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SYNAPSE



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Gerald Choa Memorial Lecture 2011

THREATS IN THE MEDICAL PROFESSION



Professor Joseph J.Y. Sung Vice-Chancellor, The Chinese University of Hong Kong

I am greatly honored to be invited to give the Gerald Choa Memorial Lecture. Being a graduate in the 80's, I do not have the luck of being Prof. Choa's student but I feel privileged to work under him for a brief period.

Prof. Gerald Choa had a unique career in that he successively worked for the University of Hong Kong, the Hong Kong Government and the Chinese University of Hong Kong and, after retirement from CUHK, was in private practice for some 15 years. In those days, professors were authoritative figures in the ward, medicine and surgery were the most popular specialties for young and brightest minds in medical school, and academic positions were very much envied jobs for graduates. But I believe that we are standing at the cross road of the medical profession. Our values have been challenged and perceptions to the healthcare profession have changed. What are the impacts on the medical profession? As academics and senior members of the profession, how should we react to these changes?

Young doctors and trainees argue for "reasonable" work hours. Working overtime or during public holidays will require monetary compensations. Medicine and Surgery are no longer the most wanted jobs among trainees. Instead of wishing to join the academia or public hospitals as consultants, trainees and fellows rush to the private sector soon after they finish training. I remember when I was a medical student, I saw professors, lecturers and senior consultants working day and night in their clinic, wards, their office and laboratories. Patient care was a dedication, research was a passion and teaching was an enjoyment. There

were many examples that these characters never considered his/her work as work, but a dedication to the patients, a honor to be in the medical service and an offering in the alter of professionalism. Things have changed a bit now.

In those days, we graduates had to go to Medical and Health Department to attend an interview for a job. In those days, Medicine, Surgery, Pediatrics, O&G are the most popular jobs. Unfortunately, more often than not, when you asked for a training position in Medicine, you would be sent to Forensic Medicine. When you indicate your interest is Surgery, you will go to Anesthesiology. But today, the ROAD to success (or a good life) is no longer demanding jobs in Medicine, Surgery or Pediatrics, O&G. the positions that attracts most of our graduates, include the top students of both medical schools are Radiology, Ophthalmology, Anesthesiology and Dermatology. I don't mean that these specialties are of less importance. I am, however, saddened by the motivation behind choosing these specialties, i.e. the promotion prospect is much faster in these specialties, the monetary return is much bigger, the "quality of life" is so much better. That, I am afraid, reflects a change in the values of our society and our students.

I don't think we can blame our young doctors, graduates or even medical students. The work environment has changed and the satisfactions are no longer there. I believe that most students, when they enter a medical school, or even when they graduate, their hearts are filled with warm blood of serving the sick, academic excellence and professionalism. Unfortunately, humanistic, patient-centered attitude fostered in classrooms do not always find their way into

the clinic and hospital. When turnover rate of beds, hospital budget and mishap hits the headline of newspaper, empathic attitudes and behaviors make little sense. The loss of autonomy in medical decision-making, the burdensome and time-consuming paperwork, the fear of malpractice litigation, the financial disincentives... threaten clinical livelihood and the sense of responsibility and professionalism. It is, I believe, more difficult to find satisfaction and self-actualization in the clinical job of our younger generations of doctors. Healthcare workers become physically and emotionally exhausted. Physicians, nursing and allied health workers find themselves frustrated and demoralized by a work environment devoid of respect and compassion for its employees. They leave the practice of medicine, especially hospital medicine, in unprecedented numbers.

In a study of UK physicians, lifestyle and other interests in life are the predominant reasons for considering leaving medicine. There is the changing relationship between physicians and their patients. I am not sure when and where did healthcare workers start calling themselves "providers". When physicians are "providers", patients become "consumer". Consumers are entitled to the best service, choose their doctors, their surgery, their medicine because



there is a lack of trust. If they are satisfied with the product, they will go to consumer council. On the other hands, providers are providing the most defensive, most "cost-effective" and most convenient way of treatment for their consumers. The advancement of diagnostic tests, imaging technology and clinical guidelines and algorithms have further reduced our use of discretion and clinical judgment. We talk less to patients but rely on MRI and blood tests. We explain less to them as the guidelines have spelled out clearly. To us, they are merely an organ, a disease and (sometime) a problem, instead of a person. While science and technology in Medicine advance exponentially, our patients' satisfaction decline paradoxically.

William Osler said "The good physician treats the disease, the great physicians treats the patient who has the disease". "It is much more important to know what sort of a patient has a disease, than what sort of a disease a patient has". The fundamental problem in our healthcare system is a lack of "meaning". The meaning of professionalism, of serving (without appropriate reward for labor) of professional ethics are not the same. Neuwirth said "One of the greatest tragedies of 20th C is that in developing the means, we have forgotten the meaning". We have forgotten that Practice of medicine is primarily a humanistic endeavor, not a scientific one.

How should we go back to the basic? How do we teach values in Medicine? What needs to be done to save our profession? I don't think we can teach values and ethics in classrooms. It has to be taught by example, and we are their examples. Mindful, dignified and collaborative healthcare service requires time and passion – the time to listen, and the passion to create meaningful relationship with the patient. Let us exemplify what doctors and healthcare workers should do.

Let me finish by paying tributes to my teachers Prof. Gerald Choa, Prof. John Vallence Owen, Prof. Sir David Todd and many others who have dedicated their life to serve and to upkeep professionalism.



Congratulations to HKCP Fellows on recent achievements

Professor Philip K. T. Li received the 'International Distinguished Medal' 2012 from the National Kidney Foundation, USA

National Kidney Foundation, USA has awarded the 'International Distinguished Medal' 2012 to Professor Philip K.T. Li, Honorary Secretary of our College, on 11th May 2012 during the National Kidney Foundation Spring Clinical Meeting held in Washington, DC, USA.



(Photo 1)
NKF INTERNATIONAL
DISTINGUISHED MEDAL

This award was established to honor the achievement of individuals who have made significant contributions to the field of kidney disease. (Photo 1) The Foundation President presents medals each year to recognize the accomplishments of individuals through their clinical work, roles in academia and scientific discoveries.

This year, the Award was presented by Dr. Lynda A. Szczech, President of the National Kidney Foundation, USA to Professor Philip K. T. Li. (Photo 2)



(PHOTO 2) AWARD CEREMONY WITH NKF PRESIDENT

Professor Richard YH Yu was conferred the Degree of Doctor of Social Science, honoris causa

This degree by the Chinese University of Hong Kong was awarded to Professor Richard Yu in recognition of his contributions to the development of the University. An excerpt of the citation delivered by Professor David Parker (full version on the website <http://www.cpr.cuhk.edu.hk/resources/press/pdf/4ee9a4f52b59e.pdf> page 20-23) follows.

The Citation

The famous Song Dynasty scholar Fan Zhongyan once said, 'If I cannot be a good minister, I would like to be a good physician.' Like a good minister, a good physician is committed to 'benefiting the people and remedying the world's woes'.

Professor Richard Yu Yue-hong was born into a medical family, the second son of Dr Yu Chiu-kwong, who had served as the Medical Superintendent of the Tung Wah Group of Hospitals and the Kwong Wah Hospital. Dr Yu senior was a physician of great skill and kindness of heart, and his four sons, under his influence, all became outstanding practitioners in the medical profession. Professor Richard Yu graduated from the University of Hong Kong with the MB BS degrees in 1958, and obtained his PhD in 1966 and MD degree in 1972. Professor Yu commenced his private practice in 1973, but his abiding interest in medical education has never waned. At the moment he is an Honorary Professor at the Department of Medicine, HKU and at the Department of Medicine and Therapeutics, CUHK, an Honorary Consultant Physician at the Ruttonjee and Princess Margaret Hospitals, a Fellow of the Academies of Medicine of Hong Kong and Singapore, and of the Royal Colleges of Physicians in the United Kingdom and Australia.

Professor Yu is a pioneer of nephrology in Hong Kong, having established the discipline as a unit on its own in the Department of Medicine at HKU as early as the 1960s. He was founding member and Honorary Treasurer of the Hong Kong Society of Nephrology in 1979. In 2006, the Hong Kong Society of Nephrology established the Richard Yu Endowment Fund, to which Professor Yu generously contributed, has since supported many doctors and investigators in research on renal diseases.

Professor Yu is a good physician and a good statesman, too: he knows only too well that social stability hinges much on a well-structured system of medical and health care. Over the years he has been an enthusiastic supporter of the work of the Hong Kong College of Physicians, having been the College's founding Honorary Secretary (1986 – 1995), Vice-President (1993 – 95) and eventually President (1998 – 2004). In his effort to help maintain good order in the public medical sector, Professor Yu has participated actively in the governance of many public hospitals, being on the governing committees of Ruttonjee Hospital and Tang Shiu-kin Hospital (1992 – 2002), and Queen Mary Hospital and Tsan Yuk Hospital (from 2003). Being a medical practitioner with the patients' well-being always in mind,



he became a member of the Pneumoconiosis Compensation Fund Board, and the Chairman of its Committee on Research, Education, Publicity and Rehabilitation. He was also a member of the Review Committee of the Trust Fund for Severe Acute Respiratory Syndrome, where his concern was whether the victims were reasonably compensated and effectively treated for rehabilitation. In recognition of his distinguished contribution to medical education in Hong Kong and the welfare of the community, the Government of the HKSAR awarded the Silver Bauhinia Star to Professor Richard Yu in 2010.

An ardent supporter of the Chinese University, Professor Yu has made generous donations to the Chinese University on many occasions. He has given funds aimed at the improvement of our clinical facilities, and in support of medical research. A number of substantial scholarships have been instituted by him. These include the Richard Yu Scholarships and the Carol Yu Louey Kwok-wan Scholarships.

When he can find some leisure time amidst his many commitments and public offices, Professor Yu has been an enthusiastic photographer for many years. Earlier this year he gave a charity exhibition of his photographic works in favour of the Hong Kong Breast Cancer Foundation.

Mr. Chancellor, it is my honour to present to you Professor Richard Yu Yue-hong, outstanding physician, educationist and philanthropist, for the award of the degree of Doctor of Social Science, *honoris causa*.

Newly Elected Fellows of The Royal College of Physicians, London

Elected in 2012

Dr Au Wing Yan	Dr Chan Yat Sun Joseph	Dr Chan Ngai Yin	Prof Lee Lai Shun Nelson
Dr Lee Shun Wah Jenny	Prof Tam Lai Shan	Dr Wong Siu Ming Raymond	Dr Ying King Yee Shirley

Newly Elected Fellows of The Royal College of Physicians, Edinburgh

Elected since 1 February 2010

Dr Chan Wing Sze Carmen	Dr Chan Chi Kin	Dr Chan Kam Hon	Dr Chan Pui Yiu Nicola
Dr Chen Yi Tin	Dr Cheng Cheung Wah Boron	Dr Cheng Hing Ming	Dr Cheung Chun Ming
Dr Chiu Ming Chee	Dr Chow Kai Ming	Dr Chow Chik Cheung Vincent	Dr Chung Tin Hei
Dr Fung Tang Tat Konrad	Dr Hung Fan Ngai Ivan	Dr Hung Cheung Tsui Lawrence	Dr Jim Man Hong
Dr Ko Wai San Fanny	Dr Kong Pik Shan Alice	Dr Kwok Man Leung	Dr Lai Wai Keung Steve
Dr Lam Bing	Dr Lam Chi Leung David	Dr Lam Man Fai	Dr Lam Yat Yin
Dr Lam Yui Ming	Dr Lau Chun Wing Arthur	Dr Lee Cheuk Kwong	Dr Leung Yu Hung
Dr Li Ho Lun Terrance	Dr Liu Sung Yu Herman	Dr Ma Ching Wan Ronald	Dr Mok Mo Yin
Dr So Kit Ying Loletta	Dr So Wing Yee	Dr So Yui Chi	Dr Tang Hon Lok
Dr Tsang Chi Chung	Dr Tsang Wing Hang Janice	Dr Tsang Kin Lun	Dr Tsang Tak Yin Owen
Dr Tsang Woon Choy Steven	Dr Tse Chi Tat Ian	Dr Tsui Chung Kan	Dr Wong Tin Yau Andrew
Dr Wong King Yan Matthew	Dr Wong Wai Sun Vincent	Dr Wong Yuk	Dr Yeung Chi Keung
Dr Yeung Shing Joseph			

EXAMINATIONS AND RESULTS

Passing rates for the PACES over the past years:

October 2001	36/72 = 50%	June 2007	44/74 = 59%
February 2002	34/74 = 46%	October 2007	36/55 = 65%
October 2002	29/72 = 40%	March 2008	36/74 = 49%
February 2003	30/69 = 43%	October 2008	29/65 = 45%
October 2003	27/59 = 46%	February 2009	39/75 = 52%
March 2004	39/64 = 61%	October 2009	24/72 = 33%
October 2004	26/69 = 38%	March 2010	33/75 = 44%
March 2005	35/75 = 47%	October 2010	40/74 = 54%
October 2005	28/75 = 37%	February 2011	23/66 = 35%
March 2006	36/75 = 48%	October 2011	34/70 = 49%
October 2006	16/73 = 22%	February 2012	32/74 = 43%
March 2007	44/74 = 59%		

Passing rate for the Part I examination for the years 2002 – 2012:

	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%)
Jan 12	45	28 (62%)

Passing rate for the Joint HKCPIE/MRPC(UK) Part II (Written) examination for the past years:

	Sitting	Pass
2 Jul 2002	53	27 (51%)
13 Nov 2002	50	24 (48%)
13 Aug 2003	110	62 (56%)
10 Dec 2003	54	31 (57%)
28 Jul 2004	65	42 (65%)
8 Dec 2004	46	32 (70%)
13 Apr 2005	32	15 (47%)
27 Jul 2005	76	56 (74%)
7 & 8 Dec 2005	26	16 (62%)
12&13 Apr 2006	29	13 (45%)
26 & 27 Jul 2006	91	68 (75%)
6 & 7 Dec 2006	33	18 (55%)
11 & 12 Apr 2007	34	22 (65%)
25 & 26 Jul 2007	80	70 (88%)
5 & 6 Dec 2007	19	13 (68%)
9 & 10 Apr 2008	21	13 (62%)
30 & 31 Jul 2008	47	36 (77%)
3 & 4 Dec 2008	17	10 (59%)
8 & 9 Apr 2009	32	25 (78%)
29 & 30 Jul 2009	50	43 (86%)
25 & 26 Nov 2009	12	7 (58%)
7 & 8 April 2010	41	34 (83%)
28 & 29 July 2010	25	19 (76%)
24 and 25 Nov 2010	8	2 (25%)
6 and 7 April 2011	45	35 (78%)
23 and 24 Nov 2011	32	25 (78%)
28 and 29 March 2012	55	43 (78%)

Dates for Joint HKCPIE/MRCP(UK) examinations in 2013

Part I	
15 January 2013	10 September 2013
Part II (Written)	
10 – 11 April 2013	11–12 December 2013
PACES	
18 – 22 March 2013	7 – 11 October 2013

Specialty Update in Infectious Disease

Outbreak of 2009 H1N1

Influenza in Hong Kong

Thomas Sik-To LAI, Owen Tak-Yin TSANG

Department of Medicine and Geriatrics, Princess Margaret Hospital
Hospital Authority Infectious Disease Centre

In the twentieth century, the world experienced three influenza pandemics: 1918, 1957 and 1968. Since then, the world has experienced one pandemic: 2009, caused by the H1N1 influenza A virus.

In terms of the loss of human lives, the 1918 pandemic (Spanish flu) was unprecedented in modern times. More people died during the pandemic than were killed in the First World War. Worldwide, at least 50 million people are thought to have died, with unusually high numbers of deaths in young and healthy people. In the influenza pandemic of 1957-58 (Asian flu), although the proportion of people infected was high, the illness was relatively mild, resulting in milder effects and fewer deaths. It is estimated that the Asian flu caused two million deaths worldwide. The 1968-70 pandemic (Hong Kong flu) was also relatively mild. It affected mainly the elderly and is thought to have caused about one million deaths globally.

Starting in March 2009, the 2009 H1N1 influenza pandemic caught the world by surprise since the focus of attention had been on human avian influenza in the prediction for the coming pandemic. A new H1N1 influenza virus derived from human, swine and avian strains was initially reported in Mexico and subsequently spread around the world. The first case of 2009 H1N1 influenza

appeared in Hong Kong in 1st of May 2009.

It had been the belief all along that the next pandemic would originate from Asia. The aetiological agent was supposed to be a new strain of influenza such as H5N1 and a high mortality rate was expected. Instead, the pandemic originated from Mexico, it involved a variant of H1N1, representing a quadruple reassortment of genetic material from 2 swine strains, one human and one avian strain of influenza¹. It was associated with an extraordinarily low mortality rate of about 0.02% compared with mortality rate of 2.4% from the much more lethal Spanish flu.

Though the disease was mild in the majority of people, in a small proportion of those infected, it caused death due to viral pneumonia and respiratory failure. Most cases occurred in persons < 50 years old and the highest incidence was in young people 10-19 years of age. The relative sparing of the older population (> 60 years old) possibly resulted from their previous exposure to antigenically related influenza viruses early in their life, conferring cross protective antibodies². Besides young age as a risk factor, other important risks for poor outcome were chronic lung diseases, cardiac diseases, immunosuppressive conditions, diabetes mellitus, pregnancy and obesity³. For all pregnant women, the odds ratio for

intensive care admission was 7.4, with a staggeringly high figure of 13.2 for those in the third trimester. The odds ratio for death among patients with morbid obesity (BMI > 40 kg/m²) was 7.6.

The 2009 H1N1 influenza displaced seasonal influenza almost completely in 2009 and the annual mortality rate was less than that of seasonal flu. Thus, there appears to be an advantage for the pandemic (H1N1) flu superficially. However, with seasonal flu, 90% of lethal cases are in persons > 65 years of age; in the 2009 flu pandemic, almost 90% of deaths were in persons < 65 years of age⁴. Analysis of life-years lost shows that this pandemic influenza has a much worse outcome than that of most flu seasons⁵.

The incubation period of this pandemic H1N1 influenza virus is estimated to be 1.5 to 3 days. However, it can extend to 7 days in some cases⁶. Most of the clinical symptoms of this novel H1N1, including, fever, cough, sore throat and rhinorrhoea, are indistinguishable from those of seasonal influenza. However, gastrointestinal symptoms like nausea, vomiting and diarrhoea seem to be more common than those with the seasonal influenza⁷. Rapid progression with diffuse pneumonitis, ARDS, shock and even renal failure can occur typically at 4 to 5 days after onset of symptoms^{8,9}.

Viral shedding

Most patients with pandemic H1N1 influenza infection may be shedding virus from 1 day before the symptoms start until 5 to 7 days after the onset of symptoms¹⁰. For infections with the pandemic influenza A(H1N1) virus, prolonged viral shedding has been reported in immunocompromised patients treated with oseltamivir, in association with emergence of viral resistance to the drug¹¹. Prolonged shedding of influenza A (H1N1) had been reported in some patients without immune depression, who

were treated with oseltamivir and in whom the virus did not develop resistance to the drug. It seems plausible that prolonged viral shedding in these patients was more likely to be associated with the rather severe clinical course¹². In severely ill patients, viral RNA may actually be detectable in endotracheal aspirates for several weeks after the initiation of oseltamivir therapy. The interval from onset of symptom to the start of oseltamivir therapy is an important independent risk factor

of viral shedding. Delay in the time of antiviral initiation increases the influenza viral load and the duration of virus detection. Younger children have been observed to have prolonged viral shedding, as compared to older children and adults, which is consistent with earlier studies of seasonal influenza. One study found that patients with pneumonia shed the virus longer and the overall duration of viral shedding was only “marginally affected” by antiviral treatment¹³.

Laboratory diagnosis

Rapid antigen assay is a point-of-care test that can give results in 15 minutes but unfortunately is only 60% to 70% sensitive. The positive predictive value is high, meaning a positive test confirms the patient does have the flu.

Direct fluorescent antibody testing takes about 2.5 hours to complete and requires special training for technicians. It has a sensitivity of 47%, a positive predictive value of 95%, and a negative predictive value of 92%.

Polymerase chain reaction (PCR) testing takes about 6 hours and has a sensitivity of 98%, a positive predictive value of 100%, and a negative predictive value of 98%. This is probably the best test, in view of its all-around performance, but it is not a point-of-care test.

Culture takes 2 to 3 days, has a sensitivity of 89%, a positive predictive value of 100%, and a negative predictive value of 88%.

PCR has now replaced culture as the gold standard for influenza virus detection. The rapid test used in emergency departments and clinic settings has good specificity but medium sensitivity of only 60%-70%; thus, a negative test result does not exclude the diagnosis of influenza. This point is emphasized

by the many diagnostic errors that resulted in withholding treatment from some patients who needed it.

Early reports showed that primary influenza pneumonia caused by 2009 pandemic (H1N1) histopathologically resembled the highly fatal avian (H5N1) infection.¹⁴ The pathology of 2009 H1N1 (diffuse alveolar damage, intra-alveolar haemorrhage, and the detection of viral antigens within pneumocytes) is quite different

from what is found after death from the usual seasonal flu. The other major factor that contributed to pulmonary failure with 2009 (H1N1) was bacterial infection. Surprisingly, some of the same pathogens found with bacterial infections in the pandemic of 1918-1919 (*Streptococcus pneumoniae*, *Staphylococcus aureus*, and group A *Streptococci*) were also found with 2009 (H1N1) influenza-associated infections^{15,16}.





Imaging

Most 2009 (H1N1) influenza A patients present with symptoms of upper respiratory infection. Currently, chest radiographic criterion is not included in the WHO diagnosis of 2009 (H1N1) influenza A. Several studies have detected initial CXR positive findings of 42-50% for this disease¹⁷. This reflects the range of clinical presentation of the study populations. In previous respiratory infectious disease

outbreaks, such as SARS and H5N1, CXRs have been shown to be useful in the prognostication of the disease. In clinical and radiological observation of the 2009 (H1N1) influenza A patients, serial CXRs reveal that lung infiltration increases with progression of the disease. It has been shown that alveolar infiltration on CXR was predominant in cases that progressed to ARDS and clinically resolving cases showed

near complete to total resolution. In CT, the most commonly reported change in 2009 (H1N1) influenza A is ground glass shadowing. Other changes recorded on CT are focal or multifocal consolidation, interstitial changes and pulmonary embolism. CT is valuable in detecting positive findings in the presence of normal CXRs and it shows more extensive pattern of involvement when compared to CXR¹⁸.

Treatment

The pandemic strain of H1N1 influenza virus 2009 was susceptible to the neuraminidase inhibitors (Oseltamivir or Zanamivir) but was resistant to the amantidine or rimantidine. The reason for this resistance profile is mainly resulted from the carriage of the Eurasian-lineage swine influenza A viral resistance M gene in the novel pandemic 2009 H1N1 strain¹⁹. It is recommended that for the at-risk population (infants and children aged < 5, the elderly (> 65 years), nursing home residents, pregnant women, patients with chronic co-morbid conditions such as cardiovascular, respiratory or liver disease, diabetes, and those with immunosuppression related to malignancy, HIV infection or other diseases) presenting with acute influenza like symptoms, antivirals should be given²⁰. A Hong Kong study has demonstrated that administration of antiviral within 96 hours is associated with a reduced risk of death²¹.

Inhalation form of zanamivir has been the licensed formulation for use. However, for those who are unable to use the inhaled form, intravenous zanamivir can be considered for compassionate use from its manufacturer through an emergency investigational new drug application to the Food and Drug Administration (FDA)²². Intravenous zanamivir has been used successfully in severely ill patients infected with the novel

pandemic 2009 H1N1 influenza virus in some anecdotal reports²³⁻²⁶.

Intravenous peramivir is another investigational neuraminidase inhibitor used for the treatment of hospitalized and critically-ill adult patients with suspected or confirmed pandemic H1N1 influenza A infection under the Emergency Use Authorization (EUA) of the FDA²². However, this authorization expired in 23 June 2010²⁷. Peramivir has already been shown in a large randomized trial to be as effective as oseltamivir for the treatment of adults infected with seasonal influenza A & B²⁸. However, the efficacy of peramivir in treating patients with 2009 pandemic influenza H1N1 virus infection was difficult to be assessed since there were no randomized trials and most patients were treated under the EUA. The majority of them were critical ill requiring intensive care and mechanical ventilation, and were started on peramivir at a relatively late stage²⁹. Despite this, it has been licensed for use in Japan and Korea since 2010.

As of 5 October 2011, 650 cases of oseltamivir-resistant infection with the pandemic 2009 H1N1 influenza virus in 32 countries have been reported to the World Health Organization. These viruses carry the H275Y substitution in the neuraminidase glycoprotein, which is well known to confer resistance to oseltamivir³⁰. The risk factors for the development of this resistance mutation include

immunocompromised state and consumption of oseltamivir. However, these mutated isolates remain susceptible to zanamivir.

Corticosteroids have been advocated by some to be the adjuvant therapy for the treatment of severe lower respiratory tract infection by the 2009 H1N1 influenza virus, based on its anti-inflammatory effect. However, its efficacy is conflicting. It has not been shown to be associated with improved survival³¹. In fact, early use of steroid may even increase the risk of critical illness and death from the pandemic H1N1 infection³². As a result, the World Health Organization recommends that systemic steroid should not be given for the treatment of severe or progressive disease due to influenza virus infection unless indicated for other reasons or part of the approved research protocol³³.

Treatment of severe 2009 H1N1 pandemic influenza virus infection with convalescent plasma has been shown in a Hong Kong study to be associated with reduced viral load, serum cytokine response and mortality³⁴. In critically ill patients with acute respiratory distress syndrome (ARDS) resulting from severe 2009 H1N1 influenza virus infection, extracorporeal membrane oxygenation (ECMO) has been tried. An observational study from United Kingdom suggested that for patients with H1N1 related ARDS, referral to an ECMO centre, had survival benefit³⁵.

Prophylaxis

Antiviral prophylaxis for those exposed to confirmed cases with 2009 pandemic H1N1 virus is general not recommended. Initiation of presumptive antiviral

treatment may be appropriate for those exposed patients with higher risk for complication from influenza virus infection. They include transplanted patients,

severe immunosuppressed patients, neonates and other vulnerable patients in other settings³³.

Infection Control aspect

There is a continuing debate about the relative merits of the N95 respirator mask versus the standard surgical mask to prevent transmission of influenza virus among healthcare

workers. A Canadian study found that the surgical and N95 masks were equally effective, but surgical masks were also cheap, comfortable, and in great supply. The Society for Hospital

Epidemiology of America (SHEA), at their April 2010 meeting, voted to recommend surgical masks³⁶. (Note: the CDC still seems to favour the N95 fit-tested masks).

Vaccination

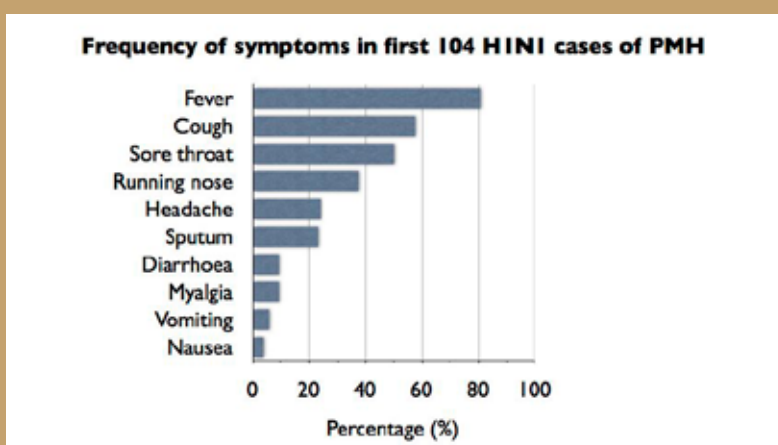
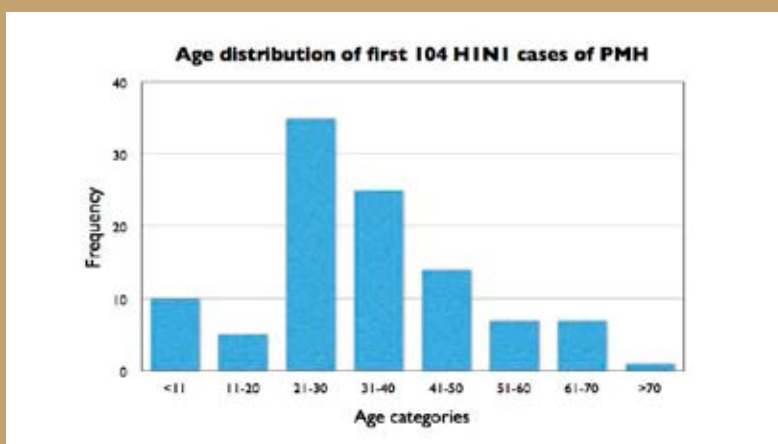
The current vaccine production system requires eggs and takes 6 months. With our current limitations in vaccine production speed and

volume, the promised large supply of vaccine did not arrive until the second peak had already started to decline. The production time will be

shortened and the yield magnified by using new methods like molecular techniques.

PMH experience

From April to September 2009, Princess Margaret Hospital and the Hospital Authority Infectious Disease Centre had received 1113 patients presented with influenza like illness. Among them, 253 were confirmed to be the novel pandemic H1N1 influenza virus. Of all confirmed cases, 50% of them were male and the age ranged from 2 days of life to 72 years old. Completed data was obtained from the first 104 cases and 41% of them were imported cases from other countries. The median age for them was 19 years old and about 70% of them were students (Fig. 1). The clinical features included fever (81%), dry cough (58%), sore throat (50%), running nose (37%), headache (24%), sputum (23%) and myalgia (10%) (Fig. 2). Gastrointestinal symptoms, like diarrhoea, were more common in paediatric cases (15.4% vs 4% in adults). Vomiting was also more common in paediatric patients (9.4% vs 2% in adult). The laboratory results of these cases were relatively unremarkable and Chest X-rays were clear in all of them. Oseltamivir was given to 80% of them on admission. None of them required assisted oxygen therapy or ICU care and all of them recovered.





Comments

The experience with the 2009 Influenza H1N1 pandemic is most instructive. The World Health Organization, public health officials, government, science and industry were engaged unprecedentedly. Despite the occurrence of many failures, we are likely to be much better prepared to deal with the myriad of influenza-related issues in the future. These include issues about surge capacity, masks, drugs, universal vaccine, communications, diagnostic testing, school closing, and social distancing. The knowledge gap that still exists is how to get people vaccinated, how to manufacture a large quantity of vaccine in less than 6 months and how to rationally and optionally use antiviral drugs.

Besides the management of clinical problems related to the 2009 H1N1

Influenza during the outbreak in Hong Kong, there were many other non-tangible issues which could also pose major challenges to the healthcare providers. In the early phase of the outbreak, when most of the infected cases were coming from afar, we had faced a lot of logistics issues like the difference in languages, cultures, foods or expectation in health care systems. Since most of these patients were relatively stable and well, their clinical needs were not immense, but their psychosocial needs were extraordinary, especially when they had to be quarantined for more than a week in the early stage. While under isolation, many of them developed a warm relationship with the healthcare workers (Fig. 3).

Moreover, though we had learnt a lot from the painful experience

of SARS and had established a number of plans and systems for future outbreaks, we were still quite perplexed when the pandemic H1N1 influenza outbreak unveiled in Hong Kong. There is still room for better communication between the clinics, the hospitals, the control centres and the Centre for Health Protection though it has been much improved since the time of SARS. Notwithstanding the drawbacks, it was gratifying to witness the professionalism demonstrated by our colleagues in tackling this pandemic. They were more knowledgeable and psychologically prepared than before. With this, we are confident that our healthcare workers can handle effectively the future challenges from other major infectious disease outbreaks.

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Updates on Training

Loretta Yam

Chairman, Education and Accreditation Committee

Completion of Self-Learning Tool (SLT)

As stipulated in the Fifth Edition of the *Guidelines on Postgraduate Training in Internal Medicine, July 2011*, completion of SLT is required for all Trainees undergoing AIM or Geriatric Medicine as broad-based training. Failure to complete any of the cycles of SLT will affect these Trainees' eligibility to apply for second Annual or Interim or Exit Assessments in AIM or Geriatric Medicine. All Trainees concerned are reminded to comply with this regulation and Specialty Programme Directors in these Specialties may be consulted for assistance if required.

Eligibility for Trainer status after 18 Jan 2012

At its January 2012 Council Meeting, the Council reiterated the importance of broad-based training through dual specialty training and decided that, with effect from 18 January 2012, future applications for withdrawal from AIM or Geriatric Medicine training in dual training will not be approved, such that all future Trainers will have undergone a broad-based Internal Medicine training. Fellows who possess single specialty accreditation (apart from AIM/Geriatric Medicine) and have already attained Trainer status in their specialties will continue to be accredited as Trainers.

Subsequent to the dissemination of the above rules, the Council reviewed the situation of all single-specialty Fellows who are not yet Trainers of the College, single specialty Trainees as well as current AIM trainees who have already been accredited in another specialty. At its 246th and 247th Meetings of 27 March and 23 April 2012, the Council deliberated on the balance between the benefit of having dually-accredited Trainers and the difficulties encountered by Fellows and Trainees arising from the immediate implementation of the above rules, and decided to grant a one-off 6-month Grace Period in the interpretation of the above rules to eligible Fellows, such that

1. All trainees who are undergoing single specialty training (other than AIM or Geriatric Medicine), and all Fellows who had undergone and completed single specialty training (other than AIM or Geriatric Medicine) after 18 July 2010, must take up dual training with either AIM or Geriatric Medicine as the broad-based specialty, before they can be eligible to become Trainers in the future.
2. All Fellows and Trainees undergoing dual training but have not completed AIM/Geriatric Medicine training as the broad-based specialty and who are not eligible for the Grace Period as detailed below must complete AIM/Geriatric Medicine training before they are eligible to become Trainers.
3. Eligibility for one-off 6-month Grace Period
 - A. Fellows who are still undergoing dual training in AIM/Geriatric Medicine as the broad-based specialty and would have been eligible, in accordance with the College's rule before 18 January 2012, to become Trainers in their specialties (other than AIM) on or before 18 July 2012, ie, **six months after 18 January 2012** (= dates of specialty accreditation on or before 18 July 2010) may now apply to their Specialty Boards to be Trainers in their specialties. All applications must be received within six months from 28 May 2012, the date of dissemination of the Grace Period to all Specialty Boards and Trainees. Please also note that Fellows who decide to benefit from this Grace Period will forfeit all past AIM/Geriatric Medicine training experience. Should they decide to acquire accreditation in AIM/Geriatric Medicine at a later date, they have to complete the full core training of 24 months.
 - B. Fellows who had undergone and completed single specialty training (other than AIM or Geriatric Medicine) on or before 18 July 2010 and would have been eligible, in accordance with the College's rule before 18 January 2012, to become Trainers in their specialties on or before 18 July 2012 may also apply to their Specialty Boards to be Trainers in their specialties. All applications must be received within six months from 28 May 2012.

Application for College Membership by Higher Physician Trainees

At its 249th Meeting of 28 June 2012, the Council noted that there are still Trainees who apply for various forms of Assessment in Higher Physician Training but are not yet College Members. Since the requirement for College Membership on commencement of Higher Physician Training had already been stipulated since the 2nd edition of the *Guidelines on Postgraduate Training in Internal Medicine, June 1998*, Page 26 under "Entry Requirements", lines 1 to 3, and re-emphasised to all Trainees again through letters from the Education and Accreditation Committee to Specialty Boards on 7 April 1999, 12 March 2008 and 16 May 2008, non-compliance will **no longer** be tolerated.

With **immediate** effect, all BPT trainees who have completed 36 months' accredited training and passed the PACES examination **must apply for College Membership within three months** after being informed by the Basic Physician Board that the College Council has approved the Dates of Completion of their Basic Physician Training. In addition, Trainees who have submitted insufficient

or inaccurate information in their application must submit clarification within one month of enquiry from the Secretariat.

Failure to apply for College Membership or respond to the Secretariat's enquiry within the time frames stated above will result in **automatic postponement of the Trainee's date of commencement of Higher Physician Training in the College records** till College Membership is confirmed, which will therefore automatically affect the subsequent progress of training.

ICU Training in Basic Physician Training

The Council at its recent Meeting has reiterated that, in accordance with the specifications on the Structure of Basic Physician Training in the College *Guidelines on Postgraduate Training in Internal Medicine*, First (1993) to Fifth (2011) Editions, formal ICU training is a full-time specialty service approved by the College and may be accredited for up to six months. Formal ICU training therefore cannot be counted towards fulfilling the requirement of 12 months of training in acute general medicine during Basic Physician Training.



Statistics on No. of Trainees in all Specialties

Updated in Marh 2012

		TRAINEES														
		HONG KONG EAST CLUSTER						HONG KONG WEST CLUSTER								
SPECIALTY	TRAINEES TOTAL (PP/DH/HA/ OTHERS)	PYNEH		RH		TWEH		FYKH		GH		QMH		TWH		
		YEAR		YEAR		YEAR		YEAR		YEAR		YEAR		YEAR		
CARDIOLOGY	24	1 2 3-I 4	1 5	1 2-I 3 4	1 2 3 4	1 2 3 4	0 0 0 0	1 2 3 4	0 0 0 0	1 2 3 4	0 4 4 4	1-II 2 3-II 4	4 2 3 6	1 2 3 4	0 0 0 0	
CLINICAL PHARMACOLOGY & THERAPEUTICS	0	1 2 3 4	0 0 0 0	1 2 3 4	0 0 0 0	1 2 3 4	0 0 0 0	1 2 3 4	0 0 0 0	1 2 3 4	0 0 0 0	1 2 3 4	0 1 3 4	1 2 3 4	0 0 0 0	
CRITICAL CARE MEDICINE	12	1-I 2 3-I 4-I	3 4	1 2 3 4	0 0 0 0	1 2 3 4	0 0 0 0	1 2 3 4	0 0 0 0	1 2 3 4	0 0 0 0	1-I 2 3 4	1 2 3 3	1 2 3 4	0 0 0 0	
DERMATOLOGY & VENEREOLOGY	13	1 2 3 4	0 0 0 0	1 2 3 4	0 0 0 0	1 2 3 4	0 0 0 0	1 2 3 4	0 0 0 0	1 2 3 4	0 0 0 0	1-I 2 3 4-I	2 2 3 1	1 2 3 4	0 0 0 0	
ENDOCRINOLOGY, DIABETES & METABOLISM	17	1 2 3 4-I	1 2 4	1 2 3-I 4	1 1 1 4	0 0 0 3	1 2 3 4	0 0 0 0	1 2 3 4	0 0 0 0	1 2 3 4	0 0 0 0	1 2-I 3-I 4-I	3 2 3 5	1 2 3 4	0 0 0 0
GASTROENTEROLOGY & HEPATOLOGY	22	1 2 3 4	0 5	1 2 3 4	0 1	1 2 3 4	0 0	1 2 3 4	0 0 0 0	1 2 3 4	0 0 0 0	1 2-I 3-I 4	2 2 3 4	1 2 3 4	0 0 0 1	
GERIATRIC MEDICINE	17	1 2 3 4	0 6	1 2 3 4	0 II	1 2 3 4-I	1 1 4	1 2 3 4	0 0 0 0	1 2 3 4	1 1 0	1-II 2 3 4	2 2 3 2	1 2 3 4	0 0 0 2	
HAEM/HAEM ONCOLOGY	6	1 2 3 4	1 2 4	1 2 3 4	0 0	1 2 3 4	0 0	1 2 3 4	0 0 0 0	1 2 3 4	0 0 0 0	1 2-II 3 4	2 2 3 5	1 2 3 4	0 0 0 0	
IMMUNOLOGY & ALLERGY	0	1 2 3 4	0 0 0 0	1 2 3 4	0 0 0 0	1 2 3 4	0 0 0 0	1 2 3 4	0 0 0 0	1 2 3 4	0 0 0 0	1 2 3 4	0 0 0 0	1 2 3 4	0 0 0 0	
INFECTIOUS DISEASE	3	1 2 3-I 4	1 0	1 2 3 4	0 0	1 2 3 4	0 0	1 2 3 4	0 0 0 0	1 2 3 4	0 0 0 0	1 2 3 4	0 1 3 4	1 2 3 4	0 0 0 0	
INTERNAL MEDICINE	209	1-I 2-II 3-V 4-X	18 34	1 2-I 3-I 4-I	3 14	1 2 3 4	0 10	1 2 3 4-I	1 2 3 2	1 2-I 3-I 4	2 4	1-IX 2-VII 3-V 4-XII	33 48	1 2 3 4	0 8	
MEDICAL ONCOLOGY	5	1 2 3 4	0 0	1 2 3 4	0 0	1 2 3 4	0 0	1 2 3 4	0 0 0 0	1 2 3 4	0 0 0 0	1 2 3 4	0 2 3 4	1 2 3 4	0 0 0 0	
NEPHROLOGY	15	1 2 3-I 4	1 4	1 2 3 4	0 0	1 2 3 4	0 0	1 2 3 4	0 0 0 0	1 2 3 4	0 0 0 0	1-II 2-I 3 4	3 2 3 5	1 2 3 4	0 0 0 3	
NEUROLOGY	14	1 2 3 4	0 4	1 2 3 4	0 2	1 2 3 4	0 0	1 2 3 4	0 0 0 0	1 2 3 4	0 0 0 0	1-I 2 3 4	1 2 3 5	1 2 3 4	0 0 0 0	
PALLIATIVE MEDICINE	6	1 2 3 4	0 0	1 2 3 4	0 2	1 2 3 4	0 0	1 2 3 4	0 0 0 0	1 2-I 3 4	1 1	1 2 3-I 4-I	2 2 3 0	1 2 3 4	0 0 0 0	
REHABILITATION	6	1 2 3 4	0 0	1 2 3 4	0 2	1 2 3 4-I	1 4	1 2 3 4-I	1 1 0	1 2 3 4	0 0	1 2 3 4-I	1 1 0	1 2 3 4	0 5	
RESPIRATORY MEDICINE	15	1-I 2 3-I 4	2 4	1 2 3 4	0 5	1 2 3 4	0 0	1 2 3 4	0 0 0 0	1 2 3 4	0 7	1 2 3 4-I	1 2 3 6	1 2 3 4	0 0	
RHEUMATOLOGY	9	1 2 3-I 4	1 2 4	1 2 3 4	0 1	1 2 3 4	0 1	1 2 3 4	0 0 0 0	1 2 3 4	0 0 0 0	1-I 2 3 4	1 2 3 3	1 2 3 4	0 1	



		TRAINEES											
		KOWLOON CENTRAL CLUSTR		KOWLOON EAST CLUSTER			KOWLOON WEST CLUSTER						
SPECIALTY	TRAINEES TOTAL (PP/DH/HA/OTHERS)	KH	QEH	HOHH	TKOH	UCH	CMC	KWH	OLMH	PMH	WTSH	YCH	
		YEAR		YEAR			YEAR						
CARDIOLOGY	24	1 2 3 4	0 1-I 2 3-II 4-I	1 2 3 4	0 1 3-I 4	1 2 3 4	1 2-I 3 4	1 2 3 4	1 2 3-II 4	1 2 3-I 4	1 2 3 4	1 2 3 4	
CLINICAL PHARMACOLOGY & THERAPEUTICS	0	1 2 3 4	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4	
CRITICAL CARE MEDICINE	12	1 2 3 4	0 1-I 2-I 3-II 4	1 2 3 4	0 1 2 3 4	1 2 3 4	0 1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	
DERMATOLOGY & VENEREOLOGY	13	1 2 3 4	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4	
ENDOCRINOLOGY, DIABETES & METABOLISM	17	1 2 3 4	0 1 2 3 4	1 2 3 4	0 1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	
GASTROENTEROLOGY & HEPATOLOGY	22	1 2 3 4	0 1 2 3-I 4	1 2 3 4	0 1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	
GERIATRIC MEDICINE	17	1 2 3 4	1 2 3 4	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4	
HAEM/HAEM ONCOLOGY	6	1 2 3 4	0 1 2 3-II 4	1 2 3 4	0 1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	
IMMUNOLOGY & ALLERGY	0	1 2 3 4	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4	
INFECTIOUS DISEASE	3	1 2 3 4	0 1-I 2 3 4	1 2 3 4	0 1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	
INTERNAL MEDICINE	209	1-I 2-I 3 4	1-V 2-III 3-VIII 4-VIII	1-I 2 3-I 4	1 2 3 4	1 2 3 4	1-I 2-II 3-II 4-I	1-I 2-VI 3-III 4-III	1-I 2-I 3-V 4-III	1 2 3 4	1-II 2-III 3-III 4-V	1 2 3 4	1-I 2-V 3-I 4-II
MEDICAL ONCOLOGY	5	1 2 3 4	0 1 2-I 3 4	1 2 3 4	0 1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	
NEPHROLOGY	15	1 2 3 4	0 1-I 2 3-I 4	1 2 3 4	0 1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	
NEUROLOGY	14	1 2 3 4	0 1-I 2 3 4	1 2 3 4	0 1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	
PALLIATIVE MEDICINE	6	1 2 3 4	0 1 2 3 4	1 2 3 4	0 1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	
REHABILITATION	6	1 2 3 4	1 2 3 4	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4	
RESPIRATORY MEDICINE	15	1 2 3 4	0 1 2 3 4	1 2 3 4	0 1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	
RHEUMATOLOGY	9	1 2 3 4	1 2 3-I 4	1 2 3 4	0 1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	



		TRAINEES													
		NEW TERRITORIES EAST CLUSTER						NEW TERRITORIES WEST CLUSTER							
SPECIALTY	TRAINEES TOTAL (PP/DH/HA/ OTHERS)	AHNH	NDH	PWH	SH	TPH	POH	TMH							
		YEAR						YEAR							
CARDIOLOGY	24	1 2 3 4	0 2 3 4	1 2 3 4	1 3-I 4	1 2 3 4	1 2-I 3 4	1 2 3 4	1 2 3 4	1 2 3 4	0 1 3 4	0 2 3 4	1 2-II 3-I 4	3 4	
CLINICAL PHARMACOLOGY & THERAPEUTICS	0	1 2 3 4	0 0 0 0	1 2 3 4	0 0 0 0	1 2 3 4	0 0 0 0	1 2 3 4	0 0 0 0	1 2 3 4	0 0 0 0	1 2 3 4	0 0 0 0	0 0 0 0	
CRITICAL CARE MEDICINE	12	1 2 3 4	0 0 3 4	1 2 3 4	0 0 3 4	1 2 3 4	0 0 1 4	1 2 3 4	0 0 0 0	1 2 3 4	0 0 0 0	1 2 3 4	1 2 3 4-I	2 1	
DERMATOLOGY & VENEREOLOGY	13	1 2 3 4	0 0 0 0	1 2 3 4	0 0 0 0	1 2 3 4	0 0 0 0	1 2 3 4	0 0 0 0	1 2 3 4	0 0 0 0	1 2 3 4	1 2 3 4	0 0 0 0	
ENDOCRINOLOGY, DIABETES & METABOLISM	17	1 2 3 4	0 1 1 4	1 2 3-I 4	1 2 2 4-I	3 3-II 4-I	1 2 3 4	0 0 0 0	1 2 3 4	0 0 0 0	1 2 3 4	0 0 0 0	1 2 3 4-I	1 1	
GASTROENTEROLOGY & HEPATOLOGY	22	1 2-II 3 4	2 1 3 4	1 2 3-I 4	1 2 3 4	1-I 2-I 3 4	2 2 3 4	1 2 3 4	0 0 0 0	1 2 3 4	0 0 0 0	1 2 3-I 4	1 2 3 4	3 3	
GERIATRIC MEDICINE	17	1 2 3 4	0 1 1 4	1 2 3 4	0 1 1 4	1 2 3 4	0 4 4 4	1 2 3-II 4	2 2 3 4	1 2 3 4	1 2 3 4	1 2 3-I 4	1 2-II 3 4	2 9	
HAEM/HAEM ONCOLOGY	6	1 2 3 4	0 0 0 0	1 2 3 4	0 0 0 0	1 2 3 4	0 4 4 4	1 2 3 4	0 0 0 0	1 2 3 4	0 0 0 0	1 2 3 4	1 2 3-I 4	1 4	
IMMUNOLOGY & ALLERGY	0	1 2 3 4	0 0 0 0	1 2 3 4	0 0 0 0	1 2 3 4	0 0 0 0	1 2 3 4	0 0 0 0	1 2 3 4	0 0 0 0	1 2 3 4	1 2 3 4	0 0	
INFECTIOUS DISEASE	3	1 2 3 4	0 1 0 4	1 2 3 4	0 0 0 0	1 2 3 4	0 2 4 4	1 2 3 4	0 0 0 0	1 2 3 4	0 0 0 0	1 2 3 4	1 2 3 4	0 2	
INTERNAL MEDICINE	209	1-I 2-III 3 4-III	7 12	1-I 3-V 4-I	7 13	1-IV 2-III 3-V 4-IV	16 47	1-I 2-I 3-II 4	4 6	1-III 2-I 3-I 4	5 5	1 2 3-II 4-I	3 9	1-II 2-VIII 3-VIII 4-IV	22 37
MEDICAL ONCOLOGY	5	1 2 3 4	0 0 0 0	1 2 3 4	0 0 0 0	1-II 3-I 3 4	3 II	1 2 3 4	0 0 0 0	1 2 3 4	0 0 0 0	1 2 3 4	1 2 3 4	0 0	
NEPHROLOGY	15	1 2 3 4	0 3 3 4	1 2 3 4	0 1 4 4	1-II 3 4-I	3 5	1 2 3 4	0 0 0 0	1-I 2 3 4	1 1 0 0	1 2 3 4	1 2 3-I 4	1 5	
NEUROLOGY	14	1 2-I 3 4	1 1 3 4	1-I 3-I 4	2 1 4	1-I 3-II 4	3 5	1 2 3 4	0 0 0 0	1 2 3 4	0 0 0 0	1 2 3 4	1 2 3-I 4	1 3	
PALLIATIVE MEDICINE	6	1 2 3 4	0 0 0 0	1 2 3 4	0 0 0 0	1 2 3 4	0 0 0 0	1 2 3 4	0 0 0 0	1 2 3 4	0 0 0 0	1 2 3 4	1 2 3 4	0 0	
REHABILITATION	6	1 2 3 4	0 0 0 0	1 2 3 4	0 0 0 0	1 2 3 4	0 0 0 0	1 2 3 4	0 0 0 0	1 2 3 4	0 0 0 0	1 2 3 4	1 2 3 4-I	1 3	
RESPIRATORY MEDICINE	15	1 2 3 4	0 3 3 4	1 2 3-I 4	1 4 4 4	1 2 3 4	0 3 4 4	1 2 3 4	0 0 0 0	1 2 3-I 4	1 1 0 0	1 2 3 4	1 2-II 3-II 4	4 3	
RHEUMATOLOGY	9	1 2 3 4	0 1 0 4	1 2 3 4	0 0 0 0	1 2 3 4	0 3 4 4	1 2 3 4	0 0 0 0	1 2-I 3 4	1 1 0 0	1 2 3 4	1 2-I 3-I 4	2 1	

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



SPECIALTY	TRAINEES TOTAL (PP/DH/HA/OTHERS)	TRAINEES	
		DH	
DERMATOLOGY & VENEREOLOGY	13	1—II 2—II 3—IV 4—III	11 10
INFECTIOUS DISEASE	3	1 2 3 4	0 1
RESPIRATORY MEDICINE	15	1 2 3 4	1 8

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

Statistics on No. of Fellows in all Specialties

Updated in March 2012

SPECIALTY	FELLOWS TOTAL (PP/DH/HA/OTHERS)	FELLOWS										HONG KONG EAST + WEST CLUSTER
		HONG KONG EAST CLUSTER				HONG KONG WEST CLUSTER						
		PYNEH	RH	TWEH	Subtotal	FYKH	GH	QMH	TWH	Subtotal		
CARDIOLOGY	217	9	7	0	16	0	5	13	0	18	34	
CLINICAL PHARMACOLOGY & THERAPEUTICS	8	0	0	0	0	0	0	2	0	2	2	
CRITICAL CARE MEDICINE	75	10	0	0	10	0	0	9	0	9	19	
DERMATOLOGY & VENEREOLOGY	88	0	0	0	0	0	0	1	0	1	1	
ENDOCRINOLOGY, DIABETES & METABOLISM	89	3	1	3	7	0	0	7	0	7	14	
GASTROENTEROLOGY & HEPATOLOGY	157	9	2	1	12	0	0	11	1	12	24	
GERIATRIC MEDICINE	170	6	12	4	22	4	0	4	2	10	32	
HAEM/HAEM ONCOLOGY	51	3	0	0	3	0	0	9	0	9	12	
IMMUNOLOGY & ALLERGY	6	0	0	0	0	0	0	0	0	0	0	
INFECTIOUS DISEASE	37	1	1	0	2	0	0	2	0	2	4	
INTERNAL MEDICINE	1112	45	24	13	82	4	10	80	11	105	187	
MEDICAL ONCOLOGY	41	0	0	0	0	0	0	8	0	8	8	
NEPHROLOGY	113	6	0	0	6	0	0	7	3	10	16	
NEUROLOGY	98	5	3	0	8	0	0	9	2	11	19	
PALLIATIVE MEDICINE	20	0	2	0	2	0	2	0	0	2	4	
REHABILITATION	49	0	3	5	8	1	0	0	5	6	14	
RESPIRATORY MEDICINE	163	8	8	2	18	0	8	10	0	18	36	
RHEUMATOLOGY	65	4	2	1	7	1	0	7	1	9	16	



		FELLOWS														KOWLOON CENTRAL + EAST + WEST CLUSTER
		KOWLOON CENTRAL CLUSTER			KOWLOON EAST CLUSTER				KOWLOON WEST CLUSTER							
SPECIALTY	FELLOWS TOTAL (PP/DH/HA/OTHERS)	KH	QEH	Subtotal	HOHH	TKOH	UCH	Subtotal	CMC	KWH	OLMH	PMH	WTSH	YCH	Subtotal	
CARDIOLOGY	217	0	13	13	0	1	8	9	1	6	1	9	0	4	21	43
CLINICAL PHARMACOLOGY & THERAPEUTICS	8	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
CRITICAL CARE MEDICINE	75	0	4	4	0	3	6	9	5	5	0	7	0	0	17	30
DERMATOLOGY & VENEREOLOGY	88	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
ENDOCRINOLOGY, DIABETES & METABOLISM	89	0	8	8	0	4	5	9	2	4	2	5	0	1	14	31
GASTROENTEROLOGY & HEPATOLOGY	157	0	8	8	0	2	3	5	4	6	2	6	0	8	26	39
GERIATRIC MEDICINE	170	5	4	9	6	2	13	21	7	10	2	15	6	6	46	76
HAEM/HAEM ONCOLOGY	51	0	7	7	0	2	2	4	0	0	0	5	0	0	5	16
IMMUNOLOGY & ALLERGY	6	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
INFECTIOUS DISEASE	37	0	5	5	0	0	1	1	0	1	0	5	0	1	7	13
INTERNAL MEDICINE	1112	5	67	72	10	20	52	82	30	45	8	58	5	25	171	325
MEDICAL ONCOLOGY	41	0	2	2	0	0	1	1	0	0	0	1	0	0	1	4
NEPHROLOGY	113	0	8	8	2	2	4	8	2	8	0	7	0	2	19	35
NEUROLOGY	98	0	9	9	0	2	5	7	1	5	1	2	1	1	11	27
PALLIATIVE MEDICINE	20	0	0	0	4	0	2	6	4	0	1	0	1	0	6	12
REHABILITATION	49	8	0	8	3	0	2	5	1	1	0	2	4	0	8	21
RESPIRATORY MEDICINE	163	6	7	13	6	3	5	14	6	6	0	5	2	1	20	47
RHEUMATOLOGY	65	1	5	6	0	2	3	5	1	2	0	3	0	2	8	19

		FELLOWS										NEW TERRITORIES EAST + WEST CLUSTER
		NEW TERRITORIES EAST CLUSTER						NEW TERRITORIES WEST CLUSTER				
SPECIALTY	FELLOWS TOTAL (PP/DH/HA/OTHERS)	AHNH	NDH	PWH	SH	TPH	Subtotal	POH	TMH	Subtotal		
CARDIOLOGY	217	1	5	13	0	0	19	2	9	11	30	
CLINICAL PHARMACOLOGY & THERAPEUTICS	8	0	0	6	0	0	6	0	0	0	6	
CRITICAL CARE MEDICINE	75	3	3	1	0	0	7	0	5	5	12	
DERMATOLOGY & VENEREOLOGY	88	0	0	2	0	0	2	0	0	0	2	
ENDOCRINOLOGY, DIABETES & METABOLISM	89	1	4	13	0	0	18	0	3	3	21	
GASTROENTEROLOGY & HEPATOLOGY	157	1	4	8	0	0	13	5	7	12	25	
GERIATRIC MEDICINE	170	1	1	6	6	3	17	1	11	12	29	
HAEM/HAEM ONCOLOGY	51	0	0	6	0	0	6	0	5	5	11	
IMMUNOLOGY & ALLERGY	6	0	0	0	0	0	0	0	0	0	0	
INFECTIOUS DISEASE	37	2	0	3	0	0	5	0	3	3	8	
INTERNAL MEDICINE	1112	16	24	75	8	7	130	11	63	74	204	
MEDICAL ONCOLOGY	41	0	0	16	0	0	16	0	0	0	16	
NEPHROLOGY	113	4	1	7	0	0	12	1	8	9	21	
NEUROLOGY	98	1	1	9	2	1	14	1	6	7	21	
PALLIATIVE MEDICINE	20	0	0	0	1	0	1	0	1	1	2	
REHABILITATION	49	0	1	2	1	1	5	0	4	4	9	
RESPIRATORY MEDICINE	163	3	6	9	0	1	19	2	6	8	27	
RHEUMATOLOGY	65	3	0	5	0	2	10	1	3	4	14	



INAUGURATION OF ENDOWED PROFESSORSHIPS

Professor LAM WAH KIT

John MacKay



When I arrived at the meeting place, the Professorial Block 4th Floor I was greeted promptly by Professor Lam. For our meeting he offered the smart waiting room, or his office. I chose his office and on entering I was pleased to have done so. It was the typical Professorial office, every surface piled high with case notes and folders, clearly the realm of a busy man. At the end of the very pleasant meeting he was gracious enough, despite his workload, to escort me through the labyrinth of the Queen Mary Hospital to the Shroff's office and to my car in the visitor's car park.

Lam Wah Kit's parents came from China to Hong Kong in 1945 after the Second World War, with four children, all boys. His father had been a teacher in China but his qualification did not count in Hong Kong so he had to start at the bottom and take the necessary exams to return to teaching. Life was very hard during that time. Lam Wah Kit was born in Hong Kong in 1947. His mother was a housewife, an educated woman, and fully occupied by bringing up a family of five boys

Of his four elder brothers, the one immediately senior to him became a doctor but very sadly died at an early age.

His primary schooling was at Tung Wah and Sun Hui Commercial primary schools. After the first two years he was either second or top of his class each year. He won a scholarship to Queen's College and another scholarship to University. He was top of his class for all seven years at Queen's College. Despite his hard work he still had time for his favorite sports, badminton and table tennis.

His wife, Leung Sau Chi, was a classmate at Hong Kong University (HKU). She specialized in Public Health, and spent a year at Berkley, University of California, studying Community Health. Before her retirement she was the Chief Executive of the Grantham Hospital. They have no children.

As a student at HKU Lam Wah Kit excelled academically, winning the Anderson Memorial Medal and being the Outstanding Graduate of the Year in 1972.

Dr. Lam spent the next two years as a Medical Officer at the United Christian Hospital, returning to the Queen Mary Hospital as a Lecturer in the Department of Medicine of HKU.

A Commonwealth Scholarship allowed him to spend from 1977 to 1979 at the Cardiothoracic Unit at the Brompton Hospital in London; during this time he passed the MRCP examination.



FATHER AND SON - 60 YEARS AGO



Dr Lam returned to HK as a respiratory specialist, and was elected to Fellowship of the American College of Chest Physicians in 1982. He became a Senior Lecturer in 1984, earning an MD (HKU) in 1986, and was elected a Fellow of the Royal College of Physicians in Edinburgh. In 1987 he was awarded an International Fellowship to study at the Webb-Waring Lung Institute, University of Colorado, Denver, U.S.A.

In 1989 he became Reader, then Professor, at the University of Hong Kong Department of Medicine and Chief of Respiratory Medicine, University Department of Medicine, Queen Mary Hospital, a position he held till 2007.

From 1993 to 1997 he was Chief of Service at the University Medical Unit at the Grantham Hospital, and Director of the Respiratory Rehabilitation Unit for people with Chronic Obstructive Pulmonary Disease at the Grantham and Tung Wah Hospitals. Together with these hospitals and the Acute Respiratory Service at the Queen Mary Hospital a comprehensive service was provided to patients in West Hong Kong Island region. In 1995 he planned, co-ordinated the protocol, and helped to launch the first lung transplantation programme in Hong Kong at the Grantham Hospital.

Professor Lam was very active in the field of education and examination. As Programme Director of the 4th and 5th years, he planned and implemented the new Problem-Based-Learning MBBS curriculum in Internal Medicine in the Faculty of Medicine, HKU.

Professor Lam was on the Examination Board of the Royal Colleges of Physicians, UK from 1993 to 2004.

1993 - 1995:

Member, MRCP (UK) Part I Examination Board

1995 - 1998:

Member, MRCP (UK) Part II Examination Board & Policy Board

1995 - 2004:

Chairman, MRCP(UK) Examination Coordinating Committee, Hong Kong



He organised the MRCP (UK) examination in Hong Kong for 10 years, including the first four years of the new PACES section. He was Chairman, Advisory Group for Formulation of Training and Accreditation Guidelines in Respiratory Medicine (1992 – 1996); and Chairman, Specialty Board in Respiratory Medicine (1996 – 2000).

He is a past President of the American College of Chest Physicians, (HK & Macau Chapter); President, Organizing Committee, 13th Asian Pacific Congress on Diseases of the Chest, Hong Kong, (1994); Governor, & Member, ACCP Board of International Regents and Governors from 1996 to 2000 and Regent (Chief Officer) from 2000 to 2003.

Professor Lam pioneered and established the first academic and Professional link between respiratory medicine in Hong Kong and mainland China, placing Hong Kong as the forum for academic exchange among Chinese respiratory academics worldwide during the 1980s to 1990s. He was a strong advocate for supporting young mainland Chinese academics and research workers in Respiratory Medicine to attend international meetings held in Hong Kong, in the early years when such opportunities for them were more limited; and raised funding for many of them for meetings in 1994, 1999, and 2004

Professor Lam was appointed in 1997 as the first Chair Professor of Respiratory Medicine in Hong Kong,

and in 2007 to the first Mok Hing-yiu Endowed Chair of Respiratory Medicine. From 2001 to 2004 he was the Chairman of the Department of Medicine at the University of Hong Kong.

During his long career Professor Lam has published 241 refereed papers, 459 abstracts and edited or contributed chapters to 52 books. Fittingly, he has been awarded numerous prestigious prizes, the Manuel Albertal Award from the American College of Chest Physicians 'for outstanding professional service in pulmonology – international recognition', Honorary Fellowships from the Royal College of Physicians and Surgeons of Glasgow, and the Hong Kong Lung Foundation.

In October Last year Professor Lam was presented with an Honorary Fellowship by the Hon Kong College of Physicians (HKCP) in recognition of his many medical achievements and for his years of contributions to the HKCP, finally as the Vice President. He had been obliged to decline the Presidency because of ill health. In 2001 he had a lung tumor removed, and in 2007 a second operation to remove a recurrence, following which he retired as Chief of Respiratory Service at HKU. During his tenure he had enhanced the research facilities at the University

with the latest equipment, set protocols for Acute and Intermediate Respiratory Care, and established the division as the leading respiratory care facility in Hong Kong. A particular research interest is the epidemiology and molecular biology regarding the increased prevalence of adenocarcinoma in non-tobacco using females in Hong Kong.

The good news regarding his health is that five years later he is fit enough to regularly go hiking with his wife. The occasional visit to the races near his Happy Valley home is another recreation that he enjoys.

As an Honorary Professor he does teaching sessions at the University, he is an Honorary Consultant at the Queen Mary Hospital, and he teaches Western Medicine to students of the Schools of Chinese Medicine at the Hong Kong Chinese and Baptist Universities. He has also continued to be International Advisor (HK) for the Royal Colleges of Physicians of Edinburgh, Glasgow and London.

Asked to comment on the present medical scene he is clear that standards in Hong Kong are on a par with international standards. However he does feel that there is too much emphasis on the technical side of medicine at the expense of the personal touch. Having recently been

a patient himself he has firm views on this subject. He regrets also the tendency to defensive medicine, the over-investigation of patients, driven by the desire of doctors not to make mistakes.

Regarding the Hospital Authority he laments the lack of a viable financial model: there is not enough finance to provide consultant posts to well-qualified specialists, so with promotion blocked they often choose to go into Private Practice. In Hong Kong 90% of hospital patients are treated by the Hospital Authority, with only 40% of the doctors. Increasing the number of Private Hospitals may ease the pressure on beds but until the increased intake of medical students have graduated, there is going to be continuing pressure on front line staff.

Professor Lam has the ambition to continue contributing to the university where he has spent nearly all his career and to which he has already contributed much.

His early ambition was to be like his father and be a teacher. He has since proved that he is a master of that art. 93% of Medical Students at HKU rate his lectures and bedside teachings as 'Excellent' compared with the average of 36% for all teachers. His early ambition is being amply fulfilled.

