospital,: Chief of Service QMH and Hong Kong West Cluster, from 2001 to 2010; Head of Department of Medicine 2004-2007; and Honorary Consultant at

WORKING AS WELLCOME FELLOW, REGIUS DEPARTMENT OF PHYSIC, UNIVERSITY OF CAMBRIDGE AND VISITING FELLOW, CORPUS CHRISTI COLLEGE, CAMBRIDGE 1989

Princess Margaret Hospital. He received the endowed Yu Chiu-kwong Chair of Medicine in 2006.

Since 1991 he has been an examiner for the MRCP (UK) and FRACP, and on the MRCP (UK) Part I and II Examining Boards, and MRCP Policy Board of the Royal Colleges of Physicians (United Kingdom). He is also the international advisor to the Royal College of Physicians (London) and Royal Australasian College of Physicians in the college journal.

He is a member of numerous International Medical Panels, Editorial Boards, Review Boards of Major International Journals, Grant and Scholarship panels; a Reviewer for Promotion to Professorship at Universities in USA, Canada and Singapore; a Member of the Medical Councils in Hong Kong, UK and two States in Australia. He is a member of the prestigious Association of Physicians of Great Britain and Ireland (founded 1907).

He authors over 500 scientific papers or chapters in international journals. He was the sole editor of two books published in 2009; 'Recent Advances in IgA nephropathy', and 'A Practical Manual of Renal Medicine: Nephrology, Dialysis and Transplantation'. He also co-edits a book, 'Diabetes and the Kidney' just published in July 2011.

International recognition of Professor Lai's achievements have been demonstrated in 2010 by the Kincaid-Smith Award for outstanding scientific achievement and the Ross Bailey Lectureship for academic merit, both from the Asian Pacific Society of Nephrology, and the award of Fellowships at nine professional colleges or academies.

In recognition of his service to the community he was created a Justice of the Peace in 2009.

He married to Diana Siu whom he had known since they were medical students together.

They have three children. Their elder son is a radiologist working in Hong Kong, their younger son is studying at the London Business School following some years with the Hongkong and Shanghai Bank, and their daughter is studying Law at Hong Kong University after graduating from Brown University in USA Diana is a Medical Oncology specialist in Private practice.

ENDOWED CHAIR, YU CHIU KWONG CHAIR OF MEDICINE, UNIVERSITY OF HONG KONG 2006

Away from the demands of work KN finds time to enjoy playing Squash and Golf. For many years KN has been an enthusiastic collector of classical Chinese Ming-style furniture of Huanghuali and zitan woods, now virtually unobtainable.

HUANGHUALI FOLDING CHAIR

Asked to comment on the highlights of his career KN replied that what gave him most satisfaction was the original research he has carried out in areas that are of international relevance like IgA nephropathy.

He is excited by his continuing research on mechanisms of fibrosis and its control, particularly in relation to peritoneal dialysis.

Professor Lai stated in his Address to the Congregation in November

2005, "… Internal Medicine is always the cornerstone of Medicine". When interviewed recently he remarked regretfully that nowadays some of the best young doctors are put off by the heavy workload and long training years in Medicine and Surgery, and go into other specialties.

His own experience as a clinician-scientist had given him "…joy and excitement…" and is one he would encourage others to follow.

His firm beliefs regarding ethics are present today, no less so than when he made the Presidential address at the 2008 Conferment Ceremony. "When I first graduated from medical school, being a doctor was considered respectable as the public knew we honoured and valued our professional merit and code of conduct. Three decades later, despite the few negative incidents that have raised doubts in the mind of the public, I still have faith in colleagues' ability to uphold medical ethics. Confucius in his Analectics, said, and I quote ' The virtues of propriety, justice, honesty and honour, are the four moral cornerstones of our society'."

So let it be.