

HONG KONG COLLEGE OF PHYSICIANS
香港內科醫學院



Sapientia et Humanitas

SYNAPSE

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Photographer
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SYNAPSE



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The President's Annual Report 2011

Patrick CK Li
President, HKCP



2011 marks an important milestone as the College celebrates its Silver Jubilee. Through the capable leadership of the past Presidents and Councils, the College has grown from strength to strength and its Fellowship now stands at 1420. Structured programmes have been developed for basic physician and medical specialty training with a fair and consistent system for assessment of performance. To rejuvenate the College and to ensure smooth succession planning, a process is in place for introduction of new blood at the Specialty Board and Committee level. The College has also maintained close ties and collaboration with overseas sister Colleges to ensure that local physician training is on par with international standards.

Our Immediate Past President has in his last annual report raised concern over the decreasing number of doctors joining the physician training programme due to the unfavourable work condition. In February, a group of doctors of the Department of Medicine and Geriatrics at Tuen Mun Hospital publicly voiced their grievances

over the heavy workload and unsatisfactory career prospect. The College has issued an open letter of support to its Fellows and trainees and urged the Hospital Authority to undertake a comprehensive review of its manpower provision based objectively on patient care demand and work intensity and to ensure equitable career advancement opportunities to doctors of all specialties. To reduce the hardship to the trainees in coping with their heavy workload, the College has decided in May to simplify the assessment system for higher physician training while maintaining the standard. The Hospital Authority has subsequently implemented a number of measures to partially address the grievances of the frontline doctors. The College will follow up with the Bureau and the Hospital Authority on the necessary measures to ensure an appropriate environment for physician training and delivery of safe and quality care to medical patients.

This Annual Report outlines the various events and achievement of the College Committees in the past year for the attention of our Members and Fellows. I wish to extend my sincere appreciation

and gratitude to the Chairpersons and Members of the different Committees and Boards as well as the Secretariat for their hard work and dedication. I would like to highlight below some of the important events for each Committee.

Education and Accreditation Committee

Under the very capable leadership of Dr. Loretta Yam, the Committee has continued to oversee basic and higher physician training including assessment of training progress and completion. The Committee has spent long hours at many of the meetings examining meticulously the details of the training requirement and accreditation to ensure consistency and fairness to all trainees. This is reflected in the consistently high pass rate in the Exit Assessment in all the specialties. The Committee has worked closely with the Specialty Boards against a tight schedule to comprehensively review and update their respective curriculum and programme and the 5th Edition of the Guidelines on Postgraduate Training in Internal Medicine was published in July 2011.

The Committee has also led the review of the assessment system for higher physician training in order to reduce the hardship faced by trainees in coping with their already heavy workload. Instead of two Annual Assessments for each of the dual training programme, trainees will only be required to sit for one Interim Assessment after at least 12 months training in each of the specialties. The format of the Exit Assessment remains unchanged but the Committee reinforced the message that original research is not a prerequisite for the dissertation.

The Committee has further developed the Self Learning Tool as a means of enriching the trainees' exposure to advanced internal medicine and awareness of patient safety. Trainees will be required to complete the assigned questions at their own throughout their higher physician training years. In addition, trainees are recommended to undertake dual training in a specialty together with either advanced internal medicine or geriatrics serving as the broad-based specialty.

National and International Liaison Committee

Professor Matthew Ng has taken up the Chairmanship of the Committee and maintained close ties with national and international professional bodies in Medicine. I had the privilege of representing the College in attending the Royal Australasian College of Physicians Congress in May and the Singapore-Malaysian Congress of Medicine in July. In recognition of our long-standing collaboration, many of the overseas sister Colleges have sent representative to attend our College's Silver Jubilee celebration.

Examination Committee

Professor C. S. Lau has taken up the Chairmanship of the Committee and has coordinated the organisation of two PACES examination annually in addition to the written Part I and Part

II examination. He has also taken up the role of Hong Kong representative on the MRCP(UK) Part I Examining Board while Professor Matthew Ng is sitting on the MRCP(UK) Part II Examining Board and Policy Board.

To familiarise the trainees with the format of MRCP PACES, the College has co-organised mock examination for stations 2 and 4 with the Training Subcommittee of the COC(Medicine), Hospital Authority. In addition, a Training Day will be held following each local diet of PACES focusing on stations 1, 3 and 5. Apart from enhancing the trainees' performance during the actual examination, such training will be beneficial in inculcating proper bedside examination techniques as well as good communication skills with patients.

Scientific Committee

Prof. Y. L. Kwong has continued to chair the Committee. The Annual Scientific Meeting of the College was held on 9 – 10 October 2010 with the theme of New Therapeutics in Internal Medicine. The meeting was attended by over 400 Fellows and Members of the College.

Research Committee

The Committee under the chairmanship of Professor Lawrence Wong selected 5 young investigators to present their research paper during the 2011 Annual Scientific Meeting of the College, with a medal to be awarded to the best presenter.

Membership Committee

Dr. C. S. Li has taken up chairmanship of the committee and has vetted a total of 55 applicants for Membership and 51 applicants for Fellowship as at 31st August.

Professional and General Affairs Committee

Dr. C. P. Wong has continued to chair the Committee and has assisted the College in reviewing

and responding to various issues raised by the Government and other local organisations. A series of radio programmes were arranged to introduce the scope of physician practice to the general public.

Synapse

Dr. Carolyn Kng has continued to serve as Editor of Synapse and the College Newsletter is published thrice annually to update to Fellows, Members and trainees about issues related to training, accreditation and College events. Professor Zhong Nan-Shan and Professor KN Lai were interviewed as profile doctors.

Administration and Finance Committee

We are grateful to our Honorary Treasurer for monitoring the financial position of the College and maintaining a healthy balance. Due to the increasing complexity of the College and running cost for the Secretariat, the Fellowship subscription was increased to HK\$1500 but remains one of the lowest among sister Colleges within the Academy. The College will continue to identify opportunities to support educational programmes for our trainees.

I would like to express my sincere gratitude to our two Vice-Presidents, our Honorary Secretary and Treasurer, Chairpersons of the Committees and Specialty Boards as well as our Council Members for their support and advice over the past year. A special word of thanks goes to the Immediate Past President and Senior Advisor for their guidance in facilitating the smooth transition of Presidency. Finally, I wish to thank our hardworking and dedicated secretaries in maintaining smooth operation of the College.



The President's Address to New Fellows at the Hong Kong College of Physicians Conferment Ceremony (2011)

Patrick CK Li
President, HKCP



Dr. York Chow, Secretary for Food and Health, Prof. Raymond Liang, President of the Hong Kong Academy of Medicine, Prof. Sir David Todd, Founding President of the Hong Kong College of Physicians, President of overseas and local Sister Colleges and their representatives, Fellows and Members of the College, Invited guests, ladies and gentlemen.

Today is an important occasion for the newly admitted Fellows and Members. On behalf of the College, I extend to you my congratulations on your achievement, which is a reflection of your dedication and hard work over the past years. I am pleased that you can share the joy with your family and loved ones. College Fellowship is a significant milestone in your professional career and I hope that you will all continue to strive for excellence.

Today is also a significant occasion for our College, as we are celebrating its Silver Jubilee. Over the past 25 years, the College has developed structured training programmes for all the medical specialties. There is a fair and consistent system for assessment of training progress and this is reflected in the consistently high pass rate in the Exit Assessment of all the specialties. Trainees are encouraged to undertake dual training in advanced internal medicine or geriatrics in conjunction with a medical specialty to ensure breadth and depth in their medical knowledge. An internet-based Self-Learning Tool has been developed in collaboration with the Hospital Authority to enhance the trainees' awareness of patient safety.

The Education and Accreditation Committee has continuously refined

and updated the training curriculum and assessment mechanism of all the specialties. It has just published the 5th Edition of the Guidelines on Postgraduate Training in Internal Medicine in July this year. To reduce the hardship faced by trainees in coping with their already heavy workload, the two Annual Assessments for each of the dual training programmes has been replaced by an Interim Assessment after at least 12 months training in each programme. A further change in the training programme which not as prominently publicised is reinforcement of the importance of professionalism for all the specialties.

Medical professionalism is under threat in the recent years. Medical practice has become increasingly complex and specialised such that the care provided by individual doctor risks being a fragmented part

of the overall patient care. Rising medical cost and drive for efficiency have led to generation of protocols, checklists and care pathways that threaten the professional freedom of doctors in how they care for their patients. The heavy patient load in public hospitals reduces the contact time with patients and as a result compromises communication and rapport. Some doctors have adopted a commercialised approach to their practice to enhance their competitiveness. The public has become suspicious and even critical towards the medical profession and the resultant complaints and litigations lead to the tendency to practice defensive medicine. We need to work together to strengthen medical professionalism and restore the image of the medical profession in the eyes of the public.

There have been many definitions of the term medical professionalism but basically it describes the set of standards and behaviour towards patients and the community at large and it underpins the trust of the public in the medical profession. The elitist, authoritative, self-regulating and protectionist position is out-dated and not tenable. A patient-centred framework must form the basis of medical professionalism. I would like to share with you my understanding of medical professionalism, which is derived from interactions with my many teachers and colleagues over the years.

In my view, the expectation by the patients of their doctor best describes the elements of medical professionalism. They would like their doctor to be competent professionally, clearly communicating the diagnosis and discussing the management plan with them, and having their welfare as the prime consideration so that they can entrust their health and their life to the doctor.

With the rapid pace of medical advances, the diagnosis and treatment of many diseases have become increasingly technology-

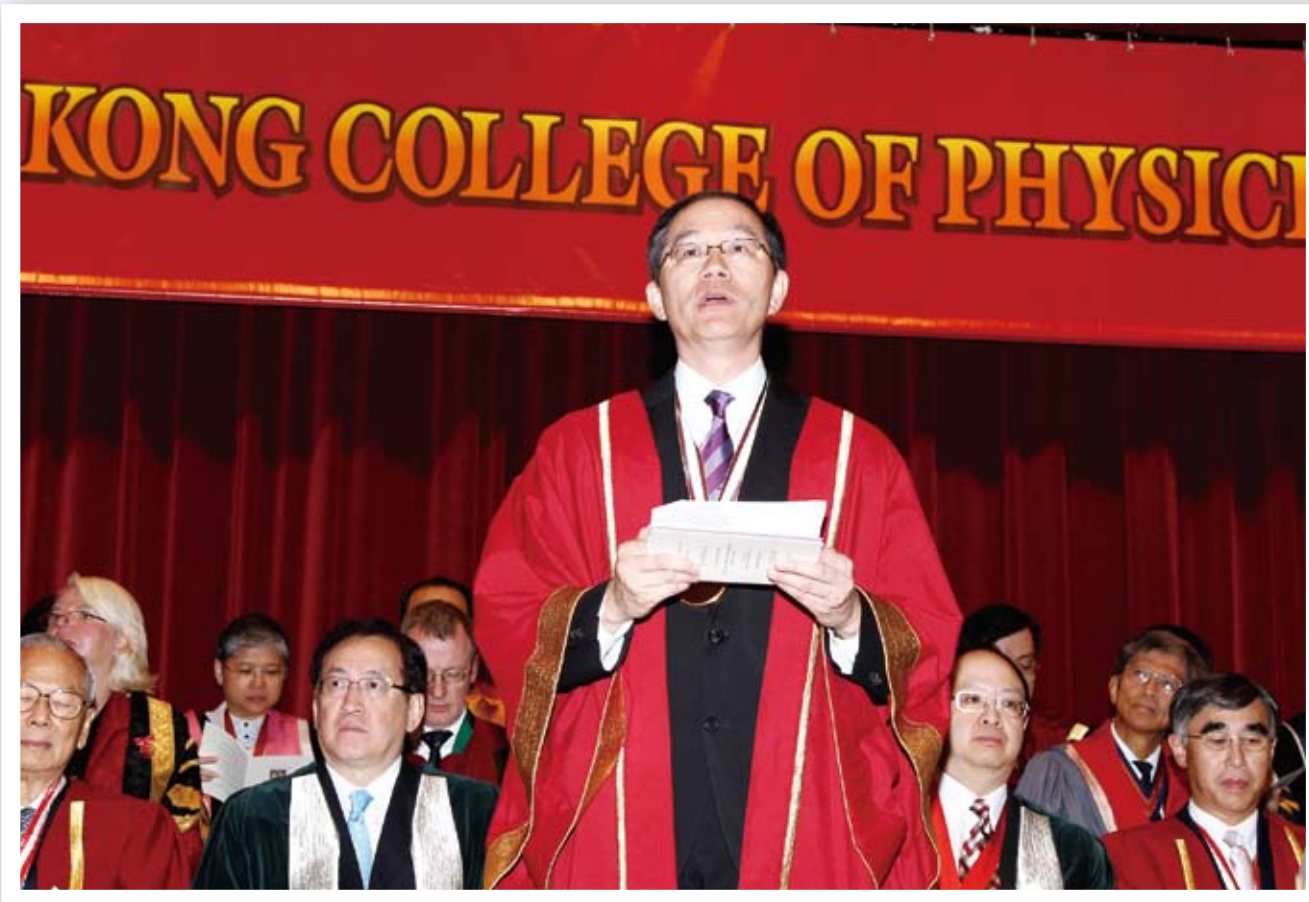
based. One might wonder if there will be a day when we can cure all medical illnesses by administering an effective drug or performing a successful procedure. Unfortunately, there are always limitations to our technology such that there will be diseases that cannot be cured. In addition, there is the human dimension to medical illnesses and its influence on the care process that necessitate individualised treatment strategy. You must have often heard the saying that the practice of medicine is a science as well as an art. Professionalism is the essence in the art of medical practice. There are five dimensions of medical professionalism that I would like to highlight for your consideration. These include safeguarding patient welfare, effective communication, leadership in teamwork, personal integrity and mentorship to the younger generations of doctors.

While we may possess sound medical knowledge on the latest advances and expertise in technical skills to provide the appropriate treatment to our patients, without professionalism, we are merely skilled technicians in the delivery of patient care. Professionalism means always putting the welfare of the patient as the prime concern, ahead of other considerations such as personal gain or recognition, administrative regulation and heavy workload. Such a principle must especially be reinforced in the present days with the close working relationship with pharmaceutical companies, the rising cost of medical investigations and treatment, and the intense competition for research outcome in the academic field. Patient safety must not be compromised by taking shortcuts in the face of heavy workload. If a doctor can uphold the principle of patient welfare as the prime concern, he should be able to instill trust and confidence in his patients. However, this can only be achieved if he can effectively communicate with them.

Apart from the ability to deliver information related to the medical diagnosis and plan of treatment in layman terms, the doctor needs to have empathy with the patients, with an understanding of their social and cultural background as well as issues that are important to them. We need to engage the patients as partner in the care process. Only with clear understanding by the patient and perceived workable options would the treatment be adhered to.

There is a need to cultivate leadership in the medical profession. Medical care has become sophisticated and often involves multidisciplinary team work. Physicians with their broad-based training in internal medicine can fulfill the important role of coordinating holistic care to the patients, rather than serving as passive provider of individual fragmented modules of the care process. Patients will value very much the professional opinion of doctors who can advise them on the treatment in the overall context of the different components of the care that they are receiving. In addition to providing expert care to their individual patients, physicians should strive to lead transformation and improvement of healthcare services and the relevant socioeconomic issues. They should also work together to devise a system to allow the maximum number of patients to benefit from the limited resources in face of the rising healthcare costs. Only then will the community be able to benefit from the medical advances.

Personal integrity is the foundation to medical professionalism. Without integrity, academic and professional achievements will be meaningless and would cast doubt on the authenticity of the work which might otherwise be conducted meticulously and at a high standard. In clinical practice involving individual patients, often only the doctor is fully aware of all the considerations



in recommending the line of treatment. This is the basis for requiring a higher moral standard for the doctors than other occupations. They should be aware of and steer clear of any conflict of interests. The doctors should exercise honesty and accountability about their own limitation, be it professional competence or system constraint. They should be open about mistakes and be willing to learn from them.

They should undergo continuing professional development to keep abreast of the latest medical advances and participate in quality assurance programmes to reflect on their own performance in comparison with their peers. Such requirements should apply to doctors working in institution as well as in solo practice, and should be undertaken with the objective of self-reflection rather satisfying mandatory requirements of the governing bodies.

With the threat to medical professionalism that we are witnessing, we should mentor our future generations of physicians to better serve their patients. Apart from coaching them in their diagnostic and technical skills, we should set personal example of upholding the highest standard of medical professionalism. We should work collectively towards this goal of restoring and maintaining public confidence in the medical profession.

Having considered the important elements of medical professionalism, we should also advocate for appropriate learning and working environment that would foster and enable medical professionalism. Imposing additional guidelines, protocols and checklists while ignoring excessive workload cannot be the right approach towards enhancing patient safety. Internal medicine by its nature requires time for interaction with the patients to

extract information important for reaching the correct diagnosis and formulating the appropriate treatment plan tailored for the individual patients. It is my firm belief that by fostering medical professionalism and allowing time for adequate communication and rapport with the patients, the quality and safety of care can be enhanced.

I would like to close by asking all of us to reflect on the occasions when we ourselves or our family members require medical care. We all cherish the doctor who can reliably provide the appropriate treatment but more importantly someone who genuinely understand and care, putting our health as the prime consideration. Let us all strive to fulfill that role for all of our patients.

May I wish all of you a promising career which is based in medical professionalism.



The 16th AJS McFadzean Oration 2011

The global challenge of

Sir Ian Gilmore Past President, Royal College of Physicians, London

It is a pleasure and a privilege to be able to take part in this annual meeting of the Hong Kong College of Physicians, and to have the twin enormous honours of delivering the annual AJS McFadzean lecture and becoming an honorary Fellow of the College. My visits to this College go back over a decade, with very happy memories of representing the RCPL here while I was Registrar of that College, of returning after being fortunate enough to be elected President, I suspect with no small measure of help from London College Fellows working in Hong Kong and also having the opportunity to be an external examiner at the Chinese University of Hong Kong. It would be invidious to pick out individuals from the many good friends I have made here over the years, but two individuals who have been 'constants' throughout this decade and more have been Richard Yu and Joseph Sung. I was particularly delighted to give the Richard Yu lecture while I was still President in June 2010 as part of Advances in Medicine Symposium organized by the CUHK. I have been equally delighted to see Joseph Sung appointed vice-chancellor

at CUHK, a position I know he will fill with distinction. The RCP (London) was privileged to hear an outstanding 2011 Lilly Lecture delivered by Joseph on the leadership lessons from events such as SARS and swine 'flu.

I feel a considerable empathy with Professor McFadzean. Like me, he was born in Scotland and in the year after my father was born, in 1914. He read Medicine at the University of Glasgow at the same time that my father did likewise at the University of St Andrews, and they both served as officers in the Second World War in the Middle East. However my father chose the quieter life of a chest physician in the north-east of England, looking after the TB pneumoconiosis of the local coalminers while Professor McFadzean was building up a first class Department of Medicine with an international reputation here in Hong Kong. It is sad that he survived only a few months into a well deserved retirement in 1974, whereas my father, after having a bronchial carcinoma resected in that same year of 1974, went on to survive another 34 years. But both saw huge changes throughout their medical careers.



However something that remained a feature throughout their careers and indeed throughout my 40 years in medicine has been the propensity for man to bring harm upon himself through seeking out and taking substances that give temporary pleasure or relief from the hardships of life but when taken in excess or over many years take their toll. It has been through my special interest in liver disease that I became aware of the burden of harm brought upon the individual and those around them by alcohol misuse, and it has been the remarkable escalation in deaths from alcoholic liver disease that has stood out so starkly during my 40 year career. We pointed out in the *Lancet* how countries like the Netherlands and Norway have stayed steady while the deaths in England have risen inexorably over the exact 40 years of my medical career. In a contrasting way, deaths in France and Spain have fallen just as sharply and what we pointed out was that the difference between following France versus staying on the same upward trajectory will translate over the next 20 years into a quarter of a million unnecessary, preventable deaths from alcohol in the UK. I try to carefully refer to alcohol and other drugs, just to remind us that alcohol is a drug, although it happens to be quite legal to consume it. However its status as a drug is not always accepted, despite the facts that alcohol is a chemical, has mind-altering properties and a predilection to cause psychological and physical dependence, and has characteristic withdrawal features.

Of course alcohol is nothing new and indeed as a nation we were drinking more at the start of the 20th century

from excess consumption. England moved from a rural, relatively disorganised workforce to an urban, more closely scrutinised and supervised one – for instance in factories, where men needed their wits about them working heavy machinery and workers who were absent in body or in mind were noticed. And in Victorian Britain there arose a greater social conscience – an awareness for example of the harm through neglect inflicted on the children of those who spent their wages and their days in alcoholic stupor. Temperance became associated with organised religion, particularly non-conformist protestant movements such as the Methodists. It was no coincidence that many of the owners of factories that paid particular attention to the housing and social needs of the workers and their families were tee-total Quakers – such as Rowntree. In the north-west England there is the idyllic village of Port Sunlight built for the workers and their families who made Sunlight soap for the Levers more than a hundred years ago.

Paradoxically, at this time there was also a greater liberalisation on the laws surrounding the sale of alcohol – probably because of the growing entrepreneurial spirit and belief in free trade and England was being described by Napoleon as a nation of shopkeepers. In 1830 the Beer Act allowed any grocer's shop to sell beer on payment of a two guinea excise fee, and some 20,000 establishments took out licenses in six months. In 1860 this was extended to selling wine from groceries, but by now the temperance movement was strong, drink had social class connotations. It was no

alcohol and other drugs

per head in England than at the start of the 21st. The Roman soldiers who invaded Britain 2000 year ago marvelled at the way that the locals drank huge amounts and got drunk at celebrations, such as bringing in the harvest, where the Romans sipped wine in moderation throughout the year. Alcohol was unashamedly used as a way of subjugating the poor in the 18th Century at the time of Hogarth's *Gin Lane*. In these times beer was not considered strong drink and was consumed as a safer alternative to water, but abuse of spirits, particularly gin was rife. One of my presidential predecessors at the Royal College of Physicians John Friend, whose portrait still hangs in the marble hall petitioned Parliament in 1725 "against the pernicious use of strong liquors" and growing consumption among the population.

There were a couple of half-hearted attempts to introduce legislation in order to tax and control alcohol production in the 18th century but they were eventually repealed. It was really the onset of the Industrial Revolution in 19th century England that brought into sharp relief the wasted productivity and lost opportunity

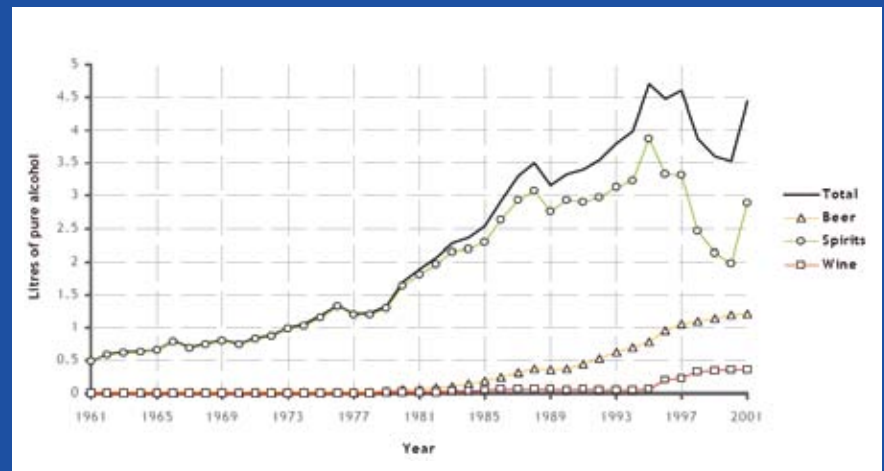
longer socially acceptable for the local lord of the manor to fall down drunk in the local hostelry, which it would have been in the times of Fielding's novel *Tom Jones* a century earlier. Many teenagers signed the pledge at mass rallies. 'Healthy' alternatives to heavy drinking sprung up in Victorian Britain, like playing fields, allotments and public libraries.

The decline in consumption continued through the first half of the 20th century and particularly through the World Wars, where destructive drinking was seen as inefficient and counter to the war effort. Also, in 1916 licensing laws were brought in to close hostelries in the afternoons for the first time, partly to keep sober the munitions workers who came in to assemble the explosive shells for use in the trenches of France. Interestingly, that law survived until 2004, when Tony Blair's Government brought in the possibility of 24-hour licenses in the mistaken belief that this would somehow turn the UK overnight into a continental wine-sipping café culture.

Alcohol use and misuse has hardly been the sole prerogative of the British, but a look at how culture has shifted in the UK in the last three centuries is surely relevant in facing up to the challenges facing Britain, Europe and indeed the whole world today from the health harms from alcohol. This rise in Britain is not unique, indeed is mirrored by the rise in per capita consumption that has occurred in China over the last 3 decades. In Russia the impact of alcohol on male life expectancy has been similar to the effect of HIV on sub-Saharan Africa. Male life expectancy has fallen by about 10 years, aided by curious preparations sold as after-shave to avoid alcohol tax but with tempting orange and lemon flavours added just in case the man decides to drink the after-shave rather than apply it to the skin. Perhaps Russia has just made a slight step in the right direction – they have been stuck in the mind-set of 17th century Britain that beer isn't actually an alcoholic beverage until a change in the law just 3 months ago that stopped every kiosk and corner-shop selling beer to anyone of any age without any sort of licence.

China –the new global market for alcohol

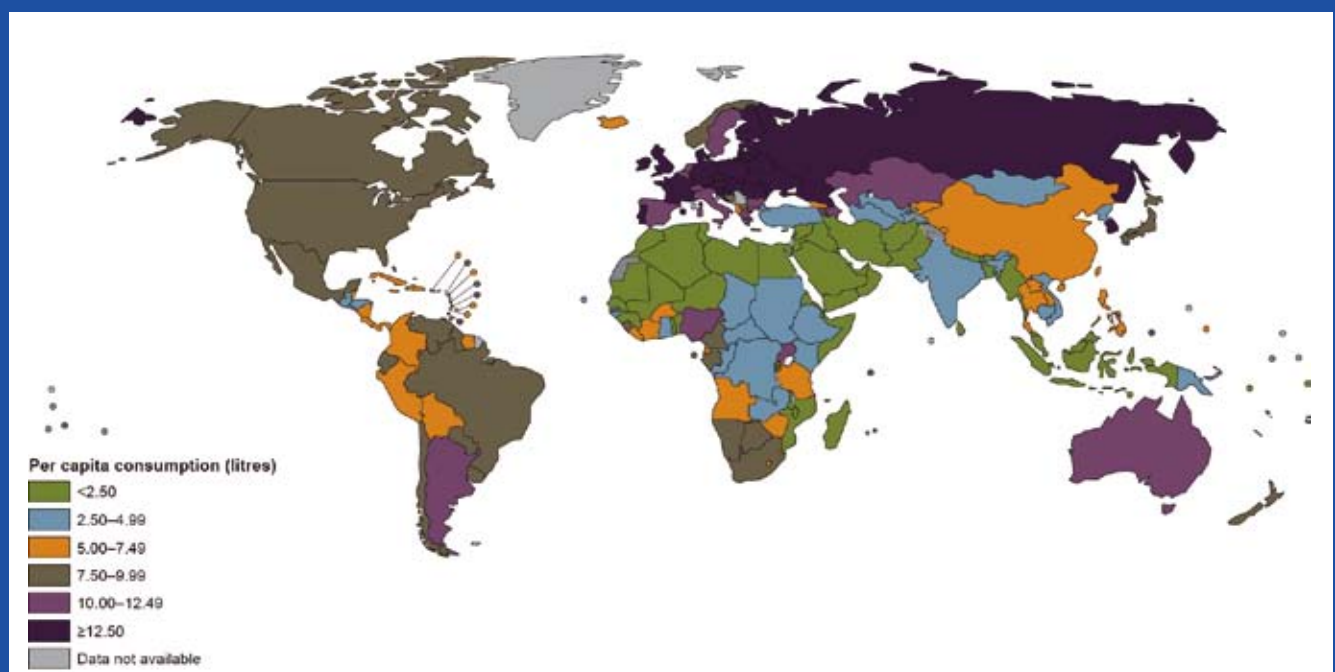
Recorded adult per capita consumption age 15+ – (unrecorded 1+)/person



Sources: FAO (Food and Agriculture Organization of the United Nations), World Drink Trends 2003

But it is in the developing world that alcohol problems can be as hidden today as they were in rural England in the 18th century. Sri Lanka, where I was just last month, is supposedly a low-consuming country, but the locally distilled coconut spirit *Kassipu* ravages the productivity in many small villages. There is huge under-recording of consumption of alcohol across the world, over 25%. In a recent assessment by the World Health Organisation, alcohol was the biggest single risk factor for death under the age of 65 in men – coming higher than tobacco for premature death in relatively young men. And it isn't just young men and it isn't just death – for example the statistics and correlation between consumption and regretted sex in young women in England are clear.

Total adult (15+) per capita consumption, in litres of pure alcohol, 2005



WHO Global Status Report 2011



In the developing countries we now have side by side the old and the new – the silent rural, unadvertised consumption of spirits that are never recorded anywhere and the smart global brands of vodka being heavily marketed in the urban bars frequented by the city traders. Another WHO publication has shown how heavily alcohol is being marketed in Africa by the multinationals, with little or no restrictions on the marketing methods used.

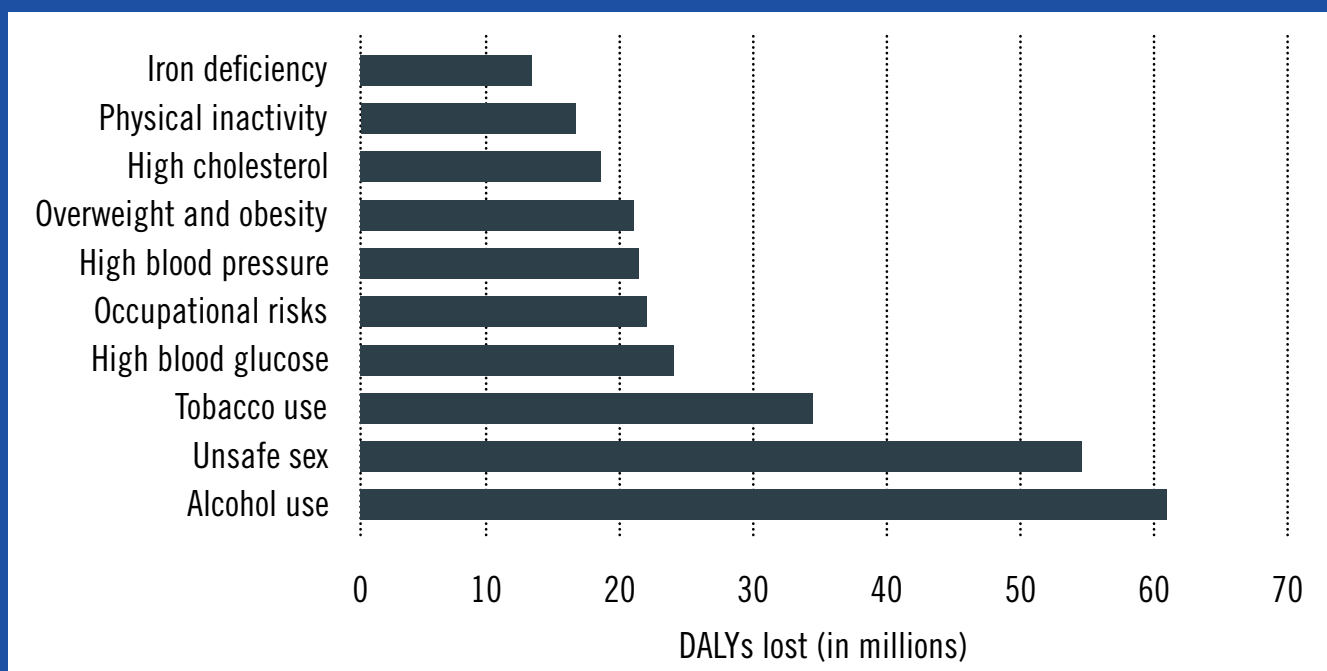
27% alcohol consumption worldwide unrecorded

World Health Organisation

But let's start by looking at the global picture. The recorded consumption –which we know underestimates in the developing world - emphasises the problems in Russia and the emerging eastern European countries. The harm can be expressed in DALYs, which are the life years lost through either death or disability, again worst in Europe. There are two specific points: firstly the impact of harm is on relatively young and potentially productive people - data from England show peak mortality in the 45-65 and alcohol as a contributory factor is the commonest cause of death in young men (28% of deaths). Secondly much of this burden is manifest through chronic diseases as opposed to injuries, data on hospital admissions in Liverpool showing that acute alcohol harm is a small fraction compared to dependence and chronic disease. This chronic disease includes cancer, and in a European study reported in the British Medical Journal in 2011, 10% of male cancers were caused by alcohol. There has been a recent United Nations meeting in New York on non-communicable diseases, which is welcome, because until now the emphasis on global health has been almost entirely on the burden of infectious diseases and at last the impact of obesity, of hypertension, of diabetes is being recognised. But the importance of alcohol as a major risk factor for these chronic diseases is not yet sufficiently appreciated.

So where do we go with our Governments in guiding them about making evidence-based policy in this area. We don't have to go too far to find the evidence – we have three decades of it. I particularly commend the 2nd edition of Tom Babor's book *Alcohol – no ordinary commodity*, which gives a wonderful summary of what has been tried in various parts of the world – and what works. I was involved in the UK Academy of Sciences publication 'Calling Time on the Nation's Drinking', and the front cover shows the scary inverse correlation between consumption and price in the UK.

Dalys lost attributable to 10 leading risk factors for the age group 15–59 years in the world, 2004



Why has health burden increased globally?

- **Fall in the relative price of alcohol**
- **Increasing availability**
- **Increased promotion by the alcohol producers and retailers**

You and I all know that correlation is not the same as causation, but the evidence for the latter certainly convinced Sir Michael Marmot, who chaired this Working Party. But in the UK it is not just the overall price, which has never been cheaper in living memory, but it is the relative price. While over the last 20 years it has got a little cheaper in pubs and bars, the big change has been in the 'off-trade' – in groceries and supermarkets where beer and wine are about 240% cheaper in real terms over just two decades. When I debate with the drinks industry, they are at pains to point out that alcohol is cheaper in France but there drinking is falling. This demonstrates that there are other, complex cultural and societal factors, but if you want real-life experiment on price you only have to go as far as Finland where they slashed tax by a third in 2004 when their neighbour Estonia was joining the EU and there would be no import restrictions. Consumption and harm jumped up immediately and have stayed there.

The other two evidence-based drivers of consumption are availability and marketing and these warrant lectures of their own. Suffice it to say that there is reasonably robust evidence, which I reviewed as chair of the Science Group of the European Commission Alcohol and Health Forum, that marketing affects children both in terms of the age at which they start drinking and how much they drink when they start. We also know that these both correlate with drinking and health problems in later life. If you doubt the subtlety of the drinks industry, you should

look at the publication by Gerard Hastings from the University of Stirling, entitled 'Alcohol marketing – last chance saloon' where he used parliamentary privilege during a health select committee to obtain commercially sensitive marketing strategies from four drinks manufacturers. Their public stance of concern about young people's drinking does not square up with their private strategies, and this and related evidence seen by the parliamentary committee led them to conclude, to my great pleasure, that government paid too much attention to industry and not enough to their CMO or the RCP!

This evidence-base really does throw into question the policies adopted by some of our governments when facing this global challenge and raises the question of why we have not learnt more from tobacco and health. In England at present our conservative-dominated coalition government has been much more persuaded by 'nudge theory' than by the evidence I have shown you. There is a new Behavioural Insights Team

in the Cabinet Office of Downing Street that draws on insights from behavioural science and behavioural economics and shows ways in which health improvements can be made without resorting to legislation or costly programmes through 'nudging' people towards healthier choices. This is based on the work of Thaler and Sunstein on nudge theory, which seeks to avoid being prescriptive in any way – nothing is banned and it is all down to free choice but with nudges in the right direction. The House of Lords Science and Technology Committee in the UK looked at this recently and their conclusion that it was less likely to be effective than regulation. There is a so-called 'ladder of interventions' and the 'nudgers' are right down at the bottom, whereas the regulators are at the top.

But the UK is a fascinating test-bed for alcohol policy at present because we are not one nation but four! Health is a devolved responsibility to Scotland, Wales and Northern Ireland, whereas tax-raising powers and defence, for example, are UK-wide government responsibilities. So while Westminster government emphasises nudging and voluntary pledges from the drinks industry there are much tougher and innovative plans afoot in Scotland. Of course historically the problems in Scotland have been worse, and currently death rates from liver cirrhosis are 50% higher than south of the border. And it is not just liver disease. On the evening of the local soccer derby between Rangers and Celtic,

alcohol advertising increases both the uptake of drinking and consumption in young people

Science Committee of the EU Commission Alcohol Forum 2009



alcohol-fuelled domestic violence shoots up, so bad that government had to call in the two managers to tackle the problem. But Scotland's ruling national party have committed to raising the price of alcohol in Scotland by setting a minimum price per unit (8g) of alcohol contained – probably about 45p or 50p, a policy supported by the last CMO of England, Sir Liam Donaldson. And one of the other major parties, the Lib-Dems who previously opposed the policy have fallen in line. We had the curious situation in the past that the Lib-Dems supported a minimum unit price in England but not in Scotland – perhaps not unconnected with the fact that many of the Lib Dem MPs had distilleries in their constituencies. You may think, and would be right, that a minimum unit price would not affect the price of a bottle of finest single malt whisky,

But it is the brightest hope on the policy frontier in the UK at present. It is salutary that it was first Ireland and then Scotland that led the way in smoke-free legislation for public places, and it may well be that on the issue of cheap drink driving our current health harm England will again be shown the way by its near-neighbours. The UK, Ireland and Malta are the only European countries with a drink driving limit of 80 rather than 50 mg% and again it may be that England will be shamed into taking action by another UK country, Northern Ireland, currently consulting on lowering their drink-driving limit.

The very hands-off approach of successive Westminster governments on alcohol misuse contrasts in a striking way to their approach to illicit drugs and this has stimulated some interesting debates in the

chairman in a very public way. There is no room for governments in the UK to appear 'soft on drugs', and recently cannabis was elevated from the lower class A to higher class B category. Cannabis is currently the most frequently used illicit drug in the United Kingdom; the (UK) Focal Point on Drugs reported that in 2008/09 an estimated 36.2 per cent of 16 to 59 year olds in the UK had used drugs in their lifetime (ever), while 10.0 per cent had used drugs in the last year (recent use), and 5.8 per cent had used drugs in the last month (current use).

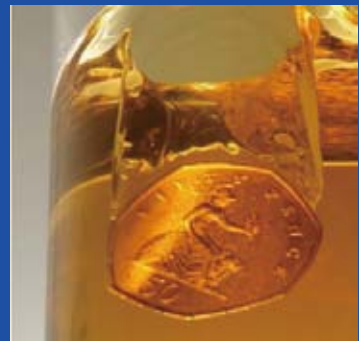
It could be argued that the legality or otherwise of different substances is an historical accident and reflects the balance of world power in previous centuries. Alcohol use has a stronger history in the West and opioids in the East. Despite its 'tough' current moral stance on opiates, the

Impact of a 50p minimum unit price

Research into the effect of a 50p minimum price per unit shows for every year (England):

- 3,393 fewer deaths
- 97,900 fewer hospital admissions
- 45,800 fewer crimes
- 296,900 fewer sick days
- And a total saving of £15 billion over ten years (health, crime, social care.)

Source: Chief Medical Officers Report 2008, Meier 2009



but it is alleged that in some of these distilleries also produce low-cost vodka. The beauty of tackling the cheapest drink through minimum unit price is that it is the heaviest drinkers who are attracted to the cheapest drink and are preferentially targeted. Also it does not hit the price in the vast majority of pubs and restaurants but rather the supermarkets and liquor stores. And modelling suggests a real reduction in alcohol-related deaths. There is some way to go before this evidence-based intervention is introduced in Scotland - the drinks industry says it will contravene European laws against stifling competition, and it throws us the spectre of the supermarkets opening stores just south of Hadrian's wall on the border between Scotland and England.

UK recently. The Chairman of the Government's own Advisory Committee on the Misuse of Drugs, Professor David Nutt, published a paper in the *Lancet* in which he compared the relative harm of various legal and illegal drugs, including alcohol and tobacco as well as heroin, cocaine and cannabis. The harm for each was made up of an estimate of the harm to the individual and the harm to society. Although heroin scored highest on harm to the individual user, when the scale of harm to others was added, alcohol came out as the most harmful of all (and well above tobacco). The subsequent debate (linked in the media to remarks by David Nutt that ecstasy was safer than horse-riding) was followed by the Home Secretary 'sacking' his

British fought the Opium Wars with China in the 19th century to protect their trading interests at the expense of the health of the Chinese nation, and we are not proud of that period of British colonial activity (which included annexing Hong Kong from the rest of China under one of the treaties of the Opium Wars).

Within Victorian Britain there was some curious double-think over drugs and alcohol, with morphine, heroin and cocaine all being used quite freely in proprietary over-the-counter medicines for a variety of complaints, including teething in babies. Public concern in some quarters led to a Royal Commission in 1893 that concluded "Opium was in general used in moderation and led to no evident ill-effects". Just as I would

argue that the process of developing rational alcohol policy currently is derailed by the power of the alcohol industry, so in those days the trade interests of the opium markets were so strong as to bring about a remarkable selectivity in the evidence the Royal Commission relied on. There was next a committee of the Department of Health in the UK set up in 1926 on opiate use, led by the then PRCP Sir Henry Rolleston. Importantly this report really set opiate addiction as a medical disease rather than some form of moral weakness, and set the path for the future.

The present criminal approach, backed up by tough penalties for possession, was enshrined in the 1971 Misuse of Drugs Act and backed up by several UN international conventions, but most serious analysts have concluded that it has not been successful. The harms to both the individual user and to society are compounded by the inherent criminality. For example the health harms in heroin users relate more to the underworld use of contaminated drugs and dirty equipment than the drugs themselves and trials of providing pure heroin under supervision using clean injecting equipment have shown real health gains. Also the societal harm is strongly associated with the crimes committed by users to feed their habit and the battles of the drug barons to keep their market and territory. While there has been a gradual downward trend in UK drug usage in the last decade, the spate of new 'legal highs' that require fresh legislation and the apparent imbalance in societal harm from legal and illegal substances has led commentators to look at other approaches. For example, in Portugal the treatment of opiate addiction as a health rather than criminal problem seems to have paid dividends,

Public health aims of a policy for drugs of dependence

- **individual:**
 - prevention of uptake by new users
 - early access to effective treatment for established users
 - prevention of complications
- **society**
 - reduce burden of illness, crime etc

although proponents and declaimers swop statistics to fit their case.

The challenges of bringing about change in the UK are very significant. Any support for decriminalisation is interpreted by sectors of the media as being 'soft on drugs' and somehow encouraging heroin to be sold in every corner shop. Political parties have seen any change as a vote-loser. But in the UK there is finally some movement towards an open and informed debate, as the Liberal-Democrat party have tackled the issue at their party conference in September 2011 and are supportive of some form of decriminalisation along the lines of policy in Portugal.

Drug regulation and its inconsistencies is an area that one drifts into at ones peril – as I discovered to my cost. It is widely thought that I decided to finish my presidency 'with a bang' – by making a public intervention in this controversial area, but nothing could be further from the truth. On a damp Saturday in May 2010, I was looking for ways to fill my private (well, fairly private) email restricted to fellows and members of the London College. I alighted on an interesting leader in the British Medical Journal on the topic of illicit drug regulation and on the same day a similar view from the chairman of the UK Bar

Council appeared in 'The Times'. My less than extreme comment - that the topic should at least get more public debate - was picked up by the organisation 'Transform Drug Policy' and they made my views public on a quiet news day in August – well it was quiet until then, and I appeared on virtually every radio station and TV channel that day. But I still stick by my view that there may be much to gain from treating heroin addiction more as an illness and using interactions with the authorities more as an opportunity for treatment than punishment. The issues around soft drugs like cannabis are more complex but worthy of being included in such a societal debate. And before long society is going to have to face up to the issue of cognitive enhancing drugs to improve brain function in people without any existing disease but who wish to perform better.

I have been accused of hypocrisy in calling for tougher legislation around the sale of alcohol while seeking the decriminalisation of drugs to be at least debated. In fact there is no conflict in those views, and if a decriminalisation approach to drugs is taken there is need for more rather than less regulation. The availability of who gets what, where and how requires very tight regulation and control. For someone who does not take illicit drugs and takes alcohol only in moderation, the way that societies deal with these substances has given me a lot of personal interest, travel and even, dare I say, fun. I am grateful to have had the opportunity to share some of that with Fellows of the Hong Kong College of Physicians in your annual AJS McFadzean oration.

Cost-effectiveness of the 'war on drugs'

- \$\$\$\$\$ prevent production
- \$\$\$\$\$ prevent importation
- \$\$\$ prevent distribution / sale
- \$\$ prevent use (education / information etc)
- \$ treat users

RCPsych / RCP report 2000

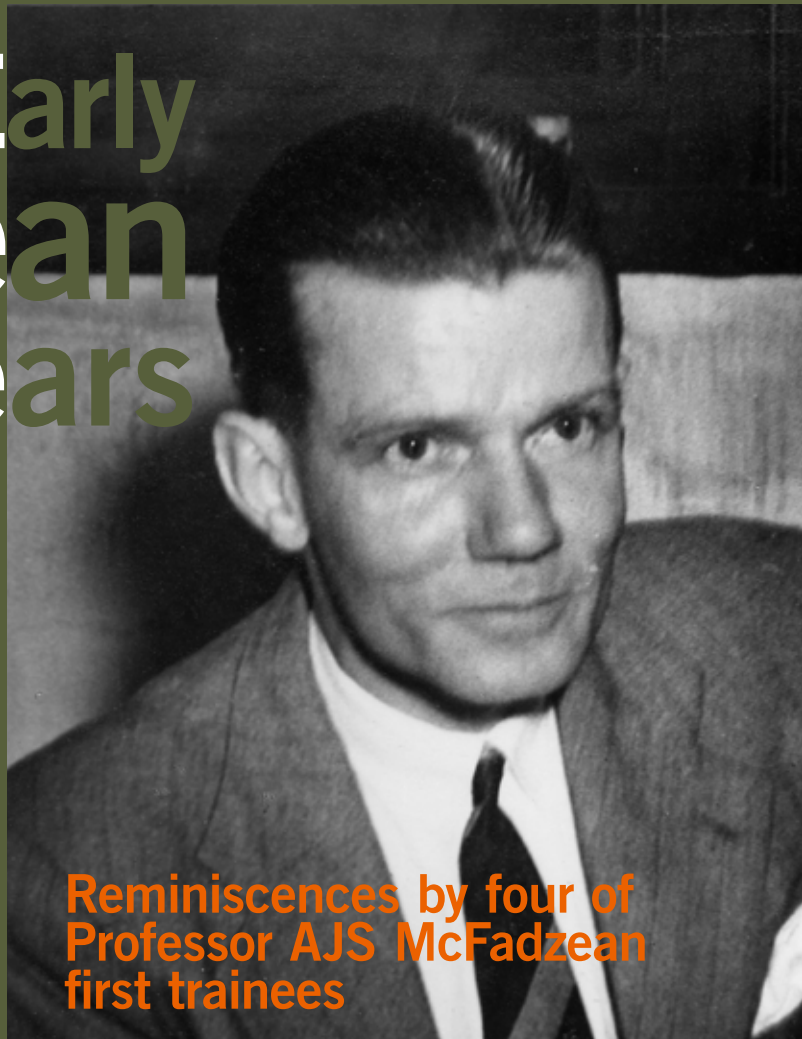


Haematology Research In The Early McFadzean Years

The Society of Haematology of Hong Kong is celebrating its 40th Anniversary in 2012.

Professor AJS McFadzean founded this specialty in Hong Kong after he was appointed Head of the Department of Medicine, University of Hong Kong in 1948. He had published important papers on disorders of the blood while at the University of Glasgow. It seems fitting to four of his first trainees to mark the occasion with reminiscences of the early years of working under him.

Prof. McFadzean brought with him the creed that an academic department of medicine should emphasize research as well as teaching and patient care. His astute observations, analytical mind and innovative thinking led to many productive investigations of which a few related to haematology will be described.



Reminiscences by four of Professor AJS McFadzean first trainees

Professor Hau Cheong KWAAN

Marjorie C Barnett Professor of Hematology-Oncology, Professor of Medicine, Northwestern University Feinberg School of Medicine, Chicago, U.S.A.

As a clinical assistant, I was encouraged to participate in many areas of research. One such project was done in collaboration with Prof. HOU Pao-Chang, an astute pathologist, who observed intense glycogen staining in the tumor cells in hepatocellular carcinoma (HCC). My role was to find out why the glycogen was not mobilized while hypoglycemic attacks were common. Needle biopsy samples of the tumors were analyzed for the ex-vivo decay of their glycogen

content. This required assays every four hours, necessitating me to get up several times at night. After months of this, my enthusiasm for this work was waning, even though positive findings were obtained. An event in 1955, however, changed all that. We encountered many patients with splenomegaly with unknown etiology, and we referred to them as cryptogenetic splenomegaly. Many of these patients had hypersplenism and were being splenectomized. It so happened that an alarming rate of bleeding complications was seen. Our Consultant Surgeon, Mr. James Cook, was most unhappy as that might have reflected on his highly regarded surgical skills. McFadzean surmised that it might be the result of poor liver function in these patients, and instructed me to perform Quick's one stage prothrombin time on blood samples collected before, during and after surgery. This assay was

done manually by the addition of several reagents to a plasma sample to produce clotting, and the time taken for clot formation was marked by a stop-watch. While performing this test on one of the first patients with major intra-operative bleeding, I encountered an amazing phenomenon. To my astonishment, the intra-operative sample did not clot. Repeating the test several times, I found that a tiny fragile clot actually formed but disappeared in a few seconds right under my eyes! On rounds the next morning, I was most embarrassed to report to the Professor that I was not able to report any results. He patiently asked to be shown the assay in the laboratory. When he, too, was convinced of this phenomenon, he exclaimed: "This is fibrinolysis, laddie!", and showed me the newly published book on Blood Coagulation and Fibrinolysis by Biggs and Macfarlane. The latter, a

renown hematologist, was a pioneer in the study of fibrinolysis. Thus, I went through this book from cover to cover in no time and learned that his studies on fibrinolysis were fascinating. Macfarlane was able to produce high fibrinolytic activity in normal subjects by applying different forms of stress. These include exercise, injection of adrenaline, surgical operations or simply intense anxiety states. Anxious students waiting for their oral examinations showed high levels of fibrinolytic activity in their blood!

My serendipitous observation started an intense investigation into the fibrinolytic system in our cirrhotic patients, confirming that cirrhotic patients had indeed high baseline level of fibrinolytic activity and, furthermore, this was intensified during the surgery. At the time, there had been other published observation of increased fibrinolysis in patients with liver diseases in the literature. Thus, our work needed to go further to demonstrate the source of this fibrinolytic activity, and to add to our understanding of the many basic physiological facts of fibrinolysis in the healthy individual. The following years from 1955-1958 were among my most enjoyable and fruitful years of research. First, we extended findings of increased fibrinolysis to over 100 splenomegalic patients, with over half having cirrhosis. We confirmed

that adrenaline administration accentuated the fibrinolysis and furthermore observed that the excessive fibrinolysis could be blunted by corticosteroid treatment. Next, we were able to demonstrate that fibrinolytic activity was derived from the veins, after various stimuli were applied to the veins in vivo in man and in experimentally induced venous thrombi in rabbits. Previously, Virchow had noted that blood in small blood vessels was more likely fluid and incoagulable than blood collected from larger vessels. He had indeed suspected that blood vessels were the origin of fibrinolysis, but our findings were the first direct observation that fibrinolytic activity was derived from veins. We attempted to understand how fibrinolytic activity was released from the veins into the circulation by performing numerous tests on human "volunteers", recruited from house staff and medical students. I was among them on many occasions. Using blood pressure cuffs, we were able to isolate venous segments from which we drew blood samples following the application of various forms of stimuli. They included ischemia, adrenaline, noradrenaline, serotonin, acetylcholine, and atropine. In addition, experimentally induced venous thrombi were produced in the marginal veins of rabbit's ears. Parallel studies using these stimuli were done using the lysis of the thrombi as the endpoint.

The findings verified those observed in the human veins. There were additional data in the animal experiments, such as the finding that feeding cholesterol to the rabbits resulted in inhibition of clot lysis. As months passed, each with new exciting findings, we began to extend our work with many different designs, such as looking into the extent of the effects of these venous stimuli. We were surprised that stimulation of a vessel wall could release fibrinolytic activity from a vessel located distally to the site of stimulation, indicating that the stimulus could be transmitted via perivascular sympathetic nerves. At the time, we had no other explanation for this phenomenon. Some fifty years later at a meeting Jim O'Rourke excitedly told me he had demonstrated that the perivascular sympathetic pathway was indeed responsible.

I was also trained to scrutinize the numerous results we were getting. Among some cirrhotic patients who went on to develop HCC, we were surprised to see their elevated fibrinolytic activity disappear. Inhibitors were found in their plasma as well as in the liver tumors. Today, we know that this is due to increased plasminogen activator inhibitor-1 (PAI-1). We also investigated whether or not the increased fibrinolysis in the stimulated normal veins in our volunteers could be inhibited. Here again, credit



Professor Sir David TODD

Emeritus Professor,
University of Hong Kong

After internship we were introduced immediately to clinical research. The laboratory was a room roughly 20x60 feet which was lined by laboratory benches on all sides with a long one in the centre. This was shared by the technical staff who performed all the blood counts, urinalysis and examination of the stools and other simple blood tests for the patients. Sputum, cerebro-spinal fluid, and body cavity aspirates were also examined.



must be given to McFadzean's vision. He directed us to study the physiological mechanisms of exercise under ischemic conditions. Indeed, we found that fibrinolysis could be inhibited consequent to exercise under ischemic conditions. Macfarlane wrote to McFadzean that our work on fibrinolysis was "the finest in the past ten years". One can imagine how a novice like me felt at the time. The enthusiasm also spread to the other colleagues in the Department of Medicine. When our first report appeared in the *Lancet*, David Todd excitedly showed me a copy the journal.

Working conditions were far from ideal. We were using Macfarlane's method of assay, which entailed the formation of a fibrin clot, and observing the lysis of the clot every six hours by measuring the amounts of diminishing fibrin content. Our bench space was no more than eight feet wide, next to the counter for urinalysis and fecal examinations. We had to wash our own test tubes. On one occasion when our only centrifuge broke down, the Professor had to take the motor to the Naval Dockyard to have the Royal Engineers re-wind the coils!

McFadzean's enthusiasm had no bounds. He would call me in every evening with a typical greeting: "How was it, old man?", whereupon I would report to him the findings of the afternoon. Early next morning,

he would have new ideas and new instructions. I had always suspected that throughout the night his mind would be endlessly turning over my findings. One morning, on his arrival at the laboratory, he exclaimed: "Guess what I dreamt of last night, 'Kwaan Chai'?" I was in the operation room and, for some reason, Mr. Cook was furious with me and threw the patient's omentum on my face, suffocating me!" That nightmare gave him the idea that we should check the fibrinolytic activity of peritoneal tissues. The findings of the nature of fibrinolysis in the peritoneal fluid was later presented at the meeting of the prestigious International Committee for Nomenclature of Blood Clotting Factors (on the occasion when the fibrin stabilizing factor was named Factor XIII) and later published.

We were fortunate to have Dr. Rita Lo join me in the laboratory. In the beginning, she was not familiar with our long hours and could not understand why we were chasing after a tiny wisp of clot. I recall that once she quietly remarked that I must be half insane. With her helping hand, however, we were able to start producing experimental thrombosis in the ear veins of rabbits. This was most valuable, as the findings confirmed our hypothesis based on the findings in blood collected from human volunteers. After a few months, she, too, was caught up with

the excitement. When McFadzean went to Scotland on his "expatriate" leave for a few months, we decided it was time to test our own (and not the Professor's) ideas and to surprise him on his return. We fed rabbits with a high cholesterol diet and found that lysis of experimental venous thrombi was impaired.

One must realize that in the early fifties, once the objective of getting the M.B.,B.S. diploma was achieved, the majority of the graduates would flock to private practice. Among the few that joined the academia, the aim is to more clinical training to hone our clinical skills. Research was the furthest object in our minds. But then, for those who worked in McFadzean's department, he changed all that. Yet he must have felt the reluctance of our group of newly graduated doctors to participate in research. As such, our fervent efforts on the fibrinolysis were mostly viewed as something esoteric, if not outright eccentric by most of our colleagues. One notable exception was a young graduate Dr. Margaret King, who came from a well known academic family. Her father, Prof. Gordon King, was responsible for re-building the war-demolished Medical Faculty after VJ Day. Though Margaret did not directly join our team, she was most supportive and helped to recruit patients and healthy volunteers for the studies.

The most grueling assignment was doing hourly complete blood counts on patients after splenectomy to determine when the hypersplenic effect ie low haemoglobin (Hb), red and white cell and platelet counts corrected. This was done manually, using pipettes, counting chambers for the cell counts (Fig.1) and blood smears for differential white counts and to indirectly estimate platelet numbers. Microscopes were monocular. One hour was needed for completion and then it was time for the next set which meant running to the surgical ward upstairs and persuading the patient that blood taking was an important part of treatment! This lasted well into the night: fortunately the counts improved after 12 hours and were then spaced out to every 6 hours and then daily. Sheer drudgery, and this perhaps was one reason the then Dr. Rosie Young took up endocrinology, in which she has excelled.

The 'pooling' effect of an enlarged spleen is now well known.

Those were before the days of chromium tagged red cell survival and an increase of faecal urobilinogen was an important quantitative method of determining excessive red cell destruction in patients with splenomegaly. This involved collecting 24 hour stool specimens, grinding them up in a Waring blender, extracting the chemical and reading the amount of urobilinogen using a primitive colorimeter. The smell in the laboratory was truly offensive. Excessive red cell destruction in the patients with massive splenomegaly was shown.

An increase in the plasma volume, as encountered in pregnancy, was found in the patients with cirrhosis and splenomegaly, using the dye T1824. This contributed to the 'anaemia'.



Fig. 1 MONOCULAR MICROSCOPE WITH COUNTING CHAMBER AND PIPETTES FOR CELL COUNTS

One explanation is that pooling of blood in the expanded portal circulation leads to sodium retention by the kidneys. Dr. Kam Chuen TSANG collaborated in much of the work on haemolysis and plasma volume and these results have been confirmed using ^{51}Cr -tagged red cells.

Perhaps the most risky was collecting cirrhotic livers, some with HCC, from the mortuary to study the hepatic circulation. This was done in

connection with investigating splenomegaly, hypersplenism and portal hypertension and were in the days before the discovery of Hepatitis B which most of the cirrhotic patients had. HC Kwaan and I wore gloves but must have directly contacted infected tissue many times. The hepatic artery, portal vein and inferior vena cava were cannulated and using different pressure gradients neoprene latex of different colours was injected (Fig.2). We managed to show that HCCs had a hepatic arterial supply and that there were many artery-venous shunts and collaterals in the cirrhotic livers. Unfortunately towards the completion of this work a group in the U.S.A. published similar results using the same technique; McFadzean did not take kindly to this and only used the material in his overseas lecture tours, never submitting it for publication. Needless to say both HC Kwaan and I were disappointed and are Hepatitis B antibody positive!

Another McFadzean discovery was erythrocytosis in HCC. It was noted



Professor Shiu Chiu TSO

Professor (Retired),
Department of Medicine,
University of Hong Kong

To a medical student, McFadzean was a highly respected yet much feared teacher. It was therefore understandable that, on joining the Department of Medicine in 1960, it took me time to regard him as an

inspiring mentor and a considerate, though stern, work-place chief. Fortunately the Department had already been under his helm for over a decade and he had gathered around him a number of dedicated lieutenants who were able and ready to give day-to-day advice.

One of the first lessons McFadzean gave to all junior staff was that a physician should strive to add to the sum total of medical knowledge, through good clinical observations and research. His other message was that "writing maketh an exact man", that it was important to present the results of one's work in writing. This was the guiding principle that defined a significant part of my activities in the Department.

that patients with advanced HCC often had normal or elevated red cell counts. Again using the dye T1824 an increased red cell mass was found in about 10% of the patients. This was subsequently confirmed with ⁵¹Cr-tagged red cells and it is now known to be the result of abnormal erythropoietin production by HCC cells.

McFadzean recognized the existence of thalassaemia in Hong Kong as early as in 1949. As more Chinese were studied in the ensuing years it became evident that the thalassaemia gene was unlikely to have been carried eastwards by migration from the Mediterranean basin, as postulated by A.I. Chernoff as late as in 1959. This has been substantiated by recent DNA studies on thalassaemia in Chinese and Southern Europeans.

In the 1950s only paper electrophoresis and foetal Hb. estimation were available for our studies. I well remember the electrophoresis expert, Dr. Rudy Khoo showing us some unusual bands. We did not realize at the

time they were Hb.H and Hb.Constant Spring....if we had known they would probably now bear the name of Hong Kong 1 and 2!

Despite the lack of resources and modern techniques, important papers on hypersplenism, haemolysis and blood volume changes in cirrhosis of the liver with splenomegaly, and erythrocytosis in HCC were published in the journal *Blood* in 1958 and the classic paper "The Distribution of Cooley's Anaemia in China" in 1964. McFadzean first directed, then inspired us to do research and for this I am forever grateful.



Fig. 2 NEOPRENE LATEX INJECTION OF HEPATIC ARTERY (RED), PORTAL VEIN (BLUE) OF A CIRRHOTIC LIVER

At that time facilities for research were gradually improving. While most laboratory procedures still relied on manual manipulation, support was coming in the form of binocular microscopes (reducing the fatigue of lengthy observations), spectrophotometers (replacing colorimeters that required tedious calibration before each use), and electronic calculators (increasing the accuracy of calculations hitherto offered by slide rules). Yet sophistication and automation were still far away. This can be seen in the case of diagnosing pernicious anaemia. Gastric aspirates were manually titrated against sodium hydroxide using the burette, with phenolphthalein as indicator, and vitamin B12 -deficiency was documented by daily reticulocyte

count following a single low dose of cyanocobalamin.

Technical support in the department was limited and all laboratory work of a "research" nature had to be performed personally. Fortunately the department was endowed with technicians willing to learn and put in extra time to help out. As more funding became available, new technical staff were appointed who, with on-the-job training, were able to make more contributions.

In the 1960s, the Department found additional research space in the 300 sq. ft. Wellcome Laboratory where I carried out erythropoietin assays for studying erythrocytosis in HCC. Bioassay was used and involved a large number of mice, first as a source of blood for hyper-transfusion

to other recipients (assay mice) and then an adequate number of the assay animals to provide statistically useful data. For each batch of assay, the animals had to be kept for about 2 weeks and during such a period, part of a Sunday routine was to cater for their welfare. Needless to say work was usually 'after hours'.

McFadzean came to the Department on Saturdays and Sundays and this provided an opportunity for junior staff to meet the Professor in a semi-official environment over cups of coffee. We were able not only to air grievances and problems, but more importantly to avail ourselves of sound professorial wisdom and advice. A warm atmosphere of esprit de corps was generated and a sense of departmental unity was forged.



Professor Tai Kwong CHAN

Emeritus Professor,
University of Hong Kong

Professor

A.J.S. McFadzean and a prize in Medicine persuaded me to become a clinical assistant (demonstrator grade) in the Department of Medicine. It was an honour although the salary was a third less than that of classmates who joined the Medical and Health Department as medical officers. We also worked harder for apart from clinical duties and some teaching we were expected to do laboratory-based research.

McFadzean and CC Wong, senior lecturer, saw a great future in the biochemical aspects of medicine so

enzymology was my assigned area of work. Research was first done on the enzymes of carbohydrate metabolism in normal and cancerous livers while Donald Yu, one year my senior, studied the serum enzymes. It was found that the enzymes of the pentose phosphate shunt (the alternative pathway of Otto Warburg) were indeed higher in liver cancer and the entry enzyme, glucose-6-phosphate dehydrogenase (G6PD), was 2-5 times higher. We worked in the Wellcome Laboratory, located midway between the main Hospital and the Pathology Building, which consisted of 4 small rooms totaling about 300 sq. ft. and the main equipments were a refrigerated centrifuge and a Beckman spectrophotometer!

Studies on erythrocyte G6PD deficiency started in 1963. Alving and Beutler in 1959 had shown that in American Blacks, G6PD deficiency was responsible for the haemolytic reactions in those given primaquine for radical treatment of malaria. Initially the Methaemoglobin Reduction Test was used to screen for the incidence of G6PD deficiency among Chinese. By quantitating the amount of methaemoglobin heterozygous females could also be detected. Blood was collected after the morning rounds and tested before Out-Patients' Clinics at 2pm. Michael Lai, from the Department of Biochemistry, assisted in characterizing the G6PD variants. At the same time I was asked to do other haematological tests and concentrate on haematology!

After further laboratory training in London on a Commonwealth Scholarship I returned in 1967 to continue studies on G6PD deficiency, further characterizing them. We had also acquired an automated Unicam Spectrophotometer. Working after clinical duties and well into the night, helped by the senior technician CS Kwan who ran the gel electrophoreses, it was found that red and white blood cells and platelets had the same enzyme, and that leucocytes were a richer source of the enzyme than red cells. Also, tissue from liver, adrenals and kidney from affected persons also had the same enzyme deficiency. These techniques and findings were cited for many years in the Index Medicus.

As for articles, McFadzean asked me to write on the distribution of G6PD variants in Southern China. I was devastated when, sitting beside him as he corrected my manuscript, almost every word and sentence was altered amidst much criticism of my standard of English! Needless to say the paper was much improved and eventually accepted for publication. He also insisted that all co-authors of papers should justify their authorship by contribution to the research and names were listed in alphabetical order, an old tradition which only the Journal of Physiology observed at that time.

With new laboratory facilities in the Professorial Block and the introduction of radio-isotopes and more sophisticated equipment, research took a turn for the better but that is another story.

Concluding Remarks

As we look back to the years with Professor McFadzean, affectionately known as Lo Mac, we realise now that we were then young and naïve, and did not know that our lives would be forever changed by being mentored by this great teacher. As we age, we appreciate with awe the wisdom, intellect and enormous width and depth of knowledge of this man. Like other visionaries before him, he was way ahead of his time. More often than not, he had to work under most difficult conditions. We are proud and privileged to be able to share with our readers some of our memorable experiences.

References will be supplied upon request

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Department of Medicine, University of Hong Kong
Queen Mary Hospital, Hong Kong.

ANNUAL SCIENTIFIC MEETING (8-9 OCTOBER 2011)

The theme of the meeting was “Degenerative disease” with lectures in cardiometabolic disease, immunology, infections and neurological diseases. The Gerald Choa Memorial Lecture by Professor Joseph Sung was greatly appreciated by the audience for profound insights in teaching values in medical education.

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 2011 presented their papers. The prestigious Sir David Todd Lecture was presented by Professor Henry Lik Yuen Chan on his work on hepatitis B genomics and hepatocellular carcinoma.

Videos of Sir David Todd Lecture 2011 and Gerald Choa Memorial Lecture 2011 can be accessed on the HKCP website for the next three months, with the kind permission of the speakers.

The website link is <http://www.hkcp.org/news.htm>



PROF RICHARD YU PRESENTED THE 2011 GERALD CHOA MEMORIAL LECTURE MEDAL TO PROF JOSEPH SUNG



DR PATRICK LI, PROF RICHARD YU, DR LINDA PATTERSON, DR LESLIE E BOLITHO, DR MIKE JONES AND DR TAN KOK CHAI



PROF WK LAM, DR TERRY MOK, DR IVAN HUNG, PROF KY YUEN AND PROF RICHARD YU AT THE 'IMMUNOLOGY AND INFECTION' SYMPOSIUM



PROF KATHRYN TAN, DR JOHN MA AND DR NELSON WAT AT THE LUNCH SYMPOSIUM



PROF EK YEOH, PROF ROSIE YOUNG, DR DONALD YU, PROF PHILIP LI AND DR LORETTA YAM



PRESENTERS OF THE BEST THESIS AWARDS WITH THEIR SUPERVISORS AND DR CS LI AND PROF HENRY CHAN
FROM L->R DR TC CHAN, DR JAMES LUK, PROF HENRY CHAN, DR CS LI, DR CC YAU, DR HILDA WONG, DR KY CHEUNG, DR MICHAEL FU



PROF KS WONG, CHAIRMAN OF THE DISTINGUISHED RESEARCH PAPER AWARD FOR YOUNG INVESTIGATORS 2011

24TH ANNUAL GENERAL MEETING, 13TH CONGREGATION AND 25TH COLLEGE DINNER

At the AGM held on the 8 October 2011, Dr Patrick Li delivered his first report as President. He paid tribute to his successors for achievements which College proudly celebrates this Silver Jubilee Anniversary. He reported on the achievements of the College's various subcommittees in the past year. The ceremony proceeded with the conferral of Fellowships and Memberships officiated by a distinguished platform party. Honorary Fellowships were conferred to Professor Sir Ian Gilmore (Past President, Royal College of Physicians London), Professor KN Lai and Professor WK Lam.



The Silver Jubilee Dinner concluded the first day of the meeting, joined by distinguished guests. Presidents of our sister overseas colleges exchanged souvenirs to mark the occasion.

All guests and fellows received a commemorative publication entitled "Sapientia et Humanitas". This chronicles the development of medicine in Hong Kong, edited by Professor Richard Yu. In addition, a handsome College pin was presented to all dinner guests. The AJS McFadzean Oration was delivered by Professor Sir Ian Gilmore on the global challenge of alcohol and other drugs. For a special treat this year, a delightful face-changing performance rounded up an evening of entertainment enjoyed by all guests.

THE FELLOWSHIP CONFERRAL CEREMONY AND THE SILVER JUBILEE DINNER 2011



PRESIDENT PATRICK LI WITH THE OFFICIATING PLATFORM PARTY AT THE CONGREGATION FOR NEW FELLOWS



DR PATRICK LI PRESENTED A SOUVENIR TO DR YORK CHOW



FROM L->R DR DONALD LI, DR CH LEONG, DR LILIAN LEONG, PROF TF FOK AND PROF PHILIP LI



FROM L->R DR TAN KOK CHAI, PROF ALAN NG, PROF TK CHAN, PROF SIR DAVID TODD AND DR TF TSE



FROM L->R (FRONT) PROF KN LAI, PROF TK CHAN, PROF SIR DAVID TODD, PROF RICHARD YU (BACK) : DR DIANA SIU, DR PATRICK LI, LADY GILMORE, SIR IAN GILMORE, PROF WK LAM, DR SC LEUNG



A CHINESE PERFORMER DAZZLES GUESTS WITH MASK CHANGING PERFORMANCE

Distinguished Research Paper Award for Young Investigators 2011

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



Dr Hung Fan Ngai Ivan

Department of Medicine,
Queen Mary Hospital

PREVENTION OF ACUTE MYOCARDIAL INFARCTION AND STROKE AMONG ELDERLY PERSONS BY DUAL PNEUMOCOCCAL AND INFLUENZA VACCINATION: A PROSPECTIVE COHORT STUDY

Hung Ivan FN, Leung AY, Chu DW, Leung DM, Cheung T, Chan CK, Lam CL, Liu SH, Chu CM, Ho PL, Chan S, Lam TH, Liang R and Yuen KY

Clinical Infectious Diseases 2010;51(9):1007--1006



Dr Lee Pui Wai

Department of Medicine & Therapeutics,
Prince of Wales Hospital

IMPORTANCE OF DYNAMIC DYSSYNCHRONY IN THE OCCURRENCE OF HYPERTENSIVE HEART FAILURE WITH NORMAL EJECTION FRACTION

Lee, AP, Song, JK, Yip, GW, Zhang, Q, Zhu, TG, Li, C, Chan, A and Yu, CM

Eur Heart J. 2010;31:2642-9



Dr Leung Wai Hong Thomas

Department of Medicine & Therapeutics,
Prince of Wales Hospital

GENETIC PREDISPOSITION OF WHITE MATTER INFARCTION WITH PROTEIN S DEFICIENCY AND R355C MUTATION

Thomas W. Leung, Sze-Fai Yip, Ching-Wan Lam, Tsun Leung Chan, Wynnie W.M. Lam, Deyond Y.W. Siu, Y. H. Fan, Natalie P.H. Chan, H.S.Y. Liu, Li-Chong Chan, Ka-Sing Wong

Neurology 2010;75:2185-2189



Dr Ma Ching Wan Ronald

Department of Medicine & Therapeutics,
Prince of Wales Hospital

GENETIC VARIANTS OF THE PROTEIN KINASE C- β 1 GENE AND DEVELOPMENT OF END-STAGE RENAL DISEASE IN PATIENTS WITH TYPE 2 DIABETES

Ronald C.W. Ma, Claudia H.T. Tam, Ying Wang, Andrea O. Luk, Cheng Hu, Xilin Yang, Vincent Lam, Alfred W.H. Chan, Janice S.K. Ho, Chun-Chung Chow, Peter C.Y. Tong, Weiping Jia, Maggie C.Y. Ng, Wing-Yee So, Juliana C.N. Chan

JAMA.2010;304(8):881-889



Dr Wong Wai Sun

Department of Medicine & Therapeutics,
Prince of Wales Hospital

HIGH PREVALENCE OF COLORECTAL NEOPLASM IN PATIENTS WITH NON-ALCOHOLIC STEATOHEPATITIS

Vincent Wong, Grace Wong, Steven Tsang, Tina Fan, Winnie Chu, Jean Woo, Anthony Chan, Paul Choi, Angel Chim, James Lau, Francis Chan, Joseph Sung, Henry Chan

Gut 2011;60:829-36



The HKCP Council 2011-2012

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	<i>Prof Matthew Ng</i>
Education and Accreditation Committee	<i>Dr Loretta Yam</i>
Professional and General Affairs Committee	<i>Dr CP Wong</i>
Scientific Committee	<i>Prof YL Kwong</i>
Membership Committee	<i>Dr CS Li</i>
Examination Committee	<i>Prof CS Lau</i>
Administration and Finance Committee	<i>Dr TF Tse</i>
Research Committee	<i>Prof Lawrence Wong</i>
Synapse	<i>Dr Carolyn Kng</i>



Sir David Todd Lecture

Hepatitis B Virus Genomics and Hepatocellular Carcinoma

Henry LY Chan

Department of Medicine & Therapeutics,
Prince of Wales Hospital,
The Chinese University of Hong Kong

Advances in molecular biology technology in the last 2 decades have allowed detailed study of the viral mutations and genomic heterogeneity of hepatitis B virus (HBV). The first mutant discovered was precore stop codon mutation. It was reported in HBeAg-negative patients and initially thought to associate with fulminant hepatitis. Subsequent studies have suggested that it is merely one of the mechanisms of losing HBeAg by the virus. Another mutation that can down-regulate the production of HBeAg is the basal

core promoter mutation, which is located in the X gene upstream of the precore region. Based on the configuration of codon 15 and the stability of the epsilon of the precore region, these 2 mutants will be differentially selected during the course of HBeAg seroconversion. The commonest HBV genotypes in Southeast Asia are genotype B and C HBV. The higher HCC risk of genotype C HBV has been confirmed by longitudinal studies in Hong Kong and Taiwan. One possible carcinogenic mechanism is its association with

basal core promoter mutation, which has also been found a risk factor of hepatocellular carcinoma (HCC). Within genotype C HBV, subgenotype Cs is predominant in Southeast Asia and subgenotype Ce is predominant in East Asia. Subgenotype Ce HBV has been found to have the highest risk of HCC as compared to subgenotype Cs or genotype B HBV. The understanding of the carcinogenic mechanisms of these HBV strains may shed light into future therapeutics in the prevention and treatment of HBV-related HCC.



Best Thesis Award Gold Award Winner

Continuous use of antipsychotics and its association with mortality and hospitalizations in institutionalized older people with behavioral and psychological symptoms of dementia (BPSD): An 18-month inter-specialty prospective cohort study

By Dr CHAN Tuen Ching
Department of Medicine
Queen Mary Hospital

Objective

The aim of this study is to investigate the relationship between continuous use of antipsychotics for more than 6 months and mortality as well as hospitalization in a large group of older people with BPSD residing in residential care homes for elderly (RCHE).

Subject and method

It was an inter-specialty (Geriatrics and Psychiatry) prospective cohort study conducted in RCHEs of Hong Kong Western and Southern Districts from July 2009 to December 2010. Older residents were stratified into the exposed group (use of antipsychotics for more than 6 months) and control group (non-users). Demographics, co-morbidity according to Charlson Co-morbidity Index (CCI), Barthel Index [BI(20)],



DR TUEN CHING CHAN AND DR PATRICK LI

Background

Previous meta-analysis suggested that antipsychotics were associated with short-term increase in mortality in dementia patients with behavioral and psychological symptoms (BPSD). In 2005, the Food and Drug Administration (FDA) issued a “black box” warning on the use of antipsychotics in BPSD. Subsequent observational studies, however, showed conflicting results. Several retrospective studies suggested that current user of antipsychotics did not experience a higher mortality. In view of the abovementioned controversies and the lack of suitable pharmacological alternative for BPSD, further research on this topic is indicated.

Abbreviated Mental Test (AMT), vaccination status for Human Swine Influenza (HSI), seasonal influenza and Pneumococcus were collected at baseline. Subjects were followed up for 18 months. All-cause mortality and hospitalizations were recorded.

Results

599 older people with dementia from nine RCHEs were included into the study. 199 older people were in the exposed group and 400 older people were in control group. The 18-month mortality rate for the exposed group was 25.1% while that for control group was 28.2% ($P=0.38$). The exposed group had a lower rate of all-cause hospitalization than that of the control group [56 (0-167) per 1000 person-months vs 111 (56-278)

per 1000 person-months; median (interquartile range), $p<0.001$]. The rate of hospitalizations for acute conditions was also lower in exposed group [56 (0-111) per 1000 person-months vs 111 (0-222) per 1000 person-months, $p<0.001$]. The difference remained statistically significant after ordinal logistic regression.

Conclusion

The continuous use of antipsychotics for more than 6 months for BPSD was not associated with increased mortality among institutionalized older people. In addition, appropriate use of antipsychotics can lead to decreased hospitalization.

Best Thesis Award Silver Award Winner

Presence of an in-situ component is associated with reduced biological aggressiveness of invasive breast cancer

By Dr WONG Hiu Yan Hilda
Department of Medicine
Queen Mary Hospital



DR HILDA WONG AND DR PATRICK LI

Background

The metastatic propensity of primary invasive ductal carcinoma (IDC) of the breast correlates with axillary node involvement and expression of the proliferation antigen Ki67, whereas ductal carcinoma in situ (DCIS) do not metastasize. To clarify whether concomitant DCIS affects IDC prognosis, Ki-67 expression and lymph node status of size-matched IDC subgroups with (IDC-DCIS) and without DCIS (pure IDC) were compared.

Methods

Tumor data obtained from 1355 consecutive female patients undergoing surgery for primary breast cancer were analyzed. Subgroups were defined by the association of IDC with or without DCIS, as well as by size and receptor expression.

Results

Corrected for IDC size, IDC-DCIS was more often ER-positive ($p = 0.002$), PR-positive ($p = 0.114$)

and/or HER2-positive ($p < 0.0005$) than was pure IDC. Ki-67 was lower in IDC-DCIS than in pure IDC ($p = 0.02$), and declined as the DCIS component enlarged ($p < 0.01$). Node involvement and lymphovascular invasion in IDC/DCIS increased with the size ratio of IDC to DCIS ($p < 0.01$). Although preliminary at a median follow-up of 29.3 months, 5-year cancer-specific disease-free survival favored IDC-DCIS over size-matched pure IDC (97.4% vs. 96.0%).

Conclusion

IDC co-existing with DCIS is characterized by lower proliferation rate and metastatic propensity than pure IDC, especially if the ratio of DCIS to IDC size is high. It may be postulated that IDC-DCIS is biologically distinct from pure IDC, reflecting an incremental pathway of tumor evolution involving an intermediate DCIS precursor.

Best Thesis Award Bronze Award Winner

Factors associated with the risk of thymoma at the presentation of myasthenia gravis

By Dr CHEUNG Kit Yan
Department of Medicine & Geriatrics
Tuen Mun Hospital

Objective

To determine the demographic, clinical as well as autoimmune antibody characteristics that may differentiate between thymoma associated MG and non-thymoma associated MG in the early course of the disease. Comparison for the clinical courses during the whole follow-up period of MG patients with or without thymoma was also made.

Methods

We retrospectively evaluated MG patients followed up at Tuen Mun Hospital in Hong Kong from year 2000 to 2010. Myasthenia gravis was diagnosed by the typical history and signs of fluctuating and fatigable muscle weakness with its associations with the following variables: the titre of anti-acetylcholine receptor antibody, an unequivocal clinical improvement in response to anticholinesterase inhibitors, and a decremental pattern on repetitive nerve stimulation test and the status of thymoma on imaging study. The



DR KIT YAN CHEUNG AND DR PATRICK LI

Background

Thymoma is found in 10-15% of patients with myasthenia gravis (MG). Thymoma associated MG is considered to be a more severe disease and all thymoma patients are indicated for thymectomy. It is unclear whether certain clinical or serological findings of MG patients at the time or early after the diagnosis can predict the presence of thymoma.

baseline characteristics, clinical presentation, courses of disease during the early and the whole follow-up periods, treatments offered, anti-acetylcholine autoantibody titers as well as the other associated autoimmune diseases were recorded and compared between the groups with or without thymoma.

Results

A total of 184 MG patients who fulfilled the criteria were identified and followed up. Thymoma was diagnosed in 19.6% of them. The mean age of patients with thymoma was older (55.08 vs 44.56; $p=0.042$); female sex was more prevalent (female vs male ratio of 1.4 vs 1) but the sex ratio was similar when compared with those without thymoma. Although the presenting symptoms and baseline MGFA scores were similar, thymoma associated patients had a significantly more rapid deterioration of MG and more severe disease with higher mean of maximum MGFA score (2.81 vs 1.26; $p<0.001$) within the first 6

months of follow-up, and were also more likely to develop generalized MG eventually (83.3% vs 38.5%; $p<0.001$) when compared with non-thymoma group. All thymoma patients had positive anti-acetylcholine receptor antibody and a higher titre was recorded. Their long term outcome was comparable to non-thymoma associated MG patients with similar MGFA score on last follow up. Autoimmune disease was present in 37% of patients overall with thyroid disease being the commonest association. Using multivariate logistic regression model, a high MGFA score at 6 months (MGFA 3-5) and a very high anti-AChR titre ($>19\text{nmol/L}$) were predictive of thymoma.

Conclusions

Myasthenia gravis patients at risk of thymoma could be identified during the early course of the disease. A high MGFA score at 6 months and a very high anti-AChR titre predicted the occurrence of thymoma.



Clarification on the Date of HPT completion

IMPORTANT news for all Trainers and Trainees

At its 243rd Meeting of 13 December 2011, the Council clarified and determined the "Date of HPT Completion" to be: **"Completion of all HPT training requirements plus a pass in the Exit Assessment of the relevant Speciality Board"**. The "Date of HPT completion" should thus be

- (1) The date of the Exit Assessment which a candidate has achieved a "Pass", if the duration of training is more than 36 months.
- (2) The end of 36 months of HPT training if the Trainee acquires a pass in the Exit Assessment* before the end of his/her HPT training.

* The rule that "Trainees may undergo Exit Assessment within the last three months of their HPT training" has not been changed.

The above change serves to align the definition of HPT training completion with the principle adopted by the College in the definition of "Date of BPT completion", which has always been "completion of 36 months of BPT training plus a pass in the HKCP Intermediate Examination/MRCP".

EVENTS AND ANNOUNCEMENTS



Congratulations

to newly elected Fellows of the Royal College of Physicians London (2011)

Chan Annie On On Chu Leung Wing Lao Wai Cheung

News for Fellows of the Royal College of Physicians, Edinburgh

The next signing of the roll ceremony will be held in Hong Kong on 12 October 2012. Details will be announced later.

EXAMINATIONS AND RESULTS



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 PACES examinations

October 2001	36/72 = 50%	March 2007	44/74 = 59%
February 2002	34/74 = 46%	June 2007	44/74 = 59%
October 2002	29/72 = 40%	October 2007	36/55 = 65%
February 2003	30/69 = 43%	March 2008	36/74 = 49%
October 2003	27/59 = 46%	October 2008	29/65 = 45%
March 2004	39/64 = 61%	February 2009	39/75 = 52%
October 2004	26/69 = 38%	October 2009	24/72 = 33%
March 2005	35/75 = 47%	March 2010	33/75 = 44%
October 2005	28/75 = 37%	October 2010	40/74 = 54%
March 2006	36/75 = 48%	February 2011	23/66 = 35%
October 2006	16/73 = 22%	October 2011	34/70 = 49%

Pass List of Joint HKCPIE/MRCP(UK) October PACES 2011

Chan Chong Ching	Chan Ka Pang
Chan Wai Keung	Cheng Yuet Wong
Chi Man Sum	Choi Wai Lok
Chung Chi Tung	Fong Ka Leuk
Ho Lo Yi	Lai King Son
Lai Wing Chee	Lam Yau Yui
Lam Yip Shun	Lau Chi Cheung Michael
Lau Ka Ki	Lau Wai San Angela
Lee Chun Hong Alan	Leung Hoi Yin
Leung Kwan Hung	Li Chun Man
Li Tsz Ching	Liu Hin Wai Henry
Ma Sze Ho	Man Lai Kwan
Poon Wai Ling Jessica	Sum Chun Yue
Ting Wan Man	Wong Cheuk Lun
Wong Nga Yin	Wong Tin Long Marc
Wong Yick Hei	Yu See Yan Sharon

Candidates from overseas and not registered with the HKCP are not included in this list

Pass Rates for the MRCP(UK) Part I examination

	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%)
Sept 11	64	49 (77%)

Pass rate for the Joint HKCPIE/MRCP(UK) Part II (Written) examination

	Sitting	Pass
2 Jul 02	53	27 (51%)
13 Nov 02	50	24 (48%)
13 Aug 03	110	62 (56%)
10 Dec 03	54	31 (57%)
28 Jul 04	65	42 (65%)
8 Dec 04	46	32 (70%)
13 Apr 05	32	15 (47%)
27 Jul 05	76	56 (74%)
7 & 8 Dec 05	26	16 (62%)
12&13 Apr 06	29	13 (45%)
26 & 27 Jul 06	91	68 (75%)
6 & 7 Dec 06	33	18 (55%)
11 & 12 Apr 07	34	22 (65%)
25 & 26 Jul 07	80	70 (88%)
5 & 6 Dec 07	19	13 (68%)
9 & 10 Apr 08	21	13 (62%)
30 & 31 Jul 08	47	36 (77%)
3 & 4 Dec 08	17	10 (59%)
8 & 9 Apr 09	32	25 (78%)
29 & 30 Jul 09	50	43 (86%)
25 & 26 Nov 09	12	7 (58%)
7 & 8 April 10	41	34 (83%)
28 & 29 July 10	25	19 (76%)
24 and 25 Nov 10	8	2 (25%)
6 and 7 April 11	45	35 (78%)



Professor Sir Ian Thomas Gilmore

BA, MA, MBBCh(Cantab), MD(Cantab), FRCP(London)

John MacKay

Sir Ian Gilmore is no stranger to the medical world in Hong Kong. He was an invited participant at the Second International Congress of the Hong Kong Academy of Medicine (HKAM); attended the 10th Anniversary Scientific meeting of the HKAM as Registrar of the Royal College of Physicians (RCP), London; attended the 20th Anniversary of the Hong Kong College of Physicians (HKCP), as President of the RCP London; was the Richard Yu lecturer in 2010 during the 'Advances in Medicine Symposium of the Chinese University of Hong Kong; and most recently attended the 25th Anniversary scientific meeting of the HKCP, at which he was presented with an Honorary Fellowship and delivered the AJS McFadzean Oration.

He is a consultant physician and gastroenterologist at the Royal Liverpool and Broadgreen University Hospitals and Honorary Professor at the University of Liverpool.

Ian Gilmore's schooling was at the Royal Grammar School at Newcastle, a prestigious seat of learning from 1545 with a Royal charter from Queen

Elizabeth 1st of England. His father was at that time a chest physician working in the north-east of England. He had qualified at St. Andrew's University in 1935, and had served in the army in the Middle-East during World War II. He developed lung cancer but survived a lung resection in 1974, and happily lived another 34 years to die aged 94.

From Newcastle, Ian Gilmore went up to Cambridge University, followed by clinical training at St. Thomas's Hospital in London. He accumulated a number of awards before graduating in 1971.

He met Hillary, a Staff Nurse, while he was working as a senior house officer at the Intensive Care Unit at St. Thomas's Hospital. They married two years later in 1974. Their three children are carrying on the family tradition, two are doctors and the third a Public Health analyst

Dr. Gilmore was appointed registrar in general medicine and gastroenterology at St. Thomas's in 1974-75. He was Medical Research Council research Fellow in the Gastrointestinal Laboratory and honorary senior medical registrar 1976-77; senior medical registrar in

general medicine and gastroenterology Charing Cross Hospital in 1978-79 and in 1980, MRC travelling Fellow at University of California San Diego.

In 1980 he was appointed a consultant physician and gastroenterologist at the Royal Liverpool and Broadgreen Hospitals, Liverpool: medical director 1995-98; University of Liverpool honorary lecturer Department of Medicine 1980-98, Chairman of the Faculty of Medicine 1991-92, and Professor 1999 till now.

Professor Gilmore's prolific research contributions to the literature on hepatology and biliary disease have won him numerous research grants and awards. He is a referee for scientific journals such as The Lancet, British Medical Journal, Gastroenterology, Gut, and Hepatology.

He was the author of a report on the Gulf War Syndrome in 1995, and later served as the Medical Research Council's advisor on the syndrome from 1997-2000.

In 2001 he chaired a RCP working party that published a report, "Alcohol-



SIR GILMORE WAS CONFERRED HONORARY FELLOWSHIP, HKCP

can the NHS Afford it? A blueprint for a coherent alcohol strategy”.

During his time as President of the Royal College of Physicians of London from 2006-2010, he used that platform to make many statements on the misuse of alcohol in UK, and initiated the ‘Alcohol Health Alliance UK’. He was appointed to the Chair of the European Alcohol and Health Forum Science Group.

In June 2010 he received a Knighthood from Queen Elizabeth for his tremendous contributions and services to medicine.

Sir Ian, in his valedictory message to colleagues on relinquishing office as President of the Royal College of Physicians, called for laws to be reconsidered with a view to decriminalising illicit drugs use: thus drastically reducing crime and improving health.

‘Sir Ian said he agreed with the argument put forward by Nicholas Green QC, the chairman of the Bar Council of England and Wales, who said last month that it was “rational” to consider “decriminalising personal drug use”.

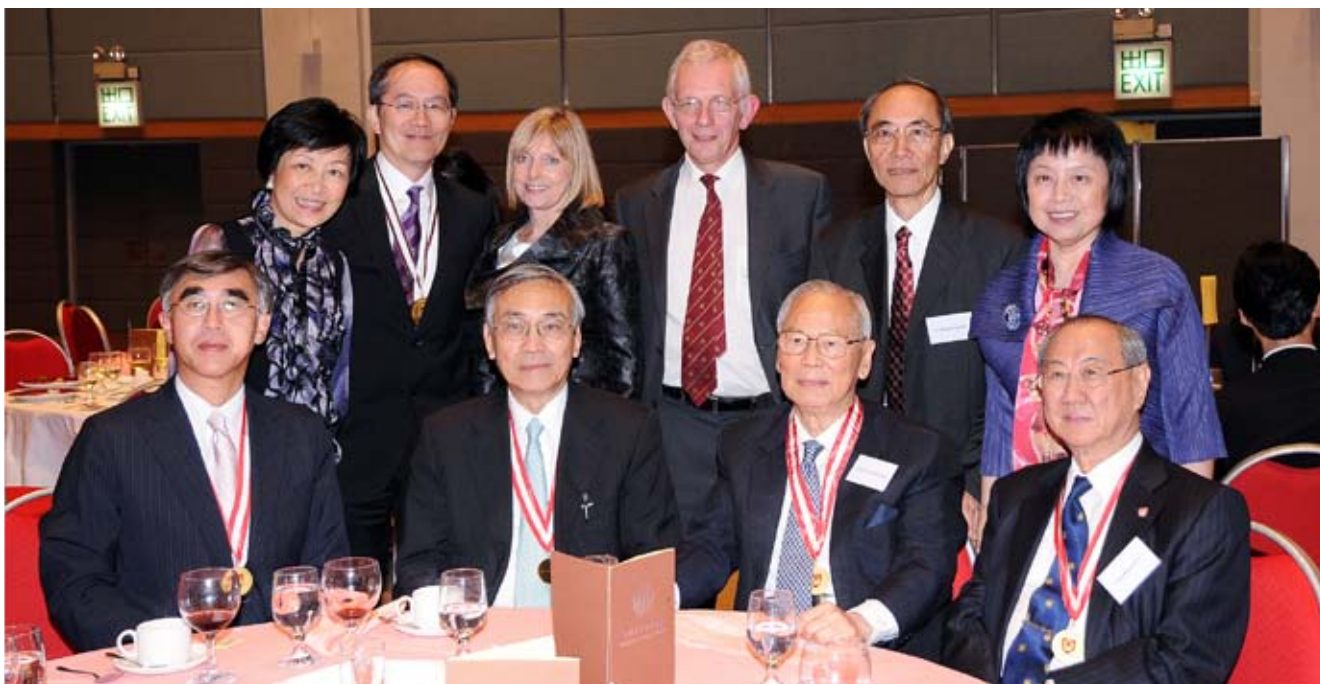
Sir Ian also said he was persuaded by a recent article in the British Medical Journal, which argued that the prohibition of drugs had been “counterproductive”, made many public health problems worse, and stimulated organized crime and terrorism.’ Daily Telegraph 17 Aug 2010.

He was overwhelmed by the resultant media interest, stimulated by an organization called ‘Transform Drug Policy’.

The honorary Fellowship bestowed on him by the HKCP this year was in recognition of his lifetime of important contributions to medicine and to his particular contribution in support of the academic and professional exchanges between Hong Kong and UK. In his AJS McFadzean Oration Sir Ian Gilmore spoke eloquently and with conviction on the dangers of alcohol abuse, backing



SIR GILMORE WITH SIR TODD AND PROF YU



FROM L->R (FRONT) PROF. KN LAI, PROF TK CHAN, PROF SIR DAVID TODD, PROF RICHARD YU
(BACK) : DR DIANA SIU, DR PATRICK LI, LADY GILMORE, SIR IAN GILMORE, PROF WK LAM, DR SC LEUNG

up his arguments with starkly illustrative graphs. This was a well-chosen topic for a jurisdiction that has recently removed all duty from Wine!

Sir Ian's present activities include the current Presidency of the Liverpool Medical Institution, which dates back to 1779 and has been in its present building since 1837 (<http://www.lmi.org.uk/>). Next June he also becomes President of the British Society of Gastroenterology for a two year term. He is a member of numerous specialist organisations, including the British, European, American and International Associations for the Study of Liver Disease.

He is about to chair the Board of Liverpool Health Partners, a partnership between the University and the teaching hospitals creating an Academic Health Sciences System to help align research, innovation, service and training. He is looking forward to this exciting project. He is also discussing with colleagues in Australia and USA the possibility of some global advocacy group on the health harms from alcohol.

Asked to give advice to young doctors Professor Gilmore said, " I don't believe in planning ahead too much – if you enjoy doing something and you do it well, the next opening will come along".

This non-stop career activity and achievement, and family responsibilities, has left him with little time to develop many leisure activities. He and Hillary enjoy golf, and he supports Liverpool FC. It appears that you cannot live and work in Liverpool without some local affiliation. Next year promises to be one of particular excitement for the Gilmore family: the first grandchild is due in January, and the wedding of his eldest child is planned for the summer.

Professor Gilmore had hardly left Hong Kong after the Hong Kong College of Physicians meeting before he was back again. This time he was a plenary speaker at the Seminar on

Alcohol and Health organised by the Department of Health. His topic was, 'Global perspective and experience in prevention of alcohol related disease'. At the seminar the Department of Health launched the 'Action Plan to Reduce Alcohol-Related Harm in Hong Kong'. Among the planned 17 Actions is one to address the fact that; 'In Hong Kong there is no age restriction on off-premises sales of alcohol'!

Sir Ian Gilmore would not surprise us if he were back in Hong Kong before long to support anti-alcohol actions of the Department of Health, and to meet with his many friends.



PRESENTATION OF THE AJS MCFADZEAN ORATION MEDAL 2011