



SYNAPSE

Hong Kong College of Physicians

August 2004

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RESTRICTED TO MEMBERS ONLY



Alexandre Yersin and his mat-shed laboratory near the Alice Memorial Hospital, Kennedy Town, Hong Kong

The French (Swiss-born) doctor Alexandre Yersin, trained under Louis Pasteur, came to Hong Kong during the outbreak of plague in 1894. By postmortem, he quickly dissected out a buboe- the swollen lymph node which characterized the plague. When examining under the microscope, he saw "une veritable puree" of organisms, which he subsequently characterised and cultured. Yersin commissioned a mat-shed to be hastily constructed near the Alice Memorial Hospital's extension at Kennedy Town (see photo).

Yersin's accurate description and culture of the plague bacillus has been acknowledged in the taxonomic naming of the bacillus- *Yersinia pestis*.

[Plague, a devastating disease leading to "Black Death" in the 14th Century, caused a severe epidemic in southern China in late 19th Century. Overcrowding and poor sanitation were known associations, but the actual cause of the plague was unknown for centuries. It was in Hong Kong that the opportune time with the unfortunate large outbreak of plague and the practice of western medicine and postmortem examinations led to the discovery of the deadly causative bacteria.]

(Photo and information - courtesy of the Hong Kong Museum of Medical Sciences)

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Editorial

From Yersinia to Corona

Philip K.T. Li
Editor-in-Chief

More than a Century ago in 1894, Plague hit southern China and Hong Kong heavily. There were at one time violent mobs who besieged the Hospital caring for patients of Plague. Doctors needed to carry their pistols while discharging their duties during that time because the public was scared by the disease and its aftermath*. One of the gratifying outcomes was the discovery of the Plague bacteria, later known as *Yersinia Pestis* by Alexandre Yersin in Hong Kong. This was described briefly in the Cover Story of this issue of SYNAPSE. At the suggestion of the Governor Sir Henry Blake, a Bacteriology Institute was built in 1905. Unfortunately, Plague continued to be a problem in Hong Kong for the next 20 years.

Last year, Asia and many parts of the world saw an unprecedented challenge for the medical profession of this generation. SARS hit the world hard with serious sequelae on our Community as well as the profession. Once again it was gratifying that the Coronavirus, the virus causing SARS, was identified by the distinguished microbiologists of Hong Kong, led by an Honorary Fellow of our College.

The Government commissioned an Expert Committee co-chaired by Professor Siân Griffiths, President of the Faculty of Public Health, the Royal College of Physicians, UK as well as Professor Cyril Chantler. The Expert Committee comprised of the world experts on infectious diseases, epidemiology and public health. SYNAPSE is honored to publish a very detailed and elaborate account of what Professor Griffiths, as a leading international expert on Public Health, described how Hong Kong dealt with SARS last year. There were a number of recommendations from the Expert Committee, also summarised in Professor Griffiths's paper, to build up the Hong Kong healthcare arena, including the establishment of the Centre for Health Protection, the building of Isolation facilities, infection control training for all staff as well as strengthening infectious diseases and public health as well as options for clinical training.

Our College was also very proactive in the reorganisation of training for Infectious Disease specialists in conjunctions with the College of Pathologists and College of Community Medicine, preparing them for future outbreaks of infections.

The Bureau of Health, Welfare and Food as well as the Hospital Authority were very responsive to the recommendations of the Expert Committee. Notably, the setting up of Centre for Health Protection, the addition of the Isolation Facilities, the enhancement of the Infection control

training and measures were all in place preparing for the return of infections. Everyone probably agrees that Hong Kong is fortunate enough this year to be spared from attacks of SARS and Avian Flu, while most of the neighboring countries are heavily affected. However, this definitely could not have been achieved without the recommendations from the SARS Expert Committee to be promptly realised through the work of the Bureau, Hospital Authority, Department of Health and the 2 medical schools.

The President's Message in this issue of SYNAPSE aptly gave praise to Dr. EK Yeoh and Dr. CH Leong who have contributed significantly to the medical field throughout their career. However, even more credit should be given to the determination and the work of the 2 leaders of the Bureau and the Hospital Authority respectively in materializing the recommendations of the SARS Expert Committee promptly in less than one year. "It is easy to leave but always difficult to stay!". The noble act of the two distinguished doctors to help to rebuild the system so quickly sows the "seed" so that Hong Kong will not fall into the same problem of Plague a Century ago. [Despite the bacteria *Yersinia* was discovered in Hong Kong in 1894, Plague continued to affect Hong Kong for the next 20 years.] As vividly described by Professor Griffiths, all sectors of Hong Kong should strive hard, "Then if SARS – or another epidemic- reemerges, Hong Kong, on behalf of the rest of the world, will be better prepared to play its crucial role in controlling the epidemic."

Health is such an important aspect of our lives that attracts public concern as well as media and political attention. Inevitably, this places our medical profession under great challenge.

Plague and SARS affected Hong Kong within 2 centuries and they bore a number of similarities and both gave us lots of lessons to learn. The deadly diseases caused by *Yersinia Pestis* and Coronavirus are dreadful enough. It is even more dreadful if societal turmoil is aroused to divide our profession. There should be no distinction and division between Health Administrators and Frontline, Seniors and Juniors, Public and Private, Doctors, Nurses and Supporting Staff. Our integral solidarity with one goal, fighting both communicable and non-communicable diseases selflessly for the benefit of the public, is the mainstay of our Healthcare system for the Society of Hong Kong and this should not be destroyed.

*: Information from Hong Kong Museum of Medical Sciences

Message From The President

In Praise of Our Fallen Heroes

Prof. Richard YH Yu
President
HKCP

The Report of the Select Committee on SARS was published on the 7th July 2004 with far reaching consequences. It has provoked even more controversy than hitherto envisaged.

This was so poignantly illustrated by "HARRY" of the South China Morning Post on the 6th of July 2004; "Senior Administrator Resignation Syndrome" – outbreak contained with only two fatalities – now PLEASE WASH YOUR HANDS!

This indeed must be the saddest and darkest chapter in the history of Hong Kong SAR's medical profession. We have lost two outstanding, and dedicated professionals because of political convenience even beyond accountability. Both Dr EK Yeoh and CH Leong shared a common vision in spite of their different background – a desire to serve the public and community; to improve the health and healthcare of the citizens with selfless dedication and great personal sacrifice. Under their leadership one cannot deny that the healthcare provision with Hospital Authority has improved enormously and modernized as compared with 50s and 60s. EK had revolutionized the healthcare system when he became the first Chief Executive with the establishment of the Hospital Authority. He introduced a culture which is patient-orientated. The standard of Hong Kong's healthcare delivery has become one of the finest in the world and recognized internationally of the highest standard. The recent expansion in rehabilitation and extended care for the elderly is but one of the examples of care provided to the aging population, in addition to achieving the highest professional standard of medical care by implementing new technological methods and concept in treatment in the various specialties – this is in the face of very severe budget constraint and funding.

The report of the Legislative Council Select Committee, while providing a comprehensive and detailed insight into the deficiency of the system – communication between Hospital Authority and the Department of Health, which is a legacy of the old Medical and Health Department, their conclusion was based on circumstances in hindsight rather than knowledge at the time. It must be emphasised that no international medical community including Hong Kong would be able to tackle such a calamitous unknown epidemic of such devastating proportion.

One very obvious omission that had not been taken into consideration was the complete absence of any professional experts to evaluate on medical evidence in the appropriate context such as:

1. The pathogenesis of this "Atypical Pneumonia" was unknown until the coronavirus was identified by Professor Yuen Kwok Yung and his dedicated team.
2. After the confirmation of coronavirus as the cause of the SARS the mode of transmission, epidemiology or pathogenesis was virtually unknown.
3. The uniqueness of "super-spreader" is a novel characteristic which has no precedent.
4. Diarrhoea as a presenting symptom and rapid spread through faeces carrying a large viral load was unknown until the very rapid spread in Amoy Gardens.

Surely these are very relevant facts that must be highlighted and taken into context in the deliberation. The only medical practitioner who claimed to be a specialist in infectious disease on the panel must and should have realised the importance and significance of these facts. Is this omission deliberate or due to incompetence and ignorance? This surely must raise the question on the motive behind the appointment of the Select Committee against the recommendation of the international panel of experts, in particular, Professor Siân Griffith, Professor of Public Health, the Royal College of Physicians, UK.

The Report had been most unfair to the Hospital Authority, the medical profession, to the community and to all those frontline healthcare workers – the nursing staff, from Consultants to all Residents and House Officers who had so bravely and selflessly dedicated their lives and sacrificed so much in the battle against the deadly and devastating virus. The coronavirus had been politicised to enable one to achieve the means to one's political end!

The saga had hopefully ended and what had the Select Committee achieved? Very sadly the cost of two extremely capable and dedicated professionals and a great loss to the community. Is this the best outcome for the healthcare system of the Community? Do we as guardians of the health and well being of the community deserve this abhorrent injustice?

From this debacle we have learnt one bitter lesson – that medicine and politics should and must not be mixed. Whilst medicine is a very noble profession, politics is but a dirty game!

I hope this will provide you all with some food for thought! For those involved it is time for some soul searching.

Special Article

SARS in Hong Kong

Siân Griffiths, OBE, FFPH, FRCP, FRCS, FDS
President, Faculty of Public Health,
Royal Colleges of Physicians of United Kingdom

The story of SARS in Hong Kong reads like a detective novel. It was winter and the authorities in Hong Kong were expecting an outbreak of infectious disease. There were fears about avian flu and a case was confirmed in February. Every winter there are around 2000 cases of pneumonia each month. Was this year going to be different? In early February rumours about cases of a new disease in Guangdong, across the border in Mainland China, were picked up in the clinical community. In mid February the media reported stories of panic buying of white vinegar in Hong Kong from across the border as well as a run on herbal medicine good for boosting the immune response particularly in cases of pneumonia. Following this media alert, the initial attempts by Hong Kong's Director of Health to find out what was going on from the Guangdong authorities elicited no response until the next day when information was made known in a bulletin from Guangdong about an atypical pneumonia which had affected healthcare workers. This was the first formal indication to Hong Kong that they too might have cases – particularly since around 300,000 people cross the border between Hong Kong and southern China everyday and much of the food for Hong Kong's 6.5 million population is produced in Guangdong.

The community was alert but not sure what it was waiting for. The first events to cause concern occurred at the Prince of Wales hospital – the teaching hospital for the Chinese University. On Monday March 10th 11 health care workers reported sick. By that evening 50 were known to be unwell. They had a mixed pattern of clinical symptoms including fever and cough with changes on the chest Xrays. The causative agent was not known. Worryingly, the disease continued to spread to healthcare workers, their families and contacts.

Within a few days the index case was identified as a patient admitted with atypical pneumonia to ward 8A of the Prince of Wales Hospital, the teaching hospital for the Chinese University. Contact tracing showed that medical students and other clinical staff who had examined and cared for this patient were more likely to have become infected- particularly after he had been put on nebuliser treatment. In addition some of his relatives were also admitted later that week. In all 143 individuals were found to have become infected through contact with this patient, including 50 healthcare workers and 17 medical students.

In tracing back to where the index case had acquired the infection a link with hotel Metropole in Kowloon was discovered.

Hotel Metropole was where a Professor visiting from Guangdong was staying before he was admitted into the infectious diseases hospital on Feb 22. Piecing the story together through the surveillance system the DH were able to identify Hotel Metropole as the source of the spread not only through Hong Kong but also internationally, providing a link to Singapore, Canada, Vietnam and Taiwan.

The epidemic at the PWH spread into the community despite best efforts to control spread of infection. One of the patients to become infected was linked to the outbreak on the Amoy gardens estate.

On the 26th of March the DH were notified about 15 suspected cases of SARS from 7 households from the Amoy gardens admitted with respiratory symptoms to the nearby United Christian hospital. A new pattern of disease was emerging – many of the cases also had watery diarrhoea. The public health team went into action – contact tracing and instituting environmental control measures. The public were briefed to be vigilant using the media who are very active in HK and also through local residents associations and health care staff. By now most people were wearing masks and the community was very scared.

By the 30th of March it was obvious that this was a major epidemic of potentially devastating scale. On the 31st the residents of Block E – the most affected block – were put into isolation by quarantining their block. When new information about a potential environmental source was made known to government that same evening, the decision was made to move the residents to a holiday camp. At 6 am on April 1st all residents were asked to pack a few things and to move. To everyone's credit this move went smoothly, 247 residents were evacuated and it was arguably this step which contained the epidemic. Within the next few days the majority of residents who had already left the building were also traced.

The distribution of cases between the blocks showed

that the infection was contained in one part of the estate – with 49% of the cases in Block E. Environmental disinfection of public areas and measures to contain environmental spread were under the control of a cross government group who had far reaching powers to ensure that all that needed to be done could be done. Schools were closed, public places disinfected, contacts traced and the public advised to wear masks and to take note of basic personal hygiene practice. The old adage coughs and sneezes spread diseases needed to be taken seriously. The evacuation of the residents contributed to the control of the epidemic, and the number of daily cases began to drop.

But why Amoy gardens? The source of infection can be traced back to a patient who lived in Shenzhen across the border in Guangdong but was having renal dialysis at the PWH. He had stayed with his brother overnight on March 4 – and had been admitted during dialysis treatment with a chest infection. He responded to treatment, was afebrile and his chest x-ray was clear so he was discharged. He stayed with his brother again on March 21, and when he attended for dialysis on March 22 was readmitted, this time with SARS.

His brother lived in block E, where the majority of cases also lived. One of the patient's symptoms was watery diarrhoea. Subsequently it was found that 73% of cases from Amoy gardens had watery diarrhoea as reported in the Lancet: diarrhoea seemed more prominent than previously reported and the severe watery diarrhoea in these patients presented a challenge to healthcare workers for infection control.

But why were so many people affected? Factors thought to have contributed to the epidemic include

- Dried up U traps- underfloor water traps, filled through a grid, normally providing a seal between the bathroom and the soil stack
- A break in the flush water pipe serving all Unit 8 of Block E, which led to the flushwater system being shut down overnight – this could have decreased the flow and increased movement of droplets in the soil stack contributing to spread
- Exhaust fan causing droplet spread.

Hypotheses are still being developed. There has even been speculation about rats and cockroaches, as yet unfounded, as well as many questions about building design. Meanwhile the government has increased its efforts to promote environmental hygiene as well as personal hygiene.

The final phase of the SARS epidemic produced yet another problem – atypical presentation. The typical presentation of SARS is of fever, respiratory symptoms, and chest Xray changes of pneumonia. However, a proportion are 'cryptic' cases presenting in other ways and not all with fever. This is particularly common in older patients who have co-morbidities and in immuno-compromised patients. The symptoms may well be masked by treatment for another disease. This raised particular issues for the care of the elderly particularly those in institutions. Special efforts were made to provide support and advice to elderly care homes which in many instances in Hong Kong are part of other high rise buildings.

By the beginning of May numbers of daily cases had dropped to below 10, and by mid May to under 5 a day.

The travel advisory ban was lifted by the WHO on May 23 and all restrictions lifted on June 23. The epidemic had claimed 300 lives and affected 1755 people. 20% of the cases were in health care workers, and 20% amongst elderly patients. 63% of the deaths were amongst these older people.

What did our report point out?

Firstly we expressed our sympathies for those who had died. We expressed our admiration for the healthcare workers and others who continued to treat patients and tackle the disease putting themselves at risk. Many of the things they did were exemplary – not least the development of a system wide information system, eSARS, which allowed contact tracing utilising the police database, the identification of the atypical coronavirus by March 23, the successful evacuation of Block E of Amoy gardens.

But there are many lessons to be learnt. Our main objective was to analyse what took place – taking care to do this from the perspective of what was known at the time that events were unfolding. Our report highlights the failings we found in the healthcare system, particularly those at the beginning of the epidemic. For instance, if there had been better communication between Guangdong and Hong Kong about infectious diseases then Hong Kong would have been alerted earlier. If there had been better infection control measures and outbreak control planning then the disease might not have spread so quickly in the beginning. If there had been better mechanisms for communication then the confusion and accusations about active suppression of information by government would have been avoided. If there had been a more comprehensive epidemiological study of Amoy gardens then the understanding of the disease would

have been enhanced. Better collaboration across all elements of the healthcare system – with private GPs, community clinics and old people's homes – would have enhanced surveillance.

But all this needs to be put against a background of a very impressive response by the whole community in Hong Kong and the expert committee remains impressed by the speed with which initial lessons were learnt and the response to the epidemic improved.

Overall, we concluded that there had been problems in the handling of the outbreak and we made a series of 46 recommendations which if implemented would, we believe, make a difference to handling of a future epidemic. These recommendations can be grouped under 3 main headings:

- **Organisation and structure**-particularly of the healthcare system and its health protection functions
- **Collaboration, coordination and communication**- Particularly the need to work across the Pearl River Delta since infectious disease does not respect international boundaries. Another major recommendation concerns relationships with the media. The confrontational approach of the beginning of the epidemic did nothing to enhance public confidence and better media relations and reporting especially around risk would be beneficial.
- **Management of epidemics**- including training, clinical practice, research, surveillance and surge capacity. Under this section we made proposals for more emphasis on infection control training for all staff as well as strengthening infectious diseases and public health as options for clinical training. We proposed a cadre of epidemiologists who would work across all sectors – hospital, community, university, department of health – who would break down some of the silo thinking which got in the way of handling the SARS epidemic. Future epidemics would benefit from a response which reflected population based analysis, thereby avoiding the false categorisation of a hospital or a community case.

We were also particularly concerned about the longer term effects of SARS not only on those who had had the disease but on the community as a whole. One of the features of the epidemic had been the discrimination by some against those who had the disease, or who were in contact with it. This was demonstrated by some people losing their jobs because they became infected. We recommended further research and also active support through a contingency fund.

All our recommendations were accepted by the government. However, the press did not give our report a very warm reception. The headline from the South China Morning Post- was "Sars panel finds fault but not blame". For a variety of reasons – including debate about Article 23, the unpopularity of the government, the widespread belief that someone must be to blame. This was reflected by the President of the Medical Association who also chairs the legislative councils health committee who was quoted as saying: 'the report has failed to fully address the issue of political accountability and government responsibility'. He has gone on to lead the establishment of a further committee to establish blame. As authors of the report we disagree with him.

Whilst the select committee process is still ongoing, our view remains that no individual was to blame, that Hong Kong responded well to SARS overall and that the most important thing is to get on with establishing the Centre for Health Protection and other recommendations. Then if SARS – or another epidemic- reemerges, Hong Kong, on behalf of the rest of the world, will be better prepared to play its crucial role in controlling the epidemic. The steps taken by the time of the first Monitoring Committee visit in October suggest good progress is being made. The threat of Avian flu highlights for us all the need for preparedness, vigilance and forward thinking to protect the health of the public rather than retrospective blame.

Further information can be found on: www.sars-expertcom.gov.hk

Council News

Invitation to the HKCP Fellowship Conferment Ceremony & College Dinner

The Council agreed that all new Fellows who attend the Fellowship Conferment ceremony on the 23 October 2004 will be entitled to bring a guest to the Annual College dinner free of charge.

Trainees to attend the Joint Scientific Meeting, 23-24 October 2004

The Council decided that all Basic and Higher Physician trainees are mandatory to attend the Joint Scientific Meeting at least once every two years. Their registration will be waived.

The forthcoming Joint Scientific Meeting organised by our College and the Hong Kong College of Paediatricians will be held on 23-24 October 2004. The theme of this year's meeting is "Novel Treatment of Common Medical Disorders".

Newly Elected Fellows of Royal Colleges of Physicians of London and Edinburgh

Congratulations to all our HKCP Fellows who have been successfully elected as Fellows of the RCP(London) and RCP(Edinburgh).

FRCP (London)

Elected 17 March 2004

Members of the College

Prof Chan, Anthony Tak Cheung

Dr Chan, Ming Houng

Dr Chu, Chung Ming

Dr Siu, Shing Chung

Dr Chan, Chi Kuen

Dr Ching, Gordon Wai Kit

Dr Liu, Lit Chung

Dr Tong, Peter Chun Yip

Dr Chan, Francis Ka Leung

Dr Choa, Brian Hormus George

Dr Ng, Shi Hon

Fellows of other College of Physicians

Prof Yuen, Kwok Yung

FRCP (Edinburgh)

Elected 25th July 2003

MRCP Holders

Dr Chan, Hamish Chi Kin

Dr Lo, Raymond See Kit

Dr Leung, Vincent King Sun

Dr Fung, Wing Hong

Dr Yee, Yuk Kei

Dr Chan, Lik Yuen

Non-MRCP Holders

Prof Yuen, Kwok Yung

Elected 22 October 2003

MRCP Holders

Dr Au, George Tak-Jor

Dr Kwan, Tze Hoi

Dr Mo, Stephen Ka Leung

Dr Tsui, Kin Lam

Dr Leung, Jenny Yin Yan

Dr Lei, Kenny Ieng Kit

Dr Lee, Gavin Ka Wing

Dr Yu, Peter Ho Chiu

Dr Wong, Francis Kim Ming

Dr Ho, Kelvin Kai Leung

Dr Chan, Kin Wah

Dr Lui, Sing Leung

Dr Szeto, Cheuk Chun

Dr Lau, Chor Chiu

Dr Chan, Kwok Keung

Dr Choi, Kin Lam

Dr Cheung, Man Tat

Dr Mok, Chi Chiu

Dr Yu, Teresa Kim Kam

Non-MRCP Holders

Prof Yuen, Kwok Yung

Elected 16th April 2004

MRCP Holders

Dr Lo, Albert Chi Yuen

Dr Chan, Frederich Kwok Wing

Dr Chan, Johnny Wai Man

Dr Yeung, Jonas Hon Ming

Dr Ho, Duncan Hung Kwong

Dr Wong, Chak Yen

Dr Li, June Kam Yin

Dr Choi, Cheung Hei

Dr Lam, Kam Wah

Dr Yiu, Siu Fung

Dr Tse, Samuel Lap Shing

Dr Shea, Paul Tat Ming

Non MRCP holder

Dr Cheng, Fanny Fan

Examinations and Results

Timetable for the MRCP(UK) examinations in 2005

MRCP(UK) Part I examinations: 25 January 2005, Tuesday
20 September 2005, Tuesday

MRCP(UK) Part II (Written) examinations: 13 April 2005, Wednesday
27 July 2005, Wednesday
7 December 2005, Wednesday

MRCP(UK) Part II Clinical PACES examinations: 7-11 March 2005

Revised Format of the Joint HKCPIE/MRCP (UK) Part II (Written) Examination

From July 2004 onwards, the format of the captioned examination will be changed from the current two 2½ hour papers to two 3 hour papers (paper 1: 1200–1500 hr, paper 2: 1600–1900 hr).

Pass list of the March PACES 2004

AU Ka Fai	SHAN Hok Shing Edwin	LAM Chi Kwan
CHAN Hau Ngai	WONG Fung Ping	LAU Kwan Hang Thomas
CHAN Man Hong	WONG Sze Man	LEUNG Wai Hung
CHEN Pui Man Cynthia	WU Hiu Lam Helen	LEUNG Yuk Wah
CHEUNG Wing Wai Winnie	YEUNG Wai Tak Alwin	LUI Chung Yan Grace
CHU Man Yee	YU Chin Wing	MA Kai Yiu
LAI Hin	YUEN Ka Yan Catherine	NG Wing Yiu
LAU Chi Pan	CHAN Chin Pang	Wong Chi Yuen
LAU Siu Ngai	CHAN Kit	WONG Lai Hung
LEUNG Wai Shing	CHAN Yui Kin Jonathan	WONG Wai Tat
LI Siu Ting Reggie	CHEUNG Ka Yin	YAU Zi May Susan
MA Hon Sum	CHOW Kai Lai	YIU Kai Hang
NG Wan Sze Vanessa	CHU Ngan Hung	YU Hing Wai

Training

Principles & Guidelines on Continuing Medical Education

Prof KN Lai

Chairman

Board of CME/CPD

May 2004

1 Objective

The purpose of CME/CPD is to enable Fellows to remain informed and up-to-date on current medical advances, and to maintain a high standard of practice in Internal Medicine through continuous professional development.

2 Supervision

2.1 The CME/CPD programme will seek and receive formal approval from the Education Committee of the Hong Kong Academy of Medicine (HKAM) before implementation.

2.2 Any changes to the CME/CPD programme will also be approved by the Academy Education Committee before implementation.

2.3 All Fellows of the College who are also Fellows of the HKAM must satisfy the full requirements of the CME programme by the end of each Cycle.

2.4 The College will ensure compliance with CME/CPD requirements. Non-compliance will be recorded and reported to the Academy Education Committee. This Committee has been empowered to recommend to HKAM Council the suspension of delinquent Fellows, unless it is satisfied that there are mitigating circumstances, and that deficiencies can be remedied within an acceptable time.

2.5 All operations related to CME/CPD issues will be undertaken by a Board of Continuing Medical Education.

3 The Cycle

3.1 A Cycle of CME/CPD assessment shall span three years.

3.2 The first Cycle commences at a date determined by the Hong Kong College of Physicians (HKCP) for current Fellows, and within 6 months of HKAM admission for new Fellows after the implementation of CME/CPD. The date of commencement will be recorded for each Fellow.

4 Measurement of activities

One Point of CME/CPD activity is normally equivalent to one hour of audience participation in a Formal College-

Approved Postgraduate Meeting (FCAPM) as specified under Section 5.2a).

5 Accreditable CME activities

5.1 Self-study

a) Self-study is accepted as a form of CME/CPD.

b) Self-study is only accredited subject to prior approval from the College, with evidence that it has been carried out diligently.

c) Certain self-assessment programmes designed for physicians are endorsed by HKCP for Self-study. A list of accredited programmes are maintained by the Board of CME/CPD, and will be updated from time to time (Appendix I). CME/CPD Points equivalent to the credits/credit-hours defined by the organising institution will be awarded on completion of each programme.

Fellows may subscribe to such programmes on an individual basis, and submit to the Board of CME/CPD documentary evidence of participation. Instructions relating to subscription will be provided by the College. Subscription to College-approved self-assessment programmes via Internet may also be accredited upon submission of evidence of participation.

Programmes from organisations not on the College-approved list should be individually submitted to the Board of CME/CPD for approval.

d) Journal reading from a College-approved list is an acceptable form of Self-study. Documentation of journal reading is required. A maximum of 45 CME/CPD Points in each three-year cycle may be accredited.

e) Self-study may be accredited a maximum of 75 CME/CPD Points per three-year.

5.2 Passive Participation

a) One CME/CPD Point is awarded for each hour of audience participation in a FCAPM, up to a maximum of eight CME/CPD Points per day.

b) Participation in international postgraduate

meetings may be retrospectively accredited upon submission of proof of attendance.

- c) Local subspecialty societies/associations must seek from the Board of CME/CPD prior accreditation for each meeting, and supply a summary of contents and speaker (with brief curriculum vitae). Criteria to accredit such meetings will be determined by the Board of CME/CPD

Public and private hospitals organizing postgraduate meetings, Journal Clubs, case presentation with literature reviews, and postgraduate seminars, must obtain prior approval from the Board of CME for accreditation.

- d) Postgraduate meetings organised by other Academy Colleges and their subspecialty societies/association may also be accredited by the College, if prior approval is sought and received in writing. CME/CPD Points equivalent to physician-organised activities may be awarded to Physician Fellows for attendance at such meetings.
- e) Proof of attendance must be provided.
- f) Passive Participation as defined above may be accredited a maximum of 75 Points per three-year cycle.

5.3 Active Participation

- a) Active Participation includes chairing or presenting in a FCAPM.
- b) Active participation as speaker may be awarded a maximum of two CME/CPD Points per presentation. Active participation as Chairman may be awarded a maximum of two CME/CPD Points per session.
- c) Active Participation may be accredited a maximum of 75 Points per three-year Cycle.

5.4 Publications

- a) A maximum of four CME/CPD Points may be awarded to the chief author, and two Points for secondary authorship of each Publication in non-indexed international journals, journals published by constituent Colleges of HKAM, or other College-approved local journals.
- b) A maximum of six CME/CPD Points may be awarded to the chief author, and three Points for secondary authorship of each Publication in journals published by HKAM and indexed international journals.

- c) A maximum of 10 CME/CPD Points may be awarded to the chief author, and 5 Points for secondary authorship of each chapter or section of a medical textbook.
- d) A maximum of 10 CME/CPD Points may be awarded to the author of a thesis or treatise.
- e) Publications may be accredited a maximum of 45 CME/CPD Points per three-year Cycle.

5.5 Quality Assurance

- a) Quality Assurance activity in itself will not be awarded.
- b) A maximum of five CME/CPD Points may be awarded to each author for the production of each College-approved Quality Assurance Report.
- c) Quality Assurance Reports may be accredited a maximum of 30 Points per three-year cycle.

6 Exclusions

Participation in the following activities will not be awarded CME Points.

Acting as Examiner in College Examinations
 Research
 Research Grant Application
 Development of New Technologies
 Undergraduate Teaching
 Postgraduate Teaching other than those listed under Sections 5.2 and 5.3.
 Attending seminars or lectures in the enrollment of a postgraduate diploma or degree course.

7 Minimum CME/CPD Requirement

- 7.1 The minimum CME/CPD requirement is 90 Points in each three-year Cycle.
- 7.2 The minimum annual CME/CPD requirement is 10 Points.

8 Certification

The Board of CME/CPD will certify completion of CME/CPD requirements for Physician Fellows at the end of each Cycle.

9 CME/CPD Registry

The Board of CME/CPD will maintain a Register of Physician Fellows who have been awarded certification under Section 8.

Self-Assessment Programmes for Continuing Medical Education (CME)

1 Royal Australasian College of Physicians – Maintenance of Professional Standards Program (MOPS)

RACP – Australia
 Associate Professor Neil Paget
 Director of Education
 RACP
 145 Macquarie Street
 Sydney NSW 2000
 Phone 02 9256 5490
 Fax 02 9252 3310
 Email paget@medeserv.vom.au

RACP – New Zealand
 Dr Peter Holst
 Director of Continuing Education
 5th Floor, St John House
 99 The Terrace
 Wellington NZ
 04 472 6713
 04 472 6718
 Email p.hoist@racp.org.nz

2 American College of Physicians

R0980
 MKSAP
 American College of Physicians
 PO Box 7777
 Philadelphia, PA 19106-0980
 Tel 800-523-2546 ext 2600

American College of Physicians
 Annals of Internal Medicine
 6th Street at Race, Independence Mall West
 Philadelphia, PA 19106
 Customer Service Telephone 800-523-1546 ext 2600
 Internet: <http://www.acponline.org/index.html>

American Society of Clinical Oncology
 Journal of Clinical Oncology
 435 North Michigan Ave, Suite 1717
 Chicago, IL 60611-4067
 Tel 312-644-0828 Fax 312-644-8557

American College of Chest Physicians
 Chest
 300 Dundee Road, Northbrook IL 60062
 Tel 847-498-1400 Fax 947-498-5460

American Society of Hematology
 Blood
 1200, 19th Street, N.W., Suite 300
 Washington, DC 20036-2422
 Tel 202-857-1118 Fax 612-623-3504

American College of Gastroenterology
 American Journal of Gastroenterology
 4900 B South 31st Street
 Arlington, Virginia 22206-1656
 Tel 703-820-7400 Fax 703-931-4520

American Academy of Neurology
 Neurology
 2221 University Avenue SE
 Suite 335 Minneapolis MN 55414
 Tel 612-623-8115 Fax 612-623-3504

American College of Cardiology
 Journal of the American College of Cardiology
 9111 Old Georgetown Road, Maryland 20814
 Tel 301-897-5400 Fax 301-897-9745

Scientific American Medicine
 415 Madison Avenue
 New York, NY 10017
 Tel 212-754-0550

American College of Rheumatology
 Arthritis & Rheumatism
 60 Executive Park South
 Atlanta, GA 30329
 Tel 404-633-3777 Fax 404-633-1870

American Academy of Allergy Asthma and Immunology
 Journal of Allergy and Clinical Immunology
 611 East Wells Street
 Milwaukee, WI 53202
 Tel 414-272-6071 Fax 414-276-3344

American Society of Nephrology
 Journal of the American Society of Nephrology
 American Society of Nephrology National Office
 1200 19th Street, N.W.
 Suite 300
 Washington DC 20036-2422
 Tel 202-857-1190 Fax 202-223-4579

The Endocrine Society
 The Journal of Clinical Endocrinology and Metabolism
 4350 East West Highway, Ste 500
 Bethesda Maryland 20814—4410
 Tel 301-941-0246 Fax 301-941-0259

3 Internet

- 3.1 All CME programmes which are accredited by the Accreditation Council of Continuing Medical Education (ACCME) and/or American Medical Association (AMA) will be recognized. **One CME Point** will be awarded for every accredited hour of participation.

Evidence of participation to be submitted to the Board of CME, when required should include the name of the College/University/Organisation offering the programme and its website, a CME certification or print-out proof of completion of the programme in question.

- 3.2 Internet CME sites

The MedConnect

Site: <http://www.medconnect.com>

It offers a CME program in Emergency Medicine which is jointly sponsored by American College of Emergency Physicians. It carries a charge of US\$95 + 6% NJ Sales tax for 12 monthly issues and up to 12 CME are accredited.

Medscape

Site: <http://www.medscape.com>

The CME curricula is on the impact of Health Outcomes on clinical practice: focus on infectious diseases.

American Heart Association

Site: <http://www.amhrt.org>

The current CME topic is on the implications of the Treatment of Mild Hypertension study (TOMHS).

A later topic will be a Guide for Reducing Cardiovascular Risk.

Marshall University School of Medicine

Site: <http://www.musom.marshall.edu/cme.htm>

This offers an interactive patient encounter counter.

Ohio Heart Failure project

Site: <http://cme-1.ohio-state/prs/ohfpcme.htm>

This CME activity is produced in accordance with the Ohio State Medical Association's Essentials and Standards.

Medical Education Internet Sites – <http://www.med.ucalgary.ca>

CME Web – <http://www/cmeweb.com>

Updated Training Guidelines

PALLIATIVE MEDICINE

(I) OBJECTIVES

- 1 To provide a broad-based training and in-depth experience at level sufficient for the trainee to acquire competency as specialist in Palliative Medicine, so as to be able
 - 1.1 To provide consultative and advisory service to physicians and surgeons in general hospitals regarding the modalities of palliative care service available and the appropriateness of referral.
 - 1.2 To provide palliative care service in hospice units, clinics, day hospices and the patients' homes.
- 2 To inculcate and enhance critical thinking, self-learning and commitment to continuing medical education in Palliative Medicine.
- 3 To lay the groundwork for future in-depth commitment to scientific research in Palliative Medicine.
- 4 To develop a sense of responsibility and leadership in the development of the hospice movement.
- 5 To become a fit teacher of Palliative Medicine to future trainees.

(II) STRUCTURE

This consists of a 3-year single accreditation programme, and should include

- 1 A minimum of two years' training in Palliative Medicine under the supervision of a trainer in Palliative Medicine recognised by the Hong Kong College of Physicians.
- 2 One of the three years' training should be in acute Internal Medicine, in which trainees are advised to rotate to medical subspecialties relevant to the specialty in Palliative Medicine for a maximum of three months each, in particular Gastroenterology & Hepatology, Haematology and Haematological Oncology, Medical Oncology and Respiratory Medicine.

(III) CONTENTS

(A) Knowledge

- 1 Pharmacology of drugs commonly used for the control of symptoms.
- 2 Methods of assessment, diagnosis and management of various symptom complexes, so as to develop appropriate management strategies taking into consideration the personal priorities of the patient, and to recognise the limits of attainable symptom control.
- 3 Management of common emergencies encountered in palliative care.
- 4 Understanding of the roles of palliative surgery, radiotherapy as well as anaesthetic techniques in the practice of Palliative Medicine.
- 5 Psychological response of the patients and their families to the terminal illness.
- 6 Effects of religious beliefs and cultural influences.
- 7 Ethical issues related to palliative care, including the patient's rights to the highest standard of care, autonomy, respect for life, advance directive and euthanasia.
- 8 A thorough understanding of the controlled drug procedures.

(B) Skills

- 1 Communication skills with respect to the patient, family and other health care professionals, regarding information transfer and therapeutic strategy development, and for purposes of support in crisis.
- 2 Ability to resolve major family problems in relation to dying patients.
- 3 Ability to work in a multi-disciplinary team, acting as the team's focus and referral to other professionals and support groups when necessary.
- 4 Bereavement counselling.

(C) Attitudes

- 1 To recognise that all days of human life are deserving of dignity, meaning and concern.
- 2 To recognise that when cure is not possible, active total care of the patient and the family is central to patient management, and quality of life is more important than quantity.
- 3 To respect and observe the privacy and confidentiality of patients.
- 4 To recognise the patient's autonomy, cost-effectiveness, indications, contra-indications and potential complications of drug therapies and various procedures in the consideration of patient care.
- 5 To be empathetic and develop good rapport with the patients and their families.

(IV) INSTITUTIONAL REQUIREMENTS

- 1 Presence of a trainer who possesses specialist accreditation in Palliative Medicine recognised by the Hong Kong College of Physicians, with a trainer to trainee ratio of at least not less than 1:2 at any one time.
- 2 Sufficient numbers of regular referrals of patients with incurable cancers.
- 3 Presence of a multidisciplinary team comprising medical and allied health professionals, in particular psychologists/counselors from religious sectors/specially trained social workers, to assist the trainer in the training of junior doctors in communication skills and family and bereavement care.
- 4 Presence of either home care, day care or out-patient clinic facilities in addition to in-patient facilities.
- 5 Designated time for regular academic activities and evaluation.
- 6 Presence of regular interdisciplinary activities including clinical meetings and care conferences.
- 7 Adequate educational facilities including library and audio-visual facilities.
- 8 Maintenance of adequate and high quality medical records with easy and prompt accessibility.

REHABILITATION

(I) OBJECTIVES

- 1 Rehabilitation
 - 1.1 To provide training experience in the principles and practice of rehabilitation.
 - 1.2 To develop clinical skills in the assessment and management of patients with impairment, disability and handicap.
 - 1.3 To provide practical experience in the establishment and co-ordination of various programme streams of rehabilitation.
 - 1.4 To develop competence and perspectives in fostering close working relationship with allied health and nursing professionals to deliver effective rehabilitation service using team approach.
 - 1.5 To enhance skills in the organisation and management of multidisciplinary teams.
 - 1.6 To promote interest in research and understanding of the literature in rehabilitation.
- 2 Modular training in rehabilitation of other related Specialties (e.g. cardiac, pulmonary, geriatric, neurological, musculoskeletal and etc.)
 - 2.1 To develop competence in the principles and practice of rehabilitation in the respective subspecialties.
 - 2.2 To provide training in the establishment and operation of rehabilitation programmes in the respective specialties.

(II) STRUCTURE

- 1 Path A: Dual Accreditation in Geriatric Medicine and Rehabilitation
 - 1.1 Two years of supervised training in Rehabilitation plus two years of supervised training in Geriatric Medicine.
AND
 - 1.2 Fulfillment of the core training requirements of the two specialties. (Rehabilitation: vide infra Item 5.1; Geriatric Medicine: Re Geriatric Medicine Training Guidelines).

- 2 Path B: Dual Accreditation in Internal Medicine (IM)/other rehabilitation-related specialty and Rehabilitation
- 2.1 Two years of supervised training in Rehabilitation plus two years of supervised training in IM or other rehabilitation-related specialty as approved by the Hong Kong College of Physicians.
AND
- 2.2 Fulfillment of the core training requirements of the two specialties. (Rehabilitation: vide infra Item 5.1; Internal Medicine and other specialties: Re Training Guidelines of respective specialty).
- 3 Path C: Single Accreditation in the specialty of Rehabilitation
- 3.1 One year of supervised training in Acute Internal Medicine/Acute Geriatric Medicine as approved by the Hong Kong College of Physicians.
AND
- 3.2 Fulfillment of the core training requirements of the two specialties. (Rehabilitation: vide infra Item 5.1; Internal Medicine and other specialties: Re Training Guidelines of respective specialty).
- 4 Path D: Modular training in Cardiac Rehabilitation, Pulmonary Rehabilitation, and the Rehabilitation Components of other specialties
- 4.1 Trainees in IM, Geriatric and other medical specialties who do not wish to complete Path A or B towards full accreditation in Rehabilitation may pursue a 6-month modular training in Cardiac or Pulmonary Rehabilitation, or other approved modular rehabilitation programmes, by fulfilling the requirements as listed under Section II Item 7.
- 4.2 The requirements for knowledge and skills for Cardiac Rehabilitation and Pulmonary Rehabilitation Modules are described under Section III(B). Other modular rehabilitation training will be considered by the Subcommittee in Rehabilitation or equivalent body appointed by the College.
- 5 Core Requirements for Specialty Accreditation in Rehabilitation
- 5.1 The two years of core training in Rehabilitation should include the full-time equivalents of supervised training in the specialty programmes listed under 5.1.1-5.1.4. The training should take place in rehabilitation settings which provide demonstrable exposure to multidisciplinary or interdisciplinary functioning in the performance of patient assessment and management, discharge planning, and active psychosocial care processes in in-patient, out-patient, out-reach settings and community rehabilitation.
- 5.1.1 Neurorehabilitation training, including (3 or 6 months)
Stroke
Non-stroke brain injuries
Neurodegenerative disorder
Neuromuscular conditions
- 5.1.2 Cardiac and/or Pulmonary Rehabilitation (3 or 6 months)
- 5.1.3 Geriatric Rehabilitation (6 months)
- 5.1.4 Musculoskeletal and Spinal Rehabilitation, which may (6 months)
include
Arthritic conditions
Chronic musculoskeletal pain
Soft tissue disorders
- 6 Elective: Either one of the following is acceptable (3 months)
Rehabilitation as listed under 5.2.1-5.2.4
Rehabilitation after fracture and joint replacement
Rehabilitation after amputation
Rehabilitation after spinal injury
Rehabilitation after nerve injury
Rehabilitation treatment of pathological conditions, related to lifestyle, exercise, recreation and stress.
- 7 Core requirements for Modular training in Cardiac Rehabilitation, Pulmonary Rehabilitation, and the Rehabilitation Components of other specialties
- 7.1 Six months of full-time equivalent of supervised training in organised rehabilitation programmes of the respective specialties.
AND
- 7.2 Demonstrable exposure to multidisciplinary/interdisciplinary functioning in the performance of assessment, management, discharge planning, and active psychosocial care processes.

- 7.3 Trainees who have already completed modular training in any of the above specialties may obtain full Rehabilitation Medicine accreditation after fulfilling the other 18 months' training requirements as listed under Section II Item 5.1.

(III) CONTENTS

- (A) General Knowledge and Skills in Medical Rehabilitation
- 1 Understanding of impairment, disability and handicap levels in the comprehensive assessment of physical, cognitive and psychological aspects of rehabilitation.
 - 2 Understanding of the application of appropriate tools in assessing functions, disability, and outcome for a broad range of impairment groups.
 - 3 Skills in planning a multidisciplinary / interdisciplinary rehabilitation programme, and mediating constructive exchange of multidisciplinary clinical perspectives.
 - 4 Knowledge and understanding of the allied health disciplines to effectively integrate their contributions into the process of rehabilitation.
 - 5 Skills in liaising with community care providers to meet the psychosocial needs of disabled persons, and to formulate effective pre-discharge planning.
 - 6 Understanding and application of concepts of community re-integration including occupational and vocational rehabilitation needs.
 - 7 Understanding of the behavioral and social sciences as they relate to rehabilitation and carer dynamics, psychopathology, motivation and learning in relation to adjustment, and compensation for lost or impaired mental and social abilities associated with physical disabilities.
 - 8 Knowledge and skills in the prescription of therapeutic exercises in neurological and musculoskeletal disabilities, and understanding of the concept of aerobic exercise and its relationship to management of chronic heart, lung, kidney diseases, diabetes mellitus and obesity.
 - 9 Knowledge of the prescription of, and indications and contraindications for, the use of adaptive devices and training required for their use.
 - 10 Knowledge of the prescription of, and indications and contraindications for prosthetic and orthotic devices, together with their biomechanical principles, methods of assessment, follow up and check out procedures.
 - 11 Knowledge of physical modalities employed in the treatment of musculoskeletal disorders including prescription, indications and contraindications of heat and cold therapy, TENS and interferentials.
 - 12 Knowledge and skills in the management of specific rehabilitation problems and complications such as spasticity, swallowing disorder, neurogenic bladder and bowel incontinence.
 - 13 Basic knowledge in neuropsychology as related to the practice of neurorehabilitation.
 - 14 Basic knowledge in the interpretation of special investigations such as electrodiagnosis for neurorehabilitation, videofluoroscopy to detect problems of swallowing, stress test to evaluate of cardiopulmonary fitness, and urodynamic studies to evaluate urinary incontinence.
 - 15 Knowledge of the indications for and skills in the administration of soft tissue injections, intra-articular injections and motor/nerve blocks are encouraged.
 - 16 Knowledge in the pathophysiology of conditions related to lifestyle, exercise, recreation and stress.
 - 17 Other related areas of knowledge and skills
 - 17.1 Knowledge and design of architecture which affects persons with disabilities.
 - 17.2 Rehabilitation engineering principles, which are relevant to clinical rehabilitation, especially mechanical, electrical and hydrodynamic principles.
 - 17.3 Understanding of clinical research designs and programme evaluation, as well as interpretation of scientific data.
 - 17.4 Understanding the concepts of quality assurance and peer review.
- (B) Special Knowledge and Skills in the modules of Cardiac Rehabilitation and Pulmonary Rehabilitation
- 1 Cardiac Rehabilitation
 - 1.1 Knowledge of the set-up and operations of inpatient, outpatient cardiac rehabilitation, as well as the maintenance phase in the community.
 - 1.2 Knowledge of clinical components of cardiac rehabilitation programmes.

- 1.3 Understanding of the concepts of aerobic exercise, activities counselling, behavioral modification as applied to cardiac patients.
 - 1.4 Knowledge and skills in the assessment of suitability for entry into rehabilitation programmes, risk stratification, exercise prescription, and the performance of exercise testing.
 - 1.5 Understanding of outcome evaluation of cardiac rehabilitation programmes.
 - 1.6 Other general rehabilitation knowledge and skills as relevant to the rehabilitation of the cardiac patients.
 - 2 Pulmonary Rehabilitation
 - 2.1 Knowledge and skills in the performance and interpretation of pulmonary function tests and classification of severity for pulmonary patients.
 - 2.2 Knowledge of clinical components of pulmonary rehabilitation programmes and understanding of the various strategies for smoking cessation.
 - 2.3 Knowledge and skills in prescribing exercise, and conducting and interpreting exercise tests for pulmonary patients.
 - 2.4 Knowledge of the prescription and application of long-term oxygen therapy and domiciliary ventilation support devices.
 - 2.5 Understanding of outcome evaluation of pulmonary rehabilitation programmes.
 - 2.6 Other general rehabilitation knowledge and skills as relevant to the rehabilitation of the pulmonary patient.
- (C) Attitudes
- 1 Attitudes acquired during basic physician training should be reinforced.
 - 2 Capacity for self-examination, and ability to realise the expertise and contribution made by other team members including the relatives and friends of the patient.
 - 3 Ability to communicate effectively at all levels with staff members, the patient and family, and medical and surgical colleagues.
 - 4 Ability to view the problems of the disabled as a challenge and with empathic and supportive attitudes.
 - 5 Ability to view specialisation as a continuing process of education and skill enhancement.

(IV) INSTITUTIONAL REQUIREMENTS

- 1 Core Training
 - 1.1 The two years of the core programme (Paths A and B) must provide active inpatient rehabilitation service in a multidisciplinary setting, under direct supervision by accredited trainers.
 - 1.2 Trainers are either Fellows of the College accredited in Rehabilitation, or Fellows accredited in one of the rehabilitation programmes of other specialties under Section II Item 5. The latter are referred to as "Modular Trainers" in both core and modular training programmes. The trainer to trainee ratio should not be less than 1:2 at any one time.
 - 1.3 The Subcommittee in Rehabilitation or its equivalent body shall be responsible to approve trainers for individual programmes. Trainers for the special modules are co-approved by the Subcommittee and co-opted representatives from the respective specialties.
- 2 Treatment and Training Facilities
 - 2.1 There should be adequate treatment areas for physical, occupational and other rehabilitation-related therapies. The design of rehabilitation units should be appropriate to the rehabilitation programmes offered and should be accessible to disabled persons.
 - 2.2 Physical therapy equipment, gait training equipment, equipment for training in activities of daily living and for recreation should be provided.
 - 2.3 For cardiac and pulmonary rehabilitation, appropriate equipment for functional testing should be provided.
 - 2.4 Access to medical library, which contains updated journals and textbooks in Rehabilitation as well as facilities for literature search, is essential.
 - 2.5 Case conferences, in-service training programmes and continuous quality improvement meetings should be part of the regular activities of the training unit.

HONG KONG COLLEGE OF PHYSICIANS
Statistics on Number of Trainees in all Specialties

SPECIALTY	TRAINEES TOTAL (PP/DH/HA)	TRAINEES								
		HONG KONG EAST CLUSTER			HONG KONG WEST CLUSTER					
		PYNEH	RH	TWEH	FYKH	GH	QMH	TWH		
		YEAR			YEAR					
CARDIOLOGY	21	1 2-1 3-1 4	1 2-2 3 4-1	1 2 3 4	1 2 3 4	0 4	1 2 3 4	1 2 3-3 4	1 2 3 4	1 2 3 4
CRITICAL CARE MEDICINE	5	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	0 4	1 2 3 4	1 2 3-1 4	1 2 3 4	1 2 3 4
DERMATOLOGY & VENEREOLOGY	7	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	0 4	1 2 3 4	1 2 3-1 4-1	1 2 3 4	1 2 3 4
ENDOCRINOLOGY, DIABETES & METABOLISM	22	1 2 3-2 4-1	1 2 3-1 4	1-1 2-1 3 4-1	1 2 3 4	2 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4
GASTROENTEROLOGY & HEPATOLOGY	15	1-1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	0 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4
GERIATRIC MEDICINE	26	1 2 3-1 4	1 2 3 4	1 2-1 3-1 4	1 2 3 4	2 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3-1 4
HAEM/HAEM ONCOLOGY	9	1 2-1 3-1 4	1 2 3 4	1 2 3 4	1 2 3 4	0 4	1 2 3 4	1 2-1 3-1 4	1 2 3 4	1 2 3 4
IMMUNOLOGY & ALLERGY	0	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	0 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4

* No. of trainers is shown in italics in right low hand corner of each hospital

SPECIALTY	TRAINEES TOTAL (PP/DH/HA)	TRAINEES								
		HONG KONG EAST CLUSTER			HONG KONG WEST CLUSTER					
		PYNEH	RH	TWEH	FYKH	GH	QMH	TWH		
		YEAR			YEAR					
INFECTIOUS DISEASE	7	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	0 4	1 2 3 4	1 2 3-1 4	1 2 3 4	1 2 3 4
MEDICAL ONCOLOGY	4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	0 4	1 2 3 4	1-1 2-1 3 4	1 2 3 4	1 2 3 4
NEPHROLOGY	14	1 2-1 3-1 4	1 2 3 4	1 2 3 4	1 2 3 4	0 4	1 2 3 4	1 2 3-1 4	1 2 3 4	1 2 3 4
NEUROLOGY	11	1 2 3-1 4	1 2 3 4	1 2 3 4	1 2 3 4	0 4	1 2 3 4	1 2 3-1 4	1 2 3 4	1 2 3 4
PALLIATIVE MEDICINE	2	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	0 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4
REHABILITATION	4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	0 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3-1 4
RESPIRATORY MEDICINE	28	1 2 3-1 4	1 2 3-2 4	1 2 3 4	1 2 3 4	2 4	1 2 3 4	1 2-1 3-1 4	1 2 3-1 4	1 2 3 4
RHEUMATOLOGY	12	1 2 3-1 4-1	1 2 3-1 4	1 2 3 4	1 2 3 4	0 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4

* No. of trainers is shown in italics in right low hand corner of each hospital

SPECIALTY	TRAINEES TOTAL (PP/DH/HA)	TRAINEES									
		KOWLOON CENTRAL CLUSTER		KOWLOON EAST CLUSTER			KOWLOON WEST CLUSTER				
		KH	QEH	HOHH	TKOH	UCH	CMC	KWH	PMH	YCH	
YEAR		YEAR			YEAR						
CARDIOLOGY	21	1 2 3 4	1 2-1 3-2 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2-1 3 4	1 2-1 3 4	3
CRITICAL CARE MEDICINE	5	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1
DERMATOLOGY & VENEREOLOGY	7	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	0
ENDOCRINOLOGY, DIABETES & METABOLISM	22	1 2 3 4	1 2 3 4	1 2 3 4	1-1 2-1 3 4	1 2-1 3 4	1-1 2 3 4	1 2-1 3 4	1 2 3 4	1 2-1 3 4	1
GASTROENTEROLOGY & HEPATOLOGY	15	1 2 3 4	1 2 3-1 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3-1 4	1 2 3-1 4	2
GERIATRIC MEDICINE	26	1 2-1 3 4	1 2-1 3 4	1-1 2 3 4	1 2 3 4	1 2 3 4	1 2-1 3-1 4	1 2-1 3-3 4	1-1 2 3-1 4	1 2 3-1 4	3
HAEM/HAEM ONCOLOGY	9	1 2 3 4	1-1 2 3-1 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1-1 2 3 4	1 2 3 4	1 2 3 4	0
IMMUNOLOGY & ALLERGY	0	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	0

* No. of trainers is shown in italics in right low hand corner of each hospital

SPECIALTY	TRAINEES TOTAL (PP/DH/HA)	TRAINEES									
		KOWLOON CENTRAL CLUSTER		KOWLOON EAST CLUSTER			KOWLOON WEST CLUSTER				
		KH	QEH	HOHH	TKOH	UCH	CMC	KWH	PMH	YCH	
YEAR		YEAR			YEAR						
INFECTIOUS DISEASE	7	1 2 3 4	1 2-1 3 4	1 2 3 4	1 2 3 4	1-1 2-1 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1
MEDICAL ONCOLOGY	4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	0
NEPHROLOGY	14	1 2 3 4	1 2-1 3-1 4	1 2 3 4	1 2 3 4	1 2 3 4	1-1 2 3 4	1 2 3-1 4	1 2 3 4	1 2 3 4	1
NEUROLOGY	11	1 2 3 4	1 2 3-1 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1-1 2 3-1 4	1 2 3 4	1 2 3 4	0
PALLIATIVE MEDICINE	2	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	0
REHABILITATION	4	1 2 3 4	1 2 3 4	1 2 3-1 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	0
RESPIRATORY MEDICINE	28	1 2-1 3 4	1-1 2 3-1 4	1-1 2 3 4	1 2-1 3 4	1 2-1 3 4	1 2 3-2 4	1 2 3 4	1 2 3 4	1 2-1 3 4	0
RHEUMATOLOGY	12	1 2 3 4	1-1 2 3-1 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3-1 4	1-1 2 3 4	1 2 3 4	1 2 3 4	0

* No. of trainers is shown in italics in right low hand corner of each hospital

SPECIALTY	TRAINEES TOTAL (PP/DH/HA)	TRAINEES					NEW TERRITORIES WEST CLUSTER TMH
		NEW TERRITORIES EAST CLUSTER					
		AHNH	NDH	PWH	SH	TPH	
		YEAR					YEAR
CARDIOLOGY	21	1 2 3 4	1 2-1 3 4	1-1 2 3 4-2	1 2 3 4	1 2 3 4	1 2 3 4-1
CRITICAL CARE MEDICINE	5	1 2 3-1 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4
DERMATOLOGY & VENEREOLOGY	7	1 2 3 4	1 2 3 4	1 2 3 4-1	1 2 3 4	1 2 3 4	1 2 3 4
ENDOCRINOLOGY, DIABETES & METABOLISM	22	1 2 3 4-2	1 2-2 3 4	1-1 2 3 4	1 2-1 3 4	1 2 3 4	1 2 3-1 4
GASTROENTEROLOGY & HEPATOLOGY	15	1 2 3-2 4	1 2-1 3 4	1-1 2 3-1 4	1 2 3 4	1 2 3 4	1-1 2 3 4-1
GERIATRIC MEDICINE	26	1 2 3 4-2	1 2 3 4	1 2 3 4	1 2 3 4	1 2-1 3-3 4	1 2 3-2 4
HAEM/HAEM ONCOLOGY	9	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4-1
IMMUNOLOGY & ALLERGY	0	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4

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SPECIALTY	TRAINEES TOTAL (PP/DH/HA)	TRAINEES					NEW TERRITORIES WEST CLUSTER TMH
		NEW TERRITORIES EAST CLUSTER					
		AHNH	NDH	PWH	SH	TPH	
		YEAR					YEAR
INFECTIOUS DISEASE	7	1 2 3 4	1 2 3 4	1 2 3 4-1	1 2 3 4	1 2 3 4	1 2-1 3 4-1
MEDICAL ONCOLOGY	4	1 2 3 4	1 2 3 4	1 2-1 3 4-1	1 2 3 4	1 2 3 4	1 2 3 4
NEPHROLOGY	14	1 2-2 3-2 4	1 2 3 4	1-1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4-2
NEUROLOGY	11	1 2 3 4-1	1 2 3 4-1	1-1 2 3-2 4	1 2 3 4	1 2 3 4	1 2 3 4-1
PALLIATIVE MEDICINE	2	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4
REHABILITATION	4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4
RESPIRATORY MEDICINE	28	1 2 3-2 4	1 2-1 3-1 4	1-1 2-1 3 4	1 2 3 4	1 2 3 4	1 2-2 3 4
RHEUMATOLOGY	12	1 2 3 4-1	1 2 3 4	1 2 3 4	1 2 3 4	1-1 2 3 4-1	1 2-1 3-1 4

* No. of trainers is shown in right low hand corner of each hospital

SPECIALTY	TRAINEES TOTAL (PP/DH/HA)	TRAINEES DH	
DERMATOLOGY & VENEREOLOGY	7	1 2-1 3-3 4	26
GASTROENTEROLOGY & HEPATOLOGY	15	1 2 3 4	0
RESPIRATORY MEDICINE	28	1 2 3-1 4	8

* No. of trainers is shown in italics in right low hand corner of each hospital

HONG KONG COLLEGE OF PHYSICIANS Statistics on Number of Fellows in all Specialties

SPECIALTY	FELLOWS TOTAL (PP/DH/HA)	FELLOWS								HONG KONG EAST + WEST CLUSTER
		HONG KONG EAST CLUSTER			HONG KONG WEST CLUSTER					
		PYNEH	RH	TWEH	FYKH	GH	QMH	TWH		
CARDIOLOGY	155	7	2	0	0	5	11	0	25	
CRITICAL CARE MEDICINE	42	2	0	0	0	0	6	0	8	
DERMATOLOGY & VENEREOLOGY	66	0	0	0	0	0	1	0	1	
ENDOCRINOLOGY, DIABETES & METABOLISM	49	1	1	2	0	1	8	0	13	
GASTROENTEROLOGY & HEPATOLOGY	93	6	2	0	0	0	11	0	19	
GERIATRIC MEDICINE	111	5	12	2	3	0	2	0	24	
HAEM/HAEM ONCOLOGY	30	3	0	0	0	0	6	0	9	
IMMUNOLOGY & ALLERGY	5	0	0	0	0	0	1	0	1	

SPECIALTY	FELLOWS TOTAL (PP/DH/HA)	FELLOWS								HONG KONG EAST + WEST CLUSTER
		HONG KONG EAST CLUSTER			HONG KONG WEST CLUSTER					
		PYNEH	RH	TWEH	FYKH	GH	QMH	TWH		
INFECTIOUS DISEASE	14	0	0	0	0	0	0	0	0	
MEDICAL ONCOLOGY	27	0	0	0	0	0	6	0	6	
NEPHROLOGY	80	4	0	0	0	0	6	2	12	
NEUROLOGY	50	3	3	2	0	0	4	1	11	
PALLIATIVE MEDICINE	10	0	1	0	0	2	0	0	3	
REHABILITATION	26	0	3	2	0	0	1	2	8	
RESPIRATORY MEDICINE	100	4	6	0	0	8	6	0	24	
RHEUMATOLOGY	28	1	1	0	0	0	4	0	6	

SPECIALTY	FELLOWS TOTAL (PP/DH/HA)	FELLOWS									
		KOWLOON CENTRAL CLUSTER		KOWLOON EAST CLUSTER			KOWLOON WEST CLUSTER				KOWLOON CENTRAL + EAST + WEST CLUSTER
		KH	QEH	HOHH	TKOH	UCH	CMC	KWH	PMH	YCH	
CARDIOLOGY	155	0	11	0	2	4	1	5	8	3	34
CRITICAL CARE MEDICINE	42	0	5	0	1	4	3	2	3	2	20
DERMATOLOGY & VENEREOLOGY	66	0	0	0	0	0	0	0	0	0	0
ENDOCRINOLOGY, DIABETES & METABOLISM	49	0	6	0	1	2	2	1	3	1	16
GASTROENTEROLOGY & HEPATOLOGY	93	0	9	0	2	2	5	5	12	2	36
GERIATRIC MEDICINE	111	5	3	6	1	9	6	6	10	3	49
HAEM/HAEM ONCOLOGY	30	0	3	0	1	1	0	0	1	0	6
IMMUNOLOGY & ALLERGY	5	0	0	0	0	0	0	0	0	0	0

SPECIALTY	FELLOWS TOTAL (PP/DH/HA)	FELLOWS									
		KOWLOON CENTRAL CLUSTER		KOWLOON EAST CLUSTER			KOWLOON WEST CLUSTER				KOWLOON CENTRAL + EAST + WEST CLUSTER
		KH	QEH	HOHH	TKOH	UCH	CMC	KWH	PMH	YCH	
INFECTIOUS DISEASE	14	0	0	0	0	0	0	0	6	1	7
MEDICAL ONCOLOGY	27	0	0	0	0	0	0	0	0	0	0
NEPHROLOGY	80	0	7	2	1	3	3	5	7	1	29
NEUROLOGY	50	0	6	0	1	2	0	3	1	0	13
PALLIATIVE MEDICINE	10	0	0	2	0	1	3	0	0	0	6
REHABILITATION	26	5	0	1	0	3	0	1	1	0	1
RESPIRATORY MEDICINE	100	6	4	5	3	4	3	1	4	2	32
RHEUMATOLOGY	28	1	2	0	0	2	2	0	1	0	8

SPECIALTY	FELLOWS TOTAL (PP/DH/HA)	FELLOWS							NEW TERRITORIES EAST + WEST CLUSTER
		NEW TERRITORIES EAST CLUSTER					NEW TERRITORIES WEST CLUSTER		
		AHNH	NDH	PWH	SH	TPH	TMH		
CARDIOLOGY	155	2	3	7	0	0	8	20	
CRITICAL CARE MEDICINE	42	1	3	1	0	0	1	6	
DERMATOLOGY & VENEREOLOGY	66	0	0	0	0	0	0	0	
ENDOCRINOLOGY, DIABETES & METABOLISM	49	1	1	9	0	0	1	12	
GASTROENTEROLOGY & HEPATOLOGY	93	0	3	8	0	0	6	17	
GERIATRIC MEDICINE	111	1	1	2	6	3	12	26	
HAEM/HAEM ONCOLOGY	30	0	0	3	0	0	3	6	
IMMUNOLOGY & ALLERGY	5	0	0	0	0	0	0	0	

SPECIALTY	FELLOWS TOTAL (PP/DH/HA)	FELLOWS							NEW TERRITORIES EAST + WEST CLUSTER
		NEW TERRITORIES EAST CLUSTER					NEW TERRITORIES WEST CLUSTER		
		AHNH	NDH	PWH	SH	TPH	TMH		
INFECTIOUS DISEASE	14	0	0	2	0	0	2	4	
MEDICAL ONCOLOGY	27	0	0	9	0	0	0	9	
NEPHROLOGY	80	2	0	5	0	1	5	13	
NEUROLOGY	50	1	1	4	0	0	1	7	
PALLIATIVE MEDICINE	10	0	0	0	1	0	0	1	
REHABILITATION	26	1	0	2	1	2	1	7	
RESPIRATORY MEDICINE	100	4	4	4	0	1	5	18	
RHEUMATOLOGY	28	0	1	3	0	1	1	6	

International Liaisons

RCP - Collegiate membership

The MRCP (UK) is a joint examination, run by the UK's three Royal Colleges of Physicians. Successful candidates can join one, two or all three Royal Colleges, or even none. They are not limited to the College through which they had applied to write the examination.

One of the benefits from joining the Colleges is access to online education activities available on the College websites. The RCP (Edinburgh) would like to remind their Fellows and Members to view their two new Continuous Professional Development (CPD) presentations on Hepatology and Respiratory Disease on the website below.

http://www.rcpe.ac.uk/fellows/CME/cme_index.html

Events

Joint Scientific Meeting, 23-24 October 2004

Novel Treatment of Common Medical Disorders

23 October 2004 – Saturday

1:00 pm	Registration
2:00 pm	Opening Ceremony
2:10 – 3:25 pm	Novel treatment of Neurological Diseases 1. Medical Management of Dementia – Dr Timothy Kwok (Prince of Wales Hospital) 2. Diagnosis and treatment of neurometabolic diseases in Hong Kong - Dr KY Chan (Princess Margaret Hospital) 3. Advances in Stroke Management – Dr R TF Cheung (Queen Mary Hospital)
3:25 – 3:50 pm	Coffee Break
3:50 - 5:30 pm	Novel treatment of Cardiovascular Diseases 1. Hypertension & ALLHAT Study – Dr Paul Whelton (Tulane University Medical School) 2. Management of Ischemic Heart Disease – Dr CS Chiang (Queen Elizabeth Hospital) 3. Future Therapies for Rhythm Disorders – Dr HF Tse (Queen Mary Hospital) 4. Advances in transcatheter interventions for congenital heart diseases - Dr YF Cheung (The Grantham Hospital)
5:30 – 6:45 pm	Presentations for the Distinguished Research Paper Award for Young Investigators Medical Student Essay Award
6:45 – 8:15 pm	AGM Fellowship Conferment
8:15 – 8:45 pm	Cocktail
8:45 – 9:45pm	Annual Dinner AJS McFadzean Oration Presentation of Awards

24 October 2004 – Sunday

8:30 – 9:00 am	Registration
9:00 – 10:00 am	Best Thesis Award
10:00 – 11:30 am	Novel Treatment of Metabolic Disorders 1. Emerging Treatment for Type 2 Diabetes Mellitus – Dr Tsang Man Wo (United Christian Hospital) 2. Management of childhood obesity – Dr T Nelson (Prince of Wales Hospital) 3. Lipid metabolism (Speaker to be confirmed)
11:30 – 11:45 am	Coffee break
11:45 – 12:15 pm	Gerald Choa Memorial Lecture Speaker: Prof Rosie Young
12:15 – 12:45 pm	Sir David Todd Lecture
12:45 – 2:00 pm	Lunch symposium The Biology of COX-2 – Dr Andrew Whelton (Johns Hopkins University Medical School)

Profile Doctor

Professor Yuet Wai Kan

MB, DSc, FRCP, FRS.

L K Diamond Professor of Haematology
Depts of Lab Medicine & Medicine
University of California, San Francisco

Professor Kan's visiting card gives evidence of significant past achievement and present high status, but only after speaking with him is it apparent how much he has achieved and how busy he still is.

He was born in Hong Kong in 1936 to parents who were both Hong Kong citizens. He was the youngest of a family of seven brothers and five sisters. During the Japanese occupation his family remained in Hong Kong, his father being able to continue as the Chief Manager of the Bank of East Asia. A tutor was employed to teach the Kan children, making up for lack of available schooling. At the end of the war he and his immediately older brother both entered form seven of Wah Yan College. This early start meant that he finished school two years younger than usual. His father decided for him what his career path should be – Medicine.

He entered Hong Kong University Medical School at the age of 16, and qualified aged 22 with an M.B., B.S. (with honours), and Distinctions in Social Medicine, Medicine, Surgery, and Obstetrics and Gynaecology. With that sort of academic record it was not surprising to hear that his memories of University were of work rather than play. He spent the next two years in Hong Kong, completing his internship and a year of residency in the Department of Medicine, Queen Mary Hospital.

Professor Alec MacFadzean was his respected, and occasionally terrifying, head of department. Professor Kan recalls one occasion when after a departmental dinner at which everyone over-indulged, Professor MacFadzean was the only person able to turn up on time for the next morning's ward round. He was very furious with his staff when they ultimately appeared. Professor Kan is grateful to Prof. MacFadzean, and Prof. David Todd for urging him to pursue a career in haematology, and it was Professor Todd who advised him to further his studies in the USA.

There followed a succession of research and academic posts in the most prestigious establishments on the east coast of America; Peter Brent Bingham Hospital, Boston; MIT, Cambridge; McGill University, Montreal; Presbyterian-University Hospital, Philadelphia; and Harvard Medical School, Boston.



Prof Kan was conferred Honorary Fellowship of the HKCP in 2000.

In 1972 he moved to San Francisco to join the University of California, where he has been working ever since. Apart from his endowed chair of Louis K. Diamond Professorship in Haematology, he is Chief of the Division of Molecular Medicine and Diagnostics, and Senior Staff, Cardiovascular Research Institute at University of California.

Research has always been a primary interest and he has published many original papers. The burgeoning field of genetic testing for hereditary diseases such as sickle-cell anemia and thalassemia got its start with Kan's work in the 1970s

In 1975, Kan discovered that a severe form of thalassemia, a blood disorder in which the body cannot make enough hemoglobin, was due to the lack of the gene encoding the alpha subunit of the globin molecule. This was the first time a gene deletion was recognized as a cause of human disease. By 1976, Kan had successfully applied this knowledge to developing a prenatal test that analyzed for the presence or absence of the defective gene.

In 1978 while working with sickle-cell anemia patients, Kan found that DNA fragment lengths of people with the disease differed from those of people without the disease. These polymorphisms thus act as markers indicating the existence, and often the general location, of a gene. Even when researchers do not know the exact sequence of a disease-causing gene in any one person, they can infer the existence of a particular mutation by tracking RFLPs through a family. DNA polymorphisms are now being widely used as markers to map the genome of humans and other organisms.

It was to honour Professor Kan for this work that he was the recipient of the prestigious Lasker Award in 1991

Kan says that over the next several years, as more gene defects are discovered and mapped out, the development of direct genetic tests will continue. "I think the more challenging problem now," says Kan, "is to test for diseases that are multifactorial, such as high blood pressure and some forms of diabetes, which are not due to a defect in a single gene." He agrees that the interplay of environmental and genetic factors in these diseases complicates this goal, but points out that "if you find a genetic factor that predisposes [people] to an environmental change, you can advise these people to avoid the environmental pressures."

In recognition of his contributions to medical knowledge Prof. Kan has been appointed to numerous Editorial Committees, prestigious medical advisory committees and Fellowships of many internationally regarded Science Academies. In 1981 he achieved the singular distinction of being the first Chinese person to be elected to Fellowship of the Royal Society in London.

The aspect of his work that gives him most pleasure these days is in teaching and encouraging younger scientists.

Professor Kan has always maintained his Hong Kong connection. In the 1970s he had research projects in collaboration with Professor Todd. He is the President of the 'Friends of Hong Kong University', a non-profit organization that allows United States resident to make tax deductible contributions to the University of Hong Kong. In 1980 he was awarded a D.Sc. from the University of Hong Kong for his work on thalassaemia. He received an honorary M.D. from the University of Cagliari in Italy and honorary D.Sc. degrees from the Chinese University of Hong Kong, the University of Hong Kong, and the Open University of Hong Kong. In 1990 he was appointed an Honorary Professor at Hong Kong University at a time when a molecular medicine research laboratory was being set up. In 1993 he became a Fellow of the Hong Kong College of Physicians at its inception.

He joined the Trustees of the Croucher Foundation in 1993 and has been Chairman since 1997. The Foundation was set up with funds donated by Mr Noel Croucher, a stockbroker in Hong Kong, to give grants to the Hong Kong universities for research in science and technology and to Hong Kong residents to pursue graduate and postdoctoral studies, initially in the British Commonwealth universities. After 1997 the scope was widened to include grants for studies at centres worldwide. The Croucher Foundation has nine areas of funding: such as Scholarships or Fellowships for PhD. Studies; Senior Research Fellowships for mid-career scientists to take a research sabbatical; Advanced Study International Seminars; Visitorships for scholars in mainland China. He regretted that there are few medical applicants for these awards, most applicants are from other scientific disciplines.

Prof. Kan has also been since 1994 a Member of the Advisory Board and Executive Committee of the Qiu Shi Science and Technology Foundation which funds outstanding scientists in China.

In addition to his immensely productive academic life, Professor Kan found time to get married, to Alvera, at that time a colleague working in a laboratory in Boston. They have two daughters, one a lawyer and the other a television broadcaster. Both are now married and have between them presented Professor Kan with four grandchildren.

He used to enjoy active sports such as tennis and skiing when the family had a holiday home at Lake Tahoe. Since then his holiday home has been a beautiful house and vineyard in the Napa Valley area north of San Francisco. With this interest Professor Kan has developed an excellent knowledge and appreciation of Californian wines. It would seem that Prof. Kan has much to enjoy even before he chooses to ease up on his busy academic and advisory career - the delights of his family, Napa Valley home and garden and vineyard, and the respect of his peers - fitting rewards for a career full of achievements of benefit to the world of medicine.

The respect of his peers was further demonstrated in May this year when it was announced that he had been honoured as the recipient of half of the first Shaw Prize for Life Sciences and Medicine for his discoveries on DNA polymorphism and its influence on human genetics. The award ceremony will take place this September, most fittingly in Hong Kong, the birthplace of this most distinguished man.

John Mackay