

JANUARY 2014 HONG KONG COLLEGE OF PHYSICIANS

# SYNAPSE

RESTRICTED TO MEMBERS ONLY

HONG KONG COLLEGE OF PHYSICIANS  
香港內科醫學院



*Sapientia et Humanitas*



Photographer  
Professor Richard YH Yu

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- BEST THESIS AWARD  
Gold award winner  
Silver award winner  
Bronze award winner



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Patrick CK Li  
President, HKCP

# THE PRESIDENT'S ANNUAL REPORT 2013

The Hong Kong College of Physicians has actively engaged in various initiatives over the past year to maintain the high standard for physician practice in Hong Kong. This has been achieved largely through the effort of the Education and Accreditation Committee, which has worked hard to review and revise the training guidelines and accreditation framework in light of the current developments within the profession. Close collaboration has been maintained with our sister Colleges both locally and internationally to ensure alignment of the professional standard. The Intermediate Examination of the College continues to be held jointly with the MRCP (PACES) examination for international benchmarking. Our Exit Assessment is now well-structured to ensure that the candidates have attained the required competence in the respective specialty. Pass in an exit assessment in the country of training or practice is now a mandatory requirement for Certification of Specialist Registration for overseas doctors.

The College has continued to reinforce the importance of dual training in a broad-based specialty, i.e. advanced internal medicine or geriatric medicine

*“the importance of dual training in a broad-based specialty ..... to maintain the holistic approach”*

in order to maintain the holistic approach to physician practice. The requirement is now mandatory for all specialty trainees and trainers, with the exception of dermatology. This approach is in fact in line with the growing international recognition of the problems resulting from over-specialisation and the need to train general physicians to cater for the growing number of elderly patients with multiple chronic medical illnesses. To recognise our dual specialty training framework, the College has again raised the importance of dual specialty accreditation for reconsideration by the Academy. This would be in the context of a broad-based specialty in addition to a subspecialty, or two closely related subspecialties, with the understanding that the specialist would be practising 50% time in each of the two. In anticipation of the growing importance of simulation training and credentialing of competence for performance of invasive procedures, the College is also working with the Specialty Boards to lay the groundwork for their incorporation into our training and accreditation framework.

The College has continued to provide technical advice to the Government on various issues related to physician practice and population health over the past year, including the importance of developing genetic and genomic services in Hong Kong and the Strategic Service Framework for Coronary Heart Disease of the Hospital Authority. A representative from the Specialty Board in Dermatology sits on the Working Group on Differentiation between Medical Procedures and Beauty Services. The College has written to the Department of Health through the Medical Council to reflect our concern over safeguarding patient welfare in processing Temporary Medical Registration for teaching activities. In addition, the College has also written to the Bureau to raise concern over possible change in the professional codes of physiotherapists to allow direct patient treatment without prior assessment by clinicians.

With the growing number of Fellows at over 1550, the College continues to encourage participation of the younger Fellows in its various activities, including presentation during the Annual Scientific Meeting, participation in its Committees and Specialty Boards, support to their research activities through funding grants, in addition to their role as Trainers to basic and higher physician trainees.

At the end of my first term as President of the College, I wish to extend my sincere appreciation to the Chairpersons and Members of the Committees and Boards for their contributions towards upholding the standard of physician training and supporting the various responsibilities and functions of the College. I would specially thank the two outgoing Vice-Presidents for their many important contributions to the College over the years in various capacities. I am also very grateful to our Honorary Treasurer for monitoring and maintaining the healthy financial position of the College. I would also like to thank our Council Members, in particular our Immediate Past President and Senior Advisor for their unfailing support and invaluable advice over the past year. Finally, I wish to thank our Honorary Secretary and the hardworking and dedicated secretarial staff in maintaining smooth operation of the College.

***“to encourage participation of the younger Fellows ..... support to their research activities through funding grants”***

# The President's Address to New Fellows at the HKCP Conferment Ceremony 2013



Patrick CK Li  
President, HKCP

Today indeed marks an important milestone for our newly admitted Fellows. Some of you may even feel complacent that you have completed your specialist training and can now practise independently as a specialist. However, you should realise that you still have a long and promising career ahead and you will need to put in considerable effort to maintain a high standard of practice. Apart from continuous professional development to keep abreast of the latest medical advances, you will be under constant scrutiny from your peers and your patients to ensure that your practice is safe and up to the accepted standard. Patients nowadays have high expectation of the quality of medical care that they receive while the public expects patient safety to be given paramount importance. To tackle this, there are already different governance systems in place in public and private institutions.

***"clinical governance ..... is in fact a framework for ensuring patient safety while maintaining professional autonomy"***

**D**r. Ko Wing Man, Secretary for Food and Health, Dr. Donald Li, President of the Hong Kong Academy of Medicine, President of Sister Colleges and their representatives, Fellows and Members of the College, Invited guests, ladies and gentlemen.

Today is a very special occasion for the newly admitted Fellows and

Members. On behalf of the College, I extend to you my congratulations on your well-deserved achievement, which is the result of your dedication and hard work over the past years. I sure that you would all appreciate the support from your colleagues, your family and loved ones, without which your success today would not be realised. I hope that you will all continue to strive for excellence and professionalism in your future career.

Many doctors may feel unfamiliar with or even threatened by the concept of clinical governance. It is in fact a framework for ensuring patient safety while maintaining professional autonomy. The framework is applicable to doctors practising in academic, public and private sectors. There are a number of components of clinical governance and I would like to share with you some which are relevant to specialist practice. These include evidence-based practice, continuous professional development, clinical audit and risk management.

Most of you should be familiar with the concept of evidence-based medicine. Based on such principles, institutions and professional bodies will develop and promulgate clinical practice guidelines and recommendations. When practising beyond the scope of the existing guidelines, as with novel treatment strategies, it would be important to consider their limitations and relative efficacy in comparison with alternative treatment. The patients should be fully informed about the known benefits, limitations and unknown risks and not be given unrealistic expectation. Highly experimental treatment strategies should only be administered in the context of clinical trials under the governance of Research and Ethics Committees.

The importance of continuous professional development in maintaining updated knowledge base for clinicians is widely accepted and is being catered for by the Continuous Medical Education framework of the College. In relation to skills in performing interventional procedures, a more complicated framework comprising training, certification, maintenance and review of competence is required.

While the commonly performed interventional procedures are mostly covered during higher physician training, proficiency in performing more novel or highly specialised interventional procedures are mostly acquired post-Fellowship. Other than in the context of clinical trials, the introduction of novel interventional procedures should be governed based on latest international experience while the operators should be required to undergo relevant training to acquire the necessary competence. In view of the higher risk inherent in such novel or complicated procedures, a framework for credentialing should be in place to monitor the throughput and outcome of individual operators in order to ensure maintenance of proficiency. The criteria and mechanism for credentialing should be objective and independent of the seniority or status of the operator.

For specialty service programmes and commonly performed interventional procedures, clinical audit would be the appropriate framework to ensure that the performance is on par with local peers and international standards. The audit should capture the clinically relevant outcome variables which should be adjusted for patient profile, clinical risk level and important confounding factors. It should be emphasised that clinical audit primarily serves the objective of identifying areas for improvement rather than being a mechanism to single out and penalize underperforming institution or staff. The outcome should be reviewed in an objective manner to identify areas of deficiency, if any, so that improvement measures can be implemented to assist the concerned institution or staff to enhance the performance and attain better

performance during the next round of audit.

Finally, there should be a system for identifying patient risks so that remedial and preventive measures can be implemented to enhance patient safety. Mortality and morbidity meetings should be conducted regularly at specialty team and department level to critically review patients with adverse treatment outcome. Root-cause analysis should be performed for significant incidents to identify need for system improvement or remedial training for staff with unsafe performance. Each adverse incident should be treated as an opportunity for learning so that our practice can be safer.

I would end by emphasising that clinical governance is a framework for enhancing patient safety and driving quality improvement while maintaining professional self-governance. It is not intended to stifle innovation, induce risk aversion or to single out and penalise staff with suboptimal performance. As specialists committed towards maintaining a high standard of professional practice, I would call upon all of you to actively engage in clinical governance so that patient safety can be safeguarded.

***“The importance of continuous professional development in maintaining updated knowledge base for clinicians is widely accepted and is being catered for by the Continuous Medical Education framework ”***

## 26th Annual General Meeting 15th Congregation and Annual College Dinner

**A**t the AGM held on the 19 October 2013, Dr Patrick Li delivered the Presidential report which summarized the work and achievements during the past year. He paid tribute to members of the various subcommittees for their continuing contributions rendered to the College. The official ceremony proceeded with the conferral of Fellowships and Memberships in the presence of a dignified platform party.

This year, Honorary Fellowship was conferred to Dr Loretta Yin Chun Yam. Her citation was delivered by Professor Philip Li, Vice President of the Hong Kong College of Physicians.

Dr Loretta Yam is a well-respected physician and hospital administrator in Hong Kong. She is a respiratory physician by background. As Chief of Service of the Department of Medicine of PYNEH since its opening in 1993, she demonstrated leadership which drove strategic changes in patient safety and quality practices not only in PYNEH, were adopted by the Hospital Authority for corporate-wide implementation. Dr Yam is deeply admired for her instrumental contributions to the HKCP over two decades of long and dedicated service. She has served in the HKCP since 1991, as Honorary Secretary from 1995 to



2004 and Vice-President since 2004 to 2013. The foundations and constant updating in physician training and accreditation are exemplified by five editions of the College training guidelines book which Dr Yam has devoted her time and expertise to coordinating. Her achievements and contributions to medicine in Hong Kong are innumerable and in the near future, Synapse will interview her as profile doctor so that readers can be inspired by her role model.

New Fellows were admitted during the annual Conferment ceremony held at the Annual College Dinner. This occasion was well attended by new and old Fellows alike, along with their family members. During the annual dinner, Professor Rosie Young delivered the 18th AJS McFadzean Oration titled "Unprecedented, unique and enduring legacy".

The President presented all the College awards for best academic achievements in the year 2012-2013.



Dr Patrick Li, President with the officiating platform party and honorable guests.



A token of appreciation to Prof YL Kwong for organizing HKCP's Annual Scientific Meetings for numerous years!





# **Annual Scientific Meeting (19-20 October 2013)**

## **Novel Diagnostic Technologies in Internal Medicine**

..... The recent College's  
..... ASM at the Hong Kong  
..... Academy of Medicine  
..... Building brought  
..... together a wide array  
..... of specialists, College  
..... trainees and fellows to  
..... learn of exciting and  
..... novel technologies  
..... which are increasingly  
..... influencing our  
..... management approach  
..... in internal medicine.

..... Advances in imaging,  
..... endoscopic and



Lunch Symposium : Diagnosis of Acute Coronary Syndrome



Dr KK Chan, Prof Rosie Young and Prof James Liao



Prof P Li, Dr P Li, Sir D Todd, Prof R Yu, Dr HT Pang and Dr CS Li

Symposium On Radiological And Isotopic Technologies



Prof Kwong, Dr PW Ng, Dr E Lee, Dr E Tse, Prof V Mok, Prof P Li and Dr P Li

Symposium on Endoscopic and Interventional Technologies



Dr P Li, Dr M Wong, Dr A Chan and Dr ST Lai

Symposium on Molecular Technologies



Chaired by Prof YL Kwong



Prof Patrick Woo



Dr Edmond Ma



Dr Chloe Mak

other interventional procedures which have significantly impacted on our diagnostic abilities in specialties such as oncology, dementia, gastrointestinal and respiratory specialties were discussed by local experts. Molecular techniques in genomics and clinical genetics rounded up the meeting on the second day.

This year, a new named lecture was made possible by the kind sponsorship of Professor Richard Yu. The inaugural lecture titled "The search for genetic predictors of diabetes and diabetic complications- from epidemiology to personalized medicine" was delivered by Professor Ronald Ma.

It complements the other prestigious named lectures during this annual scientific weekend. The Sir David Todd Lecture Medal was presented to Professor Eric Tse for his molecular research in hepatocellular carcinoma. The Gerald Choa Memorial Lecture, intriguingly titled "Chance of a lifetime" was eloquently delivered

by Professor Anthony Chan.

On the second day of the meeting, winners of the College's prizes for the Best Thesis Award and the Distinguished Research Paper Award for Young Investigators 2013 presented their work.

### The AJ5 McFadzean Oration 2013

AN UNPRECEDENTED, UNIQUE  
AND ENDURING LEGACY

Emeritus Professor Rosie TT Young  
The University of Hong Kong



### The Gerald Choa Memorial Lecture 2013

CHANCE OF A LIFETIME

Professor Anthony TC Chan  
Li Shu Fan Medical Foundation Professor of Clinical Oncology  
Director, Sir YK Pao Centre for Cancer  
Prince of Wales Hospital



### Sir David Todd Lecture 2013

PINNING DOWN  
HEPATOCELLULAR CARCINOMA –  
THE ROLE OF  
PEPTIDYL-PROLYL-ISOMERASE

Dr Eric WC Tse  
Department of Medicine  
Queen Mary Hospital  
The University of Hong Kong



### Richard Yu Lecture 2013

THE SEARCH FOR GENETIC  
PREDICTORS OF DIABETES AND  
DIABETIC COMPLICATIONS –  
FROM EPIDEMIOLOGY TO  
PERSONALIZED MEDICINE

Professor Ronald CW Ma  
Department of Medicine and Therapeutics  
Prince of Wales Hospital  
The Chinese University of Hong Kong



## Distinguished Research Paper Award for Young Investigators 2013



### Dr Alex Pui Wai Lee

Department of Medicine & Therapeutics,  
Prince of Wales Hospital

Quantitative analysis of mitral valve morphology in mitral valve prolapse with real-time 3-dimensional echocardiography importance of annular saddle shape in the pathogenesis of mitral regurgitation.

Lee AP, Hsiung MC, Salgo IS, Fang F, Xie JM, Zhang YC, Lin QS, Looi JL, Wan S, Wong HL, Underwood MJ, Sun JP, Yin WH, Wei J, Tsai SK, Yu CM.

Circulation. 2013 Feb 19;127(7):832-41.



### Dr Walter Wai Kay Seto

Department of Medicine,  
Queen Mary Hospital

A large case-control study on the predictability of hepatitis B surface antigen levels three years before hepatitis B surface antigen seroclearance.

Seto WK, Wong KH, Fung J, Hung FN, Lai CL, Yuen MF.

Hepatology. 2012 Sep;56(3):812-9.



### Dr Grace Lai Hung Wong

Department of Medicine & Therapeutics,  
Prince of Wales Hospital

Accuracy of risk scores for patients with chronic hepatitis B receiving entecavir treatment.

Wong GL, Chan HL, Chan HY, Tse PC, Tse YK, Mak CW, Lee SK, Ip ZM, Lam AT, Lu HW, Leung JM, Wong WW.

Gastroenterology. 2013 May;144(5):933-44.



### Prof Wai Sun Wong

Department of Medicine & Therapeutics,  
Prince of Wales Hospital

**Winner for the Best Oral Presentation Award**

Community-based lifestyle modification programme for non-alcoholic fatty liver disease: a randomized controlled trial.

Wong WW, Chan RS, Wong GL, Cheung BH, Chu WC, Yeung DK, Chim AM, Lai JW, Li LS, Sea MM, Chan FK, Sung JJ, Woo J, Chan HL.

J Hepatol. 2013 Sep;59(3):536-42.

## Young Investigator Research Grant 2013

The grant was established in 2012, to encourage young clinicians to conduct research in Hong Kong. Young Members or Fellows who are aged 40 years or below are invited to apply, but applications must be approved by the respective applicants' Chief of Service. Up to five Grants of up to \$50000 each are presented annually, with selection by the Grant Subcommittee.

A notice inviting applications will appear in the College website around April-May of each year.

Efficacy and Safety of Intradermal Trivalent Influenza Vaccination with the novel microneedle delivery device in institutionalized older adults : A randomized open labeled trial

**Dr Tuen Ching Chan**

Effects of collateral circulation on the hemodynamic flow status in intracranial artery stenosis as depicted by computational fluid dynamics model

**Dr Florence Sin Ying Fan**

Plerixafor in combination with azacitidine for high-risk myelodysplastic syndrome - A pilot clinical and mechanistic study

**Dr Harry Gill Harinder Singh**

The Hong Kong Multiple Sclerosis Registry (HKMSR)

**Dr Alexander Yuk Lun Lau**

Evaluation of incorporating Xpert MTB/RIF and liquid mycobacterial culture in the diagnostic algorithm of adult patients hospitalized for suspected extra-pulmonary tuberculosis

**Dr Grace Chung Yan Lui**

# BEST THESIS AWARD



Prof Patrick Li and Dr Chi Ho Lee



Prof Nelson Lee, Dr CC Mok and Dr Kelly Chan



Prof Nelson Lee, Prof YL Kwong and Dr Thomas Chan

## Medal for obtaining the highest score in AIM Exit Assessment (2013)

Dr Yat Fung Shea  
Department of Medicine  
Grantham Hospital

## Medal for obtaining the highest score in PACES (2013)

Dr Ivy Hoi Yee Ng  
Department of Medicine & Geriatrics  
United Christian Hospital





# The HKCP Council 2013-2014

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Prof Wong Ka Sing, Lawrence  
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Prof Sir David Todd

### Past President

Prof Lai Kar Neng

### Senior Advisor

Prof Yu Yue Hong, Richard

SIR DAVID TODD LECTURE



# PINning down hepatocellular carcinoma – the role of peptidyl-prolyl-isomerase

Eric Wai Choi Tse

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



**Synopsis**

Protein phosphorylation is an important post-translational modification that regulates the functions of many proteins. The newly discovered post-phosphorylation processing mediated by the peptidyl-prolyl-isomerase PIN1 has recently been shown to be a critical mechanism for further fine tuning of protein function. PIN1 binds specifically to Ser/Thr-Pro (an amino-acid sequence in which a serine or threonine precedes a proline) motifs only when the serine or threonine residue is phosphorylated. Through catalyzing *cis-trans* isomerization of the prolyl-peptide bond, PIN1 can selectively effect conformational changes and possibly also functional changes in certain proteins that are regulated by serine/threonine phosphorylation. PIN1-

mediated protein modification has now been proven to be a significant event in the pathogenesis of many human cancers.

Hepatocellular carcinoma (HCC) is one of the leading causes of cancer death worldwide. Surgical resection is the mainstay of treatment, but for inoperable tumours, the mortality remains very high despite the use of systemic chemotherapy. Newer treatment modalities such as specific targeted therapy, which are more effective and less toxic, are therefore most desirable. In the past several years, my group has been investigating the role of PIN1 in the patho-biology of HCC and its potential as a therapeutic target.

We have shown that PIN1 is over-expressed in more than 50% of

human HCC and that PIN1 over-expression confers tumourigenic properties to human hepatocytes.  $\beta$ -catenin and cyclin D1 are two of the mediators involved in the transformation process. Using both candidate proteins and proteomics approaches, we have identified other important proteins that are regulated by PIN1 and have defined the roles of PIN1 in tumorigenesis as well as in invasion and metastasis of HCC.

Hepatitis B virus (HBV) infection is strongly associated with the development of human HCC, and an HBV encoded protein, the x-protein (HBx), has been implicated in the pathogenesis. PIN1 is preferentially over-expressed in HBV-related HCC. We have found that PIN1 binds to HBx and promotes its oncogenicity. Furthermore, survivin, an inhibitor of apoptosis which is also frequently over-expressed in HCC, has also been identified to be a PIN1 binding partner. PIN1 enhances the anti-apoptotic function of survivin by facilitating the interaction between survivin and caspase-9. In addition to its role in tumourigenesis, we have also demonstrated the positive effect of PIN1 on the invasiveness and metastatic potential of HCC. PIN1 increases the expression of vascular endothelial growth factor (VEGF) by stabilizing hypoxia-inducible factor 1-alpha (HIF-1 $\alpha$ ) and thereby, promotes angiogenesis in the tumour. Conversely, suppression of PIN1 expression significantly inhibits the growth and the metastatic propensity of HCC. Currently, my team is investigating the role of Pin1, through the interplay with Cks proteins, in regulating DNA damage response and cell cycle progression in cancer and neurodevelopment. Given all these important and diverse functions of PIN1 in promoting the malignant behaviour of liver cancer cells, therapeutic intervention targeting PIN1 may represent an effective approach for the treatment of HCC.

# AJS McFadzean Oration 2013

## An Unprecedented, Unique and Enduring Legacy

Emeritus Professor  
Rosie TT Young  
The University of Hong Kong

.....●.....

**W**hen Professor Richard Yu called me up asking me to give this year's AJS McFadzean oration, my first reaction was not to accept it. The oration is to honour the late Professor McFadzean, who is universally recognized as a doyen in the medical profession and possibly the most revered medical educationist of Hong Kong. To be invited to give the AJS McFadzean oration is regarded as the greatest honour that can be conferred on a Fellow of this College. I felt that my modest reputation as a speaker did not qualify me for this honour. There are many younger and more eloquent Fellows in the College who can give a more enlightened and inspiring lecture than myself. Nevertheless Professor Yu's insistence and persuasion changed my mind. My only qualification to give this talk, is my intimate knowledge of the man and his contribution to medicine in Hong Kong during his tenure as Professor and Head of the Department of Medicine from 1948 to 1974, as Dean of the Faculty of Medicine from 1967



to 1972, and as Vice-Chancellor of the University of Hong Kong in 1965.

Professor McFadzean came to Hong Kong to take up the Chair in Medicine in 1948, having served as lecturer and then senior lecturer in his Alma Mater, Glasgow University. You may remember that this was barely 3 years after World War II and the University of Hong Kong had just opened its doors to the first batch of medical students. He had a handful of staff to help him formulate the curriculum, to teach and to provide clinical services for inpatients and outpatients at Queen Mary Hospital. This was a daunting task for

someone who knew nothing about Hong Kong. The environment and culture in Hong Kong in the 1940s was also very different from what we encounter today and was completely foreign to someone from Scotland. Moreover, very few people could speak English fluently.

### Undergraduate Teaching

Being the first Professor of Medicine after the war, he had the responsibility of devising a curriculum which would produce competent doctors to treat primarily Chinese patients and also to satisfy the General Medical

Council of the United Kingdom, which recognized our MB BS degree. In this he succeeded with flying colours. He always preached that teaching should focus on the principles of medicine and avoid overloading students with unnecessary facts. He emphasized the relevance of basic medical sciences (anatomy, physiology, biochemistry, pathology and microbiology) to the understanding of clinical medicine. In later years the curriculum was modified in line with the rapid progress in genetics and molecular biology. Teaching of clinical medicine was conducted in classrooms as lectures, and in the wards and outpatient clinics as bedside teaching. In addition there were seminars and 'clinico-pathological' conferences; each of these could be regarded as a forum where clinicians, pathologists, and others got together to discuss the presentation, pathogenesis, and management of a particular disease. Students would also take part in the ensuing lively discussions. He was widely recognized as a formidable teacher and a strict disciplinarian. Rumours were rife that he would drive students out of the classroom if they arrived late or were not properly dressed. In fact he imposed a dress code for students

entering the wards, to ensure that they could gain the respect of their patients. In lecturing he was erudite and inspiring, and he particularly welcomed challenges from students with an enquiring mind. This last practice was the exception rather than the rule in those days. Despite his stern appearance, he was the kindest of examiners. He always tried to put the candidate at ease so as to elicit the best performance from the examinee. During his tenure, the intake of first year medical students rose from 70 to 150. The Medical Faculty of the Chinese University of Hong Kong came into being in 1981 to meet the increasing demand for doctors in Hong Kong. The intake of medical students for each University at present is 210 per year. The mode of instruction has also undergone considerable evolution; emphasis is now on learning rather than teaching (especially didactic teaching). The number of lectures has been drastically reduced and replaced by interactive small group teaching. Clinical subjects and basic medical sciences are also integrated vertically or horizontally according to systems, and clinical medicine is introduced early into the curriculum.

The new curriculum has pros and cons. It requires students to take

more initiatives in self-learning and is facilitated by internet access. It also makes the early years of training in basic medical sciences more interesting, by illustrating relevance to clinical medicine. All of these innovations are undoubtedly commendable. However, I am afraid that students may have a less thorough understanding and less interest in basic medical science. One possible remedy is to attract more students to take an intercalated BSc course with a year spent on research or in-depth study of a particular subject, or they could take an MD PhD degree. Hopefully, such measures can induce more students to take up a research or academic career after graduation.

### Postgraduate Training

When Professor McFadzean came to Hong Kong in 1948 the term 'specialist' was unheard of. After serving a year's internship anyone qualified as an MBBS would be licensed by the Hong Kong Medical Council to practise as a physician, surgeon, or as an obstetrician and gynaecologist. Very early on in his tenure, he recognized the importance of postgraduate professional training and the need for doctors to acquire expertise in a particular area of medicine. While in Glasgow, he himself worked in a department with a special interest in haematology. Four of his students, David Todd, H C Kwan and later S C Tso and T K Chan followed his footsteps and took up haematology as their specialty. He also established other specialties in the department, including cardiology, respiratory medicine, endocrinology and hepatology and gastroenterology. However training was unstructured and mainly took the form of in-service training. After a few years of working in the department and having selected a specialty, several





junior doctors would be sent to an academic department in Scotland or England to pursue further training and to take the membership examination of one of the Royal Colleges of Physicians. This period of one to two years overseas training also provided the young doctor a golden opportunity to develop a research interest and skill, away from the burden of clinical duties faced every day at home. However, this privilege was only available to the lucky few who joined the University Department of Medicine. Others had to enter private practice after gaining some experience by working in the public hospitals or government outpatient clinics for a few years. Those who wished to pursue a career in internal medicine would go on working as medical officers, but received no formal or structured training. They would have to take no pay leave or obtain a Scholarship such as the British Council or Sino-British Fellowship, so as to go to the United Kingdom to undertake postgraduate training and obtain membership of one of the Royal Colleges.

All this is in stark contrast to the training stipulated by the Hong Kong College of Physicians today. Most medical specialties are now so well developed in Hong Kong that a lengthy period of overseas training is not obligatory. Nevertheless, there is a discernable advantage for a young doctor to undertake a short period of overseas study to broaden his or her experience in their specialty, to stimulate their research interest, and to build up international contacts. After all, Hong Kong is a small place and it is very easy for someone to become complacent.

The establishment of the Hong Kong Academy of Medicine in 1992 with the College of Physicians as one of its founding Colleges has put

postgraduate training on a sound and legal footing. Having overcome initial teething troubles, the Academy has evolved into an internationally renowned organization poised to lead the development of postgraduate medical education in China.

If he were alive today Professor McFadzean would be very pleased to see that the seeds he sowed in the 40s to 70s had borne fruit and continued to flourish.

### Clinical Service

In a clinical department training and clinical service are inseparable. The development of medical specialties and subspecialties as envisaged by Professor McFadzean enabled the training of young doctors to take a giant step forward. Doctors can now acquire the appropriate knowledge, skill and experience of a specialty of their choice and are expected to provide patients with the best possible state of the art service. The spectrum of illnesses facing doctors today is very different from what we saw in the 40s to 70s. In place of infections such as tuberculosis, presently the leading causes of death are malignancies and degenerative disorders such as cardiovascular diseases and strokes. Major factors that brought about this transformation were improvements in public health and advances in medicine and medical science. We now have a better understanding of the causation of most diseases, the means of making an early diagnosis, and more effective modalities of treatment. As a result, communicable diseases have assumed diminishing importance in the minds of the medical profession and the public. The outbreak of SARS in 2002/2003 came as a big surprise and reminded us that we must not relax in the surveillance of infections.

Despite the emphasis he put on the development of medical specialties, Professor McFadzean always preached holistic care and insisted that a sound knowledge of general medicine acquired in the basic physician training period (the first three years of rotation training after internship) was the foundation of professional training for all physicians.

The establishment of the Hospital Authority and reform of the public hospitals in 1990s initially satisfied the public and healthcare staff by providing a more conducive working environment, abolition of camp beds, and reduction in waiting times for hospital admission and outpatient clinics. Recently however, these problems have re-emerged and more thought must be given to healthcare reform, including funding to prevent diseases, promote health, control infections, and cure illnesses.

### Research

I mentioned earlier that as a teacher Professor McFadzean encouraged his students to ask questions and his lectures often inspired them to search for the truth. Research was always in his blood and he wanted his staff to exude the same feeling. Even as interns we were encouraged to engage in research, mostly clinical research in those days. The motive for research often began with an astute clinical observation. To quote an example given by David Todd in Synapse, Professor McFadzean noted that patients with cirrhosis of the liver suffered large bruises and bled excessively during surgery, out of proportion to their thrombocytopenia and clotting test abnormalities. While determining the prothrombin time of such a patient, the clot was seen to dissolve shortly after being formed. This immediately aroused his curiosity and study of this

'fibrinolysis' phenomenon in health and disease led to a number of widely acclaimed publications by him and HC Kwan in top international journals. When it came to research he was a harsh task master. He had no concept of time or family life. He expected all of us to work over the weekends and well into the night. We were required to obtain an MD by research in spite of our heavy clinical schedules. As a result only the very hard working ones could survive. I'll not bother you with the long list of research topics that he and his staff delved into during this period, suffice to say that they covered almost every specialty area and included both basic and clinical science. Genetics and molecular biology were in their embryonic stage then, yet Professor McFadzean had the foresight to send David Todd to the United States to learn these new disciplines. On his return David introduced the genetic study of thalassemia and together with Vivian Chan developed the first laboratory for prenatal diagnosis in Hong Kong. Whilst his legacy in research was remarkable, it was not confined to his personal achievements and those of his staff. He was a strong advocate of the need to question everything, and he firmly believed in the relevance of research to clinical practice. Besides, in those days research was conducted in 'non-existent' time with very little technical or financial support.

If he were alive today, he would have been delighted to see that funding is now provided to the universities by the University grants Committee through the Research Council and to a much lesser extent by the Government for health related issues. I am sure that like many of us here he would lament that it was still totally inadequate.



### Administration

It is widely known that as Professor and as Dean, Professor McFadzean played a pivotal role in the development of health services in Hong Kong. He did this not only through the large number of medical graduates he taught and the many government committees he served on, but also through the formal and informal advice he gave to senior government officials. Whenever there was a crisis, he was often the first person consulted by the then Director of Medical and Health Services.

I hinted earlier that if Professor McFadzean were alive today, he would be immensely proud of the progress made by our College in postgraduate professional training. I now wish to take the liberty to guess what else he might wish the College to do or to do more of. I would suggest the following:-

- 1) Research: Funding for university research is provided by the UGC, which may have a different agenda from what the medical profession wants in Hong Kong. With the weight put on research output in the assessment for promotion in the medical faculties, it is understandable that teachers focus on research resulting in publications in

international journals. The Government's provision for research in health related areas is also too restricted and inadequate. I think the College can take the lead to encourage and if possible give financial support to medical research in the prevention and treatment of diseases that are particularly relevant to Hong Kong.

- 2) The College should play a greater role in influencing public policy. I think this is easier said than done. The political climate today is very different from what it was when Professor McFadzean was here. But unity is strength and I am sure our College can join forces with other Colleges for this purpose. Any Government must recognize that the Academy of Medicine is a force to reckon with. In these ventures the medical faculties of the University of Hong Kong and the Chinese University of Hong Kong should be willing partners.

Ladies and gentlemen I am sure you'll agree with me that Professor McFadzean's legacy to Hong Kong is unprecedented, unique and enduring. I am equally certain that in certain areas such as research and medical education, his legacy goes well beyond the confines of this special administrative region.

# The Gerald Choa Memorial Lecture 2013 CHANCE OF A LIFETIME

## Professor Anthony T. C. Chan

Li Shu Fan Medical Foundation Professor of Clinical Oncology  
Sir YK Pao Centre for Cancer  
Faculty of Medicine  
The Chinese University of Hong Kong



It is with honor and some trepidation that I accepted the invitation to deliver the Gerald Choa Memorial Lecture. Unlike the previous speakers, I have neither been Professor Choa's colleague nor his student. However I am proud to say that both my personal and professional lives have been deeply connected to Professor Choa and his legacy.

In the book "Heal the Sick was their motto: The Protestant Medical Missionaries in China", Professor Choa devoted an entire chapter to the Medical Missionary education provided to wartime HKU students during the Japanese occupation made possible by the Dean of the Faculty of Medicine, Professor Gordon King. My father, Dr Wai Kai Chan, was in the same year as Professor Choa and they first met as medical students residing in Ricci



Hall where they both became devout Catholics and went into free China to continue their medical education, a bond that continued as a life-long friendship and brotherhood.

The title of my talk is borrowed from a book written by Arthur Starling on the founding of the Medical Faculty at the Chinese University of Hong Kong. Professor Choa



was Director of Medical and Health Services until 1975 and when he accepted the monumental task to be Foundation Dean of the new Faculty of Medicine, he invited his chief hospital administrator, Arthur Starling, to become the first planning officer of the Faculty. After Professor Choa's retirement, he continued to play an active role in steering new developments in the Faculty including the setting up of the Hong Kong Cancer Institute which laid the foundation for establishing the multi-disciplinary service, teaching and research model at the Sir YK Pao Centre for Cancer. The vision and goals of the Hong Kong Cancer Institute led by the two Directors Professor Philip Johnson (1992-2002) and Anthony Chan (2002-now) have been well recognized with the Cancer Centre becoming the first Partner State Key Laboratory of Oncology in South China in 2006, and the multi-disciplinary research team changing practice in cancers prevalent in Southeast Asia and China. The multi-disciplinary care model led by medical oncologists working alongside radiation oncologists, surgeons, radiologists, pathologists and other health

care team members, has been made possible with the support of successive Presidents and council members of the Hong Kong College of Physicians, most notably Professor Richard Yu.

For the past 20 years I have been most privileged to have the opportunity to contribute to improve the treatment outcome for nasopharynx cancer (NPC) through a series of clinical and translational studies. Our group defined the integrated multi-modality treatment approach to the management of NPC with the first multi-centre prospective randomized trial in locoregionally advanced disease. Our group was the first to demonstrate that concurrent cisplatin-RT (CRT) improved survival rates in endemic NPC, and subsequently demonstrated that neoadjuvant chemotherapy in addition to CRT further improved treatment outcome. We defined the prognostic significance of post-treatment Epstein-Barr virus DNA, and utilize this biomarker to risk-stratify patients for adjuvant therapy.

Today, medical oncology is the centrepiece in organ-based multi-disciplinary team approach in the research and treatment of solid cancers, establishing evidence-based and personalized approach to improve the outcome of cancer patients. With the support of the HKSAR Government, two world class phase I clinical trial centres are soon to be opened to further capitalize on our strengths.

Our journey together continues.

## Opening Remarks for the Gerald Choa Memorial Lecture

Professor Richard Yu

Past President, HKCP

Professor Gerald Hugh Choa was Vice President of the Hong Kong College of Physicians and founding Dean of the Faculty of Medicine, Chinese University of Hong Kong. He was a phenomenon – master clinician, visionary educator, Renaissance man, and one of the best of administrators.

When the CUHK Faculty of Medicine was established in 1984, Gerald had the vision to set up a Department of Oncology in parallel with the Department of Medicine and Therapeutics. At the time, cancer was primarily managed by surgery or radiotherapy. Only a handful of very toxic drugs were available for treatment, which at best was not too successful. Today, the situation is vastly different.

It is with this happy thought that I present Professor Anthony Chan, who is here this evening to deliver 12th Gerald Choa Memorial Lecture "Chance of a Lifetime". Professor Chan comes from a medical family. His father is a distinguished ophthalmologist Dr. Chan Wai Kai, and his mother Dr. Barbara Ng is a family physician noted for caring and sharing. Both parents were close and good friends of Gerald Choa. So it is natural that son Anthony should deliver tonight's Oration to honour the memory and contributions of a family friend and mentor.

It is also fitting, for in Prince of Wales Hospital Anthony is carrying on the work of the founding father of Medical Oncology in magnificent fashion. Prof. Chan graduated from University College London in 1988, and immediately began post-graduate research in solid cancers at the Royal Marsden Hospital. He returned to Hong Kong in 1993 to join CUHK as Lecturer in the Department of Oncology. He became Department Chairman in 2002, and Professor of Clinical Oncology in 2006. Prof. Chan introduced a new paradigm in cancer management, which exploits multi-disciplinary teamwork involving surgeons, radiotherapists, pathologists, and other health care personnel to offer combined expertise and the benefits of an organ-specific approach. In 2002, as chairman of the Subcommittee of the Specialty Board in Medical Oncology, he was entrusted with the task of implementing the new ideas in (no begin with) the Prince of Wales Hospital. As noted above, Medical Oncology is playing a more and more important role in cancer treatment, especially as a result of the development and optimized application of molecular target drugs in therapy. In all of this, Prof. Chan has led and trained a new breed of Medical Oncologists in the battle against a deadly but increasingly conquerable disease.

Anthony Chan has contributed greatly to reifying and fulfilling the vision and legacy of the late Professor Gerald Choa. It is remarkable, the way he reflects the master's image, as a clinician, educator, and administrator.



Professor R Yu chaired the session and introduced the speaker

## RICHARD YU LECTURE

# The search for genetic predictors of diabetes and diabetic complications- from epidemiology to personalized medicine

Ronald Ching Wan Ma

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

### Synopsis

Asia is at centre of the global diabetes epidemic. Diabetes currently affects one in ten adults in China, with an alarming proportion of young people affected. Type 2 diabetes (T2D) in Asians is characterized by the presence of positive family history, young age of onset, a tendency to impaired beta-cell function as well as visceral adiposity compared with subjects of European descent. Furthermore, Asian patients with diabetes have a particularly high predisposition to renal complications. In order to understand the pathogenesis of diabetes and diabetic complications in the Chinese population, our group has embarked on a program of epidemiological and genetic research. Using the Hong Kong Diabetes Registry, we have utilized linkage-analysis, candidate-gene as well as hypothesis-generating whole-genome approaches to identify novel genetic predictors of diabetes as well as diabetic cardio-renal complications. This has led to the identification of novel genetic markers for diabetes which are relevant for the Chinese population. We have identified several variants, including the aldose reductase microsatellite polymorphisms, and more recently, variants in the protein kinase C- $\beta$ 1 gene as important genetic variants which can predict the risk of developing diabetic kidney complications. Ongoing work is focused on translating these discoveries to impact clinical management. Our identification of novel genetic factors may help identify at-risk subjects, reveal novel biological pathways as well as guide personalized treatment strategies.



### Introducing the new Richard Yu Lecture Award

The HKCP already hosts a number of named special lectures and prizes each year. To add to this, a new named lecture was established in 2013 with the kind support of our Past President, Prof Richard Yu. Nominations are open to Fellows of the College below the age of 45 years who has excelled in clinical research work. Following independent review by three external experts, the selected lecturer will present his work at the HKCP annual scientific meeting.



Dr Patrick Li thanks Prof Yu on behalf of HKCP

# BEST THESIS AWARD Gold Award Winner

## A Clinical and Genetic Study of Subjects with Pheochromocytomas & Paragangliomas in Hong Kong

Chi Ho Lee

Department of Medicine  
Queen Mary Hospital

### Introduction

Genetic testing is crucial in the management of subjects with pheochromocytoma and paraganglioma. Ten susceptibility genes causing distinct hereditary syndromes have been discovered. Caucasian series suggested that up to 37% of these tumours are genetically determined. Nevertheless, studies involving genetic classification of Chinese subjects with pheochromocytoma and paraganglioma are lacking.

### Objectives

This cross-sectional study aimed to provide a clinical and genetic summary of subjects with pheochromocytoma and paraganglioma at a single tertiary referral centre in Hong Kong.

### Methods

Subjects with pheochromocytoma or paraganglioma from Queen Mary Hospital, Hong Kong were analyzed for the presence of seven susceptibility genes including NF1, RET, VHL, SDHB, SDHC, SDHD and TMEM 127. Clinical indicators were assessed for their association with the presence of germline mutations.

### Results

Forty-one Chinese subjects were included for analysis. Germline mutations were found in 24.4% of them and 13.9% of subjects with an apparently sporadic presentation had hereditary disease. There were two novel mutations involving SDHB and SDHD. With the increasing number of clinical indicators, namely age of onset younger than 45 years, bilateral disease, multiplicity, extra-adrenal disease, malignant or recurrent tumours, subjects were more likely to harbour germline mutations of one of the susceptibility genes. ( $r = 0.681$ ,  $p = 0.016$ ).



### Conclusions

The prevalence rate of germline mutations among Chinese subjects with pheochromocytoma and paraganglioma in Hong Kong was comparable with Caucasian data. The known clinical indicators for hereditary disease were also applicable to Chinese subjects.

# BEST THESIS AWARD Silver Award Winner

## Suicidal Ideation in Patients with Systemic Lupus Erythematosus (SLE): Incidence and Risk Factors

Kelly Kar Li Chan

Department of Medicine & Geriatrics  
Tuen Mun Hospital

### Introduction

Systemic lupus erythematosus (SLE) is a multisystemic autoimmune disease predominantly affecting women of their reproductive age. It is a potentially disabling disease which poses significant physical and psychological burden on patients. Psychiatric symptoms such as depression and anxiety are common in patients with SLE. The most devastating consequence of having depression in SLE is an increased suicidal risk.

### Objectives

To study the incidence of suicidal ideation in patients with SLE and its associated demographic, psychosocial and disease-related factors.

### Methods

Consecutive patients who fulfilled  $\geq 4$  ACR criteria for SLE were recruited for a questionnaire study on suicidal ideation. Suicidal ideation was assessed by three standard questions on suicidal thoughts and suicidal plans in the past 1 month; and the intensity of suicidal ideation was assessed by the validated Chinese version of the Beck Scale for Suicidal Ideation (BSSI). The BSSI score is calculated from summation of scores of the first 19 questions (0-38 points) in the questionnaire. The higher the score is, the greater is the suicidal intention. Anxiety and depressive symptoms were assessed simultaneously by the Hospital Anxiety and Depression scale (HADS). Disease activity of SLE was assessed by the Safety of Oestrogens in Lupus Erythematosus National Assessment SLE Disease Activity Index (SELENA-SLEDAI) and organ damage since SLE diagnosis was assessed by the American College of Rheumatology/Systemic Lupus International Collaborating Clinics (ACR/SLICC) Damage Index (SDI). Correlation of the suicidal thought with the basic demographics, psychosocial and disease-related factors was studied. A linear regression model was established to study the independent factors associated with the intensity of suicidal ideation (BSSI).

### Results

Three hundred sixty-seven SLE patients were recruited. The mean age of patients was  $40 \pm 12.9$  years and the mean SLE duration was  $9.3 \pm 7.2$  years. Sixty-seven (18.3%) patients had clinically active SLE (SELENA-SLEDAI  $\geq 5$ ). One hundred thirty-seven (37.3%) patients had organ damage (SDI  $\geq 1$ ). Forty four (12%) patients had suicidal thoughts within 1 month of study. The mean BSSI score of patients was  $1.51 \pm 3.8$  (range 0-24; median=0; IQR=1). Patients with suicidal thoughts had significantly higher mean SLEDAI scores in preceding 12 months ( $5.1 \pm 4$  vs  $2.9 \pm 2.7$ ,  $p < 0.001$ ), total SDI ( $1.4 \pm 1.7$  vs  $0.6 \pm 1.1$ ,  $p < 0.001$ ); and were more likely to be unemployed (68.2% vs 48.9%,  $p = 0.04$ ), receiving Government financial assistance (20.5% vs 10.5%,  $p = 0.02$ ), having lower educational level (10.2 years vs 11.2 years,  $p = 0.04$ ), previous suicidal attempts (22.7% vs 19.8%,  $p = 0.03$ ), a history of psychiatric disorder (50% vs 32.8%,  $p = 0.02$ ) and major life events within one month (31.8% vs 15.2%,  $p = 0.008$ ) than those without. Linear regression revealed that the BSSI score correlated with HAD-depression score (Beta 0.27,  $p = 0.001$ ), past suicidal attempt (Beta 0.12,  $p = 0.03$ ), major life events within one month (Beta 0.13,  $p = 0.01$ ) and cardiovascular SDI (Beta 0.27,  $p < 0.001$ ).



### Conclusions

Suicidal ideation is common in SLE patients. The intensity of suicidal thought is stronger in those with higher depressive scores, cardiovascular damage, recent adverse life events, as well as those with a past history of suicidal attempts.

# BEST THESIS AWARD

## Bronze Award Winner

### Venous thromboembolism in Chinese patients – a 3-year experience from a tertiary hospital in Hong Kong

Thomas Sau Yan Chan

Department of Medicine  
Queen Mary Hospital

#### Introduction

Venous thromboembolism (VTE) was considered an uncommon condition in Chinese people. Recent evidence, however, suggests an increase in prevalence of VTE in Asian countries. It is unclear whether this change in epidemiology represents a genuine change or is just due to enhanced awareness leading to increase in diagnosis.

#### Aims

To determine the prevalence of VTE in Chinese patients in a tertiary hospital in Hong Kong, and to examine the underlying aetiologies in relation to its trends in prevalence

#### Methods

Retrospective data entry and analysis were performed on patients with deep vein thrombosis (DVT) of extremities (confirmed by duplex Doppler ultrasound/post-mortem studies) and pulmonary embolism (PE) (confirmed by contrast computed tomography (CT) of thoracic region/post-mortem studies). Their baseline characteristics, associated risk factors, survival data were analysed. Prevalence of VTE in Chinese people in Hong Kong was estimated..

#### Results

A total of 446 patients (DVT, n=341; PE, n=75; DVT+PE, n=30) were enrolled into the study. The estimated prevalence of VTE in Chinese people in Hong Kong was 31.4/100000 persons years. Underlying malignancy was the largest risk factor for VTE and accounted for 36.1% of DVT and 40% of PE. The survival of patients with malignancy associated VTE was short, at a median survival of 61 days. Despite the lack of pharmacological prophylaxis, the incidence of DVT and PE in association with lower limb joint replacement surgery remained low at 0.88% and 0.18% respectively. Excluding patients with cancer associated thrombosis, the one-year survival of patients with VTE was significantly impaired, being 75.5% for DVT and 62.3% for PE.



#### Conclusions

Our study has shown that the prevalence of VTE in Chinese population is increasing, which is contributed largely by a growing population of malignancy associated thrombosis. The prognosis of this group of patients is poor. The incidence of symptomatic VTE after lower limb joint replacement surgery is low, and the benefits and risks of prophylactic measures need to be considered.



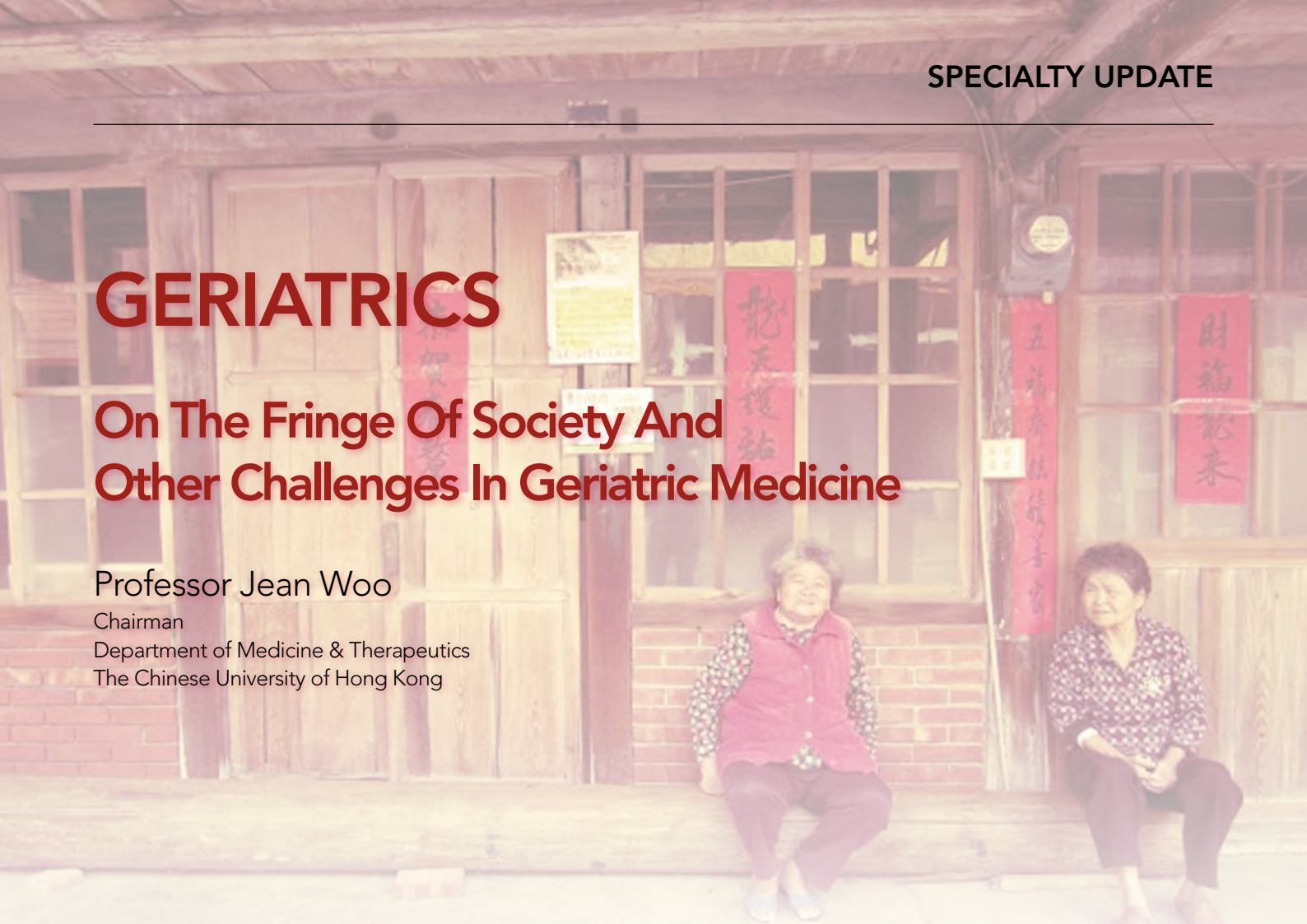
# GERIATRICS

## On The Fringe Of Society And Other Challenges In Geriatric Medicine


Professor Jean Woo

Chairman

Department of Medicine & Therapeutics  
The Chinese University of Hong Kong



**Physicians of a certain age would have witnessed a marked change in patient profile from the 1970s, when patients were younger, can give a coherent history, have diseases that fit into the standard medical textbooks, and well defined treatments. Life was fairly simple then.**



One felt confident in making a definitive diagnosis and providing treatment. Now many patients may not be able to talk, or if they do one may not trust the history and need corroboration from the family as a result of the high prevalence of dementia; they have multiple diseases and system impairments; they have cognitive as well as functional impairments; they need to be cared for as part of a social unit similar to the paediatric setting; their nutrition intake may not be adequate, and care may be more palliative instead of curative. Yet our approach to health care and the health care system remain in the era of the 1970s, with an emphasis on guidelines and protocols for individual diseases, technological developments in screening, diagnosis and treatment. The latter are frequently reported in the media. Those working in the public sector will encounter a rapidly growing number of frail elderly patients mostly in the 80-100 age range, where this approach may be inappropriate. These patients by and large fall out of the mainstream of health services in the primary and secondary sectors, neglected by many health care professionals and their needs not well understood by policy makers.


### A typical case

I saw an 80 year old woman in the geriatric outpatient clinic, who had waited many months for the appointment. She had chest pain mainly at night, an abdominal hernia, back pain (was told to have osteoporosis), knee pain, had fallen a few times as her legs gave way, lived alone after the recent death of her son. She was referred to the Cardiac Clinic in the first instance but appropriately the referral was channeled to the geriatric clinic. Her other outpatient appointments were Orthopedic (for osteoporosis and knee pain presumably) and Surgical (abdominal hernia). The Geriatric Clinic appointment was the first of the three that she had to wait over a year for. So in desperation she went to the AED, since she thought that she may well have died of heart disease or broken many bones, while waiting for the Cardiac and Orthopedic Clinics. She was there from 2pm, and left after about 10pm after being seen by a doctor and told to wait for the results of the ECG, because from her perspective no one had helped her and she was very cold. She was given a packed dinner while waiting.

A quick assessment in the Geriatric Clinic established that the history was more compatible with symptoms of a hiatus hernia; that the abdominal hernia was diffuse due to generalized weakness of the abdominal wall muscles and although easily reducible, did affect her activities in the upright posture; that she had osteoarthritis affecting the knees; that she had mild kyphosis likely from osteoporotic vertebral collapse; that she had reactive depression from the loss of her adult son; that she was worried about finances; and last of all she thought she was better off dead since the government does not seem to care and maybe deliberately made the waiting lists so long that elderly people would die quicker. She commented that the government looks after new immigrants better than old people like her, and cited in detail the total allowances that can be given out to a family of four of approximately \$20,000 per month. She stated that there will never be any equality in our society except in death. She exhibited a fascinating mixture of having cognitive impairment in some aspects, and very clear thinking on some issues.

### Our response?

I hope that readers will agree that multiple specialty referrals (cardiac, orthopedic, surgical, psychiatry) are unlikely to help her. We would also need to examine the social and care aspects, as part of management. This is a problem that could be dealt with at the primary care level, and yet the current arrangement of our health and social care system is not structured to look after her. She had been referred from the GOPD in the first place. What is needed is someone whom she can communicate with to 'direct' the management, to listen supportively about her anxieties about her own health and other issues, be able to exercise judgment regarding the appropriateness of referrals that should have a specific aim. Our health and social care systems are so complex that one has to navigate across many compartments, even within a single health care provider such as the Hospital Authority. Many readers may have some personal experience in looking after aging relatives of this procedural nightmare.



***“a rapidly growing number of frail elderly ..... their needs not well understood by policy makers”***

**“the need to raise health literacy regarding ageing issues”**

The sad thing is that when one is trying to meet her needs, there are so many obstacles that even if professionals are sensitive to her needs, they cannot help much within the current system.

Such patients are the ‘raison d’être’ of Geriatricians. Their training orientates them to the need for comprehensive assessment and multidisciplinary management of such patients in hospitals as well as in the community. Yet when one considers the health system and physical environments in which such elderly patients are cared for, geriatricians often find themselves in an advocacy role, in highlighting the needs. With this perspective, I encounter many questions in daily practice. For example fever is a common occurrence in residential care homes for the elderly. A study over a one year period showed that about 38% cannot be attributed to any organisms, and of the 62% where organism(s) were identified, up to 47% were viral in origin<sup>1</sup>. Government Infection Control policy dictates a degree of isolation which cannot be provided in many old age homes. Therefore they all go to AED and are admitted, contributing to the ‘winter surge’. In hospital, infectious disease guidelines would label this as community acquired pneumonia and intravenous antibiotics started. Yet this is not the policy in paediatric wards, where there is a period of observation. In the community, family physicians are encouraged not to prescribe antibiotics immediately. In what way are adult wards different? Likely this is a result of application of guidelines for adults without considering the appropriateness in this subgroup of elderly. This practice is not without adverse consequences, since the increase in MRSA is an indirect result of increasing antibiotic usage. Yet this is portrayed again in the media as the old age homes ‘harbouring nasty germs’, as for the situation during the SARS epidemic.


Elsewhere I have discussed the need to raise health literacy regarding ageing issues among both professionals as well as the lay public, the importance of empowerment in the management of chronic diseases in the elderly, how elder-friendly service delivery could be constructed, the quality of dying, and prioritization in healthcare and ageism<sup>2</sup>. Our health and social care systems need to be orientated to the needs of this age group. What these are needs to be identified by research studies. These are not on the mainstream research agenda, and it remains for charitable foundations such as the Hong Kong Jockey Club to take a lead in stimulating research and providing funding support through the Cadenza Fellowship Project [[www.cadenza.org.hk](http://www.cadenza.org.hk)]. It remains to be seen whether the newly established Health and Medical Research Fund will encourage more studies in these fields.

Systems need to deal with complexity and complex interventions, covering multi-morbidity, dependency, and frailty. Currently arrangement of services and service protocols/guidelines are applicable to the general adult population: frail elderly are marginalized at all levels from policy makers to frontline service providers—they do not receive high priority. The word ‘patient-centred care’ is often bandied about. For many frail patients in hospitals, this should be attention to dignity and respect, eating and drinking, use of the toilet, communication and mobility. Yet these basic aims do not feature in the portfolios of hospital quality and risk teams.

Has there been a survey to document the number of such patients in our hospitals? Surely this would have a relevance on 'patient flow' during the annual winter crisis, and focusing on this area may provide more appropriate solutions that current efforts based on single disease solutions and opening of extra beds without extra staff? I suspect the problem is simply too difficult to grapple with and it is easier to focus on quality improvement initiatives such as 24 h thrombolysis/angioplasty services for stroke and myocardial infarcts among the 50-70 age group, even though the average age for stroke patients now is nearing 80 years, and doing yearly patient satisfaction surveys which are unlikely to include feedback from these patients.

The primary care setting is even less 'elder-friendly' than the hospitals. The Hospital Authority is effectively providing all levels of care for the elderly, working in close partnership with NGOs. Family doctors clinics are not supported by multidisciplinary teams to carry out geriatric assessment and management; doctors are not aware of the role of Geriatricians. They refer to Specialists. An 80 year old women caring for her 96 year old husband who is blind and bedridden complains of 'dizziness', and the family suggest referral by the family doctor to a Geriatrician, but the doctor says this is not appropriate: the patient should be referred to a neurologist. Boulton and Wieland have also drawn attention to the need for comprehensive primary care for older patients with multiple chronic conditions<sup>3</sup>. They pointed out that care is often fragmented, incomplete, inefficient, and ineffective, a description that can be applied to the situation in Hong Kong. Improvement may be made by comprehensive assessment, evidence-based care planning and monitoring, promotion of patients' and family caregivers; active engagement in care, and coordination of professionals in care of patients, all of which should be tailored to the patients goals and preferences. Patients 'lost in transition'<sup>4</sup> and iatrogenic disability as a result of hospitalization<sup>5</sup> may be hopefully be minimized.

Currently many guidelines and protocols are based on trials carried out in populations that do not remotely resemble the frail elderly population, or the increasingly large number of 'real' patients in our hospitals who are much older, have multi-morbidity, dependency and varying proximity to end of life. Guidelines inevitably fail when they are expected to cover all the problems and treatments used in taking care of these complex patients<sup>6</sup>. For example it has taken over 10 years for studies among older people aged 70 above showing that 'normal' values for the general adult population may be different among the older age groups, to be just beginning to be taken seriously. This has huge public health impact on screening and treatment goals, and yet has been largely ignored by the public health sector. For example among Hong Kong Chinese, optimal values for body mass index and body fat distribution for best health outcomes in terms of mortality, mobility decline and falls are higher than values for younger adults. This observation has been made in two large cohorts of 2000 and 4000 people ten years apart (mean age 72-80 years), and has also been documented recently in other Elderly Cohorts in Australia and Europe. Higher BMI confers survival benefits in patients with chronic diseases such as congestive



***“Systems need to deal with complexity and complex interventions, covering multi-morbidity, dependency, and frailty”***

***“Of greatest help from her point of view was having an empathic listener”***

heart failure and chronic obstructive pulmonary disease. After age 65, each 1 mmol/L of cholesterol increase is accompanied by decrease in non cardiovascular mortality after adjusting for age and sex, and the association increases in magnitude across each subsequent decade<sup>7</sup>. Traditional vascular risk factors did not optimally predict stroke or myocardial infarct in men aged 75+ with no previous history after a 6 year follow-up<sup>8</sup>. Strict adherence of a glycemic control target of HbA1C of <7% among frail elderly aged 80 years and over may result in hypoglycemic episodes; a recent review showed that there was no evidence that statins decreased all-cause mortality in adults aged 80 years and over without known vascular disease, and that lower levels of cholesterol may be associated with higher all-cause mortality<sup>9</sup>. The single trial of blood pressure reduction of patients over 80 years used a target BP of 150/80 and documented a reduction in cardiovascular events<sup>10</sup>, and yet when this was replicated in a general practice population, 40% had adverse drug reactions such that even the HYET guidelines may be difficult to apply<sup>11</sup>, since the trial population was unlike that in ‘real life’ settings<sup>12</sup>. Optimal management of hypertension in the very elderly remains a concern and unanswered questions remain since HYVET was stopped early because of significant findings in mortality<sup>13</sup>. There has been a recent call for a new health outcomes paradigm, in putting the emphasis on goal-oriented patient care<sup>14</sup>.

## **What we could do for the patient**

Further management took place at the Geriatric Day Hospital where comprehensive assessment, relevant investigations, and treatment (pharmacological or non-pharmacological) can be planned and implemented under supervision. The pain was determined to be non cardiac in origin and responded to famotidine. The occupational therapist made an abdominal truss, which enabled her to walk in more comfort, pending surgical opinion. The physiotherapist treated the knee pain with quadriceps strengthening exercises and local pain relief. Of greatest help from her point of view was having an empathic listener who explained the symptoms and reassured her regarding her physical condition, and in so doing dealt with her ‘depression’. After one visit she was smiling and did not talk about wanting to die anymore. She also revealed another symptom which she was too embarrassed to mention even to a female doctor at the initial consultation, that she had urinary incontinence and needed to bring a change of underwear with her when she goes out. She was taught pelvic exercises and advised on the use of pads. The Day Hospital can only offer attendance for a few months, and ideally she could be followed up in a community setting combining health and social care activities. And so we lost track of her after a few months. The unanswered question is that did we help her in the long run? We know that she was helped for the brief period she was in contact with the Day Hospital, but this only represent ‘episodic care’, and the benefits may all be negated by lack of subsequent continuing community support: a relegation back to ‘the fringe’ of society.

### The challenges

What has been described above is a common scenario, and the solution is common sense and not 'high tech'. The challenges exist at all levels from frontline doctors and other healthcare professions to policy makers and those who advise policy makers, in hospital and community settings. Other than training in improving competencies, incentives to attract and retain staff to this area of care, in parallel models of care need to be redesigned that best fulfill the needs of older adults in the most cost-efficient manner. Evidence-based practice and policy should be underpinned by research data, and guidelines and protocols need to be reviewed and modified when applied to the increasingly large numbers of frail elderly aged 80 years and above in healthcare settings. Geriatricians have a vital role in defining relevant research agenda, in documenting areas of neglect in research, training and service delivery, in participating in quality improvement initiatives benefiting this age group, and above all in effective advocacy. There are many recent developments that are encouraging, but the major obstacle of inter-disciplinary and inter-specialty protectionism remains, likely fuelled by the mechanism of bidding for extra resources. Is this article appropriate for readers of Synapse, or for Fellows of the College of Family Medicine, or for the College of Community Medicine? Hopefully by the time I need care in the future, I shall be cared for as an individual and not as component organs and shunted off to different parts of the repair factory. Ultimately is this not what we all would like to see? Surely we should all work towards this goal whatever our discipline and specialty, even if altruism is tinged with self-interest as the underlying motivation.

***“a common scenario, and the solution is common sense and not high tech”***

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Joint HKCPIE/MRCP(UK)  
Part I examination for the years  
2002 – 2013:

	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%)
Sep 12	80	59 (74%)
Jan 13	41	22 (54%)
Sep 13	76	60 (79%)

Joint HKCPIE/MRPC(UK)  
Part II (Written) examination for the  
years 2002 –2013:

	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%)
12 and 13 December 2012	57	44 (77%)
10 and 11 December 2013	60	52 (87%)

Passing rates for PACES over the past years:

October 2001	36/72 = 50%	March 2008	36/74 = 49%
February 2002	34/74 = 46%	October 2008	29/65 = 45%
October 2002	29/72 = 40%	February 2009	39/75 = 52%
February 2003	30/69 = 43%	October 2009	24/72 = 33%
October 2003	27/59 = 46%	March 2010	33/75 = 44%
March 2004	39/64 = 61%	October 2010	40/74 = 54%
October 2004	26/69 = 38%	February 2011	23/66 = 35%
March 2005	35/75 = 47%	October 2011	34/70 = 49%
October 2005	28/75 = 37%	February 2012	32/74 = 43%
March 2006	36/75 = 48%	October 2012	32/74 = 43%
October 2006	16/73 = 22%	March 2013	28/75 = 37%
March 2007	44/74 = 59%	(for HK Local candidates)	
June 2007	44/74 = 59%	October 2013	28/74 = 38%
October 2007	36/55 = 65%		

## UPDATES FOR TRAINEES

Professor Philip KT Li, Chairman, Education and Accreditation Committee

### Suspension of training

At 265th Meeting of 29 October 2013, the Council approved the following steps for Trainees to apply for suspension from a training programme, and rules for Specialty Boards/Basic Physician Board to adopt in handling such applications.

1. The period of suspension must be more than six months and less than three years. Extension of suspension period is normally not allowed.
2. Trainees should seek advice from their Trainers and Programme Directors and seek approval from their Chiefs of service (COS).
3. All Trainee applicants are responsible for the completion of both Part 1 and seeking approval from Chief of Service to complete Part 2 of Section A of the Application Form (AppSuspenF 291013).
4. The completed AppSuspenF 291013 should be submitted to the respective Boards at least 8 weeks in advance of the expected commencement of suspension, unless there are urgent and unusual circumstances in which case special approval by the relevant Board is required.
5. The respective Specialty Boards and Basic Physician Board have the discretion to approve or reject such applications and should directly inform the applicants using Section B of AppSuspenF 291013, send cc copies to the individuals specified on the form.
6. The suspension of training is temporary and Trainees are expected to resume training in due course.
7. The above rules will take effect from 29/10/2013 and supersede all previous regulations of the College on deferment of training.
8. The respective Boards are required to report to the Education and Accreditation Committee every six months (in June and December) on the number of Trainees whose applications for suspension of training have been approved or rejected.

The various application forms can be downloaded from our College website: <http://www.hkcp.org>

### Penalty on late submission of Higher Physician Training (HPT) form

At its 266th Meeting of 26 November 2013, the Council noted that there are some Trainees submitted their HPT form one year after their HPT commencement date. The Council decided that all higher physician trainees must submit their training application within three months from the date of the letter on Completion of BPT issued by the Basic Physician Board, such that the Trainees could submit their applications for admission into the College as Members and their HPT application form at the same time.

The Council agreed that failure to submit the HPT application within the time frame will result in postponement of the Trainee's HPT commencement date and an additional Training Fee of HK\$2,000.00 per year (or part of a year) delayed will be charged.

In addition, the Council decided the penalty on postponement of HPT commencement date for higher physician trainees who delayed submission of their HPT applications. The Council decided the following principle:

Time of late submission of HPT applications	Postponement of HPT commencement date
More than 3 months but less than or equal to one year from the date of the letter on completion of BPT	No postponement
More than one year but less than or equal to two years from the date of the letter on completion of BPT	6 months
More than two years but less than or equal to three years from the date of the letter on completion of BPT	12 months

The effective date is 1 January 2014.