HONG KONG COLLEGE OF PHYSICIANS
香港內科醫學院

HONG KONG COLLEGE OF PHYSICIANS

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SYNAPSE

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Message from the Editor

A multispecialty working group of the Hong Kong College of Physicians has developed a position statement on cardiovascular-kidney-metabolic (CKM) syndrome, an important topic with rapidly increasing prevalence, and discusses the healthcare service gaps and challenges in incorporation of the CKM health framework into the local healthcare system. The article was published in January 2025 in the Hong Kong Medical Journal, and is reprinted in this issue of *Synapse*. The College hopes it will raise awareness and prompt timely strategies to address the growing challenges of CKM syndrome.

On 19 October 2024, the Hong Kong College of Physicians held its first Medical Education and Training Retreat to discuss the way forward for the implementation of competency-based medical education framework in physician training and assessment, so that the physician training programmes under the College will be on par with international best practice. In relation to this event, the article "Let's Advocate, Educate, Collaborate and Promulgate" in this issue by Dr Yee Man KAN from the Training Subcommittee highlights the important forthcoming developments in physician training.

The first "Trainees Conference" of the College was held on 24 August 2024. This was organized by the Training Subcommittee, aiming as an induction event to introduce the physician training pathways to newly registered physician trainees, and also to highlight various important elements to trainees. The event was very successful and received positive feedback from participants. Readers please refer to the article by Dr Andrew Lung Tat CHAN for details.

A Joint Scientific Meeting with the Royal College of Physicians of Edinburgh was successfully held on 12-13 October 2024. Both the President and Vice-President of the Edinburgh College participated in person at the event. This issue of Synapse features two named lectures: the AJS McFadzean Oration titled "The Artificial Doctor" by Professor Andrew ELDER, President of the Royal College of Physicians of Edinburgh; and the Gerald Choa Memorial Lecture titled "Equity of Care for Older Adults" by Dr Conor MAGUIRE, Vice-President (International), Royal College of Physicians of Edinburgh. Both articles are timely and insightful.

We are privileged to feature Professor Dennis LO Yuk Ming as the Profile Doctor in this issue. Professor Lo was conferred Honorary Fellowship by our College last year, and is President of the Chinese University of Hong Kong since January this year. Two outstanding young physicians, Dr Thomas Chan and Dr Jacqueline So, were asked to interview Professor Lo, on issues related to career and leadership development, and how to face up to challenges in life. The article is not to be missed.

Dr Kwok Keung CHAN
Editor

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President's Annual Report

Prof Daniel Tak Mao CHAN
President, Hong Kong College of Physicians

A move towards competency-based training and assessment is one of the major initiatives the College has taken on over the past twelve months. This started with an extensive revision and updating of our curriculum and training guidelines, highlighting the competency domains and level of capability expected of trainees at completion of training in different specialties and subjects. Train-the-trainer activities such as the Basic Medical Education Course (BMEC), HKCP Medical Education & Training Retreat, and participation in the RCP International Development Day, and supporting colleagues at educational programmes organized by HKAM, aim to build educational leadership and capacity for sustainable and continuous improvement of our training programmes. The next phase is to promulgate competency-based assessment including formats that can be carried out at the workplace. For trainees, we had a successful inaugural Trainees Conference in August, and this will become an annual induction programme for new trainees. The new format of PACES started in October 2023. Our trainees have continued to perform well, with passing rates on a par with the best non-UK examination centres. The coming year will see the implementation of new online format for the Joint HKCPIE/MRCP(UK) Part I and Part II (Written) examinations. With the establishment of the new Specialty Board in Genetics and Genomics (Medicine) in January 2024, the College now has 18 Specialty Boards / Subcommittee, and over 2000 Fellows.

The College continues to foster closer links and collaborations with international partners. A Roll-Signing Ceremony for RCPE Fellows was held in February 2024. RCPE President Professor Andrew Elder and RCPSG President Mr Mike McKirdy have visited Hong Kong and met with our College leadership. The Annual Scientific Meeting for 2024 is jointly organized with RCPE, with RCPE Vice President (International) Dr Conor Maguire presenting the Gerald Choa Memorial Lecture and RCPE President

Prof Andrew Elder presenting the AJS McFadzean Oration. College President Prof Daniel Chan represented our College at the RACP Convocation Ceremony and Vice President Prof Anthony Chan represented our College at the Singapore-Malaysia Congress of Medicine and Induction Comitia organized by the Singapore Academy of Medicine. The *Updates in Clinical Medicine* online webinar organized with RCPE on 2 May 2024 had the highest attendance rate in the webinar series to date.

Engagement and leadership development for young physician colleagues is another major theme of College activities. Young Fellows are represented in all College leadership bodies including Council, Education & Accreditation Committee, and all Specialty Boards or Subcommittees. Our Young Fellows and Trainees Committee has demonstrated exemplary energy and dedication to College affairs, and has organized programmes to support trainees and young Fellows and also career information day for interns. They have recently set up a social media platform on Instagram, which aims to facilitate communication for promoting College events, initiatives, and activities.

Still on the topic of communication and information-technology (IT), there will be a major revamp of the College website in the coming year. Over the past months, the IT Committee has been working very hard meeting with potential vendors and discussing the details of the revamp. The project will soon call for tenders. Colleagues would have noticed that Synapse, the official publication of the College, has had a revamp earlier this year. Not only does it have a more youthful appearance, the contents now include a listing of training activities, examination calendar, and an interesting '*Lunch with …*' section that showcases interviews (over lunch, paid for by the College) with different colleagues over a wide range of topics.

The above is a brief synopsis of what the College has done over the past year. Further details are available from the Committee Reports that follow. I wish to take this opportunity to thank everyone in the College Council, Education & Accreditation Committee, and Specialty Board and Subcommittees, in particular the Training Subcommittee and IT Committee, for your dedication and hard work, without which we could not have been able to achieve so much. Special thanks go to Honorary Legal Advisor Ms Jaime CY Lam who has put in a lot of time helping us with the website revamp tender and agreement documents. We thank our Honorary Treasurer and Honorary Auditor who have helped to ensure a healthy status of the College finances so that we can proceed with the various initiatives. We also thank Dr Ping Wa Yam whose term of Council Membership has just ended, for his contributions over the past years.

The strength of the College is its membership, and I look forward to your continued support to the College.

Presidential Address
Conferment Ceremony, Hong Kong College of Physicians, 12th October, 2024

Prof Daniel Tak Mao CHAN
President, Hong Kong College of Physicians

The Annual Conferment Ceremony is the happiest day in the year for the College of Physicians, because it is the day that we welcome another new generation of well-trained and dedicated physicians, who represent the bright future ahead for Internal Medicine. But before I congratulate our new Fellows and Members on your achievements, I would like to go back a few years and congratulate you on your very wise decision to enter into Internal Medicine. As illustrated by the talks on cardiovascular-kidney-metabolic syndrome and geriatric medicine in the scientific programme this afternoon, Internal Medicine is the core and major discipline in all healthcare systems, and the healthcare demand in Medicine and its many subspecialties continues to escalate globally. Therefore, we would always need a strong workforce of high quality physicians. Fast forward to tonight, I would like to commend you on your successful completion of the structured Physician Training programme, and congratulate you on being accredited specialist status in your respective fields and being conferred Fellowship of the College. When you mention to others that you are a Physician trained in Hong Kong, you would automatically earn respect because the

professional standard of Physicians from Hong Kong has long been well regarded internationally, not only in terms of knowledge and skills, but also our professionalism, ethical standard, and humanism. So how do we achieve that?

Obviously you have put in a lot of effort in the past seven years, and this has paid off. But in addition to your hard work, we also have a good training programme. The three years of Basic Physician Training and our long-term partnership with the Royal Colleges of Physicians in the U.K. ensure a solid foundation in our Physician

Trainees, and that our Trainees achieve the highest of international standards, as exemplified by their high passing rate in the MRCP(UK) Examination. Indeed, the MRCP(UK) Examination is also the obligatory Intermediate Examination of our Physician Training programme, and has been held locally with examiners from Hong Kong and the Royal Colleges of Physicians since the 1980s. With a rigorous format covering different competency domains, this examination serves as an important means of quality assurance and international benchmarking. In the phase of Higher Physician Training, we take pride in having put a lot of emphasis on ensuring that our specialists are not only skilled in their own subspecialty, but they have at least 24 months of advanced training in a broad-based Internal Medicine specialty, such as Advanced Internal Medicine or Geriatrics. We believe this is important for holistic care of patients. The rapid progress of medical knowledge and technologies leads to increasing subspecialization. But we mustn't lose sight that a patient is not just a summation of individual organs or separate diseases, but the patient as a whole. Having a broad-based knowledge on conditions outside one's own subspecialty is prerequisite to a holistic perspective, ultimately for the benefit of patients and their families.

Yet having a good Physician Training programme and having you working hard in the programme are not enough. We need people to run the programme. I would like to take this opportunity to thank, and you should also join me in thanking, your Trainers, your supervisors and teachers. Without them, one would not be able to deliver the training that is required to produce high-quality Physicians. Over the years, the College has worked with the Hospital Authority to ensure that Physician Trainees get protected time for their training. You may not know, but your supervisors and Trainers are not 'protected' in this regard. There is no 'protected time' for their contributions to training. They have devoted much of their own time, despite an already very busy clinical service, to put their effort into building structured training programmes for Trainees. Some involve simulation, while others include teach-ins, seminars and workshops. There are also various continuous medical education initiatives, some held in conjunction with local or overseas organizations. For example, in May this year we had a very successful webinar organized jointly with the Royal College of Physicians of Edinburgh, accessible to Fellows of the two Colleges around the world. All these efforts by many colleagues contribute to the success of our training programmes and the high quality of our doctors, and this is very much appreciated by the College. So I would like to congratulate you once again on achieving this very significant milestone in your professional career.

Having said that, this is but only the beginning. Obtaining specialist accreditation is just the beginning of your lifelong career. From now on, you will face a lot of choices - choices in your career, choices in what sort of work you would like to go into, and what sort of things you would like to do in life. Some might want to continue to do clinical service; some might want to do research; some might want to go into healthcare administration, and some might want to go into education and training. All of these are important to the healthcare system and to

the profession. I just want to share a bit of my personal thoughts on making career decisions. Last year, I told the batch of newly accredited Fellows that there was no such thing as ‘work-life balance’. I'm reasserting this by reminding everyone that when you make your career choices it is not a good idea to regard this so-called ‘work-life balance’ as a priority. This is a very wrong concept, as it implies that work and life are opposite of each other. In fact, work is part of life, as is family, and as are good times and bad times. One would need all these life experiences to make life wholesome. So I would urge you, whenever you make your decisions about what to do and what not to do, follow your interests and think about what are the things that you would like to put your time into - things that are of value to you, and things that would help you realize your potentials. Certain paths might appear challenging and slightly unpredictable, but would you regret it later if you forsake an opportunity and choose an easier path instead? If you decide on something that looks easy, but do not enjoy what you do, it is probably not a very wise choice. In this regard, I go back to mention our colleagues who have put a lot of effort and time into developing and strengthening our training programmes to make sure that our future generations are well-trained, very good doctors. Certainly they must think that this work is valuable and their time is well spent. And finally, in making your career choices, I do hope that you will always remember the underprivileged. And so on this note, I wish that every one of you would make your right choices in life and have a fruitful and rewarding life.

PERSPECTIVE

Incorporating the cardiovascular-kidney-metabolic health framework into the local healthcare system: a position statement from the Hong Kong College of Physicians

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Steering Committee of the Hong Kong College of Physicians position statement

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Introduction

What is cardiovascular-kidney-metabolic syndrome?

Cardiovascular-kidney-metabolic (CKM) syndrome is a new entity that emphasises interconnections among atherosclerotic cardiovascular disease (ASCVD), atrial fibrillation (AF), heart failure (HF), chronic kidney disease (CKD), excess adiposity, metabolic syndrome, and diabetes.[1] It is categorised into five stages (Table 1), reflecting the progressive nature of the pathophysiology behind this multifaceted syndrome and the increasing risk of adverse cardiovascular outcomes associated with higher CKM stages.[2-6] The CKM health framework incorporates screening, staging, and management for early identification of potential CKM-related events.[7,8]

Adaptation of the CKM model is influenced by access, financing, and care delivery. A multispecialty working group of the Hong Kong College of Physicians (HKCP) developed this Position Statement concerning incorporation of the CKM health framework into the local healthcare system, taking into consideration local healthcare needs, existing resources and limitations, as well as future healthcare directions and initiatives in Hong Kong.

Patient care challenges in real-world settings

The CKM concept aims to identify individuals at risk for suboptimal CKM health to enable timely intervention and slow disease progression. Optimal care delivery remains challenging despite improvements in local health literacy. A recent local population health survey revealed that many individuals were unaware of overweight or obesity status, as well as hypertension, diabetes, and elevated cholesterol.[9]

The ageing local population (~21% of individuals are aged ≥65 years[10]) further strains healthcare resources due to increasing numbers of patients with CKM risks, as well as end-organ damage. A lack of public awareness about CKM health and limitations in primary healthcare constitute barriers to implementing the CKM health framework.

The Hospital Authority has largely focused on specialist care, while our primary healthcare system is comparatively underdeveloped.[11] Public health expenditures reflect this focus.[12] The Health Bureau's Primary Healthcare Blueprint (2022) and the 3-year Chronic Disease Co-Care (CDCC) Pilot Scheme are promising initiatives, but their integration with specialist care remains unclear.

Screening

Screening asymptomatic individuals for metabolic risk factors (eg, overweight/obesity, central adiposity, dysglycaemia, hypertension, and dyslipidaemia) is a key component of the CKM health framework.

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TABLE 1. Stages of cardiovascular-kidney-metabolic syndrome proposed by the American Heart Association

CKM stage	Cardiovascular condition	Kidney condition	Metabolic condition
Stage 0	No subclinical or clinical ASCVD, HF, or AF	No evidence of CKD	All of the following: • Normal BMI and WC based on ethnicity-specific thresholds (ie, BMI <23 kg/m^2 and WC <90 cm [for men] or <80 cm [for women] of Asian ethnicity) • FG <5.6 mmol/L • HbA1c <5.7% • SBP <130 and DBP <80 mmHg • TG <1.52 mmol/L
Stage 1	No subclinical or clinical ASCVD, HF, or AF	No evidence of CKD	Any of the following: • Presence of overweight or obesity (ie, BMI ≥23 kg/m^2 or WC ≥90 cm [for men] or ≥80 cm [for women] of Asian ethnicity) • FG ≥5.6 and ≤6.9 mmol/L • HbA1c ≥5.7% and ≤6.4%
Stage 2	No subclinical or clinical ASCVD, HF, or AF	CKD with any of the following stages: • CKD stage 3 with normoalbuminuria (UACR <3 mg/mmol) • CKD stages 1-3a with moderately increased albuminuria (UACR 3-30 mg/mmol) • CKD stages 1-2 with severely increased albuminuria (UACR >30 mg/mmol)	Any of the following: • Diabetes • Hypertension (SBP ≥130 mmHg and/or DBP ≥80 mmHg or use of antihypertensive medications) • TG ≥1.52 mmol/L • Presence of metabolic syndrome, defined as three of five abnormalities (elevated WC, TG, BP, FG, and low HDL-C [<1.0 mmol/L for men and <1.3 mmol/L for women])

Stage 3	Any of the following:
	• Subclinical ASCVD
	  • Presence of coronary artery calcification on CT angiography or coronary catheterisation
	• Subclinical HF
	  • NT-proBNP ≥125 pg/mL
	  • hsTrop ≥22 ng/L (men) or 14 ng/L (women)
	  • Findings on echocardiography
	• High predicted 10-year CVD risk*
		CKD with any of the following stages:
		• CKD stage ≥4
		• CKD stage 3b with moderately increased albuminuria (UACR 3-30 mg/mmol)
		• CKD stage 3a with severely increased albuminuria (UACR >30 mg/mmol)
			Presence of excess or dysfunctional adiposity, or metabolic risk factors

Stage 4	Clinical ASCVD (CHD, stroke, PVD), HF, or AF	Presence of any CKD • 4a: without kidney failure • 4b: with kidney failure	Presence of excess or dysfunctional adiposity, or metabolic risk factors

Abbreviations: AF = atrial fibrillation; ASCVD = atherosclerotic cardiovascular disease; BMI = body mass index; BP = blood pressure; CHD = chronic heart disease; CKD = chronic kidney disease; CKM = cardiovascular-kidney-metabolic; CT = computed tomography; CVD = cardiovascular disease; DBP = diastolic blood pressure; FG = fasting glucose; HbA1c = glycated haemoglobin; HDL-C = high-density lipoprotein cholesterol; HF = heart failure; hsTrop = high-sensitivity troponin T; NT-proBNP = N-terminal pro B-type natriuretic peptide; PVD = peripheral vascular disease; SBP = systolic blood pressure; TG = triglyceride; UACR = urine albumin-to-creatinine ratio; WC = waist circumference

* Risk determined using the PREVENT (American Heart Association Predicting Risk of Cardiovascular Events) equation[6]

For adults aged ≥21 years, this includes annual measurements of body mass index (BMI) and waist circumference, along with periodic assessments of blood pressure (BP), lipid levels, and glycaemic status. Screening intervals depend on CKM stage: every 3-5 years for CKM stage 0 (healthy and lean), every 2-3 years for CKM stage 1 (overweight/obese or prediabetes), and annually for CKM stage 2 (diabetes, hypertension, or hypertriglyceridaemia).[1] These recommendations align with the American Diabetes Association's guidance that asymptomatic adults aged ≥35 years, or overweight/obese adults with risk factors—such as physical inactivity, family history of diabetes, hypertension, high triglyceride levels, or polycystic ovarian syndrome—undergo screening for prediabetes or diabetes every 3 years if no abnormalities are detected.[13] The need for triglyceride screening remains unclear, and discussions continue regarding BMI thresholds for overweight/obesity in Asian populations.[14]

The CDCC Pilot Scheme, launched by the Hong Kong SAR Government in November 2023, offers subsidised screening in the private sector for residents aged ≥45 years without known diabetes or hypertension.[15] Initial assessments include BP and glycated haemoglobin), with follow-up tests (lipid profile, estimated glomerular filtration rate [eGFR], urinalysis) if hypertension or diabetes is detected.

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Blood pressure thresholds for hypertension vary across guidelines.[16,17] The HKCP previously endorsed defining hypertension as BP ≥140/90 mmHg[18]; the CKM framework utilises a lower threshold of 130/80 mmHg based on recent evidence. Home BP monitoring and standardised office BP measurements are both acceptable. Early detection of CKM risk factors aligns with the Primary Healthcare Blueprint,[19] which promotes chronic disease prevention through a family-centric, community-based primary care system. A key concept, "family doctor for all," aims to enhance public access to care, including screening and diagnosis of prediabetes, early diabetes, and hypertension via coordination with family doctors in the Primary Care Register. Timely screening and intervention can reduce complications such as CKD, cardiovascular disease (CVD), and hospitalisations.

Roles of physician specialists and primary care doctors in the cardiovascular-kidney-metabolic health framework

The increasing incidence of kidney failure and growing healthcare burden of CKD, which now affects 10% of the global population, have made CKD an international health priority. Nephrologists play a central role in managing individuals across CKM stages. Chronic kidney disease substantially increases risks of cardiovascular morbidity and mortality; many patients, especially those aged ≥75 years, die of CVD before exhibiting kidney failure or requiring dialysis.[20] Among dialysis patients in Hong Kong, CVD and stroke caused 30.3% of deaths in 2022.[21] Diabetes or hypertension was the primary diagnosis for 63% of patients initiating kidney replacement therapy. Early CKD detection, particularly in at-risk individuals, allows preventive measures during asymptomatic stages. Primary care doctors are needed to identify and manage these individuals.

Cardiovascular risk factors, including CKD, often remain unrecognised until disease becomes clinically apparent. The CKM staging system prioritises early detection of cardiovascular risk factors, recommending eGFR and urine albumin-to-creatinine ratio assessments for at-risk individuals, such as those with hypertriglyceridaemia, metabolic syndrome, diabetes, hypertension (stage ≥2), or clinical CVD. Indeed, evaluation of albuminuria should also be considered in CKM stage 1, characterised by obesity or dysfunctional adiposity, which manifests as prediabetes—both risk factors for CKD.[22,23] These recommendations aim to improve kidney health awareness and promote CKD screening among primary care doctors, family physicians, and specialists, who are often the first to encounter patients in early stages of CKM.

The Predicting Risk of CVD Events (PREVENT) equation from the American Heart Association is recommended to assess 10-year CVD risk in asymptomatic individuals without ASCVD or HF. This tool estimates overall CVD risk and guides preventive therapy initiation.[6] Caution is needed because the equation may overestimate risk in individuals of Asian descent.[24,25] The PREVENT equation is preferred over the Pooled Cohort Equations[26] in the CKM framework[27] because it includes CKM-specific factors that constitute novel CVD risk factors. Although the social deprivation index is specific to the United States, the inclusion of socioeconomic background during CVD risk estimation is relevant in Hong Kong. The risk score can be calculated using the online tool provided by the American Heart Association.[28] The PREVENT equation, designed for primary prevention in individuals aged 30-79 years without coronary heart disease, stroke, or HF, helps tailor patient-centred preventive therapies according to guidelines.[26,29]

Coronary artery calcium (CAC) testing is recommended for further CVD risk stratification and statin use guidance during primary prevention.[26,27] However, routine CAC testing is not advised in Hong Kong for CKM screening or staging due to concerns about increased downstream testing and the lack of a structured follow-up programme. When CAC results are available, even for asymptomatic individuals, they should inform CKM staging and guide therapies following established guidelines.[26,27,29]

The CKM framework proposes testing for B-type natriuretic peptide (BNP),[27] N-terminal pro-BNP, or high-sensitivity troponin in at-risk individuals to detect subclinical HF.[27] Although two randomised studies demonstrated the utility of this approach for guiding renin-angiotensin-aldosterone system-modifying agent therapy,[30,31] routine cardiac biomarker testing in asymptomatic individuals is not recommended within Hong Kong. Angiotensin-converting enzyme inhibitors (ACEi) are already recommended as first-line therapy, particularly for patients with diabetes,[32] and local cost-effectiveness data are unavailable. Furthermore, it can be challenging to interpret BNP, N-terminal pro-BNP, and troponin levels in moderate to advanced CKD (a component of CKM syndrome) due to renal excretion of these biomarkers. When available, cardiac biomarker data should be considered for management of HF medications with proven benefits, even in asymptomatic individuals.[33]

Prevention of complications

The CKM health framework prioritises identifying and treating CKM risk factors during the preclinical phase to prevent clinical ASCVD, AF, HF, and kidney failure. Locally, patients with hypertension and diabetes in General Out-patient Clinics undergo regular screening for complications through

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the RAMP (Risk Assessment and Management Programs) for Hypertension and Diabetes, respectively.[34,35] Patients with diabetes in public hospital clinics also undergo regular complications screening, including cardiovascular risk assessments, urine albumin-to-creatinine ratio testing, and, in some centres, vascular Doppler studies.[34,35] In the private sector, the Health Bureau of Hong Kong has established Reference Frameworks[36,37] for diabetes and hypertension care, highlighting the importance of regular diabetic complications screening.

The incidences of CKD, metabolic diseases, and obesity are rising, even in younger individuals; greater emphasis on CKD prevention is needed, particularly regarding screening methods and timing. The CKM framework recommends CKD screening before age 21 among individuals with risk factors such as obesity, hypertriglyceridaemia, diabetes, or hypertension. Although not widely adopted locally, the HKCP supports earlier CKD detection to improve kidney survival and quality of life.[38] Screening gaps exist for albuminuria in high-risk groups, including overweight or obese individuals and those with clinical CVD.

Because most patients in early stages of CKM are asymptomatic, primary care and family doctors play a central role in ensuring regular follow-up. This role includes monitoring glycaemic status, lipid profiles, and BP, along with surveillance for CKM complications, such as CKD progression or clinical CVD.

Clinical management: an interdisciplinary care model in Hong Kong

The HKCP supports the guideline-directed management approach in the CKM health framework, although anthropometric thresholds for interventions slightly differ due to population variations. The BMI threshold for metabolic and bariatric surgery was recently updated to ≥27.5 kg/m^2 for Asian populations.[39] This threshold also applies the use of glucagon-like peptide-1 receptor agonists (GLP1RAs) for obesity treatment in patients with type 2 diabetes, aligning with the World Health Organization's recommended BMI action point for high-risk individuals in Asian populations.[40] If pharmacotherapy cost constraints are addressed, the threshold could be lowered to ≥25 kg/m^2, as indicated in some Asian guidelines.[41] In Hong Kong, access to newer CKM pharmacotherapies is limited. Among GLP1RAs approved for managing obesity in individuals without diabetes, only daily liraglutide is currently available, whereas weekly semaglutide is not. Icosapent ethyl, an omega-3 fatty acid treatment for hypertriglyceridaemia, is unavailable in the public sector. The CKM framework recommends initiating cardioprotective antidiabetic agents regardless of glycaemic control, even before metformin in individuals with glycated haemoglobin level <7.5%. However, affordability and patient preferences may impact implementation. Glycaemic control optimisation remains essential because early and effective control improves cardiorenal outcomes and reduces mortality.[42] Notably, statin pharmacokinetics differ between Chinese and Western populations[43,44]; rosuvastatin dosages should not exceed 20 mg daily in Chinese individuals due to rhabdomyolysis risk.

In CKM stage 4 (established CVD), recurrent cardiovascular event risk is high, but many patients fail to achieve the recommended low-density lipoprotein cholesterol target of <1.8 mmol/L.[45] Identification of high-risk individuals and intensification of lipid-lowering therapy with high-intensity statins, ezetimibe, and proprotein convertase subtilisin/kexin type 9 inhibitors are needed to achieve therapeutic goals.[26] In patients with HF, particularly those exhibiting reduced left ventricular ejection fraction, guideline-directed medical therapy (GDMT) classes—beta-blockers, angiotensin receptor blockers (ARBs)/neprilysin inhibitors, sodium-glucose co-transporter 2 inhibitors, and mineralocorticoid receptor antagonists—should be initiated and titrated appropriately.[33] Among patients with AF exhibiting CKM syndrome and stroke risk factors, anticoagulation is advised.46 Co-morbidities such as severe obesity and CKD should be carefully considered because they may influence direct oral anticoagulant efficacy.

Patients across all CKD and CVD stages[47] should be evaluated for kidney-protective therapies, many of which also provide cardiovascular benefits. These include ACEi or ARBs, sodium-glucose co-transporter 2 inhibitors, GLP1RAs, and the nonsteroidal mineralocorticoid receptor antagonist finerenone, as appropriate. Most patients should receive an ACEi or ARB at the maximum tolerated dose, with additional agents introduced based on individual needs and tolerability. Goals include optimising BP, reducing albuminuria, stabilising eGFR, and lowering cardiovascular risk. Some therapies may cause short-term haemodynamic effects on kidney function or adverse effects, leading to premature discontinuation. The CKM framework emphasises initiation and maintenance of these therapies. The HKCP supports their timely uptake and continued use by specialists and primary care physicians.

Implementation of the CKM health framework in Hong Kong faces challenges, including discrepancies in drug formularies between primary care and specialty clinics and inadequate coordination between these services. Patients are sometimes referred to specialty clinics solely for medications unavailable in primary care. Such referral increases

12 This position statement was first published on 24 January 2025 in *Hong Kong Medical Journal*. https://doi.org/10.12809/hkmj2412200

waiting times at overburdened specialty clinics and delays GDMT initiation. Follow-up intervals may be extended due to heavy patient loads, impacting treatment adherence and monitoring. The CDCC Pilot Scheme provides targeted subsidies to support the diagnosis and management of chronic diseases, particularly hypertension and diabetes, in the private sector. This co-care model aims to benefit patients across various CKM stages and mitigate complications.

Conclusions and the way forward

Cardiovascular-kidney-metabolic syndrome has substantial implications for patients and society. The HKCP emphasises the need for collaborative interdisciplinary care within the CKM healthcare framework, integrating primary care, specialist care, and medical subspecialties to prevent complications and protect organs. Although GDMT ensures evidence-based care, clinicians must tailor management to the unique characteristics of each patient, addressing gaps in trial data and local applicability. Conditions such as hyperglycaemia, dyslipidaemia, obesity, kidney insufficiency, and hypertension should not be viewed as "risk factors" but as chronic conditions requiring early intervention to prevent CVD and CKD. Kidney health is central to CKM syndrome, given the high prevalence of kidney failure among patients with diabetes or CVD.

Considering the strengths and limitations of the local healthcare system (Table 2), multiple actions are needed to mitigate the increasing impact of CKM syndrome. The public and healthcare professionals must be educated regarding its adverse effects and access to effective interventions. Integrated care across primary and specialist services is essential, supported by healthcare policy focusing on organ protection to ensure coordination, minimise duplication, and optimise resource use. A collaborative care model involving all stakeholders and providers is essential. The HKCP hopes this position statement will raise awareness and prompt timely strategies to address the growing challenges of CKM syndrome, ultimately improving cardiovascular, metabolic, and kidney health in the community.

TABLE 2. Strengths and limitations of the current Hong Kong health system for implementing the cardiovascular-kidney-metabolic health framework

Domains of CKM health	Strengths	Limitations
Cardiovascular	• Regular screening for complications, including cardiovascular risk factors, is available for patients with hypertension and diabetes under RAMP-HT and RAMP-DM in the public sector • The Reference Framework formulated by the Health Bureau of Hong Kong promotes regular screening for complications in patients with diabetes and hypertension • ACEis are already recommended as first-line medications, particularly for patients with diabetes	• Routine coronary artery calcium testing is not recommended for asymptomatic individuals • Routine screening of cardiac biomarkers, such as BNP, NT-proBNP, or hsTrop, is not recommended for asymptomatic individuals • Discrepancies in drug formularies exist between primary care and specialty clinics in the public sector • Follow-up intervals for monitoring treatment adherence are often prolonged in the public sector
Kidney	• Regular screening for complications, including eGFR and UACR measurements, is available for patients with hypertension and diabetes under RAMP-HT and RAMP-DM in the public sector • The Reference Framework formulated by the Health Bureau of Hong Kong promotes regular screening for complications in patients with diabetes and hypertension	• There is a notable service gap in screening for albuminuria among high-risk patients, including overweight/obese individuals and those with clinical CVD • Discrepancies in drug formularies exist between primary care and specialty clinics in the public sector • Follow-up intervals for monitoring treatment adherence are often prolonged in the public sector
Metabolic	• The vision of "family doctor for all" in the Primary Healthcare Blueprint aims to improve screening and diagnosis of metabolic dysfunction through community coordination and networking with matched family doctors in primary care • The launch of the Chronic Disease Co-Care Pilot Scheme provides subsidised diabetes and hypertension screening services for local residents aged ≥45 years	• Screening for elevated triglyceride levels is less established but often included in lipid profile testing • Some newer pharmacotherapies for CKM health (eg, semaglutide 2.4 mg weekly to treat obesity in individuals without diabetes, icosapent ethyl) are either not registered locally or not widely available in the public sector • Access to some antidiabetic agents (eg, SGLT2is, GLP1-RAs) is limited by patient affordability and preference • Differences in pharmacokinetics between Chinese and Western populations (eg, statins) must be considered • Discrepancies in drug formularies exist between primary care and specialty clinics in the public sector • Follow-up intervals for monitoring treatment adherence are often prolonged in the public sector

Abbreviations: ACEis = angiotensin-converting enzyme inhibitors; BNP = B-type natriuretic peptide; CKM = cardiovascular-kidney-metabolic; CVD = cardiovascular disease; eGFR = estimated glomerular filtration rate; GLP1-RAs = glucagon-like peptide-1 receptor agonists; hsTrop = high-sensitivity troponin T; NT-proBNP = N-terminal pro B-type natriuretic peptide; RAMP-DM = Risk Assessment and Management Program for Diabetes; RAMP-HT = Risk Assessment and Management Program for Hypertension; SGLT2is = sodium-glucose co-transporter 2 inhibitors; UACR = urine albumin-to-creatinine ratio

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Author contributions

Concept or design: SCW Tang and TM Chan.
Acquisition of data: CHL, G Tan and SCW Tang.
Analysis or interpretation of data: CHL, G Tan, SCW Tang and TM Chan.
Drafting of the manuscript: CHL, G Tan and SCW Tang.
Critical revision of the manuscript for important intellectual content: All authors.

All authors had full access to the data, contributed to the study, approved the final version for publication, and take responsibility for its accuracy and integrity.

Conflicts of interest

CH Lee has received advisory board and lecture honoraria from AstraZeneca, Bayer, Boehringer Ingelheim, Eli Lilly, Gilead, GSK, Novo Nordisk, and Sanofi Aventis. SCW Tang has reported consulting fees from Boehringer Ingelheim, Novartis, and Travere Therapeutics, as well as speaker fees from AstraZeneca, Baxter, Bayer, Boehringer Ingelheim/Eli Lilly, GSK, and Novartis. The other co-authors have no competing interests relevant to this manuscript.

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	Prof Ma Ching Wan Ronald	**Prince of Wales Hospital**	AIM, Endocrinology, Diabetes and Metabolism, Genetics and Genomics (Medicine)
	Dr Sha Kwok Yiu Edmund	**United Christian Hospital**	AIM, Geriatric Medicine
	Prof Tang Chi Wai Sydney	**Queen Mary Hospital**	AIM, Nephrology
	Prof Tse Wai Choi Eric	**Queen Mary Hospital**	AIM, Haematology & Haematological Oncology, Genetics and Genomics (Medicine)
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	Dr Lau Yuen Fun Emmy	**Pamela Youde Nethersole Eastern Hospital**	AIM, Endocrinology, Diabetes and Metabolism
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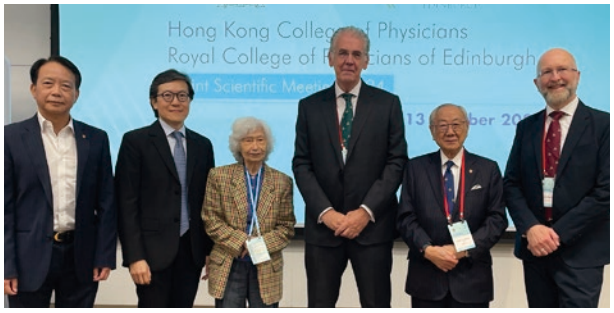
Senior Advisor	Prof Yu Yue Hong Richard	**813 Medical Centre**	AIM, Nephrology

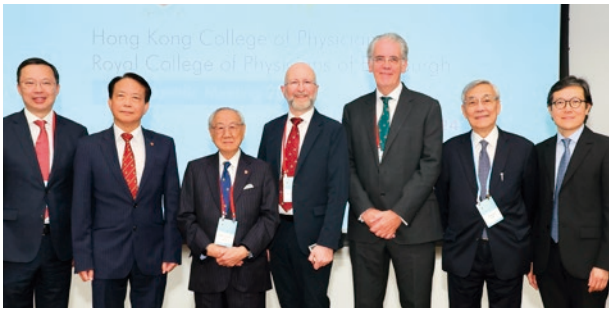
Joint Scientific Meeting 12 -13 October 2024

The Joint Scientific Meeting with the Royal College of Physicians of Edinburgh was successfully held on 12-13 October 2024, in a hybrid format with local participants physically attending the meeting.

The event featured several notable lectures which were key highlights. Dr Conor Maguire, Vice-President (International) of the Royal College of Physicians of Edinburgh, delivered an impressive talk on “Equity of care for Older Adults”. Prof Andrew Elder, President of the Royal College of Physicians of Edinburgh, presented the AJS McFadzean Oration on “The Artificial Doctor”. The Sir David Todd Lecture was presented by Dr Chow Yee Kwan Elaine who spoke on “Closing Implementation Gaps in Cardiovascular Renal Metabolic (CVRM) Care: From Organ-Protective Therapies to Integrated Digital Solutions”. Additionally, Dr Li Hei Philip, winner of the Richard Yu Lecture, gave a presentation titled “Beyond Just an Allergy Label: Pioneering Penicillin Delabelling in Hong Kong and the Asia Pacific”. The event was a resounding success.

On 13 October 2024, our College Council hosted a dinner in honour of Prof Elder to extend a warm welcome to the visiting delegates.





Council dinner with Prof Andrew Elder

Special Symposium

Dr Andrew Lung-tat CHAN

Dr Wai-kuen CHING

Symposium 1

Prof Sydney Chi-wai TANG

Dr Guangming TAN

Dr Paul Chi-ho LEE

Symposium 2

Prof Anskar Yu-hung LEUNG

Prof Daniel Tak-mao CHAN

Prof Francis Ka-leung CHAN

37th Annual General Meeting
25th Congregation Ceremony

On 12 October 2024, the College held a prestigious Conferment Ceremony. The Congregation was graced by the presence of Prof Andrew Elder, President of the Royal College of Physicians of Edinburgh, and Prof Lo Chung Mao, Secretary for Health. During the ceremony, three Fellows were conferred as the First Fellows in Genetics and Genomics (Medicine), bringing the total number of new Fellows in this specialty to 25. In addition, the College conferred an Honorary Fellowship on Prof Lo Yuk Ming Dennis.

Dinner with Prof Tom Solomon

Prof Tom Solomon, Academic Vice-President of the Royal College of Physicians, visited Hong Kong in November 2024. Our College hosted a dinner in his honor on 10 November, which also included the RCP Regional Advisor, Dr Yuk Ka Lok.

Joint HKCPIE/ MRCP (UK) Examiners' Dinner

Our College hosted a dinner on 30 October 2024 to welcome the UK examiners of the October PACES 2024. The UK team presented a beautiful painting to our College and we expressed our heartfelt gratitude to their goodwill.

AJS McFadzean Oration

The Artificial Doctor

Prof Andrew ELDER
President, Royal College of Physicians of Edinburgh

Professor CHAN, distinguished guests, colleagues, friends, fellows new and old.

Thank you very much for the generous introduction, the invitation to be with you and the great honour of delivering this oration. As those of you who know me well are aware, I have been lucky enough to visit HK on many occasions over many years. I have always found great warmth, collegiality and friendship here, as I do today, and for which I would thank you all.

I would like to start by thanking my friends and colleagues at all the institutions in the UK and USA who have helped shape my thinking over many years. Particularly the Society of Bedside Medicine and Stanford Presence in the USA, and my home university and College in Edinburgh. I add, at this point, that I have no disclosures nor competing interests in relation to any of the content of this talk.

In addition, we should all thank the man who this oration is named after, Professor AJ McFadzean. (**Image 1**) A Scot like me - from Glasgow rather than Edinburgh - and a man who made a major impact on medicine in this part of the world. In his memory, I want to talk with you today about a real tension in healthcare – that is the tension between technology, and all it can offer, and the human being, the doctor, and all we can offer. In doing so, I hope I can do tribute to some of the values that Professor McFadzean clearly upheld.

Image 1

Silicon Valley

I have had the great good fortune to spend time over the past 10 years living and working in that part of California known as Silicon Valley. The home of many of the “big tech” firms, the home of venture capital and the home of Stanford - a centre of academic excellence that straddles many disciplines. And that rich brew of money, minds and medicine creates many ideas, some that bear fruit, some that do not. The idea, the technology, that is on everyone’s lips at the moment is of course artificial intelligence.

Last year Mr Elon Musk made this remarkable statement about AI. “Artificial Intelligence will make jobs kind of pointless.” As soon as I read it this thought came to my mind. “When was the last time that Mr Musk was in a hospital?” But his statements get a lot of attention – he has 200 million followers on X.

I have only three thousand followers - the things I say do not get nearly as much attention!

But I said this anyway by way of a response – “The history of medicine is littered with tales of panacea”. We are all aware of the magical allure of the universal cure, we have seen it in medicine many times before. And we know we need to take care not to be seduced by it.

My aim in this short talk is two-fold. First – to talk about us, we humans. Amidst all the clamour around AI, all the lectures we attend telling us what AI can and will do, let’s pause for a moment to think about us. What we humans bring to patient care. And my second aim is to illustrate how technology has already changed us as doctors, has changed how we interact with patients and to highlight that if we do not take great care, it will change us further, in ways we can’t predict.

In doing this I want to stress that I am not a luddite. I am not anti-technology in healthcare – that would be a ludicrous position for anyone to adopt. But I am unashamedly pro-human – and that is a principle we should all defend.

Our Human Strengths

Philosophers have long recognized that there are two types of knowledge (**Image 2**). First, explicit knowledge, such as facts, figures and formulae. This knowledge is easy to codify and is what AI is good at collating, analysing and synthesising.

But there is also tacit knowledge, which is much more than mere facts. It is what we do with facts, how we relate facts to our perspective, experience, insight and intuition. And how we convert those facts into wisdom. And that is difficult - indeed currently impossible - to codify and something machines may never rival. But we humans bring it to the bedside every day.

Image 2

We also bring our eyes, our visual cortex, our amazing powers of observation. AI may be becoming strong at pattern recognition within static radiology images but is has only partially mastered images like the “muffin - chihuahua challenge” and still struggles with many of the irritating CAPTCHA (Completely Automated Public Turing test to tell Computers and Humans Apart) tests we all endure on many websites. And moving images, that we interpret everyday when looking at a jugular venous waveform, or the way that eyes follow our finger or the presence or absence of a tendon reflex response, are well beyond its reach.

Humans are keen listeners too. And with training the doctor learns to convert that natural talent into an art. Most of our

diagnoses are still made from the history, from what we hear from the patient, and what we find on physical examination. Not what we see on the scan, find in the blood, or discover in the genome.

Observation and Curiosity

The fictional character of Sherlock Holmes was based on an Edinburgh doctor, Joseph Bell, and created by an Edinburgh doctor, Sir Arthur Conan Doyle. And Holmes for me still crystallizes the key skills of the doctor and the key skills of the clinician scientist.

1. The ability to observe and listen to the patient.
2. The ability to hypothesize and provide an explanation for what the patient's story and physical findings tell you, as a differential diagnosis, or scientific theory.
3. The ability to determine what evidence is needed to support or refute that theory.

For example, in a clinical setting…..what do I see in these legs? (**Image 3**) What could the distal wasting mean? Why has it developed? How does the foot deformity arise? What should I look for next? What questions should I ask the patient?

Image 3 (Andrew Elder with permission)

That curiosity - asking what, how and why - remains central to clinical medicine and diagnosis.

And observation and curiosity are also central to medical research

Take just one old example – the story of Sir Alexander Fleming, another Scot. Leaving an untidy laboratory to go on holiday he left some petri dishes seeded with staphylococci exposed to the air. On his return they were contaminated by a mould.

How many amongst us would have simply thrown them in the bin? But he did not. He observed the absence of bacterial growth around a colony of the mould, and asked the questions, how and why. How and why has that happened? And his asking led to the discovery of penicillin.

Wisdom and Judgement

And then of course, as part of our conversion of explicit facts to tacit knowledge, there is wisdom, and there is judgement. Many think that Evidence Based Medicine is simply knowledge of the facts, the explicit knowledge that is derived from research. But it is more than that - it is the intersection of data from research, that explicit knowledge, with an understanding of the individual patient's values and preferences and the application of our judgement to those facts in the context of that individual's unique circumstance. Humans contextualise facts. AI may tell us what the facts are but cannot currently practice evidence-based medicine, and perhaps never will.

Presence

And there are other human strengths. We have known for many years that our presence, our manner, and our character can have an influence on our patient's health.

These words – *"Some patients, though conscious that their condition is perilous, recover their health simply through their contentment with the goodness of the physician."* were spoken by Hippocrates 2000 years ago. He recognized that core human virtues could help other humans to feel and get better.

Maya Angelou, the American authoress and poet, was not a doctor. But all doctors will recognise what she expresses in these words. *"I've learned that people will forget what you said, people will forget what you did, but people will never forget how you made them feel."* If you set her words in the context of your own career, do they resonate? They do for me. I can think of many patients, many families, who months or years after my team cared for them, will thank me for what we did. Even if our treatment was unsuccessful, even if their loved one died, they remember how we cared for them. How we made them feel. Will a machine ever do that?

But I don't think I can illustrate the idea of the impact we can have on people any better than by using another old image. Although it is a familiar image, the full story behind it is often not known. Sir Henry Tate, founder of Tate Gallery, where the image still hangs commissioned the artist Luke Fildes to portray an image of social significance in the UK of the late 1800s.

Fildes chose to portray a doctor. A doctor crouched deep in thought over a sick child, lying on two chairs for a bed, in an old Victorian household. In the background stands the father, his hand comforting his wife, the mother, seated in distress at the unfolding events.

Image 4 The Doctor Luke Fildes 1890 Tate Gallery London

What many people do not know is that this is a real-life scene. For the father is the artist, Luke Fildes, the mother his own wife, the child on the chairs their own. He based this image on the loss of their own two-year-old son, for the child in the painting died. And he painted it as a tribute to the devotion of the doctor who spent many hours at bedside, in the presence of the parents. Even though he could offer no specific treatment - he stayed. Fildes said at the time: 'The character and bearing of the doctor throughout the time of our anxiety, made a deep impression on us."

The strength of presence.

And no technology will ever match the power of that human interaction.

And these qualities, that I have briefly summarised - knowledge, its considered application, the ability to listen and to explain, the ability to empathise and to care are precisely the qualities that people look for in their doctor.

And these values, that recognition that medicine is not just the facts about the disease, but the recognition that the disease, the condition, will be different in ever unique individual we meet, was recognised by Osler in this old quotation - The good physician treats the disease; the great physician treats the person who has the disease."

That is what makes us doctors, and what technology will always struggle to match.

None of us can be sure whether we could embed machines with these qualities. And if we did, what impact this would have on us, as doctors, and on the people we treat and our relationships with them. But in what is left of this talk, I will wave a red flag. And suggest that the presence of technology is already changing us – both in how we practice and how we teach

The way we practice

Extremes are not always the best examples, but I will provide one. In a California hospital in 2019, a 78-year-old man lay on what turned out to be his death bed. A machine, crudely rigged to mimic a human, with the live moving face of a doctor at a remote site on the screen where the head should be, was wheeled to his bedside. Wheeled in to tell the patient, in the presence of his family, that all treatment options were exhausted, and that he was dying. The patient did die, the family were horrified and complained at this grotesque perversion of what might be called care. I don't think any of us will be surprised at their feelings – but we are all surprised that somebody, somewhere felt that this was acceptable.

And there are more subtle impacts of technology on the doctor patient relationship. Like the silent undercurrent of influence of the electronic medical record. My friend and colleague Dr Abraham Verghese in Stanford coined the phrase "The iPatient" to illustrate the fact that doctors increasingly interact with a digital representation of the patient on the computer screen and less with the real patient. And it is this representation that our doctors increasingly lavish their care and attention on – residents in many US programs spend over 50% of every shift on their computers and less than 10% of their time with their patients. Is this why they went into medicine? Will this send them home fulfilled? Will this improve the care of their patients? Will our patients feel more cared for?

And why do we do gaze at the computer? There is little doubt that what we find is mesmerizing. Imaging beyond imagination. More blood tests than any of us can name. Perhaps even information about the genome of the patient or the genome of the organism that infects them or the cancer that affects them. Comfortable delusions of certainty on the screen, much easier than the uncertainty that so often prevails at the bedside. But in all that screen gazing, are we really so full of hubris, so proud, so arrogant, so self-confident that we can desert the bedside - are we really beyond looking at the patient?

The way we teach

And finally, what of the impact of technology, even without AI, on the way we teach medicine.

Here is another of my very favourite old medical images, painted in Paris in the late 1800s. (**Image 5**) Entitled "The Hospital Room during the Visit of the Chief of Staff" it is in many ways from another world. The students are all male, the chief of staff is performing direct auscultation, even though the stethoscope exists. The ward is open, the patients themselves appear almost to be like exhibits in a gallery. But some other things are familiar. The student at the back of the group appears to be on a smartphone! And the student next to him is distracted – and anyone who has ever taught a group knows there is always at least one person who is distracted!

But what I believe this image really shows us. In essence it shows the master craftsman demonstrating to his learners how he goes about his craft. It shows role modelling – for good or bad; it shows how tacit knowledge can be transmitted. It is surely the physicians' equivalent of the surgical trainee observing their chief in the operating theatre.

Image 5 Aranda : The Hospital Room during the visit of the Chief of Staff Paris 1889 Museo Del Prado.

And this magical triangle of the student, the teacher and the patient – each learning from the other- is where I learnt my medicine (**Image 6**). It is a triangle that I believe Professor McFadzean, shown here at the bedside, saw great value in. A triangle that helped us learn. Not just to learn clinical medicine, but to learn the basic scientific approach, of Osler, of Fleming and of many others.

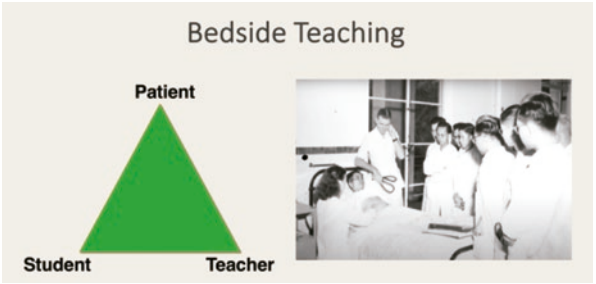


Image 6

But where are we with that approach now?

We are closer to this triangle - in which the student and teacher interact around a representation of the patient, a mannikin, an avatar or, in this case, an echocardiogram. (**Image 7**)

Image 7

It is the iPatient again.

I am trained in cardiac ultrasound and know there are many things we can learn from the echocardiogram that we can never learn from the bedside of the patient. But I know too that there are many things that one can never learn from the echocardiogram that we can only ever learn at the bedside.

We all know the difficulties in delivering patient-based teaching. Sicker patients. Busier hospitals, quicker turnover. But have we asked what this change does to our students? What it does to the doctor patient relationship. And asked whether it might contribute to the well recognized decline in empathy and compassion in medical students in their training, to their fatigue, to their burnout.

What Osler said in 1908 remains as relevant today as it was then. "To study the phenomena of disease without books is to sail an uncharted sea, while to study books without patients is not to go to sea at all."

Neither books, nor technology, can ever substitute for our patients.

McFadzean's vision of medicine

As I close, I return to Professor AJ McFadzean. He had a vision of medicine – that I unashamedly share - that basic clinical skills of history taking, physical exam and diagnostic reasoning are not only central to

the role of the doctor but are our defining characteristics. That learning in the presence of real patients is central to the creation of the doctor. That medical research – be that clinical or laboratory – is best cultivated by doctors who were clinicians trained in clinical method.

Colleagues, friends, Fellows new and old. I have tonight, in this short talk, deliberately chosen to show many old images and read many old quotations. From Hippocrates, Osler, Angelou, Fildes, and Aranda. And I close with this old Russian proverb cited by another giant of Hong Kong medicine, Sir David Todd.

"Those who live in the past are blind in one eye but those who forget the past are blind in both eyes."

For I sincerely believe that what these old images and quotes tell us is not part of a redundant vision of medicine. They tell us what we must work to hold on to, to rediscover and to reinvigorate. The most precious commodity in clinical medicine is time. And it is time that we are short of. But the solution to our shortage of time is not just more machines - it is more people, more doctors, more health care professionals of all sorts. More humans.

Medicine, patient care, and the science that underpins it, will remain critically dependent on our innate human strengths. And it will remain vulnerable to our human flaws - hubris, lack of humility, and avarice to name but a few. But for as long as humans suffer illness, live and die, they will need humans to care for them. They will, I suggest, demand that humans care for them.

Thank you for your invitation and your attention.

Gerald Choa Memorial Lecture

Equity of Care for Older Adults

Dr. Conor MAGUIRE
Consultant Geriatrician, Western General Hospital, Edinburgh, Scotland, UK
Vice President (International), Royal College of Physicians of Edinburgh

A family friend, Father Joseph Mallin, lived and worked in Hong Kong from the early 1950s until his death, aged 104 years, in 2018. He wrote to my mother every month. In one, she asked him about the secret of a long life. He replied “A simple diet, a simple sort of fitness, a purpose in life, and a faith of some sort”. He had been a teacher and felt valued and respected for this role throughout his later life.

People are living longer and, in most cases, are living healthier for longer. In Hong Kong, the population is ageing more rapidly than in most other developed countries. By 2033, 26.8% of the population in Hong Kong will be aged 65 or more, with the percentage of those aged under 55 dropping. Between 2012 and 2050, the percentage of world population aged 65 years and older will have risen from 9.4% to 16.5%, which will be 2.1 billion people, with 80% of these people living in low and middle-income countries. This demographic change will have an effect on the make up of society, and may have an economic effect, but this need not necessarily be a negative effect.

As a normal part of ageing, cellular damage and decline in organ function results in a reduction in physical, and sometimes mental, capacity. Diseases resulting from cumulative cellular damage become more frequent. However ageing, in itself, is not a disease and no two people age in the same way. Unhealthy ageing is not inevitable age a person’s age should not be used as the sole determinant of that person’s health, abilities, and value to society. In geriatric medicine we talk about chronological ageing, the number of years a person has been alive, and biological ageing, how fit and well a person is.

The fact that people are living longer is a remarkable societal achievement. The majority of older people are healthy and independent. They are not, and should not be regarded as, a burden. Most older people play a valuable role in society, whether it be within the formal workforce, as carers, providing childcare, or doing voluntary work. Older people, with lived experience, can be invaluable in resolving conflict and offering counsel. The experience of, and ability to pass on, cultural and religious heritage is unique to those who have lived for many years. Society does benefit, not alone from the active contribution of older adults, but also from their wellbeing.

As human beings we categorise people, whether it is into race, gender or age. Such categorisation may result in discrimination against that group. Robert Butler first described ageism in 1996 as an attitude of mind which may lead to age discrimination, and which may then result in actions that disadvantage older people. Categorising people based purely on their chronological age may therefore be discriminatory. Butler described three components of ageism: (1) Negative attitudes towards old age and ageing; (2) Direct and indirect discriminatory practices and; (3) Institutional practices and policies. Ageism can be conscious or unconscious, and can be other-directed or self-directed.

In healthcare, negative attitudes towards old age can include 'other directed' assumptions such as that old people are slow, forgetful or malodorous. Even the term 'elderly', so frequently used in healthcare, has connotations of disability and frailty and describing a person as elderly may be interpreted as unconscious ageism. Ageism in healthcare can be 'self directed' where an older adult may assume that any symptoms that they have are 'due to old age', and not worthy of investigation or treatment.

Discriminatory practices in healthcare may include setting age limits for treatment, not including older people in drug trials, and withholding interventions based on age alone.

Examples of an institutional practice that may discriminate against older people include developing disease specific pathways of care that favour younger people. Such practice may overlook reversible causes of conditions common in older people, such as immobility, incontinence and cognitive changes.

However, true equity in healthcare for older people does not mean treating all people the same. True equity of healthcare for all means personalising care for that individual, based on their general health, co-morbidities, social situation, and their wishes.

The McKinsey Health Institute found that the strongest determinants that predict health and happiness in older people are having a sense of purpose and actively participating in society. The World Health Organisation has launched a Global Campaign to Combat Ageism (WHO), designed to change how we think, feel and act about ageing. This includes breaking down the barriers between generations, developing communities in ways that foster the abilities of older people, and delivering person-centered integrated care and primary health services responsive to older people. Older people should be integrally involved and included in planning such services.

If we want to ensure that there is equity of care for older adults in healthcare, we need to firstly ensure that older people are treated fairly in society. This can be achieved by breaking down the barriers between generations, ensuring that younger people value the wisdom that age brings, and the many valuable roles that older people play in society. On a societal level, older people need to be encouraged to participate actively in society, and society as a whole needs to develop communities to enhance and nurture older people and to encourage intergenerational communication.

In medical education, it is vital that we teach and train those involved in healthcare that chronological age should not detrimentally govern how patients are approached, managed and treated. We must ensure that healthcare is person-centered and appropriate to the individual.

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Richard Yu Lecture

Beyond Just an Allergy Label: Pioneering Penicillin Delabelling in Hong Kong and the Asia Pacific

Dr. Philip Hei LI
Department of Medicine, The University of Hong Kong

Hong Kong's evolution from having minimal allergy services to becoming a leader in penicillin allergy research over the past six years is remarkable. Prior to 2018, the territory even lacked formal adult allergist services, let alone any drug allergy research. Today, Hong Kong is now at the forefront of revolutionizing the practice of drug allergy, particularly in penicillin allergy delabelling, and setting new standards in the Asia Pacific.

This lecture will outline Hong Kong's transformation, beginning with the epidemiology of drug and penicillin allergies in the territory. We will examine the prevalence and impact of incorrect penicillin allergy labels, which often lead to the use of less cost-effective alternatives, contributing to antibiotic resistance, higher healthcare costs and impaired quality of life. We will also explore the rate and consequences of erroneous penicillin allergy labelling, emphasizing the critical need for rapid and innovative delabelling strategies. Hong Kong's innovative approaches and strategies will be highlighted, showcasing the establishment of the Hong Kong Drug Allergy Delabelling Initiative, interdisciplinary collaborations and evidence-based educational interventions that have set a benchmark for the region.

Looking ahead, the lecture will preview upcoming hurdles, such as the significant problem of penicillin mislabelling in Mainland China and Asia Pacific, coupled with the essential need for policy modifications and enhanced education for healthcare professionals. Potential strategies and roadmaps to overcome these challenges and improve penicillin allergy labelling accuracy across the region will be discussed.

By the end of this lecture, attendees will gain a comprehensive understanding of Hong Kong's pioneering role in penicillin allergy delabelling, the progress made, and the future steps needed to ensure safe and effective allergy management in the Asia Pacific.

Sir David Todd Lecture

Closing Implementation Gaps in Cardiovascular Renal Metabolic (CVRM) Care: From Organ-protective Therapies to Integrated Digital Solutions

Dr. Elaine Yee Kwan CHOW
Department of Medicine & Therapeutics, The Chinese University of Hong Kong

It has been 40 years since the landmark United Kingdom Prospective Diabetes Study (UKPDS) demonstrated microvascular benefits of early intensive glucose control in type 2 diabetes (T2D). Sodium glucose co-transporter 2 inhibitors (SGLT2i) and glucagon-like peptide 1 receptor agonists (GLP1-ra) have been hailed as game-changers in the scene of CVRM management. At the same time, diabetes technologies such as continuous glucose monitoring (CGM) matured, accompanied by an explosion of mobile apps and wearable tech.

Despite rapid advancements, adoption of these newer lifesaving medications in the real-world has been disappointing. In Hong Kong, less than 10% of T2D patients were on SGLT2i and less than 3% were on GLP1-ra. We have shown that young adults aged 20-40 years with diabetes were most likely to receive SGLT2i and GLP1-ra, yet consistently had worst glycemic control. This picture is largely mirrored in other high-income settings. Many international societies advocate for a “pillared” approach to HF and CKD guideline-directed medical therapies. However, the complexity of simultaneous initiation and titration of multiple medications necessitates new models of care.

It has been said that on average it takes 17 years for new therapies to be implemented in routine practice. In this lecture, I shall discuss some potential solutions to close these implementation gaps.

(1) Enhancing patient self-management via remote and home-monitoring technologies. We have shown the use of CGM in diabetes and advanced CKD can guide glycaemic assessment and facilitate treatment titration, providing holistic glucose profiles especially where HbA1c is unreliable.

(2) Clinical decision systems in embedded electronic health record (EHR) systems for risk stratification. For example, in

collaboration with the Hospital Authority Data collaboration laboratory (HADCL), we recently developed machine learning model based on 1.4 million health records to identify the 10% of older adults with diabetes who are at highest risk of severe hypoglycaemia for targeted intervention.

(3) Continuing to target glycemic control and traditional CV risk factors using established agents, such as RAASi. statins and insulin.

(4) Equity and access to newer treatments. Costs remain a major barrier to widespread adoption of SGLT2i/GLP1-ra/CGM as their indications continue to expand. Clinical and cost-effectiveness evaluations in sub-populations may help policymakers prioritise resource allocation.

(5) Invest in multidisciplinary teams and cross-specialty working. We have shown a hybrid technology-assisted, team-based model to be most efficient in translating chronic disease care. Now more than ever, we need the close collaboration from primary care physicians, endocrinologists, cardiologists, nephrologists, internists to deliver the best CVRM care.

Best Thesis Award – Gold Award Winner

Exploring the Therapeutic Potentials of Trimetazidine Dihydrochloride in Lung Cancer: A Pharmacological Re-positioning Study

Dr. Yap Hang CHAN
Department of Medicine, Queen Mary Hospital, Hong Kong

Background: Metabolic reprogramming of energy processes is a cellular hallmark of lung cancers. Whether the use of trimetazidine, an anti-ischemic agent that preferentially potentiates cellular glucose oxidation, may clinically alter the survival risk of patients with lung cancers is unknown.

Methods: This territory-wide, retrospective cohort study included 279,894 ischemic heart disease patients prescribed with trimetazidine or long-acting oral nitrates from the Clinical Data Analysis and Reporting System (CDARS) of the Hong Kong Hospital Authority (period: January 1999 - December 2020). A total of 6561 patients with pre-existing or de novo lung cancers were identified. Clinical endpoints of all-cause mortality were longitudinally compared between lung cancer patients who received trimetazidine (n=547) versus non-users (control, n=6014). A multivariable Cox proportional hazards regression model was used to adjust for potential confounders and derive hazard ratios (HRs) with 95% CI on all-cause mortality.

Results: Over a mean follow duration of 902.9±1410.6 days, a lower percentage of deaths occurred in the trimetazidine group (79.0%, n=432/547) compared to controls (90.5%, n=5442/6014, P<0.001). Kaplan-Meier analyses showed that trimetazidine use was associated with significantly better all-cause mortality event- free survival (trimetazidine: mean survival=1840.6 [95%CI 1596.0 – 2085.3], versus control: 1056.7 [95%CI 1011.3 – 1102.0] days, Log Rank (Mantel-Cox)=69.4, P<0.001). Cox proportional hazards regression showed that trimetazidine use was significantly associated with reduced risk of all-cause mortality in crude (HR=0.60 [95%CI: 0.53 to 0.68], P<0.001) and multivariable analyses after adjustment for potential confounders (HR=0.65 [95% CI: 0.57 to 0.74], P<0.001). Pre-specified analyses amongst patients exclusively with pre-existing lung cancers yielded similar findings (HR=0.49 [95%CI: 0.35 to 0.67], P<0.001). Survival benefits related to trimetazidine use was predominantly on non-cardiovascular mortality (P<0.001).

Conclusion: Trimetazidine use is associated with a lower risk of all-cause mortality, and predominantly non- cardiovascular mortality, in patients with lung cancers. Modulation of metabolic reprogramming may represent a novel therapeutic target for the secondary protection against lung cancers. These findings will need to be confirmed by randomized controlled trials.

Best Thesis Award – Silver Award Winner

Bacteriology and Clinical Outcome of Peritonitis Episodes in Patients Receiving Automated Peritoneal Dialysis: A 15-Year Case-Control Study

Dr. Amelia Chien Wei CHAO
Department of Medicine & Therapeutics, Prince of Wales Hospital, Hong Kong

Background: Peritoneal dialysis (PD) is an increasingly favoured method of renal replacement therapy worldwide. PD offers several benefits over haemodialysis (HD), including the preservation of residual kidney function, enhanced patient independence, and reduced healthcare expenditures. Despite its advantages, peritonitis remains a common and serious complication of PD. However, the current treatment guidelines are largely based on patients receiving continuous ambulatory peritoneal dialysis (CAPD), whilst the optimal dosage regimen for individuals undergoing machine-assisted automated peritoneal dialysis (APD) remains undetermined.

Methods: In this single-centre, retrospective, case-controlled study, we enrolled patients undergoing APD who experienced an episode of dialysis-associated peritonitis from 1 January 2007 to 31 December 2021, and matched against peritonitis episodes undergoing CAPD. The study compared the range of causative organisms and clinical outcomes between those receiving APD and CAPD, as well as treatment response between patients undergoing intermittent and continuous dosing of intraperitoneal antibiotics.

Results: This study included 528 episodes of peritonitis, with 176 on APD and 352 on CAPD. Of those on APD, 101 underwent nocturnal intermittent peritoneal dialysis (NIPD) whilst 75 underwent continuous cycling peritoneal dialysis (CCPD). The bacteriology of peritonitis episodes in both APD and CAPD were similar. Treatment response, defined according to the International Society of Peritoneal Dialysis (ISPD), was higher for APD than CAPD (88.1% vs 80.7%, $p = 0.033$). This was also noted in NIPD as compared to those on CCPD (95.0% vs 78.7%, $p < 0.001$). Within APD, patients who received intermittent dosing of intraperitoneal antibiotics in their day dwell achieved a higher treatment response rate than those temporarily converted to CAPD and had a continuous dosing regimen (92.5% vs 73.8%, $p < 0.001$). There was no difference in the length of hospitalization between CAPD and APD patients ($p = 0.237$), and between NIPD and CCPD patients ($p = 0.654$).

Conclusion: This study demonstrated that patients on APD, in particular those on NIPD, responded more favourably to treatment for dialysis-associated peritonitis than those receiving CAPD. Notably, APD patients who received intermittent doses of intraperitoneal antibiotics via their day dwell had a superior treatment response rate as compared to those temporarily converted to CAPD and had a continuous dosing regimen. This study suggests that routinely switching patients from APD to CAPD during dialysis-related peritonitis for the administration of intraperitoneal antibiotics may be unnecessary and potentially harmful.

Best Thesis Award – Bronze Award Winner

Re-defining Standard of Care – Heart Failure and Fluid Assessment (ReDS-HF)

Dr. Ling Na WONG
Department of Medicine & Therapeutics, Prince of Wales Hospital, Hong Kong

Background: Inadequate treatment of congestion often results in heart failure rehospitalisations. The Remote Dielectric Sensing (ReDS) System is a non-invasive miniature radar-based device that rapidly and accurately quantifies lung fluid content.

Objectives: This study aimed to evaluate the prognostic impact of ReDS values in Chinese patients with recent heart failure hospitalisations in the ambulatory setting.

Methods: ReDS-HF (Re-Defining Standard of care – Heart failure and Fluid assessment) was an investigator- initiated, single center, non-randomized pragmatic retrospective study. One-off ReDS measurements were performed in 135 patients who presented to the ambulatory heart failure clinic after heart failure hospitalisations. The primary outcome was a composite of heart failure hospitalisations, treatment intensification, or all-cause mortality in 30 days.

Results: The median age was 69 years old and 71% were men. The median left ventricular ejection fraction (LVEF) was 43% and the plasma NT-proBNP level was 1324 pg/mL. 33 (24%) patients had high ReDS values (≥36%) while 102 (76%) had normal ReDS values (≤35%). The median ReDS values were 41% and 29% respectively. The primary endpoint occurred in 12 (36%) patients in the high ReDS value group and 15 (15%) in the normal ReDS value group. The high ReDS value group was associated with an increased risk of the primary outcome (odds ratio = 3.31, 95% confidence interval: 1.35-8.13, p=0.009) when compared to the normal ReDS value group. ReDS values as continuous measurements were an independent predictor of the primary outcome (odds ratio =1.13, 95% confidence interval: 1.06-1.21, p <0.0001). The high ReDS value group experienced a higher composite event rate (all-cause mortality or heart failure rehospitalisations in 30 days), with a hazard ratio of 6.51 (95% confidence interval: 1.19-35.6, p= 0.03).

Conclusion: ReDS technology is a promising tool to predict 30-day prognosis following heart failure hospitalisations.

Named Lectures and Awards in 2024

AJS McFadzean Oration

The Artificial Doctor

Prof Andrew ELDER
President,
Royal College of Physicians of Edinburgh

Gerald Choa Memorial Lecture

Equity of Care for Older Adults

Dr. Conor MAGUIRE
Vice President (International),
Royal College of Physicians of Edinburgh

Sir David Todd Lecture

Closing Implementation Gaps in Cardiovascular Renal Metabolic (CVRM) Care: From Organ-protective Therapies to Integrated Digital Solutions

Dr Elaine Yee-kwan CHOW
Department of Medicine & Therapeutics,
The Chinese University of Hong Kong

Richard Yu Lecture

Beyond Just an Allergy Label: Pioneering Penicillin Delabelling in Hong Kong and the Asia Pacific

Dr Philip Hei LI
Department of Medicine,
The University of Hong Kong

Highest score for PACES

Dr Ho Ching CHAN

Dr Yu Ching Esther WONG

Highest score for AIM Exit Assessment

Dr Thomas Ming Yam CHIM

Distinguished Research Paper Award for Young Investigators 2024

Dr Wan-Hin Rex HUI

Department of Medicine, Queen Mary Hospital

ALT to qHBsAg ratio predicts long-term HBsAg seroclearance after entecavir cessation in Chinese patients with chronic hepatitis B

Dr Che To LAI

Department of Medicine & Therapeutics, Prince of Wales Hospital

Long-term use of tenofovir disoproxil fumarate increases fracture risk in elderly patients with chronic hepatitis B

Dr Tsz On LAM

Department of Medicine & Therapeutics, Prince of Wales Hospital

Time and dose-dependent effect of systemic glucocorticoids on major adverse cardiovascular event in patients with rheumatoid arthritis: a population-based study

Dr Hei Philip LI

Department of Medicine, Queen Mary Hospital

Recapitulating primary immunodeficiencies with expanded potential stem cells: Proof of concept with STAT1 gain of function

Dr Kit Chung NG

Department of Medicine & Therapeutics, Prince of Wales Hospital

Evaluation of a Fourth-Generation Subcutaneous Real-Time Continuous Glucose Monitor (CGM) in Individuals with Diabetes on Peritoneal Dialysis

Young Investigator Research Grant 2024

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 eight grants of up to HK$80000 each are awarded annually.

Dr Ka Pang CHAN

Department of Medicine & Therapeutics, Prince of Wales Hospital

Clinical impact of respiratory viral infection on airway diseases: a territory-wide retrospective study

Dr Ting Ting CHAN

Department of Medicine & Therapeutics, Prince of Wales Hospital

A prospective study on the effect of glucagon-like peptide-1 (GLP-1) agonist in the changes of pancreatic fat in patients with fatty pancreas and type 2 diabetes mellitus

Dr Ka Shing CHEUNG

Department of Medicine, Queen Mary Hospital

Potential effect of gut microbiota on the treatment outcomes of empagliflozin on colonic adenoma in a double-blind, randomized, placebo-controlled trial

Dr Gin Wai Gerry KWOK

Department of Medicine, Queen Mary Hospital

Expanding the breadth and accessibility of solid tumor profiling with long read nanopore sequencing

Dr Hei Philip LI

Department of Medicine, Queen Mary Hospital

Provocation After Nurse-Directed Assessment (PANDA): randomized, head-to-head study comparing nurse-led direct provocation testing vs standard of care for low-risk penicillin allergy in Hong Kong

Dr Siu Ching LI

Department of Clinical Oncology, Prince of Wales Hospital

Role of circulating interlekin-1β and interleukin-6 for lung cancer risk prediction in high-risk non-smokers

Dr Kit Chung NG

Department of Medicine & Therapeutics, Prince of Wales Hospital

Empagliflozin on residual kidney function in incident Peritoneal Dialysis patients: a pilot randomized controlled trial (EMPIRIC-PD trial)

Dr Kay Cheong TEO

Department of Medicine, Queen Mary Hospital

Advanced IMaging and neurophysiology in IntraCerebral Hemorrhage (AimICH) – CEST/MISL imaging pilot study

HKCP Trainees Conference

Dr Andrew Lung-Tat CHAN
Chairman, Organizing Committee of HKCP Trainees Conference
Member, Training Subcommittee
Education and Accreditation Committee

Speakers and Organizing Committee of the HKCP Trainees Conference

The transition from internship to residency can be stressful for most, if not all, trainees. In response to the awareness of the hardship of such transition, the Training Subcommittee organized the first trainees conference in Hong Kong to support the transition of our basic physician trainees. The conference helped the trainees to achieve the following objectives:

- Familiarize with the training programs & the College activities
- Acquire practical tips in clinical practice
- Educate medical professionalism
- Promote physician well-being & resilience skills

The first Trainees Conference was held on 24 August 2024 at Kowloon Shangri-la Hotel, Hong Kong. More than 50 first-year basic physician trainees attended the half-day conference. The conference invited a panel of experienced and young physicians to give talks on the training pathway and curriculum, clinical pearls, and non-clinical topics.

Session 1: Introduction and Welcome

The new trainees were welcomed by Professor Daniel Tak-Mao Chan, Dr Johnny Wai-Man Chan and Dr Alexander Chun-Bon Law for joining the College. Dr Johnny Chan introduced the structure and functions of Education & Accreditation Committee (E&AC). He gave an overview of the typical physician training pathway. The pathway consists of a 3-year of basic physician training (BPT) followed by a 4-year of higher physician training (HPT). The majority of the trainees will choose dual concurrent training in a medical subspecialty selected together with Advanced Internal Medicine (AIM) or Geriatric Medicine as the broad-based training. Dr Chan also shared the recent developments in the College. All the trainees must attend the Core Medical Skill Course (CMSC) and Advanced Medical Skill Course (AMSC) as the mandatory simulation training during their basic and higher physician training respectively. Following the international trend of medical education, our College is moving towards competency-based medical education (CBME) and our training curriculum has been reviewed and updated. To enhance the learning experience, we are building a culture of constructive feedback through workplace-based assessment (WBA). At the same time, our College is revamping our website and will develop an e-portfolio for all the trainees.

Session 2: Curriculum & Key Milestones

The key milestones of the basic and higher physician training were summarized by Dr Victor Hin-Fai Hung, the chairman of Basic Physician Board, and Dr Yee-Man Kan, the secretary of AIM Board respectively. To complete the basic physician training, trainees are required to attend the mandatory CMSC simulation training and a total of 6 out of 9 mandatory scientific meetings during the 3 years of their training. They must finish 3 cycles of Self Learning Tool (SLT) each year. Trainees should acquire competence through supervision to perform common bedside diagnostic and therapeutic procedures. Passing the joint Intermediate Examination of the HKCP and the Membership of the Royal Colleges of Physicians of the UK (MRCP(UK)) examination is an important criterion for entering HPT. Similarly, Dr Kan mentioned that SLT and AMSC are the mandatory training activities during the HPT. Other than the dual concurrent training, trainees can also opt for sequential or single specialty training. To become fellows in our College, trainees are required to submit two case reports (for AIM only) and at least one dissertation. They also need to pass the interim and exit assessments.

The Young Fellows & Trainees Committee represents the voice of young physicians. The Committee are committed to supporting and empowering the next generation of medical professionals. Though the training journey can be demanding, Dr. Thomas Sau-Yan Chan, the co-chairman of the Committee, encouraged all the trainees to join the Committee, keep connecting and seek support to make the journey more fulfilling.

Session 3: Clinical – What You Need to Know

This session started with Dr Joyce Wai-Ting Lo (Queen Elizabeth Hospital) who emphasized acute stroke demands early recognition and initiation of timely treatment. History taking and neurological examination are important and cannot be replaced by neuroimaging. The computed tomography of the brain should be interpreted systematically and in the patient's context. The reversal of anticoagulation and meticulous titration of anti-hypertensive medications to achieve the blood pressure target are vital for the outcomes of intracerebral hemorrhage (ICH). In the next talk, Dr Ka-Lung Chui (Prince of Wales Hospital) highlighted the myocardial salvage depending on the total ischemic time and the reperfusion strategy. Dr Chui illustrated the early ECG changes in ST-segment Elevation Myocardial Infarction (STEMI) and the differential diagnoses. The application of point-of-care ultrasound (POCUS) may help to differentiate the true STEMI from its mimics. Early revascularization can be life-saving for patients with high-risk non-STEMI (NSTEMI). Physicians may be frustrated when they come across ventilator alarms in their patients. Dr Alfred Sai-Kuen Wong (Queen Mary Hospital) demystified the importance and troubleshooting of the pressure and volume alarms. He demonstrated the use of pressure readings to differentiate between pathologies

Group photo of Speakers and Participants at the HKCP Trainees Conference 2024

with high resistance and high elastance. In emergency situations, the maintenance of adequate oxygenation is the priority, and one should not attempt to reinsert an endotracheal tube or tracheostomy tube blindly. Dr Andrew Lung-Tat Chan (Queen Elizabeth Hospital) encouraged trainees to provide person-centred care and frailty-based interventions for older adults. Lastly, Dr Chan gave bitesize tips for post-discharge support and the clinical management of falls, delirium, and dementia.

Session 4: Non-Clinical–Straight Talk

The last session received overwhelmingly positive feedback from the participants. We were grateful to have Dr Kai-Ming Chow (Chief of Service, Prince of Wales Hospital), Dr Eric Woon-Leung Ng (Consultant, United Christian Hospital), Dr Chung-Ming Chu (Honorary Consultant, United Christian Hospital & Haven of Hope hospital), Dr Chris Ching-Lam Cheung (Fellow, Ruttonjee Hospital), Dr Annabel Choy (Fellow, Kwong Wah Hospital) and Dr Rex Wan-Hin Hui (Higher Physician Trainee, Queen Mary Hospital) as the panellists. They were invited to share their personal experience about the difficulties encountered in their first few years of practice, how they managed complaints and burnout, and their views on professionalism.

This extraordinary session was highly valued by our trainees. Many of them were grateful to the experienced consultants for their generous sharing of their past mistakes and invaluable experience. They felt reassured as everyone went through periods of hardship. Trainees were encouraged to seek early help if they came across stressful situations. They were also inspired and motivated to be doctors with clinical reasoning, effective communication skills and a passion for continuous lifelong learning.

Acknowledgement and Conclusion

The Conference would not have been successful without the unfailing support from our College and the contributions from the members of the organizing committee:

- Dr Thomas Sau-Yan Chan (Queen Mary Hospital)
- Dr Gary Chi-Wang Chan (Queen Mary Hospital)
- Dr Raymond Kam-Wing Woo (Caritas Medical Centre)
- Dr Carmen Ka-Man Cheung (Prince of Wales Hospital)
- Dr Maggie Li-Man Lam (Basic Physician Trainee, Queen Elizabeth Hospital)

We hope that the annual Conference provides an excellent platform to network with our new trainees and to inspire them with practical tips in clinical management and non-clinical skills.

Group photo of Speakers and Participants at the HKCP Trainees Conference 2024

HKCP Trainees Conference – Feedback from the Conference Attendees

Coordinated by:
Dr Andrew Lung-Tat CHAN
Dr Carmen Ka-Man CHEUNG
Organizing Committee of HKCP Trainees Conference

Group photo of the Basic Physician Trainees of Prince of Wales Hospital

The first Trainees Conference was organized by the Training Subcommittee of Hong Kong College of Physicians to support the smooth transition from internship to residency of our basic physician trainees. The following basic physician trainees volunteered to share their feedback about the Conference.

Chan Edward Kai Kit
(Prince of Wales Hospital)

During the last few weeks as a house officer, I became increasingly worried about my new role as a medical officer. There were doubts about whether I was ready to face the day-to-day challenges that Medicine would impose on me in the coming few months. Fortunately, the Hong Kong College of Physicians organized the inaugural Trainees Conference in October. The event introduced our training pathway as Basic Physician Trainees and provided teaching sessions on common medical emergencies. The sharing session by seniors was insightful as we learned the difficulties they faced as physicians at different stages of their careers. Lastly, it was an excellent opportunity to meet with old friends I worked with in the past year. To conclude, the conference was a resounding success, and I highly recommend newcomers to participate in the coming year.

Choi Yan Nok David
(Prince of Wales Hospital)

I was more than grateful to attend the Trainees Conference 2024, which acted as a beacon as I embarked on the journey of being a physician. We were first introduced to our training pathway and some life-saving clinical tips. It was followed by a “straight talk” session, a memorable part of the conference where doctors of various stages of their practices shared sincerely and vulnerably about their experiences, challenges, and triumphs. Their sharing had helped me significantly with approaches to face my inadequacy and to communicate with patients and relatives, for instance, appreciating their efforts when they appeared anxious.

One of the most inspiring aspects of the conference was the unwavering passion of the experienced doctors. Various doctors mentioned a common phrase, 'love of my life,' and their eyes sparkled with enthusiasm as they spoke. This passion, even after years of practice, was truly motivating. I am eager to follow in their footsteps, treating my daily work as a mission to serve those in need.

Guo Liutao Cosmos
(Prince of Wales Hospital)

As a first-year trainee with a limited understanding of what's to come in the next few years of my life, I attended the Trainee Conference with an anticipation of attaining largely technical information regarding the supposed pathways that I am supposed to evolve and grow along. Instead, to my pleasant surprise, a large part of the conference was devoted to the sharing of experiences by physicians of varying seniorities. I was grateful to have heard both the ups and downs of the people before me, and to be reassured that my experiences, as a first year, are as expected. It gave me confidence to continue. I would hence recommend this conference to all upcoming juniors.

Ho Amanda
(Queen Elizabeth Hospital)

The First Trainees Conference in Hong Kong was a platform for trainees to effectively address daily medical challenges through a blend of theoretical knowledge and practical experiences. Senior professionals shared their approaches to key clinical scenarios and stories of doctor-patient interactions, emphasizing the fusion of expertise and humanity in the field. Discussions highlighted the pressing issue of population aging in Hong Kong, stressing the importance of seamless continuity of care in the community, simplification of drug regimens, and the promotion of rehabilitation strategies to prevent recurrent hospitalizations. The conference emphasized professionalism, urging attendees to integrate their passion, skills, and empathy to provide optimal patient care. It encouraged a humble yet confident approach to unfamiliar territories, fostering an open-minded stance in the pursuit of enhanced patient care, with support from colleagues, patients' families, and other allied health professionals. Gratitude was expressed for the invaluable opportunities and knowledge shared during the event.

Thanks again for all your efforts in organizing the conference!

Sham Sze Tung Tiffany
(Prince of Wales Hospital)

The Trainees Conference 2024 organized by the Hong Kong College of Physicians was invaluable during my early months as a basic physician trainee.

The sessions on management of major organ complications, such as stroke and myocardial infarction, equipped me with essential clinical concepts and knowledge important in face of such medical emergencies.

Furthermore, the detailed insights into the training pathway, prerequisites, and exam scheduling helped me better plan my professional journey ahead.

The most impactful aspect was the opportunity to hear from experienced seniors and mentors. Their discussions on workplace attitudes, survival tips, and the importance of good communication and showing empathy towards patients and families resonated deeply with me. They emphasized on maintaining personal well-being to lead a healthy, meaningful career, and more importantly reminded us to do no harm and always be in the best interest of patients.

Overall, the conference not only enhanced my medical knowledge but also inspired me to cultivate resilience and compassion in my practice.

Shum Wing Zi
(Queen Elizabeth Hospital)

Joining the first Trainees Conference in Hong Kong on 24th August 2024 was a precious experience for me and my fellow colleagues. As a first year Basic Physician Trainee, the Conference was no doubt was a good introduction about the College, training curriculum, and the milestones ahead. Furthermore, the clinical session equipped us with the essential skills required to manage common medical problems in our daily practice- from saving neurons in acute stroke to caring for elderly with dementia.

I am most inspired by the non-clinical session hosted by seniors from different hospitals. Their heartfelt sharing demonstrated their understanding of Professionalism from years of experience. Their respect towards patients, inquisitive mind towards science, and the willingness for continual growth are characters that we should always uphold during our Physician training.

Yim Constance Scarlett
(Prince of Wales Hospital)

The HKCP Trainees Conference successfully covered a lot of important topics despite the constraints of time - addressing critical aspects of the physician training, giving practical advice as to the intricacies of diagnosis and management in cardiology, neurology, respiratory medicine, and geriatrics. Beyond the clinical knowledge, the conference also covered an unforgettable non-clinical segment - “Straight Talk". Featuring a panel of highly experienced physicians, they candidly shared their own stories, including their own journey, their struggles, and even times of self doubt. Standing at the foot of the mountain, it can be difficult to fathom how we might survive, much less make it to see the peak. Hearing the sincere stories of those that came before us, recounting their own endeavors, makes the journey ahead feel a lot less isolated and intimidating.

Everyone has to start somewhere, and everyone's path is different. It was reassuring to recognize that the greats before us too had to navigate their own challenges, and to have them offer their support in the upcoming journey. There are still many obstacles to navigate through, many more questions to ask, and many more books to read. I remember one of the speakers sharing their mentality on calls - “tonight, I am responsible for the lives of everyone living in this area”. In the midst of this almost overwhelming responsibility, I hope to keep learning, to ultimately become a more comprehensive physician to better serve the population.

Group photo of the Basic Physician Trainees of Queen Elizabeth Hospital

Medical Education and Training Retreat, 19 October 2024 *- Let's Advocate, Educate, Collaborate and Promulgate*

Dr Yee Man KAN
Training Subcommittee, Education and Accreditation Committee

On 19 October 2024, the Hong Kong College of Physicians (HKCP) held its first Medical Education and Training Retreat to discuss the way forward for the implementation of competency-based medical education (CBME) framework in physician training and assessment. The retreat was organized by the Training Subcommittee in alignment with the College's mission to advance physician training in response to the evolving healthcare and educational environment, to ensure that our training programmes continue to produce competent, reliable, patient outcome oriented, and empathetic physicians of the highest standard internationally. The half-day meeting assembled physicians from a variety of subspecialties, many of whom had an interest in training and education and had previously participated in medical education training courses, to share their insights, discuss challenges, and explore strategies for promoting effective medical training and education.

Emphasizing Competency-Based Medical Education and Training

The retreat commenced with welcoming remarks from College President Prof. Daniel TM Chan. He underscored the pivotal role of CBME in shaping the future of postgraduate education, reiterating the College's dedication to integrating new ideas and training methodologies to improve validity and quality of our training programmes. Prof Chan further highlighted the necessity of revising existing training programmes and assessment strategies to align more closely with the principles of CBME, in line with international best practice. "The College is mindful of its duty to assist and support Fellows, Members and Trainees in acquiring and refreshing essential competencies in physician training. The College is also committed to ensuring that its training and assessment programmes for physician trainees are of high quality and up to date," stated Prof Chan. "To achieve this goal, the College has conducted a number of workshops and devised various means of support to empower Trainers on skills related to clinical education and training. Our Training Subcommittee has organized and will organize more workshops on Competency-Based Medical Education (CBME) and Workplace-Based Assessment (WBA), both of which have proven effective in enhancing training experiences and outcomes."

Dr Alexander CB Law, Chairman of the Training Subcommittee, echoed Prof Chan's remarks about the College's commitment to enhancing physician training and education. He said, "The Training Subcommittee has organized workshops aimed at training trainers, equipping them with the latest knowledge in Competency-Based Medical Education. We see the active engagement of our workshop moderators and participants, facilitating the promulgation of CBME and the training of WBA. Now is the time to come together to discuss the next steps for progress."

Understanding CBME and WBA

Dr YM Kan, Secretary of the Specialty Board of Advanced Internal Medicine in Higher Physician Training, gave an overview of the principles underpinning CBME and the rationale for utilizing WBA. This foundational knowledge set the stage for an open and

constructive dialogue and group discussions among participants, who actively exchanged valuable insights regarding the application of CBME and WBA in their respective practices.

Competency- Based Medical Education: An Overview

Competency-Based Medical Education represents a paradigm shift from traditional educational models. It emphasizes the development of specific competencies that physicians must demonstrate before being deemed fully qualified. These competencies encompass a wide array of skills, including clinical knowledge, communication, professionalism, and teamwork. Colleagues are encouraged to refer to the relevant chapter in the updated Training Curriculum.

Workplace-Based Assessment: A Key Component

Workplace-based assessment is integral to the CBME framework, and can be carried out in different formats to suit distinct objectives and clinical practices. It provides a structured method for evaluating a trainee's performance in real world clinical settings, allowing for real-time feedback and continuous formative improvement. This form of assessment is crucial for identifying gaps in knowledge and skills, ensuring that trainees receive the necessary support to make progress and succeed.

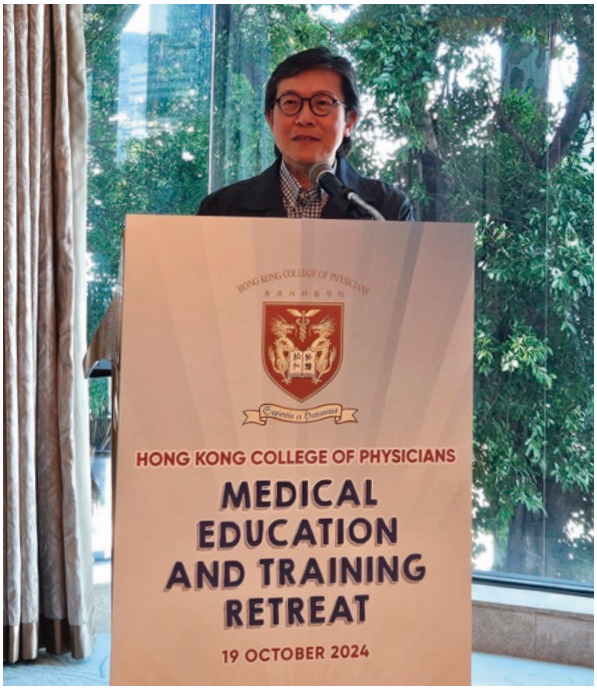
Sharing insights and Experiences

Throughout the retreat, participants shared invaluable insights and experiences regarding the implementation of CBME and WBA. Dr Andrew LT Chan, Secretary of the Basic Physician Training Board; and Dr Candy HY Kwan, Chief of Service at Kowloon Hospital, facilitated the group discussions on implementing CBME in our College, focusing on various aspects of WBA and their integration into current physician training programmes.

Key Discussions and Future Directions

The retreat fostered a collaborative environment, offering participants from diverse subspecialties the opportunity to share their experiences and insights, while highlighting the importance of tailoring CBME and WBA strategies to specific contexts. Key areas were identified and highlighted -

- Infrastructure and Human Capital Development: Identifying the necessary material and human resources and support systems required for the successful implementation of CBME and WBA.



- Stakeholder Engagement: Engaging various stakeholders to ensure a comprehensive approach to physician education.
- Workplace-Based Assessment Trial Implementation: Exploring effective methods for assessing competencies in local clinical settings and across various subspecialties with different competency requirements.
- Constructive Feedback: Emphasizing the significance of giving constructive feedback that encourages trainee's learning and development.
- Technology integration: Advocating for the use of digital platforms that facilitate real-time feedback and competency tracking.

Participants also articulated their views, including capacity enhancement, curriculum reviews, and the promotion of interprofessional collaboration. The discussions provided a platform for identifying challenges and strategizing solutions to improve the overall quality of medical education within our college. Dr Johnny WM Chan, Chairman of the Examination & Accreditation Committee of HKCP, shared his thoughts on the implementation of CBME within our College. He highlighted that the numerous subspecialties encompassed by the College, in conjunction with the ongoing shortage of clinical doctor manpower, present significant challenges to advancing towards CBME. "Despite the possible difficulties, the College has cultivated a core group of leaders and equipped a number of trainers dedicated to advancing medical education. The task group is diligently working on implementing a pilot programme specifically designed to meet the unique needs of various subspecialities while we are also advocating for the recognition and incentives related to the integration of CBME into medical education," he stated.

The first Medical Education and Training Retreat was a significant step forward in the evolution of physician training in Hong Kong. By bridging and synergistically aligning diverse perspectives and experiences, the event provided a platform for sharing of insights and strategies that help enhance the quality of medical education and serve as a springboard for implementation. To conclude the retreat, Prof Chan remarked, "The commitment to competency-based physician training and effective Workplace-Based Assessments will not only benefit trainees but will ultimately lead to improved patient care outcomes. The insights and experiences shared during this retreat will undoubtedly be vital in shaping the future of physician training locally. As we move forward, let us continue to advocate, educate, and collaborate, keeping our training programmes at the forefront of state-of-the-art medical education."

Statistics on Fellows and Trainees in all Specialties (as of 30 November 2024)

Specialty	No. of Fellows	No. of Trainees
Cardiology	349	45
Clinical Pharmacology & Therapeutics	10	0
Clinical Toxicology	5	0
Critical Care Medicine	123	20
Dermatology & Venereology	129	15
Endocrinology, Diabetes & Metabolism	150	21
Gastroenterology & Hepatology	252	28
Geriatric Medicine	236	27
Genetics and Genomic (Medicine)	25	0
Haem/Haem Oncology	98	9
Immunology & Allergy	8	2
Infectious Disease	59	6
Internal Medicine	1819	348
Medical Oncology	62	11
Nephrology	170	20
Neurology	171	19
Palliative Medicine	42	13
Rehabilitation	68	9
Respiratory Medicine	234	24
Rheumatology	110	17

Education & Training Activities in 2025

(1) **Advanced Medical Simulation Course (AMSC)**
Co-organized by Hospital Authority COC (Med) & Hong Kong College of Physicians
Date: 21, 22, 25, 26 February 2025
3, 4, 7, 8 March 2025

(2) **Core Medical Skill Course (CMSC)**
Co-organized by Hospital Authority COC (Med) & Hong Kong College of Physicians
Date: 2, 6, 9, 16, 20 August 2025

(3) **General Medicine Quarterly Update (GMQU)**
Organized by Training Subcommittee, Hong Kong College of Physicians

Date	Topic	Speaker
26 February 2025	Clinical Toxicology Made Easy	Dr Chan Chun Man Jones
14 May 2025	To be announced	To be announced
13 August 2025	To be announced	To be announced
17 November 2025	To be announced	To be announced

(4) **Basic Medical Education Course**
Organized by Training Subcommittee, Hong Kong College of Physicians
Date: 5 July & 12 July 2025

(5) **HKCP Trainees Conference**
Organized by Training Subcommittee, Hong Kong College of Physicians
Date: 26 July 2025

Case Reports that Received High Scores at AIM Interim Assessment

Candidates who take part in the AIM Interim Assessment need to submit case reports. The good examples of case reports of each examination diet have been uploaded to our College website: http://www.hkcp.org. Below is the information on the case reports for the December 2024 diet:

Case report title	Name of the candidate	Department and Hospital
A rare cause of thyrotoxicosis	Dr Ho Pui Hung	Department of Medicine Pamela Youde Nethersole Eastern Hospital
Metformin associated lactic acidosis. To fear or not to fear	Dr Ng Chin Ting Justin	Department of Medicine, Queen Mary Hospital

Examination Calendar

Please take note of the following Interim and Exit Assessment dates for various Specialties:

	Interim Assessment date	Exit Assessment date
Advanced Internal Medicine	7 June 2025	14 June 2025
Cardiology	28 June 2025	28 June 2025
Clinical Pharmacology & Therapeutics	Nil	Nil
Critical Care Medicine	28 June 2025	28 June 2025
Dermatology & Venereology	7 June 2025	7 June 2025
Endocrinology, Diabetes & Metabolism	30 May 2025	30 May 2025
Gastroenterology & Hepatology	24 May 2025	24 May 2025
Geriatric Medicine	24 May 2025	24 May 2025
Haematology & Haematological Oncology	10 May 2025	10 May 2025
Infectious Disease	21 June 2025	21 June 2025
Immunology & Allergy	27 May 2025	Nil
Medical Oncology	21 June 2025	21 June 2025
Nephrology	29 May 2025	29 May 2025
Neurology	Pending	17 May 2025
Palliative Medicine	21 June 2025	21 June 2025
Rehabilitation	9 June 2025	9 June 2025
Respiratory Medicine	14 June 2025	14 June 2025
Rheumatology	3 June 2025	3 June 2025

Pass Rate for the Joint HKCPIE/MRCP(UK) Part I Examination:

	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%)
January 2020	41	20 (49%)
September 2020	109	101 (93%)
January 2021	33	20 (61%)
August 2021	106	63 (59%)
May 2022	65	48 (74%)
August 2022	104	75 (72%)
May 2023	36	20 (56%)
August 2023	109	63 (58%)
January 2024	71	35 (49%)
August 2024	140	105 (75%)

Pass Rate for Joint HKCPIE/MRCP(UK) Part II (Written) Examination:

	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%)
27 October 2020	87	77 (89%)
23 March 2021	107	84 (79%)
5 October 2021	44	32 (73%)
1 Jun 2022	61	49 (80%)
7 September 2022	56	40 (71%)
22 February 2023	78	60 (77%)
6 September 2023	40	28 (70%)
21 February 2024	71	59 (83%)
11 September 2024	49	31 (63%)

Pass Rate of PACES over the Past Years:

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%
No examination had been conducted in 2020	
March 2021	81/119 = 68%
October 2021	84/120 = 70%
June 2022	50/87 = 57%
October 2022	32/72 = 44%
March 2023	54/89 = 61%
October 2023	46/89 = 52%
April 2024	43/76 = 57%
October 2024	54/88 = 61%

Joint HKCPIE/MRCP Oct PACES 2024 Pass List

Au Christopher Langjun
Au-Yeung Hon
Chan Hei Yan
Chan Ho Yin Matthew
Chan Ka Hei
Chan Ka Man
Chan Tin Ham
Cheng Wing Chung Cyrus
Cheung Anthony Kim Him
Cheung Chi Yuen
Cheung Ho Ming James
Cheung Jonathan Yan Man
Cheung Ming Lee
Cheung Tsz Lo
Chow Kai Pong Jacky
Choy Jonathan
Chua Jinghui Bryan
Chuk Chi Hey Brian
Chung Ho Chun
Fok Ka Man
Fong Chun Wah
Fong Pak Yui
Hizaslan Zeki Berkant
Huang Jiaxin
Ip Man Huen
Kwok Jane
Kwok Sai Pui
Kwong Wai Ying
Lam Ching On
Lau Chun Yin
Law Yee Kiu Stefanie
Lee Sharen
Leung Ka Kit
Leung King Chun
Li Lok Yin
Lo Tsz Wang Aaron
Luk Tung Wing
Ma Justin Ming Zheng
Mok Tsz Tsun
Ng Ho Fung Mathew
Pun Ka Yee
Shum Chung Pan
Siu Pak Ying Pansy
To Tsz Him
Tsoi Hin Yao Tobias
Wang Jessica Jing-Ying
Wong Cheuk Yin
Wong Hiu Lam
Wong Kar Shing
Wong Pak Laan
Woo Wai Yue Catherine
Yu Jeffrey Hong Cheung
Yu Man Wai Cecilia
Yu Yan Yiu

Report on Career Talk

Dr Tin Yau CHAN
Member
Young Fellows and Trainees Committee

Opening speech by our College President, Prof. Daniel TM Chan

The Young Fellows and Trainees Committee Career Talk was successfully held on 8th June 2024 at Queen Elizabeth Hospital. We aimed to share with our fresh graduates their upcoming medical training, especially to those who were interested in choosing Internal Medicine as their lifelong career.

The half-day Career Talk started with an inspiring speech by Professor Daniel TM CHAN, sharing his passion and dedication to his career, together with the challenges and rapid advancement in the field of Nephrology.

After Professor Chan's welcoming speech, members of the Young Fellows and Trainees Committee introduced the structure of the Hong Kong College of Physicians and its subspecialties, outlining the training pathway from Basic Physician Training (BPT) to Higher Physician Training (HPT) and the examination requirements.

The committee members also shared their lives as a physician, including the joyful and tearful moments throughout their training years, daily routines as a medical officer, the excitement of handling clinical emergencies, and the eye-opening experience of overseas training.

To better equip our doctors-to-be for the residency in their desired training units, tips and tricks on CV writing and interview techniques were also covered in the half-day programme.

Internship is known to be a fruitful but tough period. Apart from coping with the heavy workload and on-call duties, workplace learning from peers and seniors are equally important. The session on "How to make your internship more rewarding and educational?" was included to prepare the audience on how to maximise the learning potential in their internship.

Towards the end of the programme, doctors from various subspecialties were invited for small group sharing. We hoped that the young graduates could gain a more thorough understanding on the training, lifestyle and future development of their interested subspecialties through these in-depth discussions.

We would like to take this opportunity to express our gratitude to all the guest doctors who had kindly joined the programme despite their busy schedules. We hope to organise the Career Talk annually to support our new graduates and welcome them to our big family.

Attendees in Career Talk

Follow @YoungPhysicians.HKCP to keep up with our latest news!

@YOUNGPHYSICIANS.HKCP

Professor Dennis LO Yuk-Ming

Dr Jacqueline So and Dr Thomas Chan
Co-Chairmen, Young Fellows and Trainees Committee

A photo of Professor Lo at the Doctor of Philosophy graduation ceremony (Oxford, 1994)

Professor Dennis Lo Yuk-Ming, widely recognized as the "Father of Non-Invasive Prenatal Testing," has made groundbreaking contributions to the field of medicine by pioneering the detection of cell-free fetal DNA in maternal circulation. This innovative technique facilitates the identification of fetal chromosomal abnormalities through non-invasive blood tests, benefiting millions of expectant mothers worldwide. Professor Lo has received numerous prestigious accolades, including the Lasker-DeBakey Clinical Medical Research Award and the Jiménez Díaz Lecture Award. In acknowledgment of his significant contributions to molecular medicine, he has been conferred Honorary Fellowship by our College. The Young Fellows and Trainees Committee was privileged to conduct this interview with Professor Lo in his beautifully appointed office at the Science Park, where he generously shared his invaluable insights and experiences.

His path to becoming a top scientist

Professor Lo grew up in a medical environment; his father, the late Dr. Lo Wai-Hoi, was a psychiatrist who sometimes

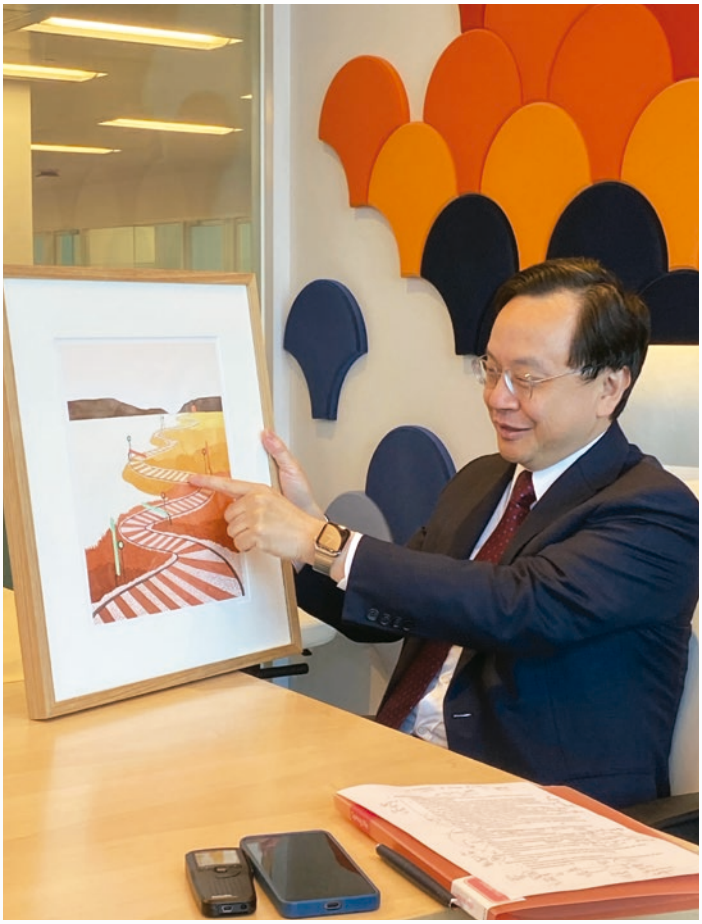
prepared medical presentations at home. Young Dennis assisted by creating transparencies for his father's overseas conferences, igniting his early passion for medicine. During his formative years at St. Joseph's College, he developed a fond interest in scientific books and magazines.

Influenced by his father, Professor Lo chose to pursue a career in medicine after graduating from St. Joseph's College. A pivotal moment came when he encountered the book Biology: A Functional Approach, which featured images of Nobel Prize laureates James Watson and Francis Crick, who co-discovered the double helix structure of DNA. This inspiration led him to study medicine at the University of Cambridge instead of engineering programs at Stanford University. At Cambridge, he was immersed in an academic environment enriched with prominent figures in scientific research, including Nobel Prize winners, which further fueled his aspirations in the field.

After three years at Cambridge, he transitioned to Oxford and Birmingham to complete his clinical training. Professor Lo became captivated by the idea of detecting male fetuses through the presence of the Y chromosome in maternal blood. He attended a lecture by Professor John Bell, a pioneer in PCR techniques, who later taught him the method. Following his housemanship, he embarked on a Doctor of Philosophy degree focusing on this research and completed his MRCP. Despite initial setbacks, after eight years of dedicated research, he ultimately discovered the cell-free DNA detection technique.

Professor Lo shows us his interesting findings on the sizes of DNA fragments from different segments of chromosomes

Professor Lo emphasizes the importance of perseverance and continuous review when faced with failures, acknowledging that serendipity also plays a not insignificant role. He believes that success often comes when the timing and the circumstances are both correct, like the technological advancements in PCR sequencing, genomic research, and research funding support in his case.



Professor Lo shows us one of his recent favourite pictures: railway map mimicking epigenetic checkpoints

His views on leadership

Having worked for 27 years at The Chinese University of Hong Kong (CUHK), including serving as the Associate Dean of the Medical School for over two decades, Professor Lo assumed office as the ninth Vice-Chancellor and President of CUHK on 8 January 2025. He appreciates the merits and values of the unique College-based system at CUHK, and may explore the feasibility of establishing a Graduate College. Drawing from his experience in patenting and entrepreneurship, he hopes to foster and promote a culture of innovation at CUHK. Professor Lo places great emphasis on teamwork, and aims to create a nurturing and supportive platform for members of the university. He would promote the collaborative spirit within CUHK. He says that this collaborative spirit has allowed him to work with many different departments throughout his research career.

When asked about the qualities one should possess to join his team, he highlights three essential attributes: first, the ability to work harmoniously with others; second, strong communication skills; and third, which is also most important, the capacity to think creatively. He shares an illustrative example from their discovery of non-invasive prenatal testing. After developing the initial method, he continued to encourage his students to explore alternative approaches, which resulted in the establishment of a new technique based on sizing rather than merely counting. Today, non-invasive prenatal testing effectively combines both methodologies.

As Vice-Chancellor, Professor Lo aims to balance his administrative responsibilities

Professor Lo with the two interviewers, Dr Jacqueline So and Dr Thomas Chan in his laboratory

with ongoing research in fetal medicine and oncology, while also exploring new avenues in understanding brain damage and neurodegenerative diseases.

Opportunities and challenges in the present era

The research landscape today is markedly different from what it was 30 years ago. With significant technological advancements and increased resources for research development, the environment is also more competitive. He underscores the necessity of multidisciplinary skills in research, including computational and statistical abilities, alongside effective communication and creative thinking.

On the topic of artificial intelligence (AI), Professor Lo anticipates more of its applications in research, noting that his team has recently developed AI tools for identifying epigenetic change from single molecule sequencing data. He encourages younger generations to seize the abundant opportunities available today, despite the heightened competition, and to engage in more research to bring positive impacts on the world.

Time outside work – "Work-Life Balance"

In his leisure time, Professor Lo enjoys traveling, watching movies, and photography, believing that images can convey profound narratives. He shared two drawings with us: one is the cover of a magazine showcasing the scenic beauty of Hong Kong's Victoria Harbour, which also illustrates the genomic locations generating

long and short circulating DNA; the other depicts a railway that mimics the functions of DNA and epigenetics.

Professor Lo's intense passion for research is evident in his perspective that it is not merely a profession but also a fulfilling hobby. Throughout our interview, we were deeply inspired by his enthusiasm, humility and professionalism in his research endeavors.

Concluding remarks

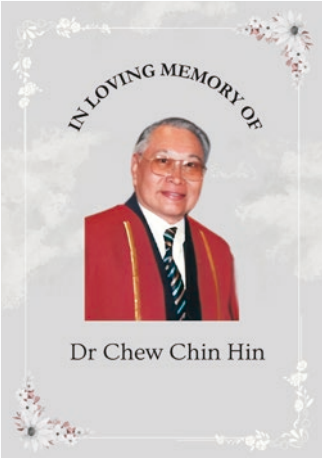
Towards the end of the interview, Professor Lo offers words of encouragement to the younger generation of physicians. He urges them to stay creative and to dedicate themselves to improving the health and well-being of people around the world.*

*Readers please refer to the Instagram post from the Young Fellows and Trainees Committee for the recorded video message.

@YOUNGPHYSICIANS.HKCP

Our College conferred Honorary Fellowship on Professor Lo in October 2024

OBITUARY
Chin Hin CHEW (b. 1931, d. 2024)



Dr Chin Hin Chew, who has died aged 93, was a widely respected clinician scholar and staunch advocate for postgraduate medical education and training, and a long-term friend of the Hong Kong College of Physicians.

Dr CH Chew came from a distinguished family of scholars and academics in Singapore. He studied Medicine at the University of Hong Kong, graduating in 1955, then obtained MRCP(Edin) in 1961. He was Senior Physician and Foundation Head of the Department of Medicine at Tan Tock Seng Hospital in Singapore from 1965 to 1982. In 1980 he became Medical Director of Tan Tock Seng Hospital. In 1982, he was appointed Deputy Director of Medical Services in the Singapore Ministry of Health, a position that he held until 1991. He was conferred Fellowship of the Royal College of Physicians of Edinburgh, Royal College of Physicians and Surgeons of Glasgow, and Royal College of Physicians, London, in 1971, 1973, and 1975, respectively. He was conferred Fellowship of the Royal Australasian College of Physicians in 1976, and Fellowship of the American College of Physicians in 1980. In the 1970s to 1980s, Dr Chew made significant contributions to the management of tuberculosis and respiratory diseases, presenting his work at major international meetings such as the 34th and 38th World Health Assembly in Geneva as Head of Delegation. He was Honorary President of the 26th International Union Against Tuberculosis and Lung Disease World Conference in Singapore in 1986.

Dr Chew ascribed great importance to advancing the standard of postgraduate medical education and training. He was Master of the Singapore Academy of Medicine from 1973 to 1975, Board Member of the Graduate School of Medical Studies from 1974, then Deputy Director and Advisor to the Graduate School of Medical Studies in Singapore from 1998 to 2001. The importance of Dr Chew's contributions to postgraduate medical education was illustrated by the many awards and honours he received. For his dedication to teaching, research and administration, the Government of Singapore awarded Dr Chew the Public Administration Gold Medal on its National Day in 1982. In recognition of his efforts towards fostering closer links and collaborations with the Singapore Academy of Medicine, Dr Chew was presented the Royal Australasian College of Physicians Medal in 1994, being the first individual outside Australia and New Zealand to have received this honour, and the Gold Medal from the Royal College of Physicians of Edinburgh in 2000. Dr Chew was the 1998 SMA Lecturer and received the Gold Medal from the Academy of Medicine, Singapore.

Through his tireless efforts, Dr Chew had succeeded in putting Internal Medicine at Singapore on the regional and global map. He was a member of MRCP(UK) Policy Committee of the three Royal Colleges of Physicians from 1995 to 2001, and Regional Advisor to the Edinburgh College for ten years. He sat on the Asia Pacific Committee of the Royal Australasian College of Physicians as Member and Advisor from 1989 to 2000. Dr Chew had always been very supportive of the Hong Kong College of Physicians. He was conferred Honorary Fellowship of the Hong Kong College of Physicians in 2002. Colleagues would have fond memories of Dr Chew attending many of our Conferment Ceremonies and Annual Dinners.

Professor Daniel T M CHAN
President, Hong Kong College of Physicians

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