HONG KONG COLLEGE OF PHYSICIANS

SYNAPSE

RESTRICTED TO MEMBERS ONLY

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Photograph by
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Calligraphy by
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CONTENTS

THIS ISSUE

4 **PRESIDENT'S MESSAGE ON COVID-19**

SPECIAL ARTICLES

6 PRESIDENT'S ANNUAL REPORT 2019

8 ADDRESS TO NEW FELLOWS

10 **24TH AJS MCFADZEAN ORATION 2019** // Medicine in Millennial Times

14 **GERALD CHOA MEMORIAL LECTURE** // Mentoring and Community Building for "Soulful-Excellent Medical Services"

16 AN OVERVIEW OF COVID-19

18 HONG KONG DOCTORS' JOB SATISFACTION SURVEY

20 **COUNCIL NEWS**

31 **EXAMINATIONS AND RESULTS**

SCIENTIFIC SECTION

33 BEST THESIS AWARDS

36 **SIR DAVID TODD LECTURE** // Enhancing Clinical Outcomes in Liver Diseases: The Way Forward in The Twenty-First Century

38 **RICHARD YU LECTURE** // Pioneering Research in Liver Cancer: From Staging to Immunotherapy

40 **TRAINING**

47 **YOUNG FELLOWS' COLUMN**

49 **FELLOW'S CORNER**

51 **PROFILE DOCTOR**

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President's Message on COVID-19

Certainties out of Uncertainties 2.0

In the last few months, Hong Kong has faced unprecedented challenges with the COVID-19. And this time, it has created more difficulties than SARS back in 2003.

The COVID-19 affects all sectors of the society and the medical communities. However, the physicians are always on the frontline of the battlefield as most of these patients will go through our isolation wards or general medical wards or intensive care units, in different stages of the patients' illnesses. Many Subspecialties of the College are in the 'war zone' in fighting against this novel virus infection.

The College would like to give praise to all our trainees, members and fellows, be it in public and private sector to join hand in hand in combating this potentially life-threatening infection.

"Certainties out of Uncertainties" was the title of the Editorial I wrote for August 2003 Issue of Synapse when I was the Editor-in-Chief. I stated: 'The uncertainty lies in the fact that no one knows what the next epidemic is like and when it will come in future. This brings out the importance of hygiene and environment, virtues that need to be maintained and protected by our community, regardless which period of time.' As of 12 April 2020, there are over 1.8 million cases of COVID-19 cases around the world. And this figure is still on the upward trend exponentially. The figure for Hong Kong is over 1,000 cases.

In 1894, Kennedy Town glassworks converted for use as a temporary hospital during the period of Hong Kong plague

A certainty is history repeats itself. We should always learn from history to get ourselves prepared. In May 1894, the plague epidemic erupted with violent intensity in Hong Kong's overcrowded Chinese quarter of Tai Ping Shan, currently the Western District. The photo (courtesy of the Hong Kong Museum of Medical Sciences) showed the interior view of the Kennedy Town glassworks, which was converted for use as a temporary hospital during the period of Hong Kong plague. This seems not unfamiliar when we compare with the recent COVID-19 in the 21st Century noting the shocking scenes in the media reported in March 2020 at the Hospitals in Madrid, Spain showing patients lying on the floor coughing (https://www.dailymail.co.uk/news/article-8142013/Horrifying-images-coronavirus-patients-lying-floor-packed-Madrid-hospital.html.) It spells out the importance of protecting our patients and also our healthcare professionals during the time of epidemic and with sufficient medical facilities supporting patient management.

The SARS outbreak started in March 2003. At that time, Hong Kong did not have sufficient isolation facilities. The physicians, the major caretakers of the infected individuals, do not have sufficient number. In 2003, we only had 12 fellows in Infectious Disease (ID), 97 fellows in Respiratory Medicine, 38 fellows in Intensive Care Medicine (ICM) and 660 in Advance Internal Medicine (AIM). In 2020, the

numbers of these are 46, 207, 108 and 1529 respectively. Thus the Hospital Authority and our College have nurtured a big increase in the specialists throughout this period for Hong Kong. Tripling ID specialists, doubling respiratory and ICM specialists and increasing AIM specialists 2.5 fold are important for Hong Kong at the time of the outbreaks, serving both public and private sectors. In both outbreaks, we witnessed the selfless contributions of our physicians and healthcare professionals in taking care of our patients. In the recent COVID-19, the voluntary participation of different levels of our physicians in many Departments of Medicine including interns, basic physician trainees (BPT), higher physician trainees (HPT), fellows, Associate Consultants, Consultants, Assistant and Associate Professors, Professors and many are so commendable. In some Departments, the long volunteer list for the 'Isolation Team' puts a waiting time for the doctors to join the team.

There are bound to have effects on our College activities under such pandemic. The most affected are the examinations. The PACES examination of the March and July 2020 diets have been cancelled. The College has been exploring with the MRCP UK office to see if we can have any alternatives. However, both internal and external factors make this not possible. Thus we are now working towards the October PACES. The College will make the most optimal arrangement to address the need for our trainees. The March and July Part 2 written examinations for this year are also cancelled by the UK Office. Once again, we will try our best to cater more candidates in the coming October diet. For MRCP Part 1 written examination in Sept 2020 diet, at the moment, this will run as scheduled. The College is very much aware of the anxiety of our trainees about the examination dates.

For our Exit Examination for all HPTs of AIM and all Specialties, the College has made the decision to go ahead in the next few months, making adjustments for dissertation submissions, and will not delay the time that our HPTs to sit in the fellowship examinations. Another example of flexibility in accommodating the specialist training during this critical period is that the College allows the extension of timeframe for cardiology trainees who need to undergo at least one month's attachment to cardiac teams of hospitals with Cardiothoracic Surgery service.

For the CME of our College Fellows, we have decided to waive the minimum requirement of 10 CME points for this year. It so happens this year is the start of our CME cycle and there will be 3 years ahead of us. The College also approved to accredit meetings organised by video conferencing.

Please be reassured that the College will try our very best to make up for all the subsequent examination quota and slots in order to reduce the impact on our trainees and members to a minimum. It is certain that the College will support all our trainees, members and fellows during this difficult time and please let me and any of the council members know what your needs are that the College can help.

Prof David Hui, Chair of our College's Research Committee, has written an excellent article on COVID-19 based on his vast and unique personal experience of the disease in this Issue of Synapse. One thing for certain that Prof Hui has pointed out is the clinical experience in managing the outbreak of SARS in 2003 in Hong Kong has facilitated the management of COVID-19 in 2020. One of the uncertainties, as of to date, is the best drug treatment of the disease. It is actually that Hong Kong, over the years, have built up the capacity in management of epidemic infections, both in facilities and in professionals, that we are in a better position to help to investigate on the drug use as clinical trial, in local setting and in a multi-centre global level.

The Cover photo of this Issue of Synapse is a beautiful picture by Prof Richard Yu and the calligraphy of Prof Joseph Sung. As Prof Sung explains to me that the meaning of the words of his calligraphy (寶劍鋒從磨礪出 梅花香自苦寒來) in English: 'Training is tough but necessary to produce clinical acumen; Tough time as it is now in HK will bring a better future'.

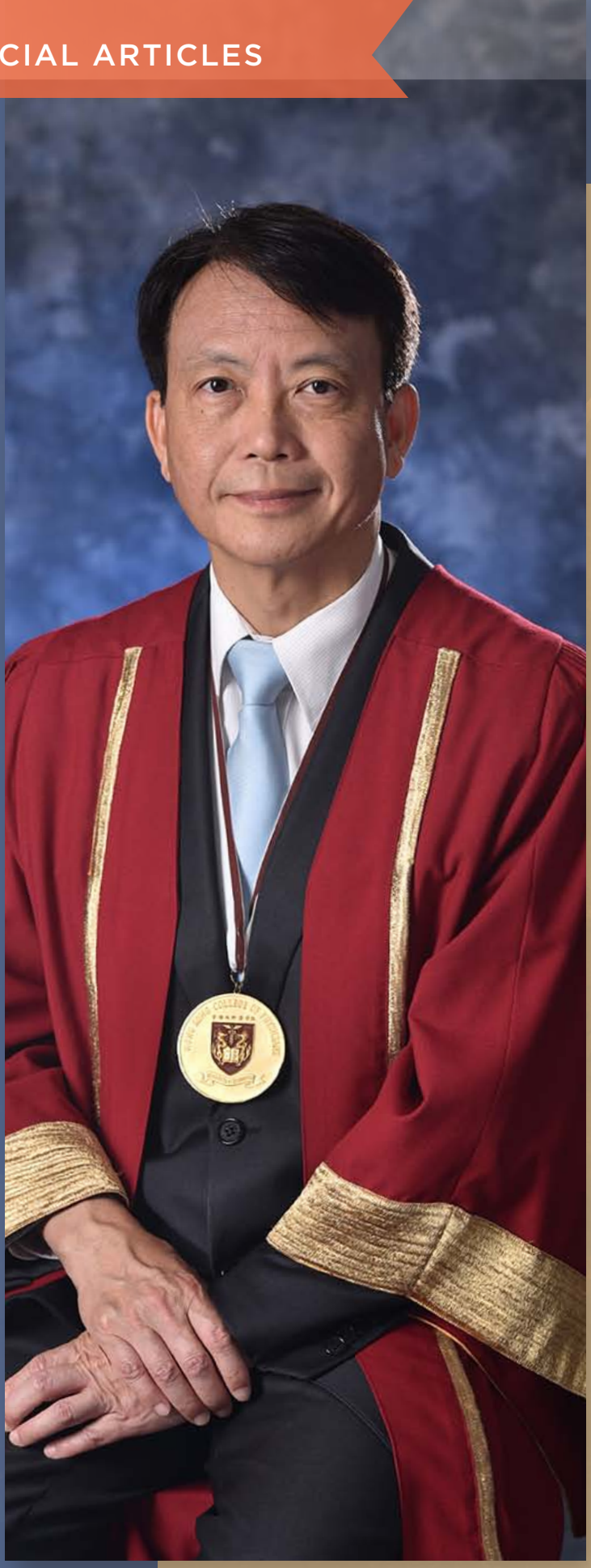
Out of all the uncertainties, some certainties are always there to remind us: COVID-19 treats us all equally and that means no matter what ethnicity, gender, culture, religion, occupation, financial status, and political beliefs, we are susceptible to the infection. Likewise, another certainty is that we as physicians and healthcare professions should always treat all our patients equally and wholeheartedly regardless of what ethnicity, gender, culture, religion, occupation, financial status, and political beliefs.

In June 2003, 3 months after the SARS outbreak, WHO lifted the travel advisories on Hong Kong affirmed that Hong Kong had effectively brought SARS outbreak under control. It is still uncertain when COVID-19 will be brought under control this time. Hopefully with all the hard work of physicians and healthcare professionals, all the containment measures of the Government and all the committed vigilance of our citizens, we can see that happening similar or close to the timeframe we controlled SARS in 2003.

I wrote 17 years ago in the SARS Editorial in Synapse and I state again unreservedly:

Salute to all Health Care Workers! Salute to all Physicians!

Prof Philip KT Li
President
Hong Kong College of Physicians



The College continues to carry out the role of overseeing the training and setting up the standards of our physicians in Internal Medicine. Under the current Training Subcommittee, a Core Medical Skills Course (CMSC) has been organised for BPT trainees in the current year. It is planned to become mandatory training programme for all Trainees in due course.

A Workshop on Physician Training and Assessment was held in July 2019 with the collaboration with Hong Kong Academy of Medicine. The Workshop was well attended. The feedbacks we received were very positive.

This year in September our College continued to organise a 2-day PACES training course at Pok Oi Hospital and Tseung Kwan O Hospital. We had invited 2 Trainers from UK and together with local trainers to have the 5 station mock examination for our candidates. In addition, our College organised two lectures on tips of passing PACES and PACES 2020 for our local trainees and examiners. These two lectures were delivered by the 2 UK Trainers.

The President's Annual Report 2019

Professor Philip Kam Tao LI
President, HKCP

Our College organised a "Retreat for Senior Physicians in Public and Private Sectors" in March 2019. There were representatives from both the public and private sectors from various Specialty Boards and Senior Fellows. We had fruitful discussion on "How can the College engage and support Fellows who have completed training", "How to enhance Training, CME and Credentialing", "How the senior physicians can contribute to the College and the medical profession", "How to enhance the morale of the profession". Our College will study the views and try to take appropriate measures to address the issues raised.

Our Young Fellows' Committee and the Hospital Authority's COC (Medicine) jointly organised the Medico-Legal Symposium in December 2018. The feedbacks received were very good. We hope similar Symposium will be held in the future.

Our College always maintains a close relationship with our overseas sister Colleges. This year we have our Joint Scientific Meeting with the Royal College of Physicians. We have also invited Presidents of various overseas Colleges to join our meeting as well as our annual College dinner. Besides, I attended the annual Congress organised by the Royal Australasian College of Physicians in Auckland in May 2019.

Our College continues to support the development of training of physicians in China and I myself and the Chairman of Young Fellows' Committee have delivered lectures about our physician training in the Summit Forum on Specialist Training organised by the Chinese Medical Doctors Association (CMDA) in Beijing in August this year.

The smooth operation and steady progress of the College owe a lot to the contributions of Chairmen and Members of the Specialty Boards, as well as Committees. I would like to thank our two Vice-Presidents for their devotion and efforts in overseeing training and international affairs. I am also grateful to our Honorary Treasurer for his very shrewd book-keeping such that the College remains in a health state financially. I would like to express my gratitude in particular to our Immediate Past President and Senior Advisor for their valuable advice and ceaseless support over the year. My final vote of thanks goes to our Honorary Secretary and the hardworking and dedicated secretariat staff in maintaining smooth operation of the College.

Address to New Fellows

Conferment Ceremony Oct 2019

Dear all New Fellows and Members,

I would like to congratulate all of you to become the New Fellows and Members of our College.

This year we have 81 new fellows and 93 new members being conferred, a record highest number of our College.

You must be particularly honored to be conferred on the occasion that we have the First Joint Scientific Meeting with the Royal College of Physicians and with the presence of Prof Andrew Goddard, the President and the senior Professors from the RCP. I take this opportunity to welcome the RCP to come to have academic exchange with us for our Joint Scientific Meeting and honor us to join our Conferment Ceremony. I would also like to welcome Prof John Wilson, President Elect of Royal Australasian College of Physicians to be in our Platform Party.

You must feel the distinct pleasure to have such a joyful moment to celebrate with your family, your friends and your seniors who are in the audience. Your hard work has paid up and at the same time, you should appreciate all who have supported you in your path to success.

May I ask all the New Fellows and Members to rise:

Wave your hands to your family, your friends and your seniors in the audience who have supported you to show your gratitude.

Thank you.

We have faced the space constraints in providing sufficient number of seats for accommodating the requests from some of you to bring more guests to this joyful event. The College is so grateful to your support and we will try to see how we can do better next year.

We face a lot of challenges in our career as a physician. Our College is always a partner with you, as new fellows and members, walking the path to overcome these challenges.

It is now 3 years since I took over as the President of the College.

From the start, I put engagement of our Fellows and Members as one of my priorities as President. I want you to feel that the College is 'of you', 'by you' and 'for you'.

The College Retreat in 2017, the Young Fellows Retreat in 2018 and the Senior Physicians Retreat in 2019 are the 3 events I organised to enhance engagement and for the College to listen to more voices from our Fellows and Members, young and senior. We would like to continue to hear from you on Workforce, Morale, Training and Academic activities how College can do more to support all of you.

Currently our College has 1,921 Fellows, 307 members and 337 trainees making a total of 2,565, the biggest in the Academy. I hope you agree that our College has already done quite a lot but has still room to tap into our own precious resources in achieving our goals.

For enhancing professionalism, this year our College has organised consecutively: Career Talk for Medical Graduates, KDIGO Hepatitis C Virus in Chronic Kidney Disease Guideline Implementation Summit, Workshop on Physician Training and Assessment, Core Medical Skills Course, MRCP PACES training days, APSN HKSN HKCP CME on Nephrology. The College would like to maintain the partnership with Specialist Societies, the Academy, Universities, Hospital Authority and other Colleges of Physicians around the world to do more and better in achieving our goals.

The College works closely with Prof Sophia Chan, Secretary for Food and Health and Dr TY Chui, Under-Secretary, on issues related to manpower, training and workload for physicians in the public Sector. I am proud to let you know that Dr Chui is our College Fellow. Hospital Authority has appointed Dr Tony Ko as the new Chief Executive starting August 2019. The College is happy to have Dr Ko, also our College Fellow, to be the new Helmsman for the Hospital Authority. We will work closely with Dr Ko, a Geriatrician before turning full time administration, to build a better healthcare for Hong Kong for the growing ageing population with multiple co-morbidities.

The recent few months in Hong Kong is probably the most difficult period that we have faced in our lifetime. The College would like to have all our Fellows and Members, regardless of political belief, to maintain the highest level of professionalism as a physician, in taking care of all our patients, regardless of any background. This is the core value of us being doctors and to help to maintain the health of our citizens and of Hong Kong.

When I discussed with Prof Goddard and his team, we felt that the challenges currently facing UK and HK are huge, be it in regular daily living and in healthcare. I just would like to wish that both of our Colleges can see the settling of the challenging events very soon and our healthcare would go into the next phase of better development for both of our Colleges. Prof Goddard, an expert with a lot of work on workforce, and healthcare funding in RCP is going to deliver the AJS McFadzean Oration on "Medicine in Millennial Times". I urge you new Fellows and Members to learn more from the wisdom of Prof Goddard.

Last year, I quoted from Asclepius, The Ancient Greek God of Healing and Medicine, to ask for positive thinking for maintaining health. This year, I was Visiting Professor to Karolinska Institute in Stockholm. As you may know, Karolinska Institute is one of the world's premier medical research institutions and home of the committee which gives out the Nobel Prize in Medicine or Physiology. One of the quotes from Alfred Bernhard Nobel that I want to share with you is: "Contentment is the only real wealth".

I sincerely hope that our Society can revert back to a normal state very soon and we as doctors and citizens can cherish Hong Kong to be a safe and livable home for all of us, as it has used to be.

Once again, congratulations to you all and welcome to our big family of the College of Physicians.

Professor Philip Kam Tao LI
President, HKCP

24th AJS McFadzean Oration 2019

Medicine in Millennial Times

Professor Andrew F GODDARD
President, Royal College of Physicians

I am honoured to be able to give the 2019 AJS McFadzean Oration and I am indebted to the Hong Kong College of Physicians for the privilege of speaking to this particular audience on this special evening of celebration. You are the future of medicine in Hong Kong and indeed the world and I am inspired by seeing you all today and learning about your achievements.

My oration will cover the changes that hospital medicine has seen over recent times from the differing aspects of medicine, doctors and our patients. I hope I will convince you that change is always with us but that the fundamentals of the art of medicine are a constant that we can use to keep us focussed on our core values. I firmly believe that medicine is brilliant and hope that by the end of this oration you will share this belief.

The younger members of the audience may not have a sense of who Professor McFadzean was so I will give a little background. Alexander James Smith McFadzean was born in Scotland in 1914 and died at the relatively young age of 60. Between 1948 and his death in 1974 he was instrumental in establishing the specialty of internal medicine in Hong Kong. He was Professor of Medicine for the University of Hong Kong for all of that time and Dean between 1967-72. He is considered to be the father of medicine in this country.

He was a rather fearsome character whom students and colleagues took care not to cross. However, his skills as a diagnostician and a teacher made him loved by all those who had the opportunity to be taught by or work with him. He inspired all of those around us.

This is, perhaps, my first key observation. Many of us end up in the careers we have because we have met an individual clinician that has inspired us. We must remember that we all have the ability to be the inspiration for others and be aware of the shadow we cast on those around us. Enthusiasm for medicine is infectious and we should all be willing to be a carrier.

This is my first visit to Hong Kong and I have enjoyed my time here tremendously. I do have some family links with Hong Kong as my sister-in-law is a cousin of Sir Edward Youde who was Governor of Hong Kong between 1982-86. The family photographs of him as a Boy Scout in Penarth, Wales show no sign of the great diplomat he was to become and perhaps reminds us that we should be wary of judging by appearances the future potential of those we meet. Family photographs are also important as they remind us of those we could not do without. I am indebted to my wife, Nicky, without whom I would never have been able to become President of the Royal College of Physicians. She is my rock. This leads to me to my second observation. We are the people we are because of our families. They allow us to excel and provide the best care we can for patients. We must work as hard at the family aspects of our lives as we do the professional ones.

This oration, as I have said will focus on changes and constants. Let me start with the changes we have seen in medicine in recent times. I will paraphrase a fellow of the RCP, Sir Cyril Chantler. "Medicine used to be ineffective, cheap and safe. Now it is effective, expensive and potentially harmful". The advances we have seen over the recent past are staggering.

When I was a junior doctor CT scanners were very few and far between and I can remember arranging a pneumoencephalogram on a patient with a suspected brain tumour. The images that are now produced by functional MRI 30 years later would have unthinkable then.

Furthermore, when I started my career in gastroenterology biologic therapy was unheard of and the sight of cachectic Crohn's patients with feeding lines and battle-scarred abdomens on hospital wards was all too common. The science behind the successful creation of monoclonal antibodies and their impact on inflammatory diseases has been one of the miracles of modern medicine.

The development and success of such treatments and technologies gives me great hope for the future of medicine. The rapid advances in the digital world and our decoding and ability to influence the genome show that we will continue to advance. Hopefully the advances will be as much in the arena of disease prevention and early detection as anywhere, although the challenge of polygenic diseases and the disparity of health between the poorest and the richest in our societies should not be underestimated.

One of the biggest issues that you, the next generation of medical leaders, will have to address is the prioritisation of healthcare. The technologies I have described are revolutionary but come at a cost. There are few new treatments for disease or new diagnostic tests that are cheaper than those that existed before. When the NHS in the UK was established in 1948 it cost about £12 billion in today's terms. The budget for the NHS is now over ten times as much at over £140 billion. It seems that society will struggle to afford all

that modern healthcare can provide. Who, then, will get which tests and which treatments? There is no easy answer and I suspect the medical profession will have to support governments to come up with the right, or least wrong, solutions.

Technology will make health information easily available to those who can access it. The nature of mobile technology has the promise of allowing access to those that previously have been denied it. On the other hand it may create a widening divide between the 'haves' and the 'have nots'. I have spent some time in countries in East, central and Southern Africa over the past few years and have been impressed by the skill, passion and knowledge of the doctors there. The resources they have, though, are limited and it must be very hard to manage a patient with diabetes knowing that their insulin costs them 60% of the minimum wage for the country. How do we ensure all parts of the world benefit from the advance of the science of medicine?

The challenge of technology is not just one of who can use it and who cannot. The innovations we have seen have been driven in the main by industry, usually funded by groups of investors. These investors want to see a quick return on their money and health care, due to the need to ensure patient safety, moves at a different speed. How we evaluate new technologies safely in this setting will require the medical profession to be pragmatic but remember why we are there. The patient must come first.

We must not be too quick to seek out the future when we have yet to curate the present effectively. The variation in the standards of care we deliver as clinicians in our individual countries is too high. It is our responsibility to reduce unwarranted variation in care and it is in our gift. Two barriers to this are professional pride and the paucity of outcome data. This is particularly true for hospital medicine. I am rather envious of our orthopaedic surgical colleagues for the wealth of outcome data they have and how they have used that to reduce infection rates and costs for joint replacement. The 'Getting it right first time' programme in the NHS has shown what is possible.

We must also not forget what I refer to as the 'four horsemen of the Apocalypse' the big influencers that hang over us like a sword of Damocles if you will allow me to mix my metaphors. Antimicrobial resistance, obesity, climate change and political changes all have the ability to derail any advances we make in healthcare through technology in the coming years. We have a responsibility to do our part to ensure that doesn't happen.

I will now move onto discuss the changing nature of the medical profession. Much has been said about the difference in the millennial generation of doctors and your predecessors, usually by the latter. I know many a senior physician who bemoans the loss of the firm structure and the vocation of medicine. It was ever thus, though, and it should be remembered that it was Aristotle who first coined the phrase 'the youth of today'.

You as millennial doctors want easy access to technology, more flexible working, a better work-life balance and a stable financial footing. The system, though, struggles with this, mainly because globally we have a problem with medical workforce undersupply.

Demographic changes in the medical profession have also changed how people want to work. Doctors retiring today will have trained at a time when 10-20% of their peer group were female. Most medical schools now graduate more women than men and in some countries women make up 80% of medical students. In the UK over 40% of female consultant physicians work less than full time compared with 5% of males. This is not something we should complain about but it does mean we will need to train more doctors than we have traditionally done. Many governments have yet to grasp this simple concept.

The final change that we are seeing is in our patients. It could be said that health services are victims of their own success. Most populations are living longer than ever before and surviving diseases that would previously stopped them developing the degenerative diseases of older ages. Twenty years ago most people aged 50 feared cancer, now they fear dementia. Our advances in the treatment of the former have not been matched in the latter.

In the NHS the average age of admission to UK hospitals is 74, at which time almost half will have three or more health conditions. They are more likely to be obese, have the metabolic consequences thereof and be less supported by their families. This all means that we as physicians need to be able to manage multiple health conditions, have the support of social care and be able to communicate with people of a different generation.

One of the positives about the ageing population is that it is predictable. We know exactly how many people in our respective countries are of a certain age and

can accurately estimate what their health needs will be. Once again, governments will need to plan for those needs and have an appropriate health and social workforce in place.

I hope, then, that I have convinced you that we live in changing times but I wish to return to the start of this oration. I am the 101st person to be the president of the RCP since we were founded in 1518. The first president, Thomas Linacre, had the advantage that he was Henry VIII's physician and thus was able to influence the government of his day. However, his reasons for establishing the college were the same as the reason we exist today - to improve the health of the public and the patients we care for. The skills Linacre used as a diagnostician were the same as we all use today – careful observation, skilful examination, thoughtful synthesis, measured communication and ultimately the best care of the patient in front of him.

These are the hallmarks of the 'art of medicine'. This art has not changed in the 500 years since Linacre's day despite all the changes in medical science that have marched forwards. We as physicians can have a huge impact on the lives of the patients we care for, and we must never forget that even the little things that we do and say can make a difference to them.

Hippocrates understood this. "For some patients, though conscious that their condition is perilous, recover their health simply through contentment with the goodness of their physician". It comes back to the phrase I used earlier - 'beware the shadow you cast'. That shadow falls on patients, their families and carers, our colleagues, our students and even ourselves.

Many doctors today take an oath or promise based on the Hippocratic oath when they qualify. My medical school did not have such a promise when I qualified (although they do now) but I was lucky enough to be involved when the RCP drew up a new charter for our members and fellows to celebrate our quincentennary. The charter summarises the qualities that make a physician for today and if I were to say what I believe it means to be a physician in millennial times I cannot say it better:

We promise to seek to provide the highest standards of patient care at all times, working with others to treat patients in the manner in which we would wish to be treated ourselves, and to involve patients, their families and carers in decisions about their care.

We promise to train, develop and support other doctors and healthcare professionals at all career stages, to champion research and innovation that improves the care we provide to patients and to commit to our own continuous professional development throughout our careers.

We promise to act as leaders to develop, influence and sustain high quality healthcare both locally and more widely, to act in our patients' and society's interests over our own and to speak up when it is right and necessary to do so.

We promise to promote good health and prevention of ill health across society, to look after our own health so that we are best placed to look after others and to use our healthcare resources justly and wisely.

Thank you for listening to me and thank you for being the doctors you are. We live in changing times and I do not fear for the future. I look around this hall and know that medicine is in safe hands. You should all be proud of what you have achieved and whatever the future may throw at us remember what it means to be a physician and also remember that medicine is brilliant.

GERALD CHOA MEMORIAL LECTURE

Mentoring and Community Building for "Soulful-Excellent Medical Services"

Dr Philemon Yuen Wan CHOI (M.D., J.P., S.B.S.)
President – Youth Global Network Limited

A. Hong Kong Medical Profession is facing the challenges of the 21st Century.

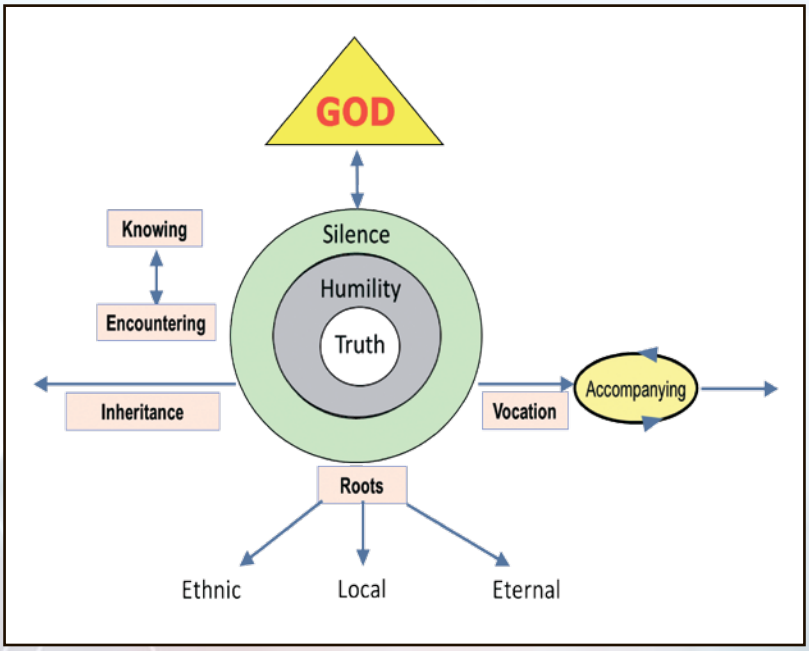
1. Harvard Professor Harry Lewis lamented that Harvard faced the crisis of《Excellence without a soul》. By soulfulness he meant "helping students to grow up, to learn who they are, to search for larger purpose for their lives, and leave college as better human beings.". Moreover, as students entering the marketplace, they should be equipped with "personal strength, integrity, kindness, co-operation, compassion, and know how to leave the world a better place than they found it"
2. Dr. Francis Fukuyama, a leading scholar in political science, made the important observation that "traditional political orders undergoing rapid change had collapsed with disorder and around the globe《Political Order and Political Decay》. His research identified "The source of political decay is the inability of instititions to adapt to changing circumstances – specifically, the rise of new social groups and their political demands." We are witnessing the process of "political decay" in Hong Kong.
3. Nobel Prize writer Dr. Angus Deaton discovered in his research that "Economics growth has been the engine of international income inequality"; and "health inequalities are one of the *great injustices of the world today.*" 《The Great Escape: Health, Wealth, and the Origins of Inequality》

B. Mentoring and Community Building for "Soulful-Excellent Medical Services

1.

Renowned Canadian Sculptor and poet Richard Kramer gave an insightful description of the mentoring process.

2. Through many years of experience of being mentored, I discovered the *ten vital ingredients of mentoring for wholistic development*《恩師和我的十堂課》

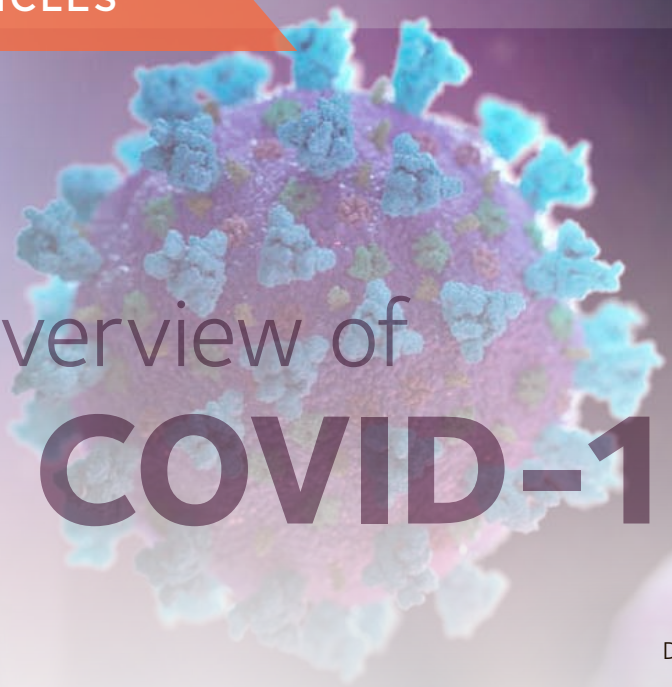


3. "Creating space for development of "Soulful excellence". A highly respected scholar in the realm of tertiary education Dr. Parker Palmer proposed a definition of soulful education: "To teach is to create space, in which obedience to truth is practiced" 《To know as we are known》

4. Building a community of multiple disciplines for wholistic medical services

   I am hopeful for the future development of the medical services in Hong Kong, because I have witnessed many models of building community of multiple disciplines for wholistic medical services in many hospitals. The communities include medical doctors, nurses, physiotherapists, dietitians, social workers, administrators, and medical students, etc. These teams allot regular time for professional seminars, building groups caring support, mentoring and spiritual care.

I feel honored to be invited to play some role in facilitating the mentoring and the community building process for "Soulful-excellent" medical services in Hong Kong.



An Overview of COVID-19

Professor David SC HUI
Department of Medicine & Therapeutics
The Chinese University of Hong Kong

On 31 Dec 2019, unusual cases of pneumonia in Wuhan, China were reported to the World Health Organization (WHO) and the outbreak was associated with a seafood market where game meat was also sold. A novel coronavirus, later named as severe acute respiratory syndrome coronavirus 2 (SARS-CoV2), was found to be the cause of this outbreak on 7 Jan 2020. There is 79.5% similarity of SARS-CoV2 in genetic sequence to SARS-CoV and 96% similarity at the whole genome level to a bat CoV[1] while pangolins are implicated to be another potential source.[2] Despite lockdown of Wuhan city on 23 Jan 2020, the outbreak quickly spread throughout China and many other countries by travelers from Wuhan. The outbreak was declared a Public Health Emergency of International Concern on 30 January 2020 and the WHO announced a name on 11 Feb 2020 for the new coronavirus disease as COVID-19. On 11 March 2020, the WHO announced the extent and evolution of the global outbreak of COVID-19 as reaching a pandemic.

As of 25 March 2020, more than 410,000 cases of COVID-19 have been confirmed in over 160 countries with 18,440 deaths. Common presenting symptoms of COVID-19 include fever (44% on admission and then increased to 89% during hospitalization), cough mainly non-productive (67.8%) while diarrhoea is uncommon (3.8%). The median incubation period is 4 days (interquartile range, 2 to 7).[3] Absence of fever in a high proportion of patients makes it difficult to detect these cases in the community in the early stage of infection. Nevertheless, there is evidence that patients in the pre-symptomatic stage and those with mild disease may transmit infection to others.[4] Similar to SARS and MERS, children infected with SARS-CoV2 generally have mild disease.[5] A retrospective study has shown that pregnant women infected with SARS-CoV2 in the third trimester had mild disease without vertical transmission while breast milk, amniotic fluid, cord blood and neonatal throat swabs were negative for SARS-CoV2.[6] Viral kinetic studies have shown that the viral load peaks on day 2 to 3 of the patient's illness,[7] and this explains the high potential of SARS-CoV2 in causing community transmission among close contacts. Serology response starts on day 7 of illness while PCR positivity in deep throat saliva could last for at least 3 weeks in one third of patients.[8]

The clinical experience in managing the outbreak of SARS in 2003 in Hong Kong has facilitated the management of COVID-19 in 2020. Since 2005, double door negative pressure isolation rooms have been installed in every acute public hospital and there are currently 1400 beds in negative pressure isolation rooms in HK. In addition to a much safer ward environment, healthcare workers are familiar with infection control and prevention measures, wearing surgical masks in low risk areas and upgrading to airborne precaution with N95 masks, protective gowns, eye shield and gloves when managing high risk patients or performing aerosol generating procedures in the isolation rooms. No nosocomial transmission of COVID-19 has occurred so far in the hospital setting.

Coronavirus contains a protease enzyme which has become a target of therapeutics. A retrospective study of patients with SARS in HK has shown that a combination of protease inhibitors (lopinavir/ritonavir) and ribavirin was more effective in reducing death rate [2.3 (0-6.8)% vs 15.6 (9.8-22.8)%] and intubation rate [0% vs 11.0 (7.7-15.3)%] vs a historical control group on ribavirin alone (n=634).[9] Another study has shown that lopinavir/ritonavir and interferon (IFN)-β1b were more effective in reducing viral loads and mortality in marmosets infected with MERS-CoV.[10] A recent RCT in Wuhan has shown that lopinavir/ritonavir was not more effective than standard of care (SOC) in achieving clinical stability, reduction in viral loads and mortality.[11] Based on the experience in managing SARS and the scientific data on treatment of marmosets infected with MERS-CoV, a combination of protease inhibitors, ribavirin +- beta interferon has become the local SOC for patients with pneumonia due to SARS-CoV2. More recently, another study in mice infected with MERS-CoV has shown that remdesivir (a RNA polymerase inhibitor) was more effective than protease inhibitors and beta IFN in reducing viral loads and lung damage.[12] Currently several RCTs comparing 5 or 10 days of remdesivir against SOC are in progress in many countries. The role of other therapeutic agents such as hydroxychloroquine, favipiravir, arbidol and IL6 antagonist is being explored in clinical trials.[13]

Containment measures have been carried out effectively in HK since Jan 2020 to limit the spread of COVID-19 in the community. These include a) early isolation of suspected and confirmed cases; b) quarantine of close contacts and HK citizens who have returned from high risk areas (eg Diamond Princess Cruise and Wuhan) for 14 days; c) social distancing measures (eg cancellation of mass gathering events, school closure, and office at home); d) promotion for the general public to maintain good personal hygiene (eg wearing of a surgical mask in public transport/ crowded areas and hand hygiene); and e) enhanced laboratory surveillance in testing for in-patients and out-patients with febrile respiratory illness for SARS-CoV2.

The recent influx of a large number of HK citizens from Europe and North America where major outbreaks of COVID-19 are occurring is posing great challenges to the healthcare system for control of COVID-19 in HK. A significant number of cases have been confirmed among the returnees recently and there are clusters of local transmission emerging without clear contact sources. It is important to maintain existing containment and social distancing measures in order to prevent widespread and sustained community transmission which may disrupt the healthcare system in HK.

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Hong Kong Doctors' Job Satisfaction Survey

Dr Pierre CHAN
Councilor
Legislative Council of Hong Kong

A survey on job satisfaction of registered doctors was conducted in 2019 by the Hong Kong Institute of Asia-Pacific Studies of the Chinese University of Hong Kong (HKIAPS) with my collaboration. Its aim of the survey was to examine job satisfaction issues and collect opinions about staff attraction and retention measures being pursued by the Hospital Authority (HA).

Table 1: Basic information

	Number (%)
Workplace	
• Hospital Authority	829 (60.3%)
• Private Hospitals/ clinics	441 (32.1%)
• Department of Health	59 (4.3%)
• Universities	14 (1.0%)
• Retired/ unemployed	9 (0.7%)
• Others	20 (1.5%)
Main work	
• Clinical work	1272 (92.6%)
• Administrative work	30 (2.2%)
• Others	55 (4.0%)
Age Group	
• <30	163 (11.9%)
• 30-34	191 (13.9%)
• 35-39	211 (15.4%)
• 40-44	206 (15.0%)
• 45-49	162 (11.8%)
• 50-54	155 (11.3%)
• 55-59	113 (8.2%)
• 60-64	64 (4.7%)
• >65	107 (7.8%)
Gender	
• Female	498 (36.2%)
• Male	847 (61.6%)

Survey questionnaires were sent to all registered doctors in Hong Kong, who were asked to reply by mail, email, online or fax to HKIAPS. The response rate was 10.4%, coming from some 1374 doctors in both the public and private sectors (their basic information in table 1). Most of the responders were engaged in HA clinical work.

The main reasons quoted by doctors considering or having to leave the HA are workload, promotion opportunities and income (table 2).

Table 2: The reasons for HA doctors considering to leave or private doctors having to leave Hospital Authority

	HA doctors N = 397	Private doctors N = 324
Workload	251 (63.2%)	168 (51.9%)
Promotion opportunities	176 (44.3%)	139 (42.9%)
Income	191 (48.1%)	123 (38.0%)

There were 13 questions concerning job satisfaction, expecting a response on a sliding scale of 1 (very dissatisfied), 2 (dissatisfied), 3 (neutral), 4 (satisfied) and 5 (very satisfied).

Thanks for the invitation by the Hong Kong College of Physicians, I attempted a subgroup analysis focusing on physicians working in the Medical Departments of the HA. In addition, an analysis on job satisfaction among physicians (doctors practicing in the field of Internal Medicine) and non-physicians working in the HA was made (table 3). A number of observations are pertinent.

When comparing physicians and non-physicians working in the HA, the former group had less overall

Table 3: Job Satisfaction

Job Satisfaction		Physicians in HA (1) N = 205	Non-physicians in HA (2) N = 624	P value (1) vs (2)
201	Overall job satisfaction	2.78	2.94	<0.05
202	Responsibility (e.g. duty and division of labour)	2.77	2.98	<0.05
203	Physical working condition	2.35	2.75	<0.05
204	Hours of work	2.45	2.91	<0.05
205	Facilities / medical devices provided in the workplace	2.59	2.87	<0.05
206	Workload	2.10	2.38	<0.05
207	Staff establishment (including arrangements of on-call day and shift day)	2.45	2.60	0.086
208	Income (including salary, allowance, welfare, gratuity, overtime salary)	2.72	2.74	0.908
209	Recognition of work by supervisor	3.31	3.19	0.198
210	Relationship with supervisors and colleagues / subordinates	3.81	3.62	<0.05
211	Training opportunities	3.19	3.11	0.494
212	Promotion opportunities	2.48	2.73	<0.05
213	Work-life balance	2.28	2.60	<0.05

job satisfaction. HA physicians had low job satisfaction scores in the areas of workload and promotion opportunity, which were quoted as the main reasons of considering to leave.

Moreover, HA physicians were less satisfied in the areas of duty and division of labour, physical working condition, hours of work, facilities provided in workplace and work-life balance, all with statistically significant responses.

On the other hand, responses in the area of income, training opportunities, staff establishment and recognition of work by supervisor did not show significant difference between the two groups.

HA physicians had higher job satisfaction scores in the area of relationship with supervisors and colleagues, when compared with non-physicians in the HA.

Despite the overall response rate of 10.4% of the response of the survey, these results have given us some insights into the job satisfaction among physicians working in the public and private sectors, and non-physicians in the HA. We should all work together to improve the situations in the areas of workload and promotion opportunities for our younger HA physicians, in a bid to attract and retain talent in the public sector.

JOINT SCIENTIFIC MEETING

on 19–20 October 2019

The Joint Scientific Meeting of the College and the Royal College of Physicians took place on 19–20 October 2019, covering a wide range of topical subjects such as "The acutely ill patients", "Healthcare challenges" and "Organ failure in acutely ill patients".

Highlights included the prestige named lectures. Prof Andrew Goddard, President of the Royal College of Physicians, delivered an impressive lecture entitled "Medicine in millennial times". Dr Choi Yuen Wan gave the Gerald Choa Memorial lecture on "Mentoring and community building for 'soulful-excellent' medical services". Dr Seto Wai Kay Walter received the Sir David Todd Lecture medal for his work on "Enhancing clinical outcomes in liver diseases: The way forward in the twenty-first century". Dr Yau Chung Cheung Thomas presented the lecture entitled "Pioneering research in liver cancer: from staging to immunotherapy".

On the second day of the meeting, recipients of College's prizes for the "Distinguished Research Paper Awards for Young Investigators 2019" lectured on their winning works.

From L to R: Prof Munir Pirmohamed, Prof Bryan Williams, Prof Andrew Goddard, Prof Richard Yu, Prof Philip Li, Prof Cheng-Hock Toh, Prof Daniel Chan, Dr Patrick Li, Dr Johnny Chan

32nd Annual General Meeting 21st Congregation and Annual College Dinner

On 19 October 2019 the College held its annual gatherings.

The AGM was presided over by Prof Philip Li who delivered the Presidential report on the work and achievements of the College over the past year.

The 21st Congregation was honoured by the attendance of Prof Andrew Goddard, President of Royal College of Physicians, and Prof John Wilson, President-Elect of Royal Australasian College of Physicians. The College also presented a souvenir to Mr Jacob Tse, the Past Honorary Legal Advisor, as a token of thanks for his dedicated service over the years.

Named Lectures and Awards In 2019

Professor Andrew F GODDARD
President,
Royal College of Physicians

AJS McFadzean Oration

Medicine in Millennial Times

Dr Yuen Wan CHOI
President –
Youth Global Network Limited

Gerald Choa Memorial Lecture
Mentoring and Community Building for "Soulful-Excellent Medical Services"

Dr Walter Wai Kay SETO
Department of Medicine,
The University of Hong Kong

Sir David Todd Lecture
Enhancing Clinical Outcomes in Liver Diseases: The Way Forward in The Twenty-First Century

Dr Thomas Chung Cheung YAU
Department of Medicine,
Queen Mary Hospital
The University of Hong Kong

Richard Yu Lecture
Pioneering Research in Liver Cancer: From Staging to Immunotherapy

Dr Ka Lok CHAN

Dr Ka Man CHEUNG

Award for Obtaining The Highest Score in AIM Exit Assessment

Dr Wai Sze KWAN

Award for Obtaining The Highest Score in PACES

Distinguished Research Paper Award for Young Investigators 2019

Dr Ka Shing CHEUNG

Department of Medicine, Queen Mary Hospital

Statins reduce the progression of non-advanced adenomas to colorectal cancer: a post colonoscopy study in 187897 patients.

Cheung K-S, et al. Gut 2019;0:1-7.

Dr Jimmy Che To LAI

Department of Medicine & Therapeutics, Prince of Wales Hospital

Chronic Hepatitis B increases liver-related mortality of patients with acute hepatitis E: a territory wide cohort study from 2000 to 2016.

Clinical Infectious Diseases 2018;67(8):1278-1284.

Dr Wing Yan MAK

Department of Medicine & Therapeutics, Prince of Wales Hospital

Significant medical and surgical morbility in perianal Crohn's disease: results from a territory-wide study.

J Crohns Colitis 2018;12(12):1392-1398.

Young Investigator Research Grant 2019

The following doctors received a research grant from the HKCP to complete their respective projects as named. Selection was decided by a scientific panel headed by Prof David Hui.

The grant was established in 2012, to encourage young Fellows aged 40 or below to conduct research in Hong Kong. Up to five grants of up to HK$50000 each are awarded annually.

Randomized controlled trial of flash glucose monitoring in reduction of hypoglycaemia in diabetes patients with chronic kidney disease

Dr Elaine Yee Kwan CHOW
Department of Medicine & Therapeutics, Prince of Wales Hospital

Intra-dermal with topical imiquimod pretreatment versus intra-muscular hepatitis B vaccination in IBD patients – a double-blind randomized controlled trial

Dr Kwan Lung KO
Department of Medicine, Queen Mary Hospital

The effect of nonsteroidal anti-inflammatory drugs on intraperitoneal cytokine levels and the concomitant alterations in peritoneal transport characteristics in peritoneal dialysis patients

Dr Winston Wing Shing FUNG
Department of Medicine & Therapeutics, Prince of Wales Hospital

Impact of penicillin allergy testing in Hong Kong

Dr Philip Hei LI
Department of Medicine, Queen Mary Hospital

Prospective clinical study of subclinical atherosclerosis burden in patients with bronchiectasis

Dr Wang Chun KWOK and Dr Gary Kui Kai LAU
Department of Medicine, Queen Mary Hospital

The HKCP Council 2019 – 2020

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Vice-Presidents	Prof Chan Tak Cheung Anthony Prof Chan Tak Mao Daniel
Honorary Secretary	Dr Chan Wai Man Johnny
Honorary Treasurer	Dr Tse Tak Fu
Council Members	Prof Chan Ka Leung Dr Chan Kwok Keung Dr Choi Cheung Hei Prof Hui Shu Cheong David Dr Lai Moon Sing Dr Lao Wai Cheung Dr Law Chun Bon Alexander Prof Leung Yu Hung Prof Ma Ching Wan Ronald Dr Mok Chun Keung Francis Dr Tse Man Wah Doris Dr Wong Mo Lin Prof Yuen Man Fung Dr Chan Chi Hey Heyson Dr Leung Yin Yan Jenny Dr Sha Kwok Yiu Edmund
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– Prof Daniel Chan

PROFESSIONAL AND GENERAL AFFAIRS COMMITTEE
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– Dr TF Tse

RESEARCH COMMITTEE
– Prof David Hui

SYNAPSE
– Dr KK Chan

YOUNG FELLOWS' COMMITTEE
– Dr Heyson Chan

Symposium on incentives and reducing disincentives in enhancing organ donation and transplantation

Organiser : Hong Kong College of Physicians

Co-organiser : Hong Kong Society of Transplantation

Supporting Organisation : Hong Kong Society of Nephrology

Date : Aug 29, 2020 (Sat)

Time : 2 pm to 5:30 pm

Venue : Lecture Theatre, HAHO Building

2:00 pm	**Welcome Message**	Philip Li
	Opening Speech	
2:15 pm	**Financial incentives to increase Canadian organ donation: quick fix or fallacy?**	John Gill
2:40 pm	**Government Initiatives to reduce financial disincentives in promoting organ donation – New Zealand experience**	Ian Dittmer
3:05 pm	**Q&A**	
3:20 pm	**Tea break**	
3:40 pm	**Challenges of Organ Donation and Transplantation in Hong Kong**	KM Chow
4:00 pm	**Organ incentive system in promoting organ donation : South Korean experience**	Curie Ahn
4: 25 pm	**A bioethical perspective on organ donation in Hong Kong**	Derrick Au
4: 45 pm	**Panel Discussion**	

Meeting with **Dr Tony Ko, Chief Executive, Hospital Authority**

The Office Bearers of our College and Senior Advisor had a meeting with Dr Tony Ko, Chief Executive and Dr Deacons Yeung, Director (Cluster Services) of Hospital Authority, on 17 December 2019. We discussed various issues with Dr Ko and Dr Yeung, in particular relating to how Hospital Authority can give more focus and support towards training and examination for our trainees. The importance of our fellows in supporting training and acquiring trainer status was emphasized and we encouraged HA to look into how the HA system could reflect such importance. The morale, workload and manpower retention of physicians were also discussed.

Meeting of our College with Dr Tony Ko and Dr Deacons Yeung
From L to R : Dr Patrick Li, Prof TM Chan, Prof Philip Li, Prof Richard Yu, Dr Tony Ko, Dr Deacons Yeung, Prof Anthony Chan, Dr Johnny Chan

Prof Philip Li delivered the lecture

Dr Heyson Chan delivered the lecture in the Summit

Report on **CMDA Summit**

On August 30-31, 2019, Prof Philip Li and Dr Heyson Chan represented our College to attend the Chinese Medical Doctor Association (CMDA) Specialist Medical Training Summit (2019年住院醫師規範化培訓高峰論壇) held in Beijing. Prof Li gave the lecture on 'Physician Training in Hong Kong: Current and Future' and Dr Chan gave the lecture on 'Specialist Training in Internal Medicine: From a Young Fellow's Perspective'. Prof Li and Dr Chan were also invited to give expert advice in a round-table discussion on standardizing specialist training in China with representatives from CMDA and officials from National Health Commission of the People's Republic of China.

Prof Li and Dr Chan shared the HKCP perspectives on Specialist Training in the Round- Table Discussion about standardizing postgraduate medical training with experts from Mainland and USA.

HKCP Scholarship for Medical Students

Venice Sze Wai LI
Medical Student (Year 6)
Faculty of Medicine, The Chinese University of Hong Kong

Ward Round in Intensive Care Unit

I was very honoured to have received the Hong Kong College of Physicians Scholarship for Medical Students, which supported me to undertake a 4-week clinical attachment at AIC Kijabe Hospital in Kenya last April. Kenya is an East African country most famous for its wildlife and exquisite natural landscapes. However, it is also notorious for its high corruption, and having one of the world's highest rates of HIV/AIDS infection and infectious diseases.

AIC Kijabe Hospital is a Christian private hospital situated in Kijabe, about an hour's drive from Nairobi, Kenya's capital city. During my 4-week attachment there, I rotated for 2 weeks in Female Medical Wards, 1 week in Intensive Care Unit (ICU), and 2 weeks in Outpatient Department and HIV/TB Clinic. My duties include managing patients like a House Officer, prescribing medications under supervision, and taking night shift calls. I also broke bad news and discussed treatment options with relatives. Apart from work, I attended lunchtime lectures across specialties, and underwent a training course in ICU.

I also had the opportunity to manage an HIV patient during my elective. I met a 30-year-old lady, who presented with a massive right leg swelling up to the groin with foul-smelling ulcerations and purple nodules, when I was on call one evening. According to the history taken from her, the swelling started 2 years ago and was preceded by a skin prick in the right foot. She complained of pain around the ulcerations, and cough for 2 weeks but no other systemic symptoms. It all sounded like a complication of trauma. However, the local House Officer immediately spot-diagnosed her condition from its appearance – Kaposi's sarcoma, a vascular tumor caused by Human herpesvirus 8, commonly associated with immunosuppression. Despite repeatedly denying about her HIV status, she was found to be HIV positive since 2014, yet refusing antiretroviral therapy (ART) due to self-stigma. Her clinical situation was very likely a complication of her untreated AIDS. She subsequently had severe headache, which revealed aseptic

4-week elective attachment at AIC Kijabe Hospital, Kenya

meningitis and cryptococcal infection. She was put on ART and treatment for cryptococcal meningitis. However, with conditions deteriorating rapidly, the patient eventually passed away 3 weeks later due to pulmonary hemorrhage from HIV-related thrombocytopenia.

This is the first time I have ever witnessed opportunistic infections such as Kaposi's sarcoma and cryptococcal meningitis. Despite feeling heartbroken for her condition, I could not ignore the impact of stigma towards HIV and AIDS in society, which was the trigger of her delay in treatment. It reminded me the importance of doctor-patient relationship, and communication of diagnosis to the patient. AIDS is a debilitating disease not just physically, but also psychologically and socially. As a future doctor, I am reminded to have empathy and be supportive to my patients on top of treating their diseases.

Coming from Hong Kong, which has a well developed, sophisticated healthcare system, I had a huge cultural shock when I first experienced Kenya's distorted healthcare system. Unlike Hong Kong where healthcare is heavily subsidized by the Hong Kong government, Kenyans sought quality medical care in private hospitals. Public hospitals are of poor quality due to low salary of staff, which causes experienced doctors to take on multiple jobs at a few public and private hospitals. Many Kenyans who are unable to afford private healthcare are deprived of medical services. I have seen patients who could not even afford a chest X-ray. Many times, consultants only attend to the patients in public hospitals once a week. There were helpless moments when I saw young patients dying because there was no available treatment due to limited resources. Numerous patients who could not afford investigations or treatments that would easily be accessible in Hong Kong. Yet, this has helped me to cultivate my "clinical sense" that professors often emphasized in class, which is to diagnose and manage patients with the least investigations and imaging possible, and to rely on medical knowledge and clinical judgment as the foundations.

My colleagues in the Internal Medicine Team of Kijabe Hospital

Once again, I would like to express my sincere gratitude to the donors of the Hong Kong College of Physicians Scholarship for Medical Students. It would not have been possible for me to undertake this elective attachment without their generous support. It is my aspiration to become an impactful doctor with love, empathy and compassion. I had the opportunity to utilize my medical knowledge in a resource-limited setting to provide healthcare for the impoverished and underprivileged African people. This valuable experience motivates me to prepare myself with the essential qualities that a future doctor needs - an optimistic attitude and excellent communication skills. I promise I will contribute my medical knowledge to society in the future, and continue to inspire younger generations as a role model of excellence and compassion.

Hiking Mt. Longonot

Newly elected FRCP (Edin) January – November 2019

1 **Dr Au Ka Fai Ronald**
Department of Health, Shau Kei Wan Jockey Club Polyclinic

2 **Dr But Yiu Kuen David**
Private practice

3 **Dr Chan Chi Hey Heyson**
Department of Medicine & Therapeutics, Prince of wales Hospital

4 **Dr Chan Hiu Lam**
Department of Medicine, Pamela Youde Nethersole Eastern Hospital

5 **Dr Chan Chun Kong Raymond**
Department of Medicine & Geriatrics, United Christian Hospital

6 **Dr Chan Sau Yan Thomas**
Department of Medicine, Queen Mary Hospital

7 **Dr Chan Yuk Kit**
Department of Medicine & Geriatrics, Pok Oi Hospital

8 **Dr Cheng Tin Sik**
Department of Health, Social Hygiene Service

9 **Dr Cheung Kit Yan Shirley**
Department of Medicine & Geriatrics, Pok Oi Hospital

10 **Dr Fan Tam Ting**
Department of Medicine, Tseung Kwan O Hospital

11 **Dr Fu Yat Pang Michael**
Department of Medicine & Geriatrics, Tuen Mun Hospital

12 **Dr Ho Tsz Ling**
Department of Medicine, Tseung Kwan O Hospital

13 **Dr Hung Hin Fai Victor**
Department of Medicine & Geriatrics, Princess Margaret Hospital

14 **Dr Hwang Yu Yan Gloria**
Department of Medicine, Queen Mary Hospital

15 **Dr Ip Tai-Pang**
Department of Medicine, Tung Wah Hospital

16 **Dr Kan Yee Man**
Department of Medicine & Geriatrics, Kwong Wah Hospital

17 **Dr Ko Kwok Chun Jason**
Private practice

18 **Dr Kwok Chi-hang**
Department of Medicine & Geriatrics, Princess Margaret Hospital

19 **Dr Lau Gary Kui Kai**
University Department of Medicine, Queen Mary Hospital

20 **Dr Lee Kar Lung**
Intensive Care Unit, United Christian Hospital

21 **Dr Lee Ting Lam**
Department of Medicine, Pamela Youde Nethersole Eastern Hospital

22 **Dr Myint Ma Wai Wai Jennifer**
Private practice

23 **Dr Ng So-shan Susanna**
Department of Medicine & Therapeutics, Prince of Wales Hospital

24 **Dr Pang Wing Fai**
Department of Medicine & Therapeutics, Prince of Wales Hospital

25 **Dr Poon Yat Sing**
Intensive Care Unit, United Christian Hospital

26 **Dr Sha Kwok-yiu Edmund**
Department of Medicine & Geriatrics, United Christian Hospital

27 **Dr Tai Ling Fung**
Department of Medicine, Pamela Youde Nethersole Eastern Hospital

28 **Dr Tong Ka Hang Matthew**
Department of Medicine & Geriatrics, Pok Oi Hospital

29 **Dr Wang Kwan Ling Julie**
Department of Medicine, Queen Mary Hospital

30 **Dr Wu Ka Lun Alan**
Department of Clinical Pathology, Pamela Youde Nethersole Eastern Hospital

31 **Dr Yip Pok Siu Terence**
Department of Medicine, Tung Wah Hospital

32 **Dr Yuen Mae Ann Michele**
Private Practice

33 **Dr Yuen Sze-Kit**
Department of Medicine & Geriatrics, Caritas Medical Centre

Newly Elected FRCP (London) 2019

1 **Dr Chan Pak Hei**
Department of Medicine, Queen Mary Hospital

2 **Dr Tsui Chung Kan**
Department of Medicine & Geriatrics, Kwong Wah Hospital

3 **Dr Lui Hiu Tung Colin**
Department of Medicine, Tseung Kwan O Hospital

4 **Dr Singh Gill Harinder**
Department of Medicine, Queen Mary Hospital

5 **Dr Lee Kwok Kuen Harold**
Department of Medicine & Geriatrics, Princess Margaret Hospital

6 **Dr Ma Hon Ming**
Department of Medicine & Therapeutics, Prince of Wales Hospital

7 **Dr Choo Kah Lin**
Department of Medicine, North District Hospital

8 **Dr Chung Yiu Kwan Kenneth**
Department of Rehabilitation, Kowloon Hospital

9 **Dr Fung Ka Shun Samuel**
Department of Medicine & Geriatrics, Princess Margaret Hospital

10 **Dr Choi Sik Ling Simon**
Department of Medicine & Geriatrics, Caritas Medical Centre

11 **Prof Wong Wai Sun Vincent**
Department of Medicine & Therapeutics, Prince of Wales Hospital

12 **Dr Chan Yiu Han**
Department of Medicine, Queen Elizabeth Hospital

13 **Dr Woo Yu Cho**
Department of Medicine, Queen Mary Hospital

14 **Dr Ma Kam Man**
Department of Medicine, Queen Mary Hospital

Passing rate for the Joint HKCPIE/MRCP(UK) Part I in the past years

	Sitting	Pass
September 2002	100	33 (33%)
January 2003	124	55 (44%)
May 2003 (SARS Special)	21	7 (33%)
September 2003	54	29 (54%)
January 2004	93	39 (42%)
September 2004	29	16 (55%)
January 2005	96	68 (70.8%)
September 2005	24	15 (62.5%)
January 2006	95	74 (80%)
September 2006	21	13 (62%)
January 2007	87	67 (77%)
September 2007	23	12 (52%)
January 2008	56	38 (68%)
September 2008	47	32 (68%)
January 2009	59	47 (80%)
September 2009	47	28 (60%)
January 2010	45	28 (62%)
September 2010	62	39 (63%)
January 2011	44	23 (52%)
September 2011	64	49 (77%)
January 2012	45	28 (62%)
September 2012	80	59 (74%)
January 2013	41	22 (54%)
September 2013	76	60 (79%)
January 2014	30	20 (67%)
September 2014	84	64 (76%)
January 2015	29	20 (69%)
September 2015	100	71 (71%)
January 2016	33	18 (55%)
September 2016	84	63 (75%)
January 2017	36	19 (53%)
September 2017	69	56 (81%)
January 2018	25	12 (48%)
September 2018	108	74 (69%)
January 2019	43	19 (44%)
September 2019	96	64 (67%)

Passing rate for the Joint HKCPIE/MRCP(UK) Part II (written) examination over the past years:

	Sitting	Pass
2 July 2002	53	27 (51%)
13 November 2002	50	24 (48%)
13 August 2003	110	62 (56%)
10 December 2003	54	31 (57%)
28 July 2004	65	42 (65%)
8 December 2004	46	32 (70%)
13 April 2005	32	15 (47%)
27 July 2005	76	56 (74%)
7 & 8 December 2005	26	16 (62%)
12 & 13 April 2006	29	13 (45%)
26 & 27 July 2006	91	68 (75%)
6 & 7 December 2006	33	18 (55%)
11 & 12 April 2007	34	22 (65%)
25 & 26 July 2007	80	70 (88%)
5 & 6 December 2007	19	13 (68%)
9 & 10 April 2008	21	13 (62%)
30 & 31 July 2008	47	36 (77%)
3 & 4 December 2008	17	10 (59%)
8 & 9 April 2009	32	25 (78%)
29 & 30 July 2009	50	43 (86%)
25 & 26 November 2009	12	7 (58%)
7 & 8 April 2010	41	34 (83%)
28 & 29 July 2010	25	19 (76%)
24 & 25 November 2010	8	2 (25%)
6 & 7 April 2011	45	35 (78%)
23 & 24 November 2011	32	25 (78%)
28 & 29 March 2012	55	43 (78%)
12 & 13 December 2012	57	44 (77%)
10 & 11 April 2013	60	52 (87%)
11 & 12 December 2013	48	34 (71%)
9 & 10 April 2014	54	46 (85%)
10 & 11 December 2014	26	25 (96%)
25 & 26 March 2015	53	45 (85%)
9 & 10 December 2015	68	65 (96%)
6 & 7 April 2016	29	28 (97%)
7 & 8 December 2016	62	50 (81%)
29 & 30 March 2017	25	21 (84%)
28 & 29 November 2017	58	54 (93%)
27 March 2018	21	14 (67%)
24 October 2018	20	15 (75%)
26 March 2019	79	71 (90%)
22 October 2019	17	12 (71%)

Passing Rates: PACES – 2001 - 2019

October 2001	36/72 = 50%
February 2002	34/74 = 46%
October 2002	29/72 = 40%
February 2003	30/69 = 43%
October 2003	27/59 = 46%
March 2004	39/64 = 61%
October 2004	26/69 = 38%
March 2005	35/75 = 47%
October 2005	28/75 = 37%
March 2006	36/75 = 48%
October 2006	16/73 = 22%
March 2007	44/74 = 59%
June 2007	44/74 = 59%
October 2007	36/55 = 65%
March 2008	36/74 = 49%
October 2008	29/65 = 45%
February 2009	39/75 = 52%
October 2009	24/72 = 33%
March 2010	33/75 = 44%
October 2010	40/74 = 54%
February 2011	23/66 = 35%
October 2011	34/70 = 49%
February 2012	32/74 = 43%
October 2012	32/74 = 43%
March 2013	28/75 = 37% (for HK local candidates)
October 2013	28/74 = 38%
February 2014	29/74 = 39% (for HK local candidates)
October 2014	21/74 = 28%
March 2015	36/75 = 48%
October 2015	35/75 = 47%
March 2016	40/75 = 53%
October 2016	36/75 = 49%
March 2017	26/74 = 35%
October 2017	26/75 = 35%
March 2018	32/75 = 43%
October 2018	38/75 = 51%
March 2019	46/85 = 54%
October 2019	47/86 = 55%

Pass list (2019): Joint HKCPIE/MRCP(UK) Part II PACES Examination October

Chan Cheuk Him Charlie
Chan Hin Chi
Chan Jasmine Ka-Lei
Chan Ting Kong
Chan Wai Hong
Chan Wing Hong
Chan Yat Kwan
Chao Chien Wei Amelia
Cheung Pak Nung Rocco
Chim Ming Yam Thomas
Choi Chris Yau Chung
Choi Ka Him
Chow Edith Wing Kar
Chow Hiu Cheong
Chow Tsz Fung
Choy Kai Tung Annabel
Chu Hoi Ming
Fung Chun Yu
Fung Yuk Kiu Chloe
Ho Hiu Yan Agnes
Ho Man Yan Audrey
Hui Po Lok
Kam Shou Kin
Lai Chin Wai
Lam FungLam Lok Sang
Lau Chun Ling
Lau Wing Tung
Lau Wing Yan Tiffany
Lau Yuk Ming
Lui Chun Man
Lui Wai Ting
Luk Wing Lam Fion
Mok Kit Shun Kevin
Ngai Cheong
Pang Kit Hing
Shum Jacqueline Si Yan
Tam Rana Wai Lam
Tang Chi Kin
Tang Ho Cheung Arthur
Tang Hoi San
Tsoi Man Ho
Wan Man Hin
Wong Fung Yee
Wong Sum Lung
Wu Wing Gi
Yu Anthony Shing-yiu

BEST THESIS AWARD
Gold Award Winner
Prevention of Recurrent Idiopathic Gastroduodenal Ulcer Bleeding – A Double-Blinded Randomized Controlled Trial

Dr Louis Ho Shing LAU
Department of Medicine & Therapeutics, Prince of Wales Hospital

Background and objectives

Present guidelines are conflicting for the prevention of recurrent ulcer bleeding in patients with a history of *Helicobacter pylori (H. pylori)*–negative idiopathic bleeding ulcers, *i.e.* in the absence of *H. pylori* and a drug history of non-steroidal anti-inflammatory drugs (NSAIDs) and/or antiplatelet agents (e.g. Aspirin). This group of patients has a considerable risk of recurrent ulcer bleeding and complication, despite years after the index bleeding episode.

We hypothesized that a proton pump inhibitor (lansoprazole) is superior to a histamine-2 receptor antagonist (famotidine) for the prevention of recurrent ulcer bleeding in this group of patients.

Methods

For this industry-independent, double-blinded, randomized controlled trial performed in an academic tertiary hospital in Hong Kong, we screened patients with a history of idiopathic *H. pylori*-negative non-NSAID-related bleeding ulcers. After endoscopic confirmation of ulcer healing, we randomly assigned patients on an 1:1 basis with a computer-generated list of random numbers to receive oral administrations of either lansoprazole 30mg or famotidine 40mg once per day for a period of 24 months. Both patients and investigators were masked to the treatment.

The primary endpoint was recurrent upper gastrointestinal bleeding (defined as documented episodes of hematemesis, melena or per-rectal bleeding; or a drop in hemoglobin 2 g/dL, with endoscopic confirmation of ulcer recurrence) within 24 months. The primary endpoint was analyzed in the intention-to-treat population with death as the competing risk. The secondary endpoint was the presence of recurrent peptic ulcer detected by the end-of-study endoscopy.

Results

A total of 228 patients were enrolled in our study. 114 patients were assigned to each study group, all of whom were included in the intention-to-treat population. Recurrent upper gastrointestinal bleeding was suspected in 10 patients in lansoprazole arm and 10 patients in famotidine arm; which was confirmed by an independent adjudicator in one patient in lansoprazole arm (one duodenal ulcer) and three patients in famotidine arm (two gastric ulcers and one duodenal ulcer). The cumulative incidence of recurrent bleeding after 24 months was 0.88% (95% CI 0.08%-4.37%) in lansoprazole arm and 2.63% (95% CI 0.71%-6.91%) in famotidine arm (p= 0.313; crude hazard ratio 0.33, 95% CI 0.03-3.16; p= 0.336). None of the patients who rebled had used aspirin, NSAIDs or other antithrombotic drugs. Endoscopic ulcer recurrence was detected in 6.1% of patients in lansoprazole arm and 9.6% of patients in famotidine arm respectively. Eight patients in lansoprazole arm and five patients in famotidine arm died respectively. No treatment-related deaths occurred during the study.

Conclusion

This 2-year double-blinded randomized controlled trial did not demonstrate any superiority of either lansoprazole or famotidine for the prevention of recurrent ulcer bleeding in patients with a history of *H. pylori*–negative non-NSAID-related idiopathic bleeding ulcers. However, these patients are still at considerable risk of endoscopic recurrence and overall mortality, despite a low incidence of recurrent gastrointestinal bleeding.

BEST THESIS AWARD
Silver Award Winner

Beta-lactam Allergies: Factors Predicting Genuine Allergies and Prevalence in Hong Kong

Dr Philip Hei LI
Department of Medicine, Queen Mary Hospital

Introduction

Beta-lactams are the most frequently reported cause of drug allergy. The local epidemiology of beta-lactam allergy and the predictors of genuine allergy are unknown. Availability of clinical predictors of genuine allergy and local epidemiological data would be of immense benefit.

Methods

Patients admitted to medical wards were analyzed to identify the prevalence and factors associated with the presence of beta-lactam allergy labels. A combined cohort of patients having completed allergy investigation for suspected beta-lactam allergies in Hong Kong and the United Kingdom were analyzed. Association analysis comparing the clinical characteristics of confirmed beta-lactam allergic and non-allergic patients was performed to identify predictors of genuine allergy.

Results

Analysis of 4361 admissions over a six-month period indicate that the local prevalence of betalactam allergy labels was 5%, which was associated with female gender and concomitant nonbeta-lactam antibiotic allergy labels. However, patients referred for suspected allergies indicate that the rate of genuine beta-lactam allergy was only 14%. History of anaphylaxis and duration of less than a year since the index reaction were independent clinical predictors of genuine allergy. The negative predictive value of penicillin skin testing was 90%. There was an alarmingly high rate of confirmed piperacillin-tazobactam allergy.

Discussion

The estimated true prevalence of genuine beta-lactam allergy in Hong Kong is around 0.5%. This high rate of mislabeling highlights the need for comprehensive allergy evaluation. History of anaphylaxis and duration since the index reaction were clinical predictors of genuine betalactam allergy. piperacillin-tazobactam allergy may pose a unique challenge to our locality.

BEST THESIS AWARD
Bronze Award Winner

Effect of Low Body Mass Index in Outcome of Micra Leadless Pacemaker Implantation

Dr Tsz Kin TAM
Department of Medicine & Therapeutics, Prince of Wales Hospital

Background

Implantation of Micra transcatheter pacing system (TPS) requires introduction of a large caliber delivery catheter into patient's venous system and right heart. While the investigational device exemption study population had a mean body mass index (BMI) of 27.6kg/m2, implantation outcome in patients with small body size requires further investigation. This study sort to evaluate the effect of low BMI in outcome of Micra TPS implantation.

Method

Consecutive patients undergoing Micra TPS implantation between 19 September 2015 and 24 May 2018 in a single tertiary referral center was studied. Procedure efficacy outcome was defined as successful implantation with threshold being low (≤2.0V/0.24msec) and stable (increase in threshold of ≤1.5V / 0.24 msec) tested at implantation and all clinical follow up in the first year. Procedure safety outcome was defined as absence of major complications in the first year after implantation. A primary analysis was planned to identify factors affecting the composite procedure efficacy and safety outcome, with the hypothesis that low BMI would be associated with poor composite outcome. A secondary analysis was planned to study the effect of BMI on final implant position, number of device deployment and procedure time.

Results

147 patients were included in the study. The mean BMI of the cohort was significantly lower than the investigational device exemption study (23.7±3.7kg/m2 vs 27.6±5.3 kg/m2, p<0.0001). Composite procedure safety and efficacy outcome was reached in 136 patients (92.5%). Low BMI and low body weight were both associated with poor composite procedure and safety outcome (p=0.001 and p=0.007, respectively). After dividing the included patients into low BMI and high BMI using median BMI of 23.76kg/m2 as cut off, low BMI group was more likely to result in mid or high septal deployment (51% vs 17%, p<0.001), required more deployment attempts (1.86 +/- 1.97 vs 1.27 +/- 0.97, p=0.026), more likely to require recapture (31% vs 17%, p=0.049) and had a longer procedure time (46.0 +/- 20.5 minutes vs 37.7 +/- 15.4 minutes, p=0.007).

Conclusion

Micra leadless pacemaker implantation in patients with low BMI was associated with an unfavorable composite efficacy and safety outcomes. Implantation in patients with low BMI was associated with a higher implantation position, requiring more deployment attempts and longer procedure time. More data is needed to determine the optimal pacing approach for this high-risk group of patients.

SIR DAVID TODD LECTURE

Enhancing Clinical Outcomes in Liver Diseases: The Way Forward in The Twenty-First Century

Dr Walter Wai Kay SETO
Department of Medicine
The University of Hong Kong

"Hong Kong is a land of fortune (福地)", this is a message repeatedly told to my generation as we were growing up. And indeed, despite the lack of natural resources, Hong Kong has had some truly remarkable achievements. In the area of higher education and research, three of the top 50 universities worldwide are found in Hong Kong (with a fourth university ranked at 52th),[1] more than many top cities in Asia and worldwide. Our high ranking is despite Hong Kong having a relatively low researcher density of 3.4 researchers per thousand, a figure lower than many Western countries as well as many Asian regions, including Mainland China, Japan, Korea, Taiwan and Singapore.[2] Hong Kong's academic excellence can be a reflection of our culture of dedication and diligence, evidenced by the many excellent research works presented in our College.

Concerning the field of liver disease, one of the most recent significant is the World Health Organization's establishment of a Global Strategy for Viral Hepatitis, aiming to eliminate viral hepatitis, including hepatitis B virus (HBV), as a public health threat by 2030. This implies 90% reduction in incidence, 65% reduction in mortality, 90% increase in diagnostic coverage and 80% increase in treatment accessibility.[3] It is particularly relevant to Hong Kong; the latest HBV prevalence is at 7.8%. Among individuals born locally after the introduction of universal HBV vaccination, the prevalence is at 1.8% (3.4% if including migrants born outside Hong Kong). While vaccination has greatly reduced the prevalence of HBV, HBV will remain endemic in Hong Kong for decades to come.

Hong Kong has contributed much to the understanding of the natural history and disease outcomes of chronic

HBV infection. One aspect is investigating the seroclearance of hepatitis B surface antigen (HBsAg) in chronic HBV, otherwise now known as the functional cure of HBV. While uncommon, HBsAg seroclearance can cumulatively occur in 10.2% to 12.4% of patients. Once HBsAg seroclearance is achieved, the risk of liver-related complications is markedly decreased, although liver cancer can still develop. This is currently the only clinical scenario in which nucleoside analogue therapy can be reliably stopped, as well as the target treatment endpoint in current HBV-related clinical trials. While HBsAg seroclearance does not signify a "complete cure", it is the

currently the best possible disease outcome in chronic HBV infection. There are currently various viral-related and host-related predictors of HBsAg seroclearance, although the clinical application of such predictors is limited by suboptimal positive predictive values or lack of prospective validation. The search for the ideal biomarker in predicting the function cure of chronic HBV continues.

HBV is known to reactivate during immunosuppressive therapy, and without appropriate treatment, can lead to acute-on-chronic liver failure, which responds to nucleoside analogue therapy poorly and is associated with high mortality rates. HBV reactivation is also possible in HBsAg-negative, antibody to hepatitis B core antigen (anti-HBc) positive individuals when undergoing certain forms of high-risk immunosuppressive therapies. The most well-known immunosuppressants associated with HBV reactivation in HBsAg-negative, anti-HBc positive individuals are the anti-CD20 monoclonal antibodies, e.g. rituximab, of which indications in both malignant and non-malignant disease are currently expanding, and accessibility is expanding worldwide due to the introduction of generic biosimilars. Another high-risk immunochemotherapeutic regimen is allogeneic hematopoietic stem cell transplantation, of which accessibility is increasing worldwide. While possible management methods include a monitor-and-treat strategy or predicting reactivation via available biomarkers, the currently recommended method is prophylactic nucleoside analogue therapy. More importantly is the awareness and screening of serum HBsAg and anti-HBc among health care providers providing immunosuppressive therapies in regions of HBV endemicity.

The development of non-invasive methods of liver fibrosis assessment, e.g. transient elastography, has facilitated the assessment of fibrosis in stable patients without the invasiveness of a liver biopsy. Among on-treatment chronic HBV patients with good virological control, metabolic factors e.g. diabetes, obesity and metabolic syndrome are increasingly recognized to play a role in liver-related disease progression. Novel metabolic-related methods of assessment e.g. controlled attenuation parameter quantification of liver steatosis, are emerging. As the HBV-infected population gradually ages, the concomitant presence of metabolic parameters will only increase. The linkage between HBV and metabolic factors hence remains an area that requires much research.

Areas requiring further research include implementation studies investigating HBV-related linkage of care. This is particularly relevant in Hong Kong; a prevalence study showed 47% of chronic HBV patients to be not aware of their disease, while a modelling study found the diagnostic and treatment uptake rates in Hong Kong to be only 22% and 27% respectively, way below the corresponding World Health Organization 2030 targets of 90% and 80%. Another area of interest will be the interdisciplinary utilization of novel technologies may play a role in the future of personalized clinical management of liver diseases. These include novel magnetic resonance metrics of liver assessment and the application of artificial intelligence in the monitoring of liver disease.

Many will agree that as of 2019, Hong Kong is at a crossroads. If Hong Kong is to continue to be a "land of fortune", as health care professionals, we will have to continue to showcase our professionalism and values to the local, regional and international community. From a personal perspective, this will mean the University of Hong Kong-Shenzhen Hospital in Shenzhen, a hospital that I had been involved in the service development since 2012, and now one of the premier general hospitals in the Greater Bay Area. Specific for liver diseases, we are in the midst of establishing HBV guidelines for primary care physicians in Mainland China, which will be crucial in establishing linkage to care. Professionalism can also benefit future generations within Hong Kong. An example would be a project investigating the harmful effects of recreational ketamine to the biliary system, and its potential reversibility after ketamine abstinence. This project facilitated outreach to various vulnerable populations in Hong Kong, and enhanced community efforts in combating drug abuse in our society. There are many other examples of how our health care community has contributed to Hong Kong's social progress. As Hong Kong looks forward into the twenty-first century, so should we, with perseverance, diligence, and dedication.

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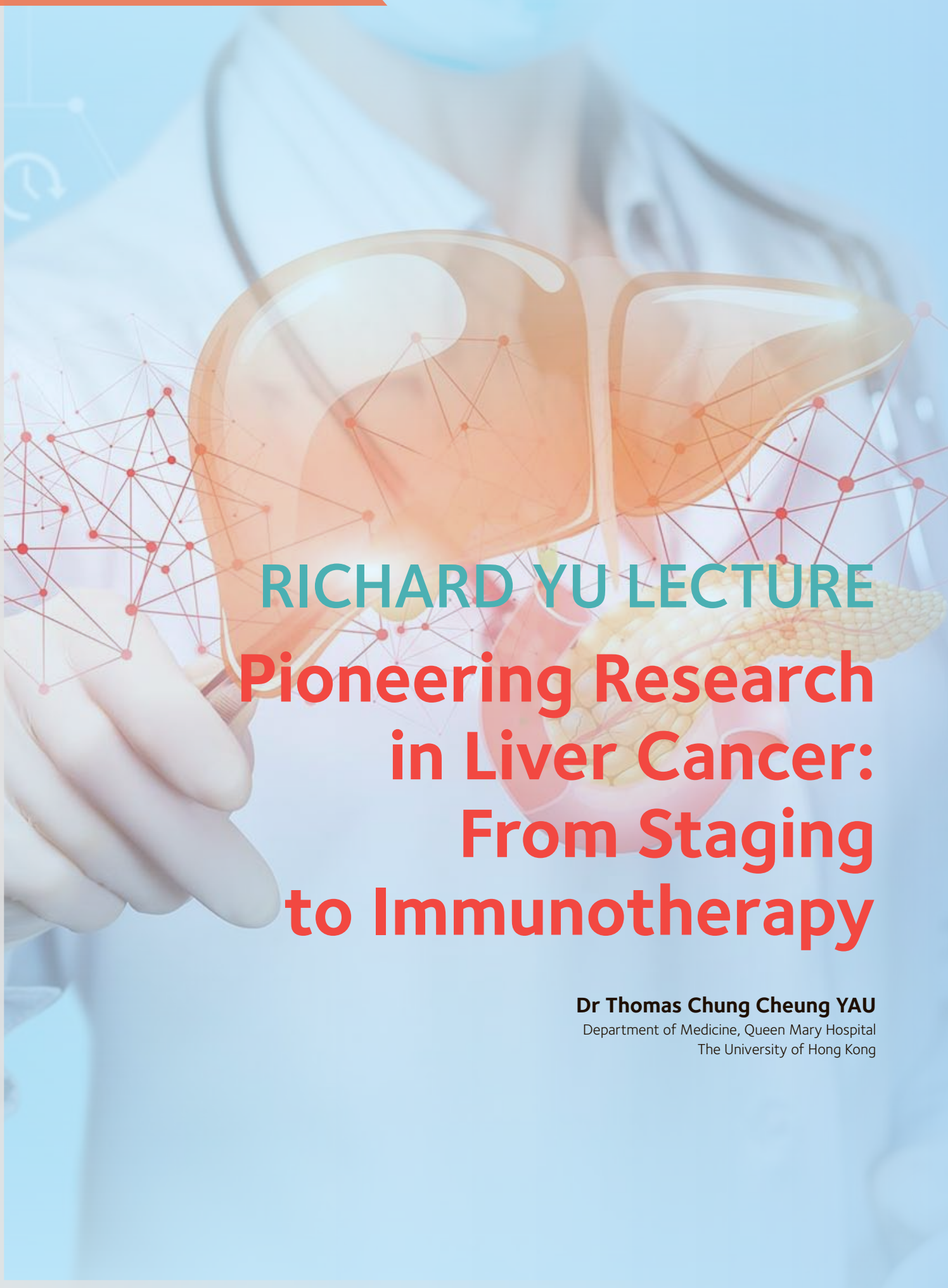


RICHARD YU LECTURE

Pioneering Research in Liver Cancer: From Staging to Immunotherapy

Dr Thomas Chung Cheung YAU
Department of Medicine, Queen Mary Hospital
The University of Hong Kong

My main research interests are gastrointestinal oncology, early phase clinical trials and translational research. I have special interest in treating hepatocellular carcinoma and had published more than 110 peer-review publications with articles in various leading oncology journals, namely Lancet, Lancet Oncology, Cell Stem Cell, Gastroenterology, Hepatology and Clinical Cancer Research. I had also delivered more than 180 invited regional and international lectures. I currently serve as associate editor and the editorial board members of many international peer-reviewed journals.

I am currently the International Member of US NCI Hepatobiliary Task Force, Vice President of Asia Pacific Neuroendocrine Tumour Society, International Faculty Board Member of International Association of Surgeons Gastroenterologist and Oncologists, and General Secretary of Hong Kong Liver Cancer Foundation.

I pioneered Hong Kong Liver Cancer (HKLC) classification and published this as the cover page article in the leading journal Gastroenterology with accompanying editorial. The HKLC classification has revolutionized the treatment algorithm of patients with liver cancer nowadays. Most countries treatment guidelines and algorithms have modified according to HKLC. More importantly, I am the global drug development leader in the field of liver cancer. I have led a number of novel targeted therapies global clinical trials in liver cancer with interesting results. Recently, I pioneered the use of immunotherapy mainly checkpoint inhibitors in treating patients with advanced liver cancer. Our provocative phase 1/ 2 results published in the Lancet and led to the FDA accelerated approval of the use of nivolumab in advanced liver cancer patients who had been refractory to sorafenib treatment. Based on our clinical findings, now nivolumab was approved to treat advanced liver cancer in most countries. Currently, I am leading a global clinical trial (CHECKMate 459) in comparing single agent nivolumab versus sorafenib as the first line treatment for advanced liver cancer patient. The result are still eagerly awaited and might potentially change the future treatment landscape in advanced liver cancer patients.

Looking ahead, I have a strong interest in exploring the use of immunotherapy for the treatment of liver cancer patients. In collaboration with various drug companies, I am investigating whether it is beneficial to use immunotherapy as adjuvant therapy to liver cancer patients who have received potential curative surgery. Moreover, I am also heavily involved in few clinical trials in investigating whether we can combine checkpoint inhibitors together or with various targeted therapies to improve the outcomes of the liver cancer patients receiving immunotherapy. Last but not least, I like to devote more efforts to translational research. I will like to explore any biomarkers that can guide the personalized use of immunotherapy in liver cancer patients. At the moment, we are collaborating with Harvard University in discovering few promising genomic markers for immunotherapy response in liver cancer patients and we hope the results from these experiments can help us to understand the complex immune environment in liver cancer patients and also the potential markers for response in liver cancer patients treated with immunotherapy.

Report on Core Medical Skill Course (CMSC)

Dr Candy Hoi Yee KWAN
Convenor, CMSC/ AC, Department of Respiratory Medicine
Kowloon Hospital

Aiming to provide structured training to all basic physician trainees and to maintain quality in patient care, the HKCP and COC(Med) jointly organized the Core Medical Skills Course (CMSC) for the first time in 2019. Three identical classes were run successfully in Nethersole Clinical Simulation Training Centre on 17 and 31 August, and 30 November. The course content aligned with the curriculum of basic physician training, emphasizing procedural sedation and common bed-side procedures, and was delivered through a lecture, small group tutorials, scenario-based simulation training, and hands-on workshops. High standard manikins and teaching materials would be sorted to optimize candidates' learning experience.

All medical departments were invited to nominate their BPT to attend one of these classes in advance. We limited the class size to below 30 to target a low instructor

Group photo taken in CMSC Class C held on 30th November 2019
[Instructors in front row, from left to right: Dr Anthony Yau, Dr Frankie Choy, Mr Tacko Tsoi (nursing coordinator), Dr Pauline Yeung, Dr Macy Lui, Dr LM Hau, Dr Thomas Chan, Dr Candy Kwan (Convenor), Prof Philip Li (President of HKCP), Dr KW Lam, Dr CM Ho, Dr Natalie Leung, Dr Eugenie Hui, Dr Germaine Chan, Dr HW Chan, Dr KS Mak]

Instructors attending pre-course instructor workshop in August 2019
(Front row, from left to right: Mr Tacko Tsoi (nursing coordinator), Dr Candy Kwan (Convenor), Miss Lydia Hung (Program executive); Second row, from left to right: Dr Natalie Leung, Dr LM Hau, Dr Samantha Luk, Dr SO SO, Dr LH Shek; Third row, from left to right: Dr Howard Wong, Dr Thomas Chan, Dr Eugenie Hui, Dr HW Chan, Dr KS Mak, Dr Anthony Yau, Dr Frankie Choy)

to trainee ratio, especially for hands-on workshops. The high participation rates (100%, except one absentee in the last class) reflected the need for training of this sort. We received very positive feedback from all participants. Many of them rated the course very high, and found the teaching stimulating and useful for their daily practice. Our instructors, who are mostly experienced simulation educators also, received very encouraging ratings.

We hope this course will continue to improve and achieve teaching excellence. From July 2020 onwards, attendance at the CMSC would be made mandatory for all BPT, marking another milestone in physician training in Hong Kong.

As always, we need to provide more structured training to our trainees, including AIM trainees. As we anticipate the need for more instructors, our next focus would be on Train-the-Trainer courses.

Last but not least, I would like to take this opportunity to thank all the instructors and administrative staff for their enthusiasm in working out the course structure, enriching its content and delivering the classes. Special thanks would also go to Dr CB Law, Chairman of COC(Med) and Prof Philip Li, President of HKCP. Without their tremendous support, the CMSC would not have been that successful.

Thank you HKCP for sponsoring our lunch!

Sir David Todd Memorial Scholarship

New Challenges, New Horizons: Structural Heart Disease Fellowship at Henry Ford Hospital

Dr Chak Yu SO
Department of Medicine & Therapeutics
Prince of Wales Hospital

With great honor to receive the Sir David Todd Memorial Scholarship, I started my 1-year overseas fellowship at Henry Ford Hospital in Detroit, United States from July 1st, 2019. The center of structural heart disease at Henry Ford Hospital is one of the most comprehensive and largest volume structural heart intervention center in US. It is nationally renowned to perform advanced innovative transcatheter aortic, mitral and tricuspid valve interventions. The structural team is a big family with 4 attending structural heart interventionists, 2 dedicated structural heart imagers, 3 cardiac surgeons, 3 cardiac anesthetists, 7 nursing practitioners and physician assistants, and many research staff. This year we have 2 advanced structural fellows. My co-fellow Guson is an American-born Korean graduated from Yale University and trained in interventional cardiology at Stanford University. He is a very nice and smart buddy, whom taught and helped me a lot especially during the adjustment period of my training. Detroit is a rising city, safer than expected and has very beautiful sub-urban areas. I live in the hospital apartment. The hospital staff here are very friendly and helpful. Around 30-40% of the cath lab staff here are from Canada because of the proximity of Detroit to Winsor, Canada. Asians are minority here. However, there is a small Chinese Market around 20 minutes' drive from the hospital, where I can enjoy Chinese foods or buy Asian groceries.

Henry Ford Hospital

Team photo

My staff photo and the catheterization lab I spent most of my time with my co-fellow

The very rare occasion that I and my co-fellow double scrub in the same procedure

The training at Henry Ford has been very practical and hands-on from day 1. Each Monday and Tuesday 7:30am, we have 1-2 hour of multi-disciplinary meetings to discuss aortic valve cases, mitral and tricuspid valve cases respectively. We have 3 full procedural days running in 2 simultaneous hybrid/catheterization lab with cardiac anesthetist support each week. Procedures not requiring anesthetist support are scheduled on the other 2 days. Besides, fellows are assigned a half day clinic session each week. Occasionally, we also go to Children's Hospital of Michigan for adult congenital heart procedures. Over the past 6 months, I have performed near 300 different structural heart interventions, including many alternative access transcatheter aortic valve replacement (TAVR), new percutaneous devices and techniques to treat various valvular and structural heart diseases. I am also very fortunate to be involved in many mechanical circulatory support procedures and the National Cardiogenic Shock Initiative founded by Dr William O'Neill (director of our center), and hopefully can also bring the skillset back to optimize the care of cardiogenic shock patients in Hong Kong too.

Visiting Program Director, Marvin Eng's house with my co-fellow, Guson; and the ugly sweater party

During this period, FaceTime becomes the most essential tool for me to keep in touch with my family, and Uber/Lyft also become my very good friend. During weekends, I prepare my food for the week as off-work hour at weekdays are usually quite late. I also enjoy watching NBA games (Detroit Piston) with my co-fellow. During Thanksgiving and Christmas, we visited our program director, Marvin Eng's house. I also enjoyed my first "ugly sweater party" in our imaging guru, Dee Dee Wang's house. Besides, I have travelled to New York, San Francisco and Las Vegas for training courses and conferences, where I also met some of our Hong Kong colleagues and friends.

Meeting friends from Hong Kong

I am very fortunate to be able to come to Henry Ford Hospital for training, and even more so to receive the scholarship and hopefully to establish future collaborations. During the past 6 months of challenging time, I was brought to new horizons in structural heart interventions and patient care. In the remaining 6 months, I hope to learn more and build more friendship!

Dr Donald Farquhar delivered a lecture to workshop candidates with practical tips for the PACES examination

Report on PACES Training Programme in September 2019

Professor Ronald MA
Chairman
Examination Committee

Panel of examiners providing feedback to training workshop candidates

PACES (Practical Assessment of Clinical Examination Skills) is an objective and structured assessment of basic physician trainees before entrance into specialist training. Two PACES, each lasting for 5-6 days in 5-6 different hospitals, are held in Hong Kong each year. Each examination day comprises 3 sequential cycles and in each cycle there are 5 clinical stations. In each station a set of core clinical skills are evaluated by two examiners (1 UK and 1 HK examiner). Fifteen candidates are examined each day and a total of 75-90 candidates, mostly local medical graduates, are examined in each examination. Since the first PACES hosted in H.K. in 2001, the local pass rate has been around 30-60%, though recent success rate appears to have been overall lower compared with before.

The College has therefore appointed council members, young College fellows, university academics and HA (Hospital Authority) Consultants to form a working group with a view to improve trainees' performance in PACES. It was decided that an integrative training programme should be organized by the College, incorporating elements of training workshop on communication skills previously commissioned by HA, as well as the PACES training day on Saturday that was held after PACES, which focused on physical examination skills.

The first integrated PACES training programme was conducted on 1st and 2nd September 2018 at Alice Ho Miu Ling Nethersole Hospital and Northern District Hospital, with two U.K. PACES examiners, Dr. Donald Farquhar and Dr. Nicola Zammitt invited as overseas trainers. Twelve local trainers, seasoned PACES examiners from various subspecialties also participated in the training programme. The programme was successful and candidates feedback indicated that the great majority of candidates found the training educational (please refer to Synapse March 2019 issue for full report).

Following the success of the first PACES training programme, a second PACES training programme was organized in 2019. This was conducted during 20-22 September 2019, at Pok Oi Hospital and Tseung Kwan O Hospital. Dr Donald Farquhar, International Associate Medical Director, MRCP (UK), and Dr. Alan Patrick (Consultant Physician in the

Royal Infirmary, Edinburgh and Chair of the PACES 2020 psychometric group) were invited to lead the workshop as overseas trainers. Twelve local trainers, experienced PACES examiners from various subspecialties also participated in the training programme.

The training day was preceded by an evening lecture delivered by Dr Donald Farquhar on 20 September 2019 on upcoming changes to PACES 2020. The format of the training programme was slightly modified from the first workshop, based on feedback received from the participants and trainers at the first workshop. The second workshop comprised of 4 sessions. Each session included a presentation from the U.K. trainers who explained the key features of PACES stations, assessment procedures, expectation from examiners and addressed concerns and questions from candidates. This was followed by a mock PACES examination following the exact format and procedures and with comparable levels of difficulty as in real PACES except that there was only one instead of two examiners in each station. The trainees joined in groups of 3, of whom 1 was asked to be the candidate and the other two as observers in each station and they changed roles between stations so that they all have the experience of PACES candidates in at least some stations. After a complete cycle, a detailed debriefing was conducted in which the 2 U.K. and 3 local trainers commented on the general and specific performance of the candidates whom they examined. At the end, the candidates gave feedback on their experience in a standard evaluation form.

A total of 59 out of 60 evaluation forms were completed and returned by candidates after the programme and their feedback was evaluated. The training day has met the expectation of all responding candidates. Most candidates agreed or strongly agreed that the contents of the lectures by the overseas examiners, bedside teaching and the whole class debriefing were appropriate and the teaching overall has been useful and satisfactory. Some candidates expressed the preference to go through all rather than only some of the stations. Most candidates found the training helpful.

In summary, the second integrative training programme for PACES was well received by basic physician trainees. Its impact on candidates' performance during the subsequent examination would have to be evaluated in due course. The training programme has also provided the hosts with the opportunity to prepare themselves as new PACES centres in response to the increase in number of candidates waiting to sit for the examination. We are most grateful to our overseas and local examiners for sparing the time to provide this invaluable training opportunity.

Candidates at the workshop listening to feedback from the panel of examiners

AIM Examinations: A Young Fellow's Perspective

Dr Thomas SY CHAN
Member, Young Fellows' Committee

Introduction

In this issue of Young Fellows Column, I have prepared some practical tips on the interim and exit examinations on Advanced Internal Medicine (AIM). Most trainees have reflected to us that this is a difficult subject, as it lacks a formal 'curriculum'. While preparing for the examination, they simply do not know where to put their focus on.

The purpose of AIM is to equip trainees with the ability to handle complex medical problems, and to seek help from appropriate specialists if those are beyond their abilities. As opposed to a family physician, a specialist in AIM possesses not only the breadth but also the depth of the knowledges, particularly on some common disorders. Readers would agree with me that in our daily practice, we often encounter cases which are outside the expertise of our own specialties. Examples include an oncology patient with electrolyte disturbance, or a patient with myocardial infarction having hyperglycaemia requiring more intensive glucose control. Problems like these are beyond the ability of a generalist but should be comfortably dealt with by AIM specialists.

Contents

The training guidelines in internal medicine published by the Hong Kong College of Physicians (The College) stipulates the requirements for an AIM specialist. I have tried to summarize them into three main categories (of equal importance). Readers are referred to the official training guidelines available in The College website at: www.hkcp.org

Category A: Medical skills and knowledges

- Diagnosis and management of medical emergencies: examples include acute myocardial infarction, acute pulmonary embolism, acute pancreatitis etc. Prompt diagnosis and effective initial management are important so one should expect more stringent requirement from the examination panels
- Diagnostic skills to effectively manage complex conditions with unusual presentations: for these disorders, much emphasis is put on a logical approach and making the right diagnosis, as their subsequent management is handled by specialists. For example, in a patient with thrombotic thrombocytopenic purpura presented with classical pentad
- Update in knowledge on the management of common acute and chronic disorders, in acute and extended care setting, in an evidence-based manner. For example, management of diabetes with an ever-growing armamentarium of hypoglycaemic agents
- Skills in performing important diagnostic and therapeutic procedures, with suitable level of sedation, and their indications

Category B: Screening and preventive strategies

- To be able to know the rationale of strategies in preventive care and early detection of diseases in collaboration with primary or community health care workers

Category C: Concept of medical administration, medical statistics and ethics

- Only basic concepts are required. Examples include the use of two-tailed testing, p-value, critical appraisal of publications, etc.

Formats and Practical Tips

Interim and exit examination differ slightly in terms of the format:

1. Interim examination: one case scenario, around three sets of data or image interpretation
2. Exit examination: two scenarios on acute medical care, two scenarios on chronic medical care and two scenarios for ethical discussion
3. Conference questions are asked in interim examination

In all clinical scenarios or data interpretations, the principles listed above would remain. Trainees are expected to know in-depth about common diseases, from diagnosis to at least the principle of management. For example, they should know how to investigate a patient presented with hypercalcaemia, and the subsequent management if the case turns out to be hyperparathyroidism. For rare diseases, emphasis would be put on the approach of logical deduction and initial management. An example would be a patient with family history of sudden cardiac death presented with syncope. If it transpires to be a case of Brugada syndrome, one should be able to recognize the typical ECG changes and arrange a prompt referral to cardiologists.

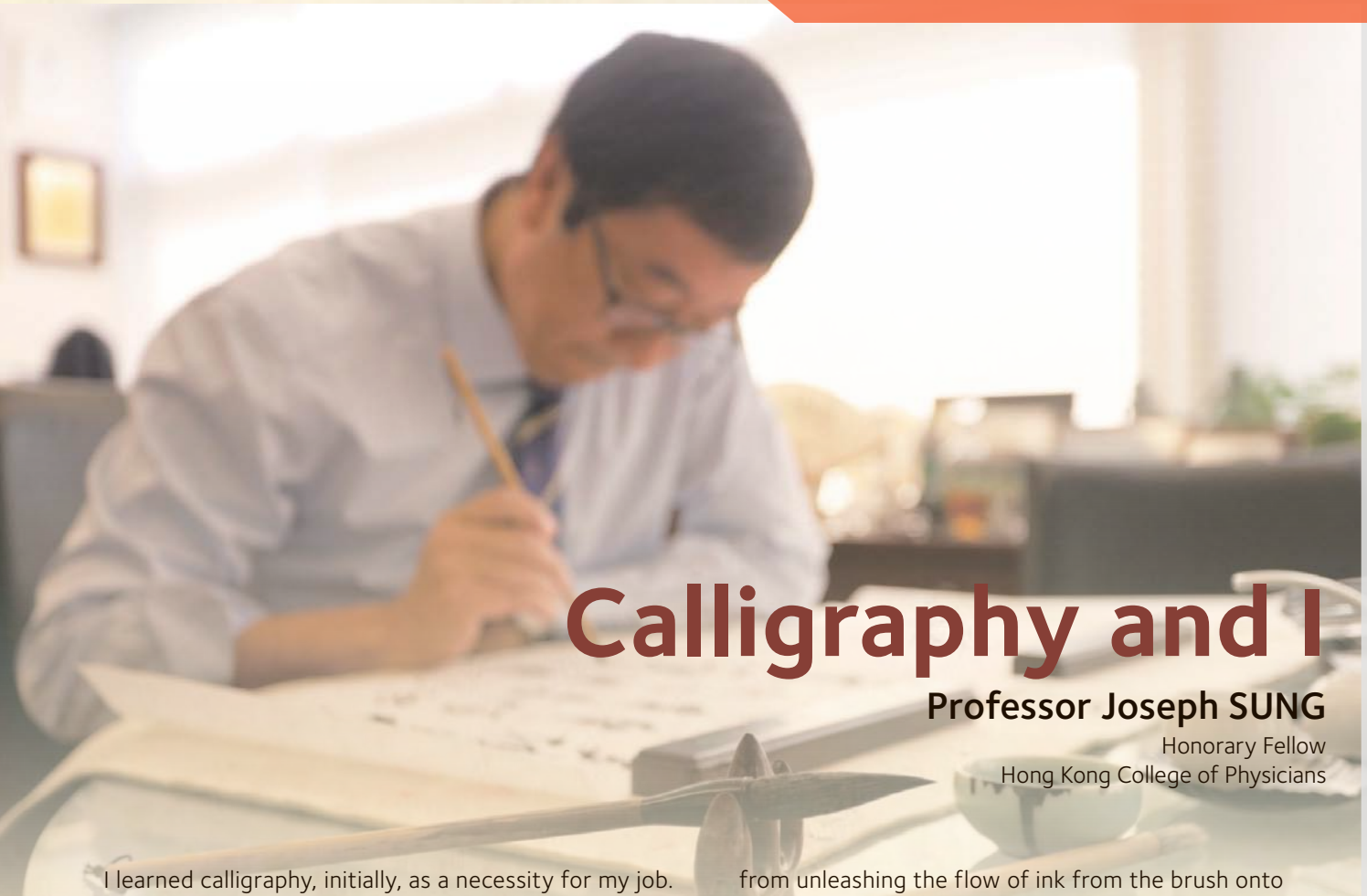
A physician should always adopt a logical approach when tackling clinical problems. We have seen candidates when presented with a case of normochromic normocytic anaemia with no evidence of gastrointestinal bleeding, giving an answer of upper endoscopy as first line investigations. These 'reflex action' type of management approach is strongly discouraged.

For ethical scenarios, there should not be a right or wrong answer. It is often a matter of perspectives, judging from the four ethical principles which the readers should be familiar with: beneficence, non-maleficence, autonomy and justice (equity).

For conference questions, it is understandable that some trainees might not be able to attend the whole of all three major local medical conferences. Please obtain information from colleagues who have attended. Questions will mainly focus on some common or hot topics.

Conclusions

The College is very keen to listen to the feedbacks from the candidates on how to improve the examinations. Please do let us know your feedbacks through your trainers, program directors or colleagues in the young fellows or examinations committee. I wish you all a 'super-pass' (‘勁過’) in AIM examinations!



Calligraphy and I

Professor Joseph SUNG
Honorary Fellow
Hong Kong College of Physicians

I learned calligraphy, initially, as a necessity for my job. In 2010, when I visited a university or an institute as a Vice Chancellor of the university, particularly those in the mainland, I was often asked to write a few words as "Treasure of Ink" 墨寶 of the visitor. At first, when I was given a brush to write on a huge piece of paper, my hand was shaking so bad and I almost sweated on it. It was at least 40 years ago when I last used a brush of Chinese calligraphy to write anything. So, I turned to my Crohn's disease patient for help. He is a long-term friend of mine since I looked after his bowel condition some 20 years ago. He is a left-handed calligrapher and he picked up my right hand to write. I felt my hand being lifted up and down dancing on the paper. That is how I started to learn calligraphy, in fact, to practice how to write my Chinese name properly.

As time goes on, I fell in love with calligraphy and I really enjoyed my monthly lessons.

To me, calligraphy is a "mindfulness" exercise. When I pick up the brush, soak it into the pool of ink and start writing, I have to stay focused. The movement of my right hand, right arm and my shoulder, even my breathing and my heart beat, as well as my mind, have to be totally indulged onto the piece of paper that I am writing on. At that moment, nothing in the entire world would matters to me anymore. I will forget my business in office, my meeting agenda, my family issues, my budget plan... nothing, nothing on earth will stop me from unleashing the flow of ink from the brush onto the paper. Whether it should be a heavy stroke or light touch, it should be a long or short brush, a straight or curly line... that is all I care about. At the end of the one or two hours practicing, I have an unspeakable sense of relief and satisfaction. All my worries are behind me. All my troubles are not bothering me. Sometime even my headache disappears and my blood pressure calm down. THAT... is the pleasure of calligraphy. That is a soul healing effects of Chinese arts.

To me, calligraphy is also a chance of meditation. Meditation on the traditional wisdom of Chinese literature. As a medical graduate, studied and trained in western medicine, there was not much chance for me to be immersed into the beautiful world of Chinese poem and songs and words of wisdom from ancient Chinese scholars. Calligraphy gives me that moment of truth.

I love the beautiful poems of 蘇東坡. Just one example

定風波

莫聽穿林打葉聲，何妨吟嘯且徐行。
竹杖芒鞋輕勝馬，誰怕？一簑煙雨任平生。
料峭春風吹酒醒，微冷，山頭斜照卻相迎。
回首向來蕭瑟處，歸去，也無風雨也無晴。

After going through storms and rainy days in his life, Xu now stepped down from the peak of his career and returned to his "ordinary life". Looking back at where all he had been, and where the dark, the winds and rains began, he could see the sun atop the hills shining slantingly with a bottle of wine in his hand. That is the kind of sentiment that I echoed so much.

I wrote the opening song 臨江仙 by 楊慎from the famous novel "Three Kingdom"

三國演義

滾滾長江東逝水，浪花淘盡英雄。
是非成敗轉頭空。青山依舊在，幾度夕陽紅。
白髮漁樵江渚上，慣看秋月春風。
一壺濁酒喜相逢。古今多少事，都付笑談中。

This song keeps reminding me that there is nothing in the entire world that last forever, nothing is unperishable. All the rights, all the wrongs, all the good people, all the bad people, one day will pass like water in the river, leaving merely a story. A story that you will talk about with your friends, over a glass of wine, for a laugh.

If I were not practicing calligraphy, writing these words again and again, I probably won't resonate so deeply the wisdom from these beautiful lyrics. I probably won't ponder so much about perspectives and opinion, about success and failure, about life and death. Calligraphy leads me breathing in the spirit of humanity.

So, my heartfelt gratitude to our ancestors for their wisdom, my unreserved recommendation for you to pick up calligraphy.

Professor Francis Ka Leung CHAN
SBS, JP

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Choh-Ming Li Professor of Medicine and Therapeutics
MBChB(Hons)(CUHK), MD(CUHK), DSc(CUHK), FHKCP, FHKAM(Med), FRCP(Irel), FRCP(Edin), FACG, FRCP(Lond)

John MACKAY

Professor Chan started his career in medicine at the medical school of The Chinese University of Hong Kong (CUHK), repaid his training with stellar contributions as a clinician, in teaching and in research, and is now the Dean.

It was a pleasure to meet him this week, a tall, slim figure looking younger than his age, happy to share for this Profile the background to his remarkable career.

Francis Chan was born in Hong Kong to parents born in Hong Kong. His father was the graduate of a university in China but found his degree did not benefit him in Hong Kong. Despite that he had a successful life, marrying, and with his wife, raising two boys, both of whom have risen from a humble background to achieve professional careers; Francis in Medicine, his brother as a barrister.

Francis went to a local school in Kowloon, did very well, qualified for University, and chose Medicine because of his interest in Biology and his assessment that a professional career would be interesting and rewarding. He chose CUHK because it had just opened, in 1981, and offered a different challenge from that of the older University of Hong Kong.

He did very well at University, qualifying in 1988 as the top student in his year and gaining the Gold Medal in Surgery. He remembers with respect the Professor of Surgery, Arthur Li, and toyed with the idea of becoming a surgeon, but was also impressed by the commitment to teaching juniors and students of Dr Joseph Sung He joined the Gastroenterology department, initially just Dr Sung and himself.

1993 was a big year. Dr Chan married, his wife also a doctor. He took her with him when he went to Canada to spend a year in Calgary on a Croucher Foundation Scholarship. He studied the biophysiology of liver transplantation in mice, enjoying the challenge of learning to do everything for himself - designing experiments and implementing them. He is still in touch with colleagues from those days.

Dr Chan was appointed a Lecturer at CUHK in 1997. He enjoys teaching and received the Faculty Teacher of the Year Award for five consecutive years from 1999 to 2004, Master Teacher Award in 2004 and Vice-

chancellor Exemplary Teaching Award in 2000 and 2007.

During the next years the department expanded rapidly, publishing papers, notably on peptic ulcer bleeding, helicobacter pylori and endoscopic therapy.

He was made Professor of Medicine and Therapeutics in 2005.

Professor Chan has published over 500 full scientific articles in high impact international journals and his h-index is 94. He is the only researcher in academic history who has published eight first-author original research articles in two prestigious medical journals, namely The New England Journal of Medicine and The Lancet. He is the first scholar in China to be selected for a profile by The Lancet, in May 2007 to exemplify excellence in clinical research.

In recognition of his outstanding academic achievements, he received the degree of Doctor of Science from CUHK in December 2011. He was appointed Interim Dean in 2013 and Dean in 2014.

At his Gerald Choa Memorial Lecture in 2014 to the Hong Kong College of Physicians Professor Chan said, "Now the Medical Faculty in CUHK is much more than a second medical school to relieve shortage of local doctors, it has emerged as one of the best educational and research institutions in Asia. We are dedicated to nurturing competent and compassionate doctors who will make a difference to the world." The Medical School now ranks in Top 50 in international rankings, being one of the youngest in the list.

He is now into the first year of his second five-year tenure. Despite being a full-time Dean he finds time to see patients, teach and do research.

His contributions to medical research have been recognized worldwide with many national and international awards, and invitations to speak at numerous important conferences.

He views Medical Education in Hong Kong as being very much influenced by the practice in UK. In the maintenance of knowledge and skills, and protection of professionalism and ethics.

He has a particular pride in the Global Physician Leadership Stream, launched in 2013 at CUHK, in which students, not necessarily the most academic, who have potential as leaders are invited to undertake additional training at the university and abroad. The GPS graduates are expected to play future pivotal roles in the local and global medical community. The Program is very well-received by local community and has been the top program with the highest admission score in Hong Kong for six consecutive years.

He was appointed a Justice of the Peace, (J.P.) in 2010 in recognition of his work during the SARS epidemic in organizing the testing of 12,000 Hong Kong citizens for carriers of the SARS virus.

Last year he was awarded a Silver Bauhinia Star, (SBS), by the Government for his contributions to advisory and governing boards of public bodies in the medical and health sector.

Regarding current affairs in Hong Kong following the disturbances over the last six months, Professor Chan emphasized that professional and ethical standards should be maintained at all times despite politics. Different views should be embraced. There should be no violence. "Unrighteous behavior is never a means to achieve a righteous end."

Professor Chan is excited by the future prospects of the Medical School. At present 265 students are admitted each year, about ten percent of the applicants. Government wishes more students to be enrolled. To make that possible the university is enhancing the capability of the present buildings, opening a new teaching and research campus in proximity to the Tai Po Science Park. Later, there are plans, for a new building at the Prince of Wales Hospital to be a student residence and facility for educational and research; and the first 100% university-run private teaching hospital in Hong Kong.

The Shenzhen Medical School is for mainland students but will also cater for academic research and exchange with the University in Hong Kong.

Asked what he will do four years from now when he finishes his tenure as Dean, Professor Chan replied that he had no specific plan, but would wait and see what was available at that time; whatever it was he would apply his energy with the same passion that had carried him so far.

He will continue with his interest in Chinese antiques, especially jade.

His days as a Basketball player are now over.

He has been a member of the Hong Kong Jockey club for many years, mainly so that his daughters could enjoy their wish to ride; in 2015 he was elected a Voting Member.

He will have more time to share with his family; his elder daughter is at present in London studying microbiology while his younger daughter is still at school – neither wish to become a Doctor of Medicine like their parents. Their father particularly, too hard an act to follow?