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SYNAPSE

RESTRICTED TO MEMBERS ONLY



Photographer
Professor Richard YH Yu

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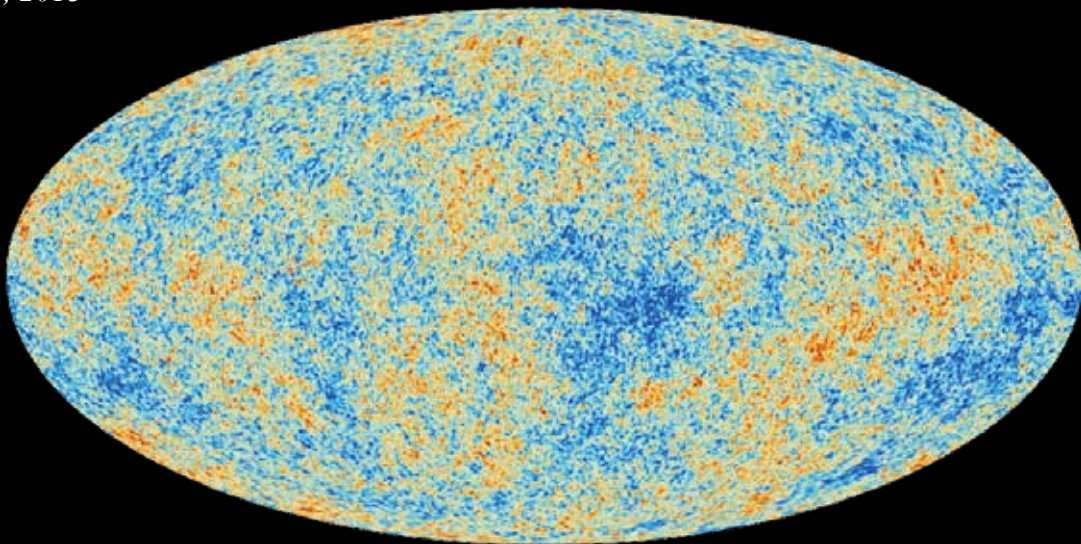
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The Communication of Advances in Medicine

William S.M. Summerskill
Senior Executive Editor
The Lancet

This article is based on the Richard Yu lecture delivered at the 16th Advances in Medicine conference organized by the Chinese University of Hong Kong at the Hong Kong Convention and Exhibition Centre on June 29, 2013



(Image credit: European Space Agency and the Planck Collaboration
http://www.nasa.gov/mission_pages/planck/multimedia/pia16873.html)

This is an image of our Universe taken by the Planck telescope.

Some say that the Universe is made of atoms; others that it is made of stories

I wonder how you see it?

As a general practitioner, my consultations were dominated by patients' experiences (their stories). By contrast; as a teacher of evidence-based medicine, it was ruled by numbers (atoms). This dichotomy

between the narrative and scientific aspects of our professional lives made me uncomfortable, until I recognized that both are not only valid, but essential. The universe is made up atoms and stories. Likewise, as you know, good clinical practice involves a judicious

combination of both evidence and patient-centredness. Similarly, to communicate Advances in Medicine effectively, both approaches are required: atoms for the scientific rigour and stories for the human context. This will be the focus for the 2013 Richard Yu lecture.

good clinical practice involves a judicious combination of both evidence and patient-centredness

It is my great privilege to give the Richard Yu lecture today. One cannot do so without reflecting on the remarkable progress in nephrology over the past 50 years. In molecular pathology, immunology, genetics, therapeutics, and transplantation, to name a few areas. The contributions of Richard Yu and his generation of researcher-clinicians to advances in medicine can be told both in atoms and in stories. In terms of

atoms, many forms of kidney disease are now so manageable, that the controlled biochemistry values seen in clinic are reflected by often normal lives. But this was not always so. I want to share with you one story of kidney disease from an earlier era – because in it, there is a possibility that Richard Yu and I may have unwittingly crossed paths at the Hammersmith hospital in London.



(image credit <http://www.imperial.nhs.uk/mediacentre/imagelibrary/>)

The year was 1963. Let me set the scene.

There had been a severe water shortage in Hong Kong. In the UK, the Beatles released their first album. US President John F Kennedy was assassinated and the Chinese University of Hong Kong had just been established.

Richard Yu was a clinical assistant on the renal unit at the Hammersmith Hospital. I was a 6 year-old child and remember having been fascinated by all the bare plywood at the Hammersmith – something I had never seen in a hospital before. Such was the state of the UK NHS!

Richard Yu came to the Hammersmith from Hong Kong to get his PhD at University College

London. Work from which – on angiotensin – he published in *The Lancet*.

I came to the Hammersmith from a stay in Seattle, where my mother was an early recipient of a Scribner shunt that enabled her to receive regular dialysis. She came to the Hammersmith for a new kidney.

The transplant did not happen for my mother. But over the years, kidney transplants happened for more and more people in more and more locations. Parallel advances in medicine resulted in enormous leaps in treatment. Each advance at an atomic level will have been magnified by many stories at a human level. The legacy of Richard Yu and his fellow nephrologists, is

to inspire all of us, regardless of specialty, with the confident hope that those diseases that challenge us today, will be effectively treated by our successors tomorrow.

It is the communication of advances in medicine that brings those glory days closer.

The seeds of future success – the advances yet to come – may well be planted during this weekend's conference. How will they be communicated? And – more importantly – how will they be implemented? You will hear the science in more than 2 dozen presentations over the next 2 days; and during the breaks, anecdotes – stories – that will seemingly affirm or refute the advances that you have heard. Which will hold sway in your universe, I wonder, the science of populations or the stories of individuals?

When you return to your institutions next week, how will you communicate the conference to your colleagues and patients: in terms of science or stories? The likelihood is that your recollections will be a combination of both: one reinforcing the other. But communication is subject to recall bias.

“it is easy to confuse personal opinion with evidence or personal ignorance with genuine scientific uncertainty”.

David Naylor

So during the conference, you may wish to consider David Naylor's observation, that "it is easy to confuse personal opinion with evidence or personal ignorance with genuine scientific uncertainty".

Communication about advances in medicine is enhanced by recognizing the story – the likely benefit of the advance to individual patients. However, to limit bias, communication must be firmly rooted in evidence. The more solid the underlying science, the easier it becomes to share.

My job as an editor is to champion evidence, to present advances in science clearly and fully so that they

can be implemented into practice to become advances in medicine, and ultimately, improvements in patient outcomes. But it would be arrogant – and misinformed – to assume that publication is the only form of communication, or indeed that it is a reliable medium to change thinking or practice. People consume information in many different ways and each of us is aware of the contextualization of research (both positively and negatively) through social media.

I would suggest that it was the obvious benefit and human stories of pain-free surgery, relayed by both surgeons and patients that drove

the uptake of anaesthesia, while the atoms of Mendel's work could not be comprehended in social or scientific terms by contemporary clinicians.

Interestingly, despite the rapid spread of William Morton's anaesthetic techniques, his name is not widely known, while Gregor Mendel is studied throughout the world in secondary schools. Both men shape our universe today – through the human story of painless surgery and at the atomic level through genetics. Perhaps it is appropriate, therefore, that Jacob Bigelow's epitaph for Morton is written in poetry, rather than in the vocabulary of science.



Morton's Epitaph reads:

*"By whom pain in
surgery was averted
and annulled, before
whom in all time
surgery was agony,
since whom science has
control of pain"*

Recognizing the power of science and narrative to reinforce a common message, editors try to combine the two in a way that makes research findings more widely accessible. Several tools can enrich a message, such as publishing commentaries to provide scientific context and editorials to provide social context. Supplemental material can be posted as web appendices, publication can be timed to key events, media release targeted, and advocacy coordinated with other organizations. All of these techniques accompanied the publication earlier of *The Lancet's* 4th China-themed issue on June 7, 2013.

Our Asia editor, Helena Wang, who oversaw this issue and I, and all the editors at The Lancet are grateful for the intellectual contributions made by Sian Griffiths and her colleagues at CUHK to this issue. I hope that you will enjoy reading it, particularly the combination of science and stories, from the EV71 vaccine for young children to the burden of Alzheimer's disease in older adults.

But not all research has a clear message for those who might use it. Sometimes it is not definitive, or transferable. At other times there seems to be a disconnect between what researchers – or funders – prioritise for study, and what clinicians – or patients – or health systems – need to know. So I want to conclude by asking for your help as clinicians and investigators to better align research with the requirements of those who use it, because I firmly believe that by doing so, findings will be more readily incorporated into practice and better able to benefit patients. I choose this venue for my request, because of the leading example given by Joseph Sung and Francis Chan. They have a world-wide reputation for anticipating and answering just the type of research questions that front-line clinicians need to know to provide the best care for their patients. Their many randomized controlled trials in people at risk for peptic ulcer disease have defined care for those who require long-term anti-inflammatory treatment.

In addition to selecting this venue, I have chosen this time, because the golden jubilee of the Chinese University of Hong Kong provides

Journals and clinicians areobliged to use our privileged position at the clinical interface to feed back into the research process as advocates for patients.

a special opportunity to reflect on its scientific success over the past 50 years and to consider the role of clinical research in shaping the university's international leadership for the future.

Improved alignment of research and practice can be achieved by dialogue and design. **Dialogue** in which everyone in this room has a stake and should participate: clinicians, patients, policy makers, and researchers – to elucidate which questions are important (atoms), why they are important (stories), and, crucially, what types of answers to those questions will be most useful to inform care. **Design**, so that funders and researchers use precious resources wisely, with appropriate methodology, power, and end-points that are meaningful to all stakeholders. In this way 'atoms' are contextualized into the broader 'story' of illness and health within which we all live.

At its best, communication between researchers and those who commission, use, or receive care should be a two-way process. Journals and clinicians are not only vehicles to improve the translation of science into care, but we are

also obliged to use our privileged position at the clinical interface to feed back into the research process as advocates for patients.

Let's return to nephrology, with which this talk began. The involvement of the kidney in two of the world's most common disorders: hypertension and diabetes, will keep nephrologists and scientists busy well into the next 50 years. How that research is focused and the extent to which findings will be of direct benefit to patients, their families, and societies will depend on several factors. It should – and can – include you and me, your colleagues and your patients. Advances in medicine show where we are; they can also inform aspirations and be a launch pad for where we would like our profession to go. You can help direct that future.

Enjoy the conference. Celebrate the advances you learn about, communicate them, and implement them. Moreover, I hope that you will find inspiration to share with researcher-colleagues those knowledge gaps from your own practice that cause you or your patients irritation, that they may stimulate pearls for future AIM meetings



Respiratory Medicine

Interventional Pulmonology: a rapidly growing field

Johnny Wai Man Chan

Consultant Physician
Head of Respiratory Division,
Department of Medicine
Queen Elizabeth Hospital

Respiratory Interventions: a short history

Since the introduction of flexible (fiberoptic) bronchoscopy in the 1960s, it has remained the predominant interventional diagnostic tool for respiratory physicians. For airway protection, control of bleeding and patient comfort, bronchoscopy was conducted under general anaesthesia in the operation theatre setting. More complex interventional procedures such as airway stenting and laser therapy were usually performed by surgeons with rigid instruments. However, with technological advances in the recent one to two decades, a growing number of interventions in the respiratory system can now be carried out under conscious sedation in endoscopic suites using flexible

instruments. Such procedures have extended from being purely diagnostic tools to those with therapeutic utility, and thus offer minimally invasive management alternatives for patients with borderline performance status. Moreover, interventions are no longer confined to the central airways as newer tools can reach out to the mediastinum, hilum, lung periphery and the pleural space.

Interventional pulmonology (IP) has been defined as "...the performance of diagnostic and invasive therapeutic procedures that require additional training and expertise beyond that required in a standard pulmonary medicine training programme"¹. It has been considered by some to bridge the gap between respiratory medicine and thoracic surgery². Procedures listed under IP¹⁻⁵ constitute a steadily growing list. Although increasing numbers of

respiratory physicians in Hong Kong have started up services after undergoing relevant training, the development of IP in Hong Kong lags behind the western world, where structured guidelines have been available for more than a decade.^{1,3}

Endobronchial Ultrasound (EBUS): Extending the boundary of bronchoscopy

Endobronchial ultrasound-guided transbronchial needle aspiration (EBUS-TBNA) is carried out with a special bronchoscope that incorporates a 7.5 MHz convex ultrasonic transducer at its tip. This provides real-time ultrasonic guidance in obtaining samples adjacent to the airway wall via

22G needle aspiration. [Fig.1] Its superior diagnostic performance in mediastinal lymph node staging of lung cancer was reflected in its reported sensitivity, specificity and diagnostic accuracy of 92.3%, 100% and 98% respectively, which compared favourably to computed tomography (CT) and positron emission tomography (PET).⁶ Since its introduction to Hong Kong in 2006, the procedure has increased in popularity and with reported results comparable to international series.⁷ It can also be used in the diagnosis of non-malignant conditions⁸ and other central pulmonary lesions adjacent to the airways.⁹ EBUS-TBNA provides a safe and less invasive diagnostic alternative when compared to mediastinoscopy¹⁰ and can be performed under conscious sedation in endoscopic suites as a day procedure.

Endoscopic ultrasound via the oesophageal route (EUS-TBNA) was also noted to have a pooled sensitivity and specificity of 83% and 97% respectively.¹¹ It can be complementary to EBUS-TBNA with the different lymph node stations that they can reach, and the two procedures was recently reported to be performed with a single endoscope.¹²

EBUS is also employed for the diagnosis of peripheral lung lesions with the use of a miniature (outer diameter of 1.7 mm) 20 MHz radial ultrasound probe ("mini-probe"), with or without the use of a guide sheath. The probe can be employed inside the working channel of the usual flexible bronchoscope to provide real-time localization of the target lesion to improve the diagnostic yield, with a pooled sensitivity of 73%.¹³ Fluoroscopy and electromagnetic

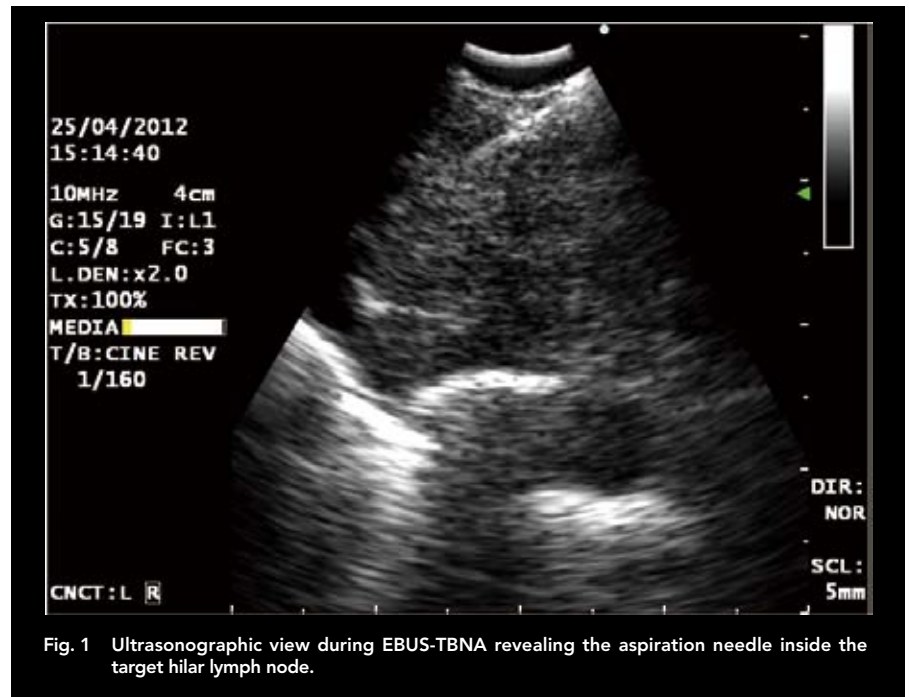


Fig. 1 Ultrasonographic view during EBUS-TBNA revealing the aspiration needle inside the target hilar lymph node.

navigation technology can provide additional guidance and further improve the diagnostic yield to almost 90% in the diagnosis of such peripheral lesions.¹⁴

Autofluorescence Bronchoscopy (AFB): Early detection of precancerous lesions

Due to changes in epithelial thickness, intracellular metabolism and blood flow, dysplastic and neoplastic bronchial epithelium possess different light fluorescent characteristics from those of normal tissue. Employing this principle, AFB has been shown to increase the detection rate of high grade precancerous lesions and early lung cancer by at least 2 folds on top of white light bronchoscopy alone.¹⁵ A local study had demonstrated that AFB can be potentially useful in patients with suspicious cells in sputum cytology.¹⁶ Other indications of AFB include the detection of synchronous tumours, surveillance

following cancer resection and definition of the margin for ablative therapies for precancerous lesions.^{3, 5} However, its possible role as an effective cancer screening tool remains controversial and is partially compromised by reducing incidences of centrally locating cancer types such as squamous cell carcinomas.¹⁷ In contrast to AFB, narrow band imaging (NBI) is another autofluorescence technique that has already been built in with some newer bronchoscopic processors. Notwithstanding the ability to discern the abnormal mucosal vascular patterns in dysplastic and malignant lesions, as well as a reported additional diagnostic yield of 23%¹⁸ and a possibly higher specificity than AFB¹⁹, its use in bronchoscopy is at present relatively limited.

Endobronchial valve (EBV): device with dual purposes

As surgical options for advanced emphysema such as lung

transplantation and lung volume reduction surgery are major operations with significant inherent risks, these are only rarely applicable to advanced COPD patients. In contrast, EBVs are small one-way valves that can be implanted via the bronchoscopic route to the target bronchial segments to achieve "endoscopic lung volume reduction" (BLVR).²⁰ They allow air (and secretions) to exit from such target segments during expiration but the entry is restricted during inspiration, and thereby achieving progressive collapse in these lung segments. "Lung volume reduction" (LVR), a concept initially applied in thoracic surgery, aims at removal of the more severely emphysematous areas and thereby improving the hyperinflation and its associated adverse respiratory and cardiac effects.²¹ Evidence from randomized clinical trials revealed modest improvements in lung function and exercise capacity.²⁰ However, such effects would be compromised in the presence of factors such as incomplete fissures and collateral ventilation and hence careful patient pre-procedural evaluation and selection would be necessary.^{20, 22} In fact, there are now other emerging endobronchial therapies with preliminary encouraging results in BLVR.^{23, 24}

On the other hand, the one-way valve concept of EBV in BLVR has also been employed in the management of persistent air leaks in pneumothorax by reducing the air flow across and facilitating healing of the fistula. [Fig.2] In contrast to its use in BLVR, data with this indication exists only in case reports and series.^{25, 26} However, apart from being relatively safe, it provides a relatively non-invasive option for those who are otherwise unable to undergo surgery.

Pleuroscopy: Increasing the transparency of the pleural window

Also known as medical thoracoscopy, pleuroscopy can be performed under local anaesthesia and conscious sedation in an endoscopic suite, employing usually only 1 port of entry. In contrast to video-assisted thoracic surgery (VATS) which requires general anaesthesia and double-lumen endotracheal intubation, a semi-rigid instrument with similar operation to flexible bronchoscopy has become available in recent years. The latter provide a less invasive and more accurate diagnostic tool for patients with undiagnosed pleural effusions. Introduced to Hong Kong in 2007,²⁷ this has become a commonly performed procedure that is available in many local hospitals. The overall sensitivity and specificity of the semi-rigid instrument are 91% and 100% respectively, with few complications and no mortality.²⁸ A

recent randomized study revealed no significant differences in the diagnostic yield and quality of samples obtained between the rigid and semi-rigid instruments.²⁹ Apart from its diagnostic role, it can also be employed as a therapeutic tool such as talc pleurodesis for malignant pleural effusions.^{2, 3, 5}

Transthoracic ultrasonography: an increasingly important bed-side tool

Pleural procedures under ultrasound guidance have been more commonly performed by radiologists in many areas. However, recommendations by recent international guidelines for ultrasound guidance with pleural procedures (including aspiration and drainage for pleural effusions)³⁰ will likely increase ultrasound utilization by general and respiratory physicians. Our



Fig. 2 The three endobronchial valves that were removed several weeks after the successful treatment of persistent airleak in the right upper lobe of a patient with secondary spontaneous pneumothorax.

preliminary data revealed its superior diagnostic efficacy (75-100%) and safety profile in the performance of diagnostic and therapeutic pleural procedures including aspiration, pleural and transcutaneous lung biopsies, drainage and pre-pleuroscopic assessment. [Fig. 3] In particular, it is potentially helpful in small and loculated pleural effusions³¹. Apart from greater flexibility in scheduling appointments, performing ultrasound by trained clinicians can be advantageous in guiding the choice of interventions at the bedside and the subsequent management plans post-procedure.

Indwelling pleural catheter (IPC): a palliative alternative in malignant pleural effusions

While pleurodesis has been a mainstay palliative treatment for patients with recurrent symptomatic malignant pleural effusions, it is not a procedure without problems. Apart from its associated adverse effects such as pain and fever, the requirement for hospitalization and a significant failure rate, pleurodesis

is not feasible in patients with “trapped lungs” where the pleural membranes cannot meet.

IPC are tunneled catheters that can be placed inside pleural cavity under local anaesthesia for domiciliary periodic drainage and outpatient management of malignant pleural effusions. [Fig. 4] Apart from efficacious symptom relief, it is safe with few complications and can achieve “auto-pleurodesis” without chemical instillation in over half of the cases.³² Although superiority over pleurodesis in symptom relief was not demonstrated in a recent randomized trial³³, it can reduce the need for hospitalizations and subsequent pleural procedures in such patients.³⁴

Ablative therapies: “Fire and ice”

Amongst the various endobronchial ablative therapies, cryotherapy and argon plasma coagulation (APC) are available in some local hospitals and can be performed under local anaesthesia and conscious sedation with flexible bronchoscopy. By delivering extreme cold (-89°C) to the target tissues via a flexible probe bronchoscopically, tissue destruction is achieved through repeated freeze and thaw cycles. It can also produce the “cryo-extraction” effect to remove the target material. Apart from the treatment of airway lesions such as early cancers and tumour debulking, cryoprobe can be used in performing foreign body removal and bronchoscopic biopsies.^{3,4} Although it can be performed with flexible bronchoscope, majority of the evidence come from series that employed a combination of flexible and rigid instruments,³⁵ which can be advantageous as bleeding

Fig. 3 A hand-held ultrasound machine being employed in the localization of the port of entry before a pleuroscopic examination inside the endoscopic suite





Fig. 4 An indwelling pleural catheter just being implanted under local anaesthesia.

was a relatively common reported adverse event (4-10%).⁴ Also, as the destructive effects are delayed, a follow-up bronchoscopy is usually required to remove the necrotic materials.

In contrast, APC produces thermal tissue destruction, which is considered a cheaper and possibly safer alternative to laser therapy that is also available in some local centres. In contrast to electrocautery, it is a non-contact mode of treatment that can bring about desiccation, coagulation and thereby debulking of obstructive endobronchial tumours and

granulation tissues. It effectively achieves haemostasis in visible endobronchial lesions.²⁻⁴ Apart from uncommon occurrences (<2%) of airway perforation³⁶ and gas embolism³⁷, the procedure is generally considered as safe if all due precautions are taken. As with cryotherapy, most literature on APC involved the use of rigid bronchoscope.⁴

The future

The procedures mentioned in this article are those which are

available locally in at least some respiratory units, though this is by no means a complete list. As the field is growing, new interventions have emerged rapidly in the recent years. One potentially promising intervention might include bronchial thermoplasty (BT) for patients with severe persistent asthma.^{2,4} By delivering radiofrequency current to airway smooth muscle with a probe inserted via the flexible bronchoscope over 3 separate sessions, BT has been shown to improve quality of life, together with a reduction of severe exacerbations, emergency room visits and days lost from school and work when compared with sham bronchoscopic controls,³⁸ with beneficial effects maintained for more than 2 years.³⁹ However, until more evidence is available, its exact position in asthma management remains uncertain at this juncture.

As some of these procedures are relatively sophisticated and time-consuming, collaboration amongst respiratory physicians, thoracic surgeons, anaesthesiologists and interventional radiologists might not only deliver safer and effective interventions, it will also facilitate existing multi-disciplinary patient management as well as potentially lead to development of more advanced tools. On the other hand, while there are international guidelines on advanced procedural competency in interventional pulmonology,^{1,3,5} these are not yet available in Hong Kong where interventional pulmonology is still at its infancy stage. However, as the field matures in the future, there will be a need for structured training programs and credentialing mechanisms to ensure competency amongst interventional pulmonologists in performing these procedures efficiently and safely.

EXAMINATIONS AND RESULTS

Joint HKCPIE/MRCP(UK) Part I examination for the years 2002 – 2014:

	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%)
Sept 12	80	59 (74%)
Jan 13	41	22 (54%)
Sept 13	76	60 (79%)
Jan 14	30	20 (67%)

Joint HKCPIE/MRPC(UK) Part II (Written) examination for the years 2002 –2014:

	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%)
9 and 10 April 2014	54	46 (85%)

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%	February 2014	29/74 = 39%
			(for HK Local candidates)

Quotability of Qualification

Dr Li Chun Sang, Hon Secretary, HKCP

Recently, our College has confirmed with Medical Council of Hong Kong that the qualification "Fellow of Hong Kong College of Cardiology" is not currently included in the List of Quotable Qualifications. According to section 5 of the Medical Council's *Code of Professional Conduct*, only those qualifications approved by the Medical Council may be quoted on signboards, stationery (including visiting cards, letterheads, envelopes, prescription slips, notices), telephone directories, the practice website, service information notices, doctors' directories etc.

Our Hon Legal Advisor advised us that a doctor may contravene the professional code of practice if he/she quotes as a qualification any title which is not approved by the Medical Council as a quotable qualification. The safest approach for any doctor is not to mention any non-quotable qualification, in whatever form, in any document which the doctor is going to give to a third party. Fellows are reminded that quoting non-approved qualifications may be regarded as professional misconduct with serious consequence.

HKCP Annual General Meeting 2014

The HKCP Annual Scientific Meeting will be held on the 18 -- 19 October 2014 at the HKAM Jockey Club Building. The Annual General Meeting will be held at 6 pm on 18 October 2014 at the same venue. The flyer with details of the program will be sent out shortly.

Congratulations

The Council wish to extend our heartiest congratulations to our Fellows !

New elected Fellows of the Royal College of Physicians, London (2014)

- | | | | |
|----------------------------|--------------------------|----------------------|-------------------------|
| 1. Dr Chan, Nicola Pui-Yiu | 2. Dr Lam, Ting Wa Jodis | 3. Dr Lau, Kam Shing | 4. Dr Lau, Kam Piu |
| 5. Dr Lau, Yuk Kong | 6. Dr Lee, Cheuk Kwong | 7. Dr Wong, Siu Yin | 8. Dr Yau, Chung Cheung |

New elected Fellows of the Royal College of Physicians, Edinburgh (2014)

- | | | | |
|---------------------|---------------------------|--------------------|--------------------|
| 1. Dr Chen Wai Hong | 2. Dr Ng Chiu Ming Jason | 3. Dr Sheng Bun | 4. Dr Tai Kian Bun |
| 5. Dr Tam Cheuk Yin | 6. Dr Wong Man Lok Edmond | 7. Dr Yiu Kai Hang | |

TRAINING

UPDATES FOR BPT TRAINEES

Dr. Lai Moon Sing, Secretary, Education and Accreditation Committee

At 270th Meeting of 28 March, 2014, the Council noted that one of the BPT trainees who had resigned from the Hospital Authority (HA) and was working in Department of Health (DH) without having yet completed 36 months' training of BPT. The trainee would consider higher training in Specialty of Dermatology and Venereology afterwards.

According to the prevailing training guidelines of BPT, the trainee will need to rotate back to accredited BPT training centre in hospitals under HA since experience in Dermatology clinic in DH can be counted for at most 6 months and other services in DH are NOT recognized for BPT training. Furthermore, it should be envisaged that there may be substantial problem in arrangement of such rotation because it is difficult for medical departments of HA to rotate one BPT to DH in return.

Therefore, for BPT trainees who may consider higher training in the Specialty of Dermatology and Venereology, the Council advises them NOT to join DH BEFORE completion of their BPT training. The Council also advised them to consult their BPT Programme Directors or trainers before making such decisions.

Finally, those BPT trainees who have decide to join DH before completion of their BPT training should apply to BPT Board for suspension of training during the period of working in DH.

Statistics on No. of Trainees in all Specialties

Updated in May 2014

		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	21	1 2 3 4	0 5	1—I 2 3 4—I	2 2 2	0 2 3 0	1 2 3 4	0 0 0	1 2 3 4	0 0 0	1 2 3 4	—II —I 3 II	3 2 3 4	1 2 3 4	0 0 0
CLINICAL PHARMACOLOGY & THERAPEUTICS	1	1 2 3 4	0 0	1 2 3 4	0 0	1 2 3 4	0 0	1 2 3 4	0 0	1 2 3 4	0 0	1 2 3 4	1 1 1 1	1 2 3 4	0 0
CRITICAL CARE MEDICINE	8	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	1 2 3 4	0 0	1—I 2—I 3—I 4	3 2 3 4	1 2 3 4	0 0
DERMATOLOGY & VENEREOLOGY	9	1 2 3 4	0 0	1 2 3 4	0 0	1 2 3 4	0 0	1 2 3 4	0 0	1 2 3 4	0 0	1 2 3—I 4	1 1 0 0	1 2 3 4	0 0
ENDOCRINOLOGY, DIABETES & METABOLISM	12	1 2 3—I 4—I	2 3 4	1 2 3 4	0 0	1 2 3 4	0 3	1 2 3 4	0 0	1 2 3 4	0 0	1 2 3—I 4	1 1 5	1 2 3 4	0 0
GASTROENTEROLOGY & HEPATOLOGY	26	1 2—I 3 4	1 5	1 2 3—I 4	1 1	1 2 3 4	0 0	1 2 3 4	0 0	1 2 3 4	0 0	1 2—I 3 4	1 1 8	1 2 3 4	0 0
GERIATRIC MEDICINE	17	1 2 3 4	0 6	1 2 3 4	0 II	1 2—I 3 4	1 3	1 2 3 4	0 3	1 2 3 4	0 2	1—I 2 3—II 4	3 2 3 2	1 2 3 4	0 1
HAEM/HAEM ONCOLOGY	3	1 2 3—I 4	1 2 4	1 2 3 4	0 0	1 2 3 4	0 0	1 2 3 4	0 0	1 2 3 4	0 0	1 2—I 3 4	1 1 7	1 2 3 4	0 0
IMMUNOLOGY & ALLERGY	0	1 2 3 4	0 0	1 2 3 4	0 0	1 2 3 4	0 0	1 2 3 4	0 0	1 2 3 4	0 0	1 2 3 4	0 0	1 2 3 4	0 0
INFECTIOUS DISEASE	3	1 2 3 4	0 0	1 2 3 4	0 0	1 2 3 4	0 0	1 2 3 4	0 0	1 2 3 4	0 0	1 2 3 4	0 1	1 2 3 4	0 0
INTERNAL MEDICINE	178	1 2—III 3—III 4—I	7 36	1—I 2 3—III 4—I	5 15	1 2 3 4	0 II	1 2 3 4	0 3	1 2 3 4—I	1 7	1—V 2—V 3—X 4—VIII	28 53	1 2 3 4	0 9
MEDICAL ONCOLOGY	2	1 2 3 4	0 0	1 2 3 4	0 0	1 2 3 4	0 0	1 2 3 4	0 0	1 2 3 4	0 0	1 2 3 4	0 2	1 2 3 4	0 0
NEPHROLOGY	19	1 2—I 3 4	1 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	1 2 3—II 4	2 6	1 2 3 4	0 3
NEUROLOGY	21	1 2—I 3 4	1 4	1 2 3—I 4	1 3	1 2 3 4	0 0	1 2 3 4	0 0	1 2 3 4	0 0	1—I 2—I 3—I 4—I	4 8	1 2 3 4	0 0
PALLIATIVE MEDICINE	5	1 2 3 4	0 0	1 2 3—I 4	1 2	1 2 3 4	0 0	1 2 3 4	0 0	1 2 3 4—I	1 2	1 2 3 4	0 0	1 2 3 4	0 0
REHABILITATION	2	1 2 3 4	0 0	1 2 3 4	0 2	1 2—I 3 4	1 4	1 2 3 4	0 1	1 2 3 4	0 0	1 2 3 4	0 1	1 2 3 4	0 4
RESPIRATORY MEDICINE	13	1 2 3 4	0 4	1 2 3 4	0 5	1 2 3 4	0 0	1 2 3 4	0 0	1 2 3 4	0 8	1 2 3—I 4	1 5	1 2 3 4	0 0
RHEUMATOLOGY	9	1 2 3 4	0 2	1 2 3 4	0 1	1 2 3 4	0 1	1 2 3 4	0 0	1 2 3 4	0 0	1 2 3—I 4	1 4	1 2 3 4	0 1

TRAINING

SPECIALTY		TRAINEES																		
		KOWLOON CENTRAL CLUSTR		KOWLOON EAST CLUSTER				KOWLOON WEST CLUSTER												
		KH	QEH	HOHH	TKOH	UCH	CMC	KWH	OLMH	PMH	WTSH	YCH								
TRAINEES TOTAL (PP/DH/HA/OTHERS)	YEAR		YEAR				YEAR													
CARDIOLOGY	21	1 2 3 4	0 1 2 3 4	1 2 3 4	2 1 3 10	1 2 3 0	0 1 3 0	1 2 3 2	2 1 1 6	1 2 3 4	1 1 3 1	1 2 3 4	0 0 3 4	1 2 3 0	1 2 3 8	0 1 3 4	1 2 3 0	0 1 3 4	1 2 3 0	
CLINICAL PHARMACOLOGY & THERAPEUTICS	1	1 2 3 4	0 1 3 0	1 2 3 0	0 0 3 0	1 2 3 0	0 0 3 0	1 2 3 0	0 0 3 0	1 2 3 4	0 0 3 0	1 2 3 4	0 0 3 0	1 2 3 4	0 0 3 0	1 2 3 0	0 0 3 0	1 2 3 0	0 0 3 0	
CRITICAL CARE MEDICINE	8	1 2 3 4	0 1 3 0	1 2 3 5	1 2 3 4	0 1 3 0	1 2 3 3	0 0 3 4	1 2 3 6	1 2 3 4	1 2 3 3	0 0 3 4	1 2 3 4	0 0 3 5	1 2 3 4	0 0 3 4	1 2 3 5	0 0 3 4	1 2 3 0	0 0 3 0
DERMATOLOGY & VENEREOLOGY	9	1 2 3 4	0 1 3 0	1 2 3 0	0 0 3 0	1 2 3 0	0 0 3 0	1 2 3 0	0 0 3 0	1 2 3 4	0 0 3 0	1 2 3 4	0 0 3 0	1 2 3 4	0 0 3 0	1 2 3 0	0 0 3 4	1 2 3 0	0 0 3 0	
ENDOCRINOLOGY, DIABETES & METABOLISM	12	1 2 3 4	0 1 3 0	1- II 2 7	2 2 3 4	1 2 3 0	0 1 3 3	1 2 3 3	0 0 3 4	1- I 2 3 3	1 2 3 2	1 2 3 4	0 0 3 4	1 2 3 4	0 0 3 4	1 2 3 4	0 0 3 4	1 2 3 0	1 2 3 4	1 1 3 1
GASTROENTEROLOGY & HEPATOLOGY	26	1 2 3 4	0 1 3 0	1- III 2 7	5 2 3 4	1 2 3 0	0 1 3 2	1- I 2 3 2	2 2 3 4	1- II 2 3 3	4 2 3 3	1 2 3 4	1 2 3 6	0 0 3 4	1- I 2 3 4	2 2 3 5	1 2 3 4	0 0 3 4	1 2 3 0	0 0 3 6
GERIATRIC MEDICINE	17	1 2 3 4	0 1 3 5	1 2 3 3	1 2 3 4	1 2 3 3	1 2 3 2	1 2 3 4	1 2 3 8	1 2 3 4	1 2 3 7	1 2 3 4	1 2 3 8	0 0 3 1	1 2 3 4	1 2 3 13	0 0 3 4	1 2 3 4	1 2 3 5	2 1 3 0
HAEM/HAEM ONCOLOGY	3	1 2 3 4	0 1 3 0	1 2 3 2	0 0 4 0	1 2 3 0	0 0 3 2	1 2 3 2	0 0 4 1	1 2 3 4	1 2 3 0	0 0 3 4	1 2 3 0	0 0 3 4	1 2 3 0	0 0 3 3	1 2 3 4	0 0 3 0	1 2 3 0	0 0 3 0
IMMUNOLOGY & ALLERGY	0	1 2 3 4	0 1 3 0	1 2 3 0	0 0 4 0	1 2 3 0	0 0 3 0	1 2 3 0	0 0 4 0	1 2 3 0	0 0 3 0	1 2 3 0	0 0 4 0	1 2 3 0	0 0 4 0	1 2 3 0	0 0 4 0	1 2 3 0	0 0 4 0	0 0 3 0
INFECTIOUS DISEASE	3	1 2 3 4	0 1 3 0	1- I 2 2	2 2 3 4	1 2 3 0	0 0 3 0	1 2 3 0	0 0 4 1	1 2 3 4	0 0 3 0	1 2 3 0	0 0 4 0	1 2 3 0	0 0 3 4	1 2 3 3	0 0 3 4	1 2 3 0	0 0 3 0	
INTERNAL MEDICINE	178	1 2 3 4	0 1 3 3	1- VI 2- VI 3- VI 4- IV 53	22 2 3 4	1- I 2 3 4	2 3 4 3	1- III 2- II 3- III 3- III 4- III 39	8 8 18 39	1- I 2- II 3- I 4- V 24	13 13 13 24	1 2 3 4	8 6 2 42	0 0 3 4	1- III 2- V 3- III 4- II 43	13 13 2 43	1 2 3 4	0 0 3 4	1 2 3 4	7 1 3 20
MEDICAL ONCOLOGY	2	1 2 3 4	0 1 3 0	1 2 3 2	0 0 4 0	1 2 3 0	0 0 3 0	1 2 3 0	0 0 4 0	1 2 3 4	0 0 3 0	1 2 3 0	0 0 4 0	1 2 3 0	0 0 3 1	1 2 3 4	0 0 3 4	1 2 3 0	0 0 3 0	
NEPHROLOGY	19	1 2 3 4	0 1 3 0	1 2 3 7	2 2 3 4	1 2 3 0	0 0 3 2	1 2 3 2	1 2 3 4	1 2 3 3	1 2 3 4	0 0 3 7	1 2 3 4	0 0 3 5	1 2 3 4	1 2 3 5	0 0 3 4	1 2 3 0	1 2 3 2	
NEUROLOGY	21	1 2 3 4	0 1 3 0	1- I 2 3 4	3 2 3 4	1 2 3 0	0 0 3 2	1- I 2 3 2	2 2 3 4	1 2 3 4	1 2 3 4	0 0 3 4	1 2 3 4	0 0 3 4	1- I 2 3 4	2 2 3 2	1 2 3 4	0 0 3 4	1 2 3 0	0 0 3 0
PALLIATIVE MEDICINE	5	1 2 3 4	0 1 3 0	1 2 3 0	0 0 4 3	1 2 3 0	0 0 3 0	1 2 3 2	0 0 4 2	1 2 3 4	1 2 3 0	0 0 3 4	1 2 3 0	0 0 4 1	1 2 3 4	0 0 3 4	1 2 3 4	0 0 3 0	1 2 3 0	0 0 3 0
REHABILITATION	2	1 2 3 4	1 1 3 4	1 2 3 7	0 0 3 4	1 2 3 1	0 0 3 4	1 2 3 0	0 0 4 2	1 2 3 4	0 0 3 0	1 2 3 0	0 0 4 0	1 2 3 0	0 0 3 1	1 2 3 4	0 0 3 4	1 2 3 4	0 0 3 0	
RESPIRATORY MEDICINE	13	1 2 3 4	0 1 3 5	1 2 3 6	0 1 3 4	1- I 2 3 5	1 2 3 4	1- I 2 3 2	2 2 3 4	1 2 3 4	1 2 3 4	0 0 3 4	1 2 3 3	0 0 3 4	1 2 3 5	2 2 3 4	1 2 3 4	0 0 3 2	1 2 3 4	0 0 3 1
RHEUMATOLOGY	9	1 2 3 4	0 1 3 0	1 2 3 3	1 2 3 4	0 1 3 0	1 2 3 2	0 0 3 4	1 2 3 3	1 2 3 4	1 2 3 0	0 0 3 2	1 2 3 4	0 0 3 2	1 2 3 4	2 2 3 3	1 2 3 4	0 0 3 0	1 2 3 4	1 1 3 1

TRAINING

SPECIALTY		TRAINEES													
		NEW TERRITORIES EAST CLUSTER						NEW TERRITORIES WEST CLUSTER							
		AHNH	NDH	PWH	SH	TPH	POH	TMH							
TRAINEES TOTAL (PP/DH/HA/OTHERS)		YEAR						YEAR							
CARDIOLOGY	21	1 2 3-I 4	1 2 3 4	1-I 2 3 4	1 2 3 4	1 2-I 3 4	1 2 3 4	0 0 0 0	1 2 3-I 4	1 2 3 4	0 0 0 0	1 2 3 4	1-I 2 3 4	1 2 3 4	
CLINICAL PHARMACOLOGY & THERAPEUTICS	1	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	
CRITICAL CARE MEDICINE	8	1 2 3-I 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 0 0 0	1 2 3 4	0 0 0 0	1 2 3 4	0 0 0 0	1 2 3-I 4	
DERMATOLOGY & VENEREOLOGY	9	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	
ENDOCRINOLOGY, DIABETES & METABOLISM	12	1 2-I 3 4	1 2 3 4	1 2 3 4	0 0 0 0	1 2-I 3 4	1 2 3-I 4	1 1 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 3	
GASTROENTEROLOGY & HEPATOLOGY	26	1 2 3 4-I	1 2 3-I 4	1 2 3-I 4	1 2 3 4	1-I 2 3-I 4	2 2 3 4	1 1 0 0	1 2 3 4	1 2 3 4	0 0 0 0	1 2 3 4-I	1 2 3 4	1 2 3-I 4	
GERIATRIC MEDICINE	17	1 2 3 4	0 0 0 1	1 2 3 4	0 0 0 1	1 2 3 4	0 0 3-I 4	1 1 7 0	1 2 3-I 4	1 2 3-I 4	1 1 3 3	1 2 3 4	0 0 3-II 4	1 2 3 4	
HAEM/HAEM ONCOLOGY	3	1 2 3 4	0 0 0 0	1 2 3 4	0 0 0 0	1 2 3 4	0 0 3 4	1 1 0 0	1 2 3 4	0 0 0 0	1 2 3 4	0 0 0 0	1 2 3 4	0 0 2 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 1 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 4	0 0 2 0	1 2 3 4	0 0 0 0	1 2 3 4	0 0 3 4	1-I 1 0 0	1 2 3 4	0 0 0 0	1 2 3 4	0 0 0 0	1 2 3 4	0 0 2 0	
INTERNAL MEDICINE	178	1 2-II 3-III 4-II	7 10 10 10	1-I 2-I 3-II 4	4 13 13 13	1-III 2-III 3-IV 4-IV	14 54 54 54	1-III 3-II 4-I	6 6 6	1-I 2 3-II 4-I	4 4 6 6	1 2 3 4-II	2 12 12 12	1-II 2-V 3-V 4-V	17 41 41 41
MEDICAL ONCOLOGY	2	1 2 3 4	0 0 0 0	1 2 3 4	0 0 0 0	1 2 3-II 4	2 15 15 15	1 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	
NEPHROLOGY	19	1 2-I 3 4	1 1 1 1	1 2 3 4	0 0 0 0	1 2-I 3-II 4	3 5 4 4	1 0 0 0	1 2 3 4	0 0 0 1	1 2 3 4	0 0 0 1	1 2 3 4	1-I 2-II 3-I 4	
NEUROLOGY	21	1 2 3 4-I	1 1 1 1	1 2-I 3-I 4	2 1 1 1	1-I 2 3-I 4	2 7 4 4	1 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-I 3 4	
PALLIATIVE MEDICINE	5	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 1 1 1	1 2 3 4	0 0 0 0	1 2 3 4	0 0 0 0	1 2 3 4	0 0 0 0	
REHABILITATION	2	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 0 0 0	1 2 3 4	0 0 0 1	1 2 3 4	0 0 0 1	1 2 3 4	0 0 0 2	
RESPIRATORY MEDICINE	13	1 2 3 4	0 0 3 0	1 2 3 4	0 0 3 3	1 2 3 4	0 4 4 4	1-I 1 0 0	1 2 3 4	0 0 1 1	1 2 3 4	0 0 0 0	1 2 3 4	1 2-I 3 4	
RHEUMATOLOGY	9	1 2 3 4	0 0 0 1	1 2 3 4	0 0 0 0	1 2 3 4	0 3 4 4	1 0 0 0	1 2 3 4-I	1 1 2 2	1 2 3 4	0 0 0 2	1 2 3 4	1 2-I 3 4	

* 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	9	1—I 2—II 3—IV 4—I	8 11
INFECTIOUS DISEASE	3	1 2 3 4	0 2
RESPIRATORY MEDICINE	13	1 2 3 4	0 10

* 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 May 2014

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	244	9	7	0	16	0	6	19	0	25	41
CLINICAL PHARMACOLOGY & THERAPEUTICS	8	0	0	0	0	0	0	2	0	2	2
CRITICAL CARE MEDICINE	87	11	2	0	13	0	0	11	0	11	24
DERMATOLOGY & VENEREOLOGY	99	0	0	0	0	0	0	1	0	1	1
ENDOCRINOLOGY, DIABETES & METABOLISM	104	4	2	3	9	0	0	11	1	12	21
GASTROENTEROLOGY & HEPATOLOGY	174	6	2	1	9	0	0	13	0	13	22
GERIATRIC MEDICINE	180	6	13	3	22	3	2	4	2	11	33
HAEM/HAEM ONCOLOGY	58	3	0	0	3	0	0	11	0	11	14
IMMUNOLOGY & ALLERGY	6	0	0	0	0	0	0	0	0	0	0
INFECTIOUS DISEASE	40	3	0	0	3	0	0	2	0	2	5
INTERNAL MEDICINE	1252	56	26	12	94	3	13	96	11	123	217
MEDICAL ONCOLOGY	44	0	0	0	0	0	0	9	0	9	9
NEPHROLOGY	122	6	0	0	6	0	0	8	3	11	17
NEUROLOGY	107	5	4	0	9	0	0	8	2	10	19
PALLIATIVE MEDICINE	25	0	2	0	2	0	2	2	0	4	6
REHABILITATION	54	0	3	3	6	2	0	1	5	8	14
RESPIRATORY MEDICINE	178	11	6	2	19	0	8	10	0	18	37
RHEUMATOLOGY	72	4	2	1	7	0	0	8	1	9	16

TRAINING

		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	244	0	16	16	0	3	6	9	2	7	1	11	0	5	26	51
CLINICAL PHARMACOLOGY & THERAPEUTICS	8	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
CRITICAL CARE MEDICINE	87	0	6	6	0	4	6	10	5	5	0	8	0	0	18	34
DERMATOLOGY & VENEREOLOGY	99	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
ENDOCRINOLOGY, DIABETES & METABOLISM	104	0	8	8	0	4	4	8	3	5	2	5	0	2	17	33
GASTROENTEROLOGY & HEPATOLOGY	174	0	8	8	0	3	3	6	5	10	1	8	0	7	31	45
GERIATRIC MEDICINE	180	7	4	11	3	2	13	18	8	10	2	15	6	5	46	75
HAEM/HAEM ONCOLOGY	58	0	8	8	0	2	2	4	0	0	0	5	0	0	5	17
IMMUNOLOGY & ALLERGY	6	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
INFECTIOUS DISEASE	40	0	6	6	0	0	1	1	0	0	0	5	0	0	5	12
INTERNAL MEDICINE	1252	10	76	86	6	27	51	84	35	52	8	70	7	23	195	365
MEDICAL ONCOLOGY	44	0	3	3	0	0	2	2	0	0	0	1	0	0	1	6
NEPHROLOGY	122	0	8	8	2	2	5	9	2	8	0	9	0	2	21	38
NEUROLOGY	107	3	9	12	0	2	4	6	2	5	1	4	1	1	14	32
PALLIATIVE MEDICINE	25	0	0	0	4	0	2	6	4	0	1	0	1	0	6	12
REHABILITATION	54	9	0	9	2	0	3	5	1	0	1	2	4	0	8	22
RESPIRATORY MEDICINE	178	5	7	12	6	4	7	17	6	6	0	5	3	1	21	50
RHEUMATOLOGY	72	2	4	6	0	2	3	5	3	4	0	3	0	2	12	23

		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	244	3	4	15	1	0	23	5	9	14	37	
CLINICAL PHARMACOLOGY & THERAPEUTICS	8	0	0	5	0	0	5	0	0	0	5	
CRITICAL CARE MEDICINE	87	3	5	1	0	0	9	0	5	5	14	
DERMATOLOGY & VENEREOLOGY	99	0	0	3	0	0	3	0	0	0	3	
ENDOCRINOLOGY, DIABETES & METABOLISM	104	1	5	16	0	0	22	0	4	4	26	
GASTROENTEROLOGY & HEPATOLOGY	174	1	4	10	0	1	16	4	10	14	30	
GERIATRIC MEDICINE	180	1	2	6	9	3	21	3	12	15	36	
HAEM/HAEM ONCOLOGY	58	0	0	5	0	0	5	0	5	5	10	
IMMUNOLOGY & ALLERGY	6	0	0	0	0	0	0	0	0	0	0	
INFECTIOUS DISEASE	40	2	1	3	0	0	6	0	2	2	8	
INTERNAL MEDICINE	1252	20	28	82	11	10	151	14	67	81	232	
MEDICAL ONCOLOGY	44	0	0	16	0	0	16	0	0	0	16	
NEPHROLOGY	122	5	1	8	0	1	15	1	8	9	24	
NEUROLOGY	107	1	2	11	1	0	15	1	3	4	19	
PALLIATIVE MEDICINE	25	0	0	0	2	0	2	0	1	1	3	
REHABILITATION	54	0	1	2	1	1	5	1	3	4	9	
RESPIRATORY MEDICINE	178	3	7	7	0	3	20	2	9	11	31	
RHEUMATOLOGY	72	3	0	5	0	2	10	1	5	6	16	



Loretta Yin Chun Yam BBS

MB, FRCP (Edin), FRCP(Glasg), FRCP(Lond), FHKCP, FHKAM (Medicine)

Loretta Yam knew from the age of fourteen that she wanted to be a doctor, but could never have guessed that she would become one of the most respected members of the Public Health system in Hong Kong.

Neither of her parents were doctors; they were in business and despite many odds saw all eight of their children well educated and into useful careers. Despite Loretta's warnings of the hard work involved, her youngest sister also became a doctor, an O&G specialist.

Loretta spent her entire schooling at the prestigious Sacred Heart Canossian College, and is listed amongst the college's most famous alumni along with Prof Rosie Young Tse Tse GBS, OBE, JP and The Hon. Dr. Anson Chan Fong On San, GBM, GCMG, CBE, JP. Her main sporting interest was badminton which she kept up until she suffered a knee injury, now she swims for exercise. At school she also developed a life-long interest in classical music and ballet.

She went on to the Faculty of Medicine at Hong Kong University from which she graduated in 1973, with the award of the CP Fong Gold Medal in Pathology.

Despite her declaration that she is a private person Loretta talked to me enthusiastically about her very full career, with the proviso that certain facts were for private information only.

She completed her preregistration year at the Queen Mary Hospital before moving to the Tuberculosis and Chest Disease unit at Kowloon Hospital as a Medical Officer for one year, returning

to the Queen Mary Hospital for 1975-1977 as Registrar in Internal Medicine. Loretta recalls this time as one of the busiest in her career as she was fortunate to have been trained for a year in the intensive care unit under Dr Donald Yu and Dr Tse Tak-fu.

In 1976 Loretta married Michael, an academic currently the Director of the Business School at the Tung Wah College. They are very supportive of each other's careers, and share many interests such as ballet and travel. They enjoy cooking, he makes rich French food at week-ends and she counterbalances with fat-free meals several times during the week.



On a fine food foray in Dijon, France

In 1977 she returned to the Kowloon Hospital briefly before going for specialist training in London during which time she passed her MRCP (UK). Professor Christopher John Dickinson was the Head of Department of Medicine at the St Bartholomew's Hospital, and Professor Dame Margaret

Turner-Warwick was the head of the ICU and Respiratory teaching at the Brompton Hospital, both of whom Loretta remembers as excellent teachers.

One lesson that she learned in England has stayed with her ever since. The hospital doctors talked with their patients, rather than at them or about them as too many hospital clinicians did in those days. She recalls one consultant who was persistently abrupt with patients and staff, and only started smiling at anyone just before he went off into private practice. Loretta recommends that all doctors should read a book about communicating with patients:- *Healing Words: The power of apology in medicine* by Michael Woods, Joint Commission Resources Mission. The other book recommendations she makes are BMJ publications:- *How to Read a Paper* by Trisha Greenhalgh, 5th Edition 2001, *How to Write a Paper* Edited by George M Hall 5th Edition 2012.

After spending eight years at the Caritas Medical Centre, Loretta began her long and fruitful relationship with the Department of Medicine, Alice Ho Miu Ling Nethersole Hospital in 1988. The hospital became the Pamela Youde Nethersole Eastern Hospital (PYNEH) when it moved from mid-levels on Hong Kong Island to Chai Wan, later joining the Eastern Cluster of the Hospital Authority. She was consultant in charge then Chief of Service of the Department of Medicine until she stepped back from clinical work in 2005. From 1997 to 2005 she was also an Honorary Clinical Professor at Hong Kong University.

Loretta was involved in the SARS epidemic in 2003. She led the PYNEH

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Respiratory and Critical Care Team to screen over 500 febrile patients, of whom nearly a hundred had confirmed SARS. The team managed these patients from diagnosis through ICU care to recovery, with a case fatality rate of 4%. She was awarded the Hong Kong SAR Government Bronze Bauhinia Star in 2004 for her services to Medicine.



From 2005 to 2011 she became the Chief Executive of the PYNEH and of the Hong Kong Eastern Cluster, which turned out to be a most rewarding career move. It was during this time that she declined to be considered for the Presidency of the Hong Kong College of Physicians, (HKCP) on the grounds that she was no longer in active clinical practice.

She had joined the HKCP in 1987 and served with distinction in the Education and Accreditation Committee as Secretary from 1991 to 2004 and then as Chairman till 2013, which entailed devotion of many hours each week in college affairs, and in particular to guide the publication of five editions of the Training Manual. She was a member of the HKCP council for 22 years, during which she was Hon Secretary for nine years then Vice-Chairman for the same duration. In recognition of her contributions to the College she was awarded Honorary Fellowship of the Hong Kong College of Physicians in 2013.

In addition to involvement in professional societies like the Hong Kong Thoracic Society and Hong Kong Lung Foundation, Loretta participated actively in public and community services. To name a few, she was member of the Hospital Authority Board, Research Council and the Health and Medical Development Advisory Committee of the Food and Health Bureau, Scientific Committee on Emerging and Zoonotic Diseases of the Centre for Health Protection, Elderly Commission of the Labour & Welfare Bureau, and Council of the

Hong Kong Polytechnic University. In 2014 she was conferred an Honorary Fellowship by the Hong Kong Polytechnic University.

There are two achievements regarding which she is particularly happy. The first came during her chairmanship of the Specialty Board in Critical Care Medicine in Hong Kong from 1993 to 1999 when a formal structure of training was laid down and the discipline was recognised as a Specialty, such that there are now sufficient physician-trained specialists to serve the many critical care units in the Hospital Authority. She gives thanks to her three mentors in ICU for their inspiration and significant contributions to this achievement.

The second achievement was the award of accreditation status from the Australian Council on Healthcare Standards for PYNEH, the first hospital in Hong Kong to have achieved that distinction. Even today the hospital maintains exemplary performance in delivery of healthcare and standards of management.

During her career so far Loretta has published 54 articles in peer-reviewed journals, authored or co-authored nine book chapters, and published 98 abstracts. She has also reviewed articles for The Hong Kong Medical Journal, Chest and the Lancet.

Loretta's current activities show that she is in no way slowing down. She is continuing her relationship with the

PYNEH, now back there as a part time consultant. She is a 'Surveyor' for the Australian Council on Healthcare Standards, and for the International Society for Quality in Healthcare (IsQua); Honorary Consultant to the Department of Intensive Care at PYNEH, and Honorary Advisor to The Hospital Authority. As Adjunct Professor at the Hong Kong Jockey Club School of Public Health and Primary Care, Chinese University of Hong Kong, she is enjoying her work with Professor EK Yeoh on regulatory research and on evolving ways to reduce hospital admissions through enhancing ambulatory care, which fits in with her other research on healthcare quality as Honorary Professor of Health Services Management at the Business School of Tung Wah College. She is also a member of the Court of the Polytechnic University and the Social Welfare Advisory Committee of the Labour & Welfare Bureau.

She has no plans to work in the private sector and has no regrets at not having done so in the past. She enjoys her present sessions as a PYNEH part time consultant which give her the opportunity to use her clinical skills and to spend time communicating with patients.

There could be no way more appropriate to conclude this article than to quote the motto of the school at which Loretta spent thirteen years of her young life, a motto that seems to have become a part of her character.



Michael and Loretta in Kanazawa, Japan

'VIA – WAY To walk confidently and joyfully in the path of life, overcoming all difficulties with fortitude and prayer.

VERITAS – TRUTH To be sincere in word and action, and to be open to truth and knowledge.

VITA – LIFE To live for others, be ready to share, serve and sacrifice for others.'