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*Medical  
Education*



# Contents

## Editorial

■ Editorial	2
<i>Dr. Dawson FONG</i>	
<i>Dr. Godfrey CF CHAN</i>	

## Education Bulletin

■ Reflections on a Medical Education System in Evolution	3
<i>Prof. Sum-ping LEE</i>	
■ Medical Education in Hong Kong - Past, Present, and Future	6
<i>Prof. Tai-fai FOK</i>	
■ Hong Kong Academy of Medicine and Specialist Training in Hong Kong	9
<i>Prof. Raymond HS LIANG</i>	
■ Medical Training in Hong Kong	11
<i>Dr. Po-mui LAM</i>	
■ Working Hours and Training	14
<i>Dr. Ka-lau LEUNG</i>	
■ Medicine as Our Liberal Arts	15
<i>Dr. Gilberto KK LEUNG</i>	
■ Human Swine Influenza 	17
<i>Dr. Vincent CC CHENG</i>	
■ MCHK CME Programme Self-assessment Questions	20

## Radiology Quiz

■ Radiology Quiz	8
<i>Dr. WK TSO</i>	

## Society News

25

## Medical Diary of August

23

## Calendar of Events

■ Meetings	25
■ Courses	25

# The Cover Shot



We were travelling in Bhutan and passed by a small town known as Wangdue Phodrang. With curiosity, we requested to visit a local school and it was their morning gathering. We saw around 200 primary and secondary school students standing orderly in the middle of the school playground. They listened attentively to the abstracts of international news reading out by one fellow student in English. I captured these 2 little kids who appeared to be tired and bored of the seemingly lengthy narration of matters with doubtful relevance to them. As in any form of education, traditional didactic large group lectures, especially those with too much detail, may be hard to digest for some learners.

*(Cannon 5D, Mark II, EF 70-200)*



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Each monthly issue of the Medical Diary has a theme on a branch of medicine or a specific disease. It is an effort of the Federation of the Medical Societies of Hong Kong to fulfil one of its missions - striving to facilitate dispersal of the latest advances in the various fields of medicine. Commendations for such format encourage us to go on in this direction.

A few months ago, in an enjoyable meeting between a delegation of office bearers of the Federation and Professor Sum-ping Lee, Dean of the Medical Faculty of the University of Hong Kong, there was a candid exchange of views on the current generation of medical profession and the quality of medical education Hong Kong is very proud of. All of us were left with much food for thought.

Medical knowledge is important but we must take heed also of the way it is delivered, viz. medical education itself. While the world is moving forward at an unprecedented pace, as medical science is exploding like never before, how should medical education cope? How should we prepare the next generation of doctors to meet the rising expectation of community? the needs of the doctors themselves?

Without hesitation, the Editorial Board decides that we should dedicate an issue of the Diary to this very subject. The idea is supported by the Deans of both medical schools - Professor Lee of the University of Hong Kong and Professor Tai-fai Fok of the Chinese University of Hong Kong - and the President of the Academy of Medicine Professor Raymond Liang. Together these three institutions are responsible for education of the medical profession from undergraduate level to specialty training and beyond. Views and vision of the leaders are certainly pivotal to shaping the future of how doctors are to be trained. We have articles from academics commenting on the curriculum - attempting to compare it to liberal arts; alumni and legislator giving an account from a different angle and discussing the impact of the contentious working hour requirement on training. As we are unceasingly learning, a CME article on the menacing Human Swine Influenza by Dr Vincent Cheng completes the compilation for this month.

The Federation would like to thank all the contributors for their insightful articles in this unique issue on Medical Education. I hope you will all find it an excellent reading like I do.

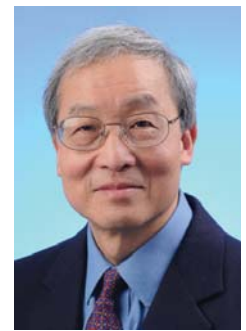


# Reflections on a Medical Education System in Evolution

**Prof. Sum-ping LEE**

MD, PhD

*Dean, Li Ka Shing Faculty of Medicine, The University of Hong Kong*



Prof. Sum-ping LEE

## Preamble: Changing Times

Nothing is permanent, and nothing stays perfectly still. Life and society undergo a dynamic evolution and changes unfold inexorably onward. So does medical education. While the need, the mission of fostering future generations of doctors to serve and enrich this noble profession have always been the theme of medical education, the perception, the objectives, the methodology and instruments of teaching have been topics of rediscovery, reinvention, as well as controversial debates. These have been influenced by the accelerated advances in biomedical science and exponential proliferation of information; changing societal and ethical values amongst a background of fluctuating economic ups-and-downs. There is a fear that because of the emphasis and reliance on high level technological devices, that we have been producing doctors who are more like technocrats and they adopt a robotic way of prescribing expensive sophisticated tests and drugs and procedures. These may then erode into the compassion and idealistic humanitarian qualities which underpin the basis of the practice of Medicine. There is also a fear that the delicate balance of entrepreneurial objectives and altruism has been perturbed by the zest for materialistic considerations and that patients might be regarded as tradable commodities. And in the name of efficiency, we do not listen enough and care enough any more. What is more alarming is that ethical standards may so be compromised.

Can a medical education system be improved so that the medical graduates and ultimately the practitioners of Medicine will attain an Utopian equilibrium? I think not. There are many societal forces that determine and shape the phenotype, choices, and behaviour of the young men and women after they have graduated from medical school. But I think we should try. We must try.

## Mission and Principles of Medical Education

The mission of medical education in Hong Kong is to serve the community by educating and training a diverse medical workforce capable of meeting our need for doctors who are engaged in the practice of clinical medicine and particularly family medicine. Included in the workforce are doctors engaged in public health practice, biomedical and health services research, medical education, and medical administration. Although numerically small, medical graduates can

have substantial contribution to fields such as ethics, law, public policy, business, and journalism. The medical education system has this unique responsibility to educate and train highly competent medical practitioners. The design, contents and the process of medical education ensure that the graduates acquire and possess throughout their careers the knowledge, skills, attitudes, and values needed for medical practice as members of an interdisciplinary health care team.

In order to achieve this goal, the medical education system must be able to attract and successfully educate a diverse group of learners; to support the health and well being of these learners; and to cultivate mentoring relationships for learners at each stage of their careers. The medical education system is a vehicle to execute the will and the trust of the community. Medical education must be effective, efficient, high-quality and yet affordable. A good medical education provides opportunities for learners to engage in different effective learning experiences throughout their careers.

The medical system must also recognise that learning is not the antiquated classroom learning but to capitalise on the remarkable advance in information technology. Access to information used to be the limiting step in learning and many generations of learners had studiously copied, word for word, the lectures of their professors reading from the notes in a lecture room, dimmed to accommodate the projection of slides. Now, with a click of a "mouse", anyone can download hundreds of papers, reviews and materials which no one can have the time to deal with, in the current era of information overload. Therefore, the old paradigm of teaching must change to include time and information management. Learning is not the drudgery of memorising isolated facts, but knowledge is acquired by guiding a motivated and inspired mind to seek the appropriate answers. If this skill can be passed on, then learning will become a life long gift and process, and will continue after the student has left the medical school.

To produce practitioners of medicine with excellent competency and professionalism, and who will provide high quality care to the patients, the medical education system must promote a humanistic approach to medicine. In doing so, we should avoid turning the medical school experience into a vocation training centre and have students develop a "tunnel vision" view of their profession and lives. The students must not see only the leaf but not the tree. They should see the tree, the forest, and the interrelationship and interdependence of the forest with the mountains and the streams. To this



end, a broadening of the educational profile including the humanities and liberal arts will encourage our learners to adopt a wider visual field. True education enriches human beings and cultivates a sense of value and identity for the individual, as well as the individual's relationship to others and the community at large. The medical education system should be a patient-centred approach to medical care. The process of education embraces an appreciation of the importance of basic research in the advancement of medical practice. It also generates an understanding of the organisation, financing, and the delivery of health care in Hong Kong, as well as a global perspective on contemporary health issues. In addition to providing the best possible curriculum, learning environment, clinical context and experience, learners are encouraged to broaden their learning experience as an exchange student with a different (overseas) medical teaching institution, preferably in a clinical setting. To appreciate Medicine at a global scale, they must experience being a global citizen. During the course of learning, ethics and legal issue, when appropriate, will be integrated into the curriculum. As a result, the graduates will be able to listen and communicate

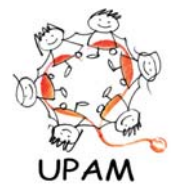
effectively, weigh quality of life issues appropriately; assess and use evidence critically; apply resources efficiently and effectively; use resources and technologies with sound judgement appropriately. They will also participate in multi-disciplinary and team approaches to patient care, contribute to the elimination of medical errors and improving the quality of health care, and achieve a balance between individuals and population health needs when making patient care decisions.

## Medical Educators

In our zest to achieve research recognition, faculty members of medical schools are often directly or indirectly encouraged to focus on their research productivity. As a result, achievements in excellent medical education may be under-recognised. Passion, devotion and commitment to teaching must be rewarded because teaching is a primary mission of the medical schools. It is important for the leadership of any university to realise that excellent teachers are to be recognised and revered.



DEPARTMENT OF PAEDIATRICS AND ADOLESCENT MEDICINE  
LI KA SHING FACULTY OF MEDICINE THE UNIVERSITY OF HONG KONG



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For enquiries, please contact Ms D Lai at 2817 0641 (Tel) / 2855 1523 (Fax)/ [paedoff@hkucc.hku.hk](mailto:paedoff@hkucc.hku.hk).

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# Medical Education in Hong Kong - Past, Present, and Future

**Prof. Tai-fai FOK**

*Dean of Medicine, The Chinese University of Hong Kong*



Prof. Tai-fai FOK

## The Past

Historically, mainstream Western medicine was closely associated with religious activities. Dating back to the early Middle Ages, the church played a dominant role in the provision of medical education in Europe. Physicians were trained as apprentices in monastery infirmaries and hospitals. With the development of universities in western Europe, medical training gradually shifted to the medical schools. However, the mentor-apprentice relationship between medical teachers and students continued for many centuries until the 17th and 18th centuries when medical education began to assume its modern characters. Basic sciences teaching and application of scientific principles to patient management started to be incorporated into the medical curricula. In Britain, the establishment of the General Medical Council following the passage of the Medical Act in 1858 allowed a statutory regulatory body to exert greater control and influence over medical education, as well as to ensure better quality assurance of medical practice. This had resulted in significant improvements in medical education standard across the country.

The improvement in the quality of medical education in Europe was however not seen in the United States where medical schools were mainly profit-driven with profits being derived from hefty school fees. Standards were very variable and in general quite low. Many medical schools did not provide patient-based education. This abysmal situation lasted until the turn of the last century when Abraham Flexner published the historic Flexner Report that revolutionised medical education in the US. A school teacher-cum educational researcher, Flexner was impressed by the medical schools he saw during his tours around Europe, especially those in Germany. After returning to the US, he was commissioned by the Carnegie Foundation to make recommendations on the way forward for medical education in the US. He visited all the 155 medical schools in the US and Canada, and published a report which severely criticised the medical schools for their lack of standard, poor evaluation method and lack of clinical teaching. He pointed out that medical education should be a form of formal university education rather than an enigmatic process of apprenticeship. He recommended the introduction of robust basic sciences training in the laboratories, to be followed by clinical teaching in teaching hospitals. He believed that the two sets of training should be very distinct with no overlapping in between. The Flexnerian curriculum was adopted by most medical schools and became the mainstay of medical education for a few decades, including that in Hong Kong, until the late 20th century.

## The Present

During the 1990's, the Flexnerian model was challenged because of the compartmentalisation of basic sciences and clinical training, and the lack of skills training. Many medical educationists were of the opinion that because of these deficiencies, the curriculum was inadequate in preparing students to become practitioners who were capable of meeting the demands of the patients and the society in the present days. The Flexnerian model gradually lost its dominance as many medical schools underwent curriculum reforms in the late 1990's. In all these reforms, "integration" became the buzzword. HKU introduced a new integrated curriculum with a heavy element of PBL (problem-based learning) in 1997 while CUHK adopted an integrated curriculum with less elements of PBL in 2001.

In the design of the new medical curriculum in CUHK, we have made reference to the famous book "Tomorrow's Doctors" published by the General Medical Council in 1993. We agreed with the GMC's observation that the then existing curriculum burdened the students with excessive factual information and unnecessary memorisation, and lacked training in the skills that physicians needed to acquire before they could provide holistic and compassionate care to their patients. The new curriculum significantly trims down the core teaching content by 30%, and introduces student-selected components that allow in-depth studies in areas of particular interests to the students. It also places significant emphasis in three areas: firstly the training of skills in communication, secondly the methodologies for searching and critically appraising evidence in medical practice, and thirdly the development of proper attitudes and behaviours as a responsible medical practitioner. Replacing a subject-based curriculum that segregates basic sciences from clinical teaching, the new curriculum is system-based with horizontal (among disciplines) and vertical (between basic sciences and clinical) integration. Students are given opportunities to have clinical contact as early as in their first year of studies. Many of the large-class lectures are replaced by small group teaching. Student assessments have also been revamped with the introduction of formative and summative components. In short, the curriculum has become much more structured in terms of teaching and learning as well as assessments.

In introducing major changes to our curriculum, we recognise the importance of keeping under review its effectiveness. The new curriculum at CUHK has now been implemented for a total of seven years. Throughout



this period the Faculty has been diligently collecting student feedback through a number of channels. While there is still much room for improvement, the new curriculum has so far received very positive feedback from our students. There is a general feeling among the students that they can now spend more time taking part in extracurricular activities which make them feel more like "receiving university (as opposed to vocational) education". They also feel that with early clinical contact and the integrated approach to basic sciences and clinical learning, they now have a better understanding of the clinical applications of the scientific principles. Comments from external examiners have in general been very favourable. The evaluation scores given by the intern supervisors to the first two batches of interns who have graduated from the new curriculum also compared favourably with their predecessors.

## The Future

Although we are pleased with the initial outcome of the curriculum reform and are convinced that the direction of our change is correct, we are fully aware that there are still deficiencies in the design as well as our execution of the new curriculum. After a few years experimenting with the new curriculum, it is apparent that some of our colleagues still do not embrace the new concept of the reform. They are concerned that the reduction in the teaching of factual information would produce a generation of medical students and doctors who do not possess the full range of knowledge necessary to enable them to become safe medical practitioners. With this perceived knowledge gap, the skeptics fear that the new curriculum is going to produce a group of second class doctors. To ensure the success of the new curriculum, it is our duty to convince these colleagues that in this day and age, there are more important things and skills that students need to acquire other than pure factual knowledge. As an example, with the rapid advances in medicine, it is more important for the students to equip themselves with the skills that would enable them to access new knowledge on their own rather than memorising voluminous amount of factual information fed to them which may have no direct relevance to their practice. This is particularly true when much of this information may become out-of-date within a very short period of time. To give students more time to learn these new knowledge and skills, it is only appropriate to reduce much of the "over-teaching" that was so prevalent in the past. In fact, even with the trimming of our core teaching, our curriculum may still be too broad and the scope too ill-defined so that the students might lose their focus in their studies. They would certainly run the risk of "missing the forest for a tree" if they are unable to differentiate the essential information from the less important ones. In compliance with the requirements of the University Grant Committee, our Faculty is now putting a lot of effort in devising a set of outcome-based guidelines for teaching and learning. Hopefully this will provide the students and teachers with a more clear-cut indication of what the students are expected to achieve upon completion of every stage of their medical studies.

In the review of our new curriculum, I believe that we

are still deficient in two areas that need improvement. The first is the imbalance between hospital-based specialty teaching and teaching in primary health care. Primary health care has been hailed as the gate-keeper of the health care system by international authorities such as the WHO, our own government, and to some extent the public. Primary care teaching has however not been given its fair share of emphasis in the curricula of our medical schools. The family medicine units are underprovided when compared to their counterparts in countries where primary health care is well established. There are historical reasons for this lopsided phenomenon. The academic clinical units are duty bound to provide clinical services to hospital patients and there is therefore a need for a sufficient number of clinical professors to shoulder this service load. Primary health care in the past was not considered a specialised field in Hong Kong as it was provided mainly by general practitioners who had little or no postgraduate training. However in this day and age, we all recognise the importance and sophistication of primary care, so much so that the Hong Kong College of Family Physicians requires its trainees to go through 6 years of structured post-internship training. Yet the teaching of primary care to medical students, which we all agree should be in the community rather than in the hospitals, still depends to a large extent on the good will of primary care physicians in the community who are providing free teaching services to the faculties. Given this arrangement, quality assurance would not be easy, and little can be done to stimulate the interest of our students in considering primary health care as their future career. In all the other developed countries where primary health care is well organised, such as the UK, Canada, and Australia, their governments have all injected substantial resources into primary health care teaching in medical schools. Primary care physicians in the community are reasonably remunerated so that they can dedicate a certain number of sessions every week to providing structured undergraduate teaching. It is only through the support of our Government that we can bring life to primary care teaching, and prepare our students properly for a career as primary care providers. It is now time for the two medical schools at HKU and CUHK to work together towards a better primary care service for our community.

Another area of deficiency in our medical education is character building of our students. From time to time, we hear criticism about our junior doctors being immature, self-centred, emotionally fragile, and lack of compassion for their patients. It seems that our efforts in enhancing teaching on communication skills, ethics and attitudes in the new curriculum have not helped building the character of some of our students. This is not surprising since 'Rome was not built in one day'. It would be unrealistic to expect that we can shape, or change, these young people's attitude and character through classroom teaching of some ethical principles or a glossary of technical jargons. It is through life experiences and wider exposure to humanity issues that students can learn the ways to improve their interpersonal skills as well as their emotion and adversity quotients, to cultivate a demeanour that can gain them the trust of their patients, to be sensitive to the special needs of their patients, and to understand the dimensions of life and personality of their patients





beyond their physical illnesses. Lack of such exposure is a major deficiency in disciplines with a strong emphasis in vocational training, such as medicine. While character building should have begun during the early formative years of the individuals (primary and secondary schools), the introduction of the 3+3+4 curriculum may provide us with an opportunity to correct, to a certain extent, the deficiency since medical students will join the university at an earlier age and for an additional year. We should make use of this extra year to implement a programme for character building and training appropriate for future medical practitioners. More emphasis on general education to enhance the exposure of our students to philosophy, literature and culture, traditional values, and ethics may also help.

No medical education programme can claim to be perfect. There is more to being a good doctor than being able to make an accurate diagnosis or design an effective treatment plan. We expect a good doctor to be confident, empathetic, compassionate, humane, personal, responsible and forthright. To keep up with rapid advances in medicine, the doctor also needs to be a life-long learner. To design a curriculum that helps students to acquire all these diverse attributes is indeed a great challenge. Despite the deficiencies mentioned above, I believe we are moving in the right direction with our new curriculum. We will need however to be vigilant to ensure that we will not derail. Through continuous self reflection and improvement of our curriculum we hope to achieve our mission of providing education to our students who are ready to provide quality health care to our community upon their graduation.

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## Radiology Quiz



## Radiology Quiz

### Dr. WK TSO

Consultant, COS of Department of Radiology, HKWC and Queen Mary Hospital



Dr. WK TSO



### Case of the week:

What do you find on the radiographs of the pelvis, hips and the knees of this 67-year old male patient?

(See P.26 for answers)



# Hong Kong Academy of Medicine and Specialist Training in Hong Kong

## Prof. Raymond HS LIANG

MBBS, MD, FRCPRCPS(Glasg), FRCP(Edin), FRCP(Lond), FRACP, FHKCP, FHKAM(Medicine)  
*President, Hong Kong Academy of Medicine*



Prof. Raymond HS LIANG

The idea of introducing specialist registration in Hong Kong was first considered by the Medical Council in 1968. In November 1979, the Medical Council formed the "Working Party on a Specialist Register for Hong Kong". The Final Report of the Working Party was submitted to the Medical Council in July 1982. One of the conclusions reached was that the postgraduate training of doctors in Hong Kong at that time was inadequate, and it recommended that the professional training of doctors intending to specialise should be improved as a necessary step towards the setting up of a specialist register.

In August 1983, a joint ad-hoc committee was set up to examine the recommendations of the Working Party on a specialist register for Hong Kong. The committee concluded that the legal requirements for training after registration in Hong Kong at that time were inadequate. An establishment with improvement of facilities for specialist training was required as a step towards having a specialist register of Hong Kong.

In March 1985, the Medical Council decided that action should be taken to deal with, firstly, the design/organisation of suitable postgraduate training programmes for registered medical practitioners and secondly, to set up an accreditation body to grant recognition to such programmes. The creation of a specialist register would be considered later when the first two stages were completed.

In October 1986, the Hong Kong Government established a Working Party on Postgraduate Medical Education and Training. The Report prepared by the Working Party, which was published in October 1988, recommended that there should be a "Hong Kong Academy of Medicine" composed of Fellows accredited after completion of approved training and prescribed examinations.

In February 1990, the Hong Kong Government established the Hong Kong Academy of Medicine Preparatory Committee. The Preparatory Committee completed draft legislation and submitted it to the Executive and Legislative Councils in December 1991. The Hong Kong Academy of Medicine Ordinance (Cap. 419) was passed by the Legislative Council on 25 June 1992 and came into effect on 1 August 1992. The Government appointed an Interim Council, comprising six Officers (office-bearers) and the Presidents of 12 designated Academy Colleges.

Professor David Todd was appointed President of the Interim Council. After scrutinising and approving the

constitutions of the 12 designated Academy Colleges, namely Anaesthesiologists, Community Medicine, Dental Surgeons, General Practitioners (now called Family Physicians), Obstetricians & Gynaecologists, Orthopaedic Surgeons, Paediatricians, Pathologists, Physicians, Psychiatrists, Radiologists and Surgeons, the Interim Council formally admitted these 12 colleges as Academy Colleges. Two Faculties, namely Ophthalmologists and Otorhinolaryngologists, were also admitted under the College of Surgeons by the Interim Council.

An Inaugural Ceremony, attended by over 167 overseas dignitaries, was held on 9 December 1993 during which over 2,000 Fellows were admitted according to the admission criteria set by the Interim Council. The Interim Period ended on 19 July 1994 when the first annual general meeting was held. On 2 October 1995 two new Academy Colleges, namely the College of Ophthalmologists of Hong Kong and the Hong Kong College of Otorhinolaryngologists, were admitted at the 2nd Annual General Meeting. These two Colleges were formerly Academy Faculties under the College of Surgeons. On 16 January 1997 another new Academy College - The Hong Kong College of Emergency Medicine was admitted, increasing the total number of Academy Colleges to 15.

Currently, the Hong Kong Academy of Medicine is the highest academic organisation in Hong Kong that is established by statute. It has the mandate to maintain the standard of specialist training and specialist continuing medical education (CME) and continuous professional development (CPD) in the territory. The Academy has 15 Medical and Dental Colleges. Over half of the registered medical practitioners in Hong Kong are Fellows of our Academy. The number is now over 5000. They have all gone through at least six years of structured training in accredited centres, under the supervision of accredited trainers, and have passed the intermediate and the exit examinations of the respective College. To ensure reaching an international standard, these examinations are either conducted with international partners or have external expert examiners participating. Within the 15 Colleges of the Academy, there are around 60 specialties and subspecialties. At the moment, we have over 2000 registered specialist trainees in the system.

The Academy assists the Medical Council of Hong Kong, the Registration body of Hong Kong doctors, in maintaining the Specialist Register (SR) since its inception in 1997. Fellows of the Academy of Medicine are eligible to be registered in the SR. Under the



Medical Registration Ordinance (Cap 161), a medical practitioner whose name is included in the SR is legally allowed to use the title: "Specialist in a certain specialty". Furthermore, the Academy is responsible for vetting qualifications for temporary medical registration of the Medical Council of Hong Kong.

The Academy is taking the lead in the development of CME/CPD not only for our Fellows, but also for general practitioners who join the CME scheme of the Medical Council of Hong Kong. We are an Administrator, Accreditor and Provider of this scheme. To further enhance and facilitate the CME/CPD activities of our Fellows, we are developing web-based learning. This is done in collaboration with international Academies and Colleges. They include the Royal College of Physicians and the Royal College of Surgeons of United Kingdom, Academy of Medicine Singapore, Academy of Medicine of Malaysia, Royal Australasian College of Physicians, Royal Australasian College of Surgeons and Royal College of Physicians and Surgeons of Canada. We have a common goal of promoting life-long learning in medicine and conducting research on knowledge transfer. All Fellows are required to fulfil cyclical CME/CPD requirement in order to maintain their status in the SR.

Our Academy is committed to taking an active role in improving the health care provision in Hong Kong through our involvement in postgraduate professional training of doctors and dentists. We continue to advise the Hong Kong Special Administrative Region Government on matters related to health and health regulations. The Academy strives to serve the Community of Hong Kong, China Mainland and the World.

Life is full of turbulence. The economic tsunami last year has resulted in global financial meltdown and a panic state. We have witnessed a massive breakdown of confidence to the financial system worldwide.

Quoting Democritus, a Greek philosopher (460 BC - 370 BC):

*"Do not trust all men, but trust men of worth.  
The former course is silly, the latter a mark of prudence."*

How about the trust of our health care service? Our profession has long been enjoying a high respect from the society. This is built on solid foundation of clinical excellence, dedication and empathy. We need to sustain this hard-earned trust. This was challenged by SARS in 2003 and we survived it. At the time of writing, we have the human swine flu at our doorsteps.

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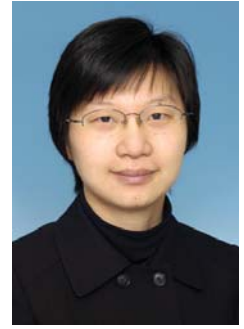


# Medical Training in Hong Kong

## Dr. Po-mui LAM

MBChB, MRCOG, FHKCOG, FHKAM (O&G), MD

*Chairlady of the Chinese University of Hong Kong Medical Alumni Association*



Dr. Po-mui LAM

What we teach our medical students and young doctors is broadly speaking how we will be treated in the future as patients. Medical education and training are the keys to the maintenance and improvement of Hong Kong's already high standard of care. It is essential that we keep reviewing what and how we teach so that no opportunity to improve is missed. It is my honour and privilege to reflect on the medical education and training of Hong Kong as I am a relatively junior product of this system, or more precisely, the Chinese University of Hong Kong (CUHK), at both undergraduate and postgraduate levels.

## Undergraduate Medical Training

In 1981, the Faculty of Medicine in CUHK admitted its first batch of students. It was a traditional curriculum largely based on the Cambridge model with clear delineation between preclinical and clinical years. It was formulated with the requirements of the General Medical Council (United Kingdom) very much in mind. The resulting graduates were, not surprisingly, familiar to the medical establishment and were quickly accepted into the medical community of Hong Kong. However, this curriculum was radically revamped with the new millennium. In the academic year of 2001-02, CUHK replaced the traditional medical undergraduate programme with an integrated, systems-based curriculum. The old curriculum tended to overwhelm students with factual content at virtually every stage of the 5 year programme. The new programme was both vertically and horizontally integrated. Thus, it was easier for students to appreciate the importance of what was being taught. Together with early clinical contact, students could apply what is taught and develop their clinical sense more easily and at an earlier stage of their education. More importantly, communication and life-long, self-directed learning skills teaching are emphasised, thus enhancing the graduate's ability to adapt to a rapidly changing world. In this way, it is anticipated that our next generations of graduates will be better prepared to meet the challenges of modern-day health care and serve the community with clinical excellence and compassion. As a graduate of the traditional curriculum and a clinical teacher of the new one, I am gratified to observe the differences and improvements. There have been trade offs but overall, I think it is a development in the right direction.

While we have a formal structure for the core curriculum which encompasses the essential knowledge and skills as well as the appropriate attitudes that the

students must acquire before graduation, it is important to give the students the flexibility and opportunities to explore their own interests in depth. Non-core curriculum consists of selected study modules in the first three years and the elective training in the fourth year of the programme. Every student is unique and should be given reasonable choices in the way they learn. These 'non-core' programmes are no less important than the core syllabus. Indeed, they are the extension which allows the students to pursue experiential learning in various disciplines that interest them and to develop the skills and attitudes required for critical and analytical thinking.

To prepare for the real world of being a doctor, nothing is better than practical experience through clinical contact and hands-on training. Clinical teaching is emphasised, especially in the later half of the programme. After the successful completion of the 5-year medical curriculum, all graduates undergo a one-year internship in various approved local hospitals before they become registered medical practitioners in Hong Kong. In the past, interns spent an inordinate amount of time doing clerical work and other tasks such as taking blood. Whilst these tasks are not unimportant, employment of more phlebotomists and clerk stewards has allowed interns to participate more in direct patient care and hands-on practical training. It is a better and more sensible use of their training time.

Medical culture is inherently perfectionistic. Furthermore, patients are increasingly intolerant of almost any short coming. I am sure every student wants to be a good doctor, and the educational system should ensure that all graduates are competent professionals. Medical training involves substantial investment in time, money and effort from both the students and society. A robust process of monitoring throughout training is important and, if any students are struggling, this should be recognised early and handled appropriately. More importantly, students should make the right choice to start with. There are considerable societal and family pressures on excellent students to train in medicine, sometimes against their natural interest. To make choosing to study medicine more informed for the students, our alumni have been organising mentorship programmes for both medical and secondary school students so that the students know more about the life of being a medical student or a doctor before commencement of training.

## Postgraduate Medical Training



It is now accepted that continuous medical education (CME) and continuous professional development (CPD) are essential in professional development and maintaining high standards of care. However, medical knowledge is rapidly evolving and ensuring that the practising doctors are continually accessing and using the latest information in their daily practice is no easy matter. Whilst CME and CPD activities do not always ensure that this happens, there is thus far no better alternative. Nevertheless, improvements such as greater use of Information Technology and the vast knowledge that is readily available on the internet promise to make the task easier. For example, internet-based CME programmes are becoming more common. It is cheaper and more convenient but not necessarily more effective than traditional programmes. At the end of the day, it is the system's ability to deliver caring, competent and committed professionals to those in need that is of paramount importance.

Although some form of ethics education has been included in the undergraduate training, there is a comparative paucity of such training in the postgraduate area. Appropriate training in ethics not only cultivate virtuous clinicians but also provides a set of skills to address ethical dilemmas we encounter in daily practice in a well-reasoned way. All doctors must demonstrate a commitment to fulfilling professional responsibilities, adherence to ethical principles, and sensitivity to an increasingly diverse patient population. Doctors remain one of the most trusted professions in our society and we should not take this for granted.

Medical graduates may pursue their professional training in a specialty or even a particular sub-specialty subsequently. Our profession needs clinical experts in various fields, but it is at least equally important for some to develop specialised expertise in research. My interest in research developed when I spent a year's elective in research at the Prince of Wales Hospital. I would probably have missed this transformational experience if I was not working in a university teaching hospital. Therefore, it is important to give the students and new graduates the opportunities to explore their own interests. Postgraduate research training and degrees such as Doctoral of Medicine are available in the two medical schools in Hong Kong. However, this remains a difficult career path. In order to practise evidence-based medicine, clinical research is essential and can never be replaced totally by laboratory research. Furthermore, the role of clinician-scientists remains crucial to the continuing success of modern medicine, the power of which will continue to grow if we can preserve and enhance the art and science of our profession. Although only a small minority of each graduating class will become clinician-scientists, it is essential that there are some to carry on this precious tradition.

A good health care system needs competent and safe doctors as well as administrators with a clear commitment to creating patient services that deliver excellence. It is crucial to have clinicians in these leadership and management roles. Therefore, all doctors should have a reasonable grounding in management skills. It is possible to further improve postgraduate clinical and administration training.


Indeed, organisations such as the Hospital Authority and Department of Health are already intimate partners with the universities in this endeavour. It is not the preordained destiny of all doctors to treat patients; some will be called upon to care for organisations.

## The Chinese University of Hong Kong Medical Alumni Association (CUHKMAA)


Formed in 1992, CUHKMAA now has more than 3000 potential members. It provides a network platform among our medical alumni and organises various social events such as dragon boat races and golf tournaments. Moreover, the Association also serves as a platform for promoting the good name of our medical school and serving the medical profession. The possibility of setting up a section on Medical Education on our web has been discussed. Medical education never ends at any stage though it may be in various forms. It has certainly been my privilege to be involved in it.

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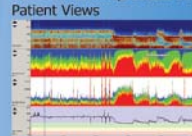
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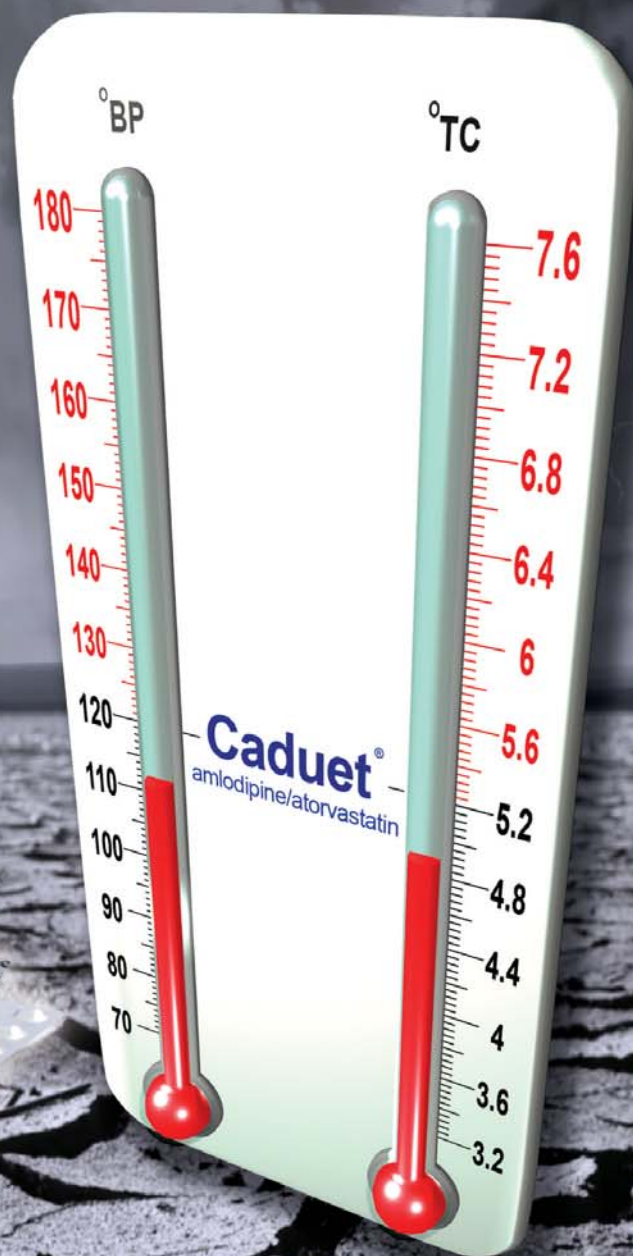
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## Working Hours and Training

### Dr. Ka-lau LEUNG

MBChB, FRCS(Edin), FCSHK, FHKAM, MD



Dr. Ka-lau LEUNG

Representing the Medical sector in the Legislative Council does not give me much authority to comment on medical training. However my strong belief in "standard working hours" has raised concern, I would like to defend myself from the perspective of a unionist.

When the issue of standard working hours was raised, the media, the general public and even some colleagues thought that I was trying to limit the working hours of public doctors to 44 hours per week. When public hospitals were overloaded and the economics went downhill, a proposal to limit working hours would not gain any public support.

To limit working hours may just be an intended misinterpretation by the Hospital Authority and its lawyers. From the very beginning, I had made it very clear that, the "standard working hours" written in our contract is not a limit; it is a reference to calculate basic salaries and other fringe benefits. All hospital staff may be required to work overtime when necessary, and in return, if the overtime is beyond certain extent, the staff should be entitled to compensation in term of time-off or allowance as the case may be.

In the Court of Appeal, the Honourable Madam Justice Yuen agreed with us, *"With respect, it seems to me that that [HA's] argument confuses the issue. The doctors are not refusing to work overtime or to be rostered on call. They are simply asking for recompense for the additional time worked - primarily by asking that their employer provide for time-off. The fact that doctors are prepared by virtue of their culture and ethos to attend to patients whenever required does not justify an employer denying them proper recompense for the work they do. To suggest otherwise, it seems to me, is to take unfair advantage of that culture and ethos."*

The argument equally applies to on-the-job basis training with productive component. Some constituent Colleges of the Hong Kong Academy of Medicine have expressed concern that limiting working hours to 65 hours per week (as proposed by the Hospital Authority) will jeopardise the training of their trainees. It is the Colleges' authority to decide how much their trainees should work for training, but I hope the Colleges would agree that their trainees should be rewarded for the overtime service they provide to the Hospital Authority.

In the past, training was a valuable by-product of serving in public sector. When there was severe shortage of doctors in public hospitals, majority of

colleagues worked overtime excessively, and clinical experience accumulated very fast in the course of treating numerous patients. Fulfilling training itself was not a criterion for the employment.

As a natural development of the society, more medical graduates were trained, but the Government and Hospital Authority did not have a concerted manpower planning. In the early 90s, because of the increased subsidy from Government, the Hospital Authority could retain most of the newly registered doctors. However the additional manpower was used mainly to expand its service rather than replacing the deficit. No wonder the private medical sector gradually shrank.

Finally when the Government subsidy reached plateau, and at the same time the wastage of public doctors fell to 2% yearly, the Authority was not be able to employ all new doctors. In May 1997 it was reported that ~100 new doctors would not be employed. After negotiation the 100 colleagues were only offered 3-year contract (in contrast to permanent contract in the past) in view of funding uncertainty. Since then, by virtue of the excuse of "under training", the Hospital Authority made it a fixed rule to offer contract terms to junior doctors.

Although there were only 3449 public doctors in 1997, as funding was inadequate, the 100 new doctors became redundant and were only employed to be "trained". Last year we had 5059 public doctors, and the Government had promised to increase subsidy. The Hospital Authority then asked for 500 new doctors yearly from the two medical schools.

Every stakeholder has his own concern and authority on manpower and training. As a lesson, "standard working hours" serves as an important parameter to force the Hospital Authority to obtain the adequate resources for its service load. If the Hospital Authority is required to expand its services, it should provide more resources to retain the necessary manpower, rather than asking the staff to work overtime excessively. Junior colleagues should be retained in the public sector if they wish. The time required for training may be longer, but it is much better than pushing them to the private market pre-maturely.

## Medicine as Our Liberal Arts

**Dr. Gilberto KK LEUNG**

*Assistant Professor, Department of Surgery, Li Ka Shing Faculty of Medicine, The University of Hong Kong*



Dr. Gilberto KK LEUNG

Liberal arts originated in Ancient Greece as a body of knowledge considered essential for a *free man*. Not many students in Hong Kong have the opportunity for a pre-medicine undergraduate education in liberal arts. Some accept it with regret or indifference, others rejoice or wonder. Few entertain that Medicine already is our liberal arts.

The *Trivium* of grammar, rhetoric and logic, together with the *Quadrivium* of geometry, music, astronomy and arithmetic, were the seven liberal arts in medieval times. These evolved into a modern curriculum which now includes literature, science, languages, history, philosophy and art. In North America, an undergraduate education in liberal arts is often recommended as a desirable preparation for medical school. It aims to impart not only general knowledge, but also training for the intellect and nourishment for the soul.

Medicine and liberal arts value the same attributes in the educated. What enables a physician to detect pallor and anaemia, and diagnose alcoholism and depression in one patient, and an occult tumour in another? Prepared observation for details, a panoramic view of the consortium of known facts, organised thinking, informed decision-making and timely action are what make a competent doctor. In much the same way, a liberal arts education promotes these qualities to prepare its graduates as future governors, engineers, bankers or scholars. It is the tuned intellect and the practical mind that the two curricula nurture, well beyond the mere acquisition of factual information.

Both emphasise an active engagement with knowledge. Learning is a life-long and lively process. A few years in university will not instill all that one needs to know. A liberal arts student learns how to learn, and how to continue to learn years after a graduation gown was donned. To see things in context and to career upon a journey of continuous self-education is also what medicine asks of its practitioners. The climate in medical schools is changing and students are no longer passive recipients of facts. The introduction of Problem Based Learning in this Faculty is an example of Medicine acknowledging its duty to coach self-teaching. By acquainting with the dynamics of the latter, students may also embrace teaching others in later years with ease and passion. It rises above problem-solving. A study on the genealogy of Ivy League professors will testify.

And Medicine is creative just as liberal arts encourage the cross-fertilisation of ideas. When we recount the development from Mendel's work on pea-plants to gene

therapy, or the aesthetics underpinning I.M. Pei's Pyramids of the Louvre, we provide our students with glimpses of how a trained and creative mind is capable of surprises and benefits to mankind. While liberal arts students may at times mistake creativity for nonconformity, medical students should recognise their potential and duties in transforming not only medical practices but this world also.

Indeed, Medicine should be taught like liberal arts. Functioning high above information gathering are the faculties for critical evaluation of evidence and argument. Whether evidence-based medicine leads to better patient care is one discussion that will outlast the shelf-lives of our beloved journals. But it has undeniably ignited our minds for clear and independent thinking when faced with distortions and dogmas. What gives Medicine the unique distinction over other sciences in this respect is that Medicine, for all its worth, is not exactly a science, or at least not an exact science, but an art based on science. Liberal arts guide us to live certainly in an uncertain world. In Medicine, we are taught to make hard decisions based on incomplete information, forever balancing the risks and benefits to our patients amidst the internal dialogues between our conscience and ego. Liberal arts and Medicine echo each other in this symphony of human conditions; their students must learn to master its lyrical and mathematical beauty - orderly but never the same, soberly passionate, calculated and spontaneous.

A liberal arts education illuminates the coherence and relationships between facets of our lives. A country, one comes to understand, may find its roots of unhappiness in economical, political, religious and cultural conflicts, individually contributory and mutually influenced. Doctors must similarly appreciate the interplay between physical diseases and psychology in their patients, and prescribe treatment compatible with the existing ethical standards, resources and expectations of families and society. Nothing short of a holistic world-view will suffice.

*But aren't we professing all these already as enlightened medical teachers?*

Yes, but so far only for producing better doctors. It is only by elevating medical training to the level of an explicit and complete education for individuals that we will also produce better leaders, citizens, colleagues, teachers, spouses, parents and friends. And there is more than just utilitarian gain. Medicine shows us that





work and responsibilities can be fun, that our transient existence is precious and miraculous; just as logic unveils for us the comedy behind a paradox, and geometry makes us marvel at the hidden beauty of foliage on the first day of summer.

To treat Medicine as a stand-alone or part of a liberal arts curriculum is not about drawing comparison and borrowing from each other. Medicine already possesses many elements of a liberal arts education. What is important and lacking is the very *awareness* that it does. It is an awareness that must be articulated and shared by both students and teachers.

Medicine was deficient in the past with its rigid curriculum and a relentless desire to download (or is it 'upload'?) time-honoured bytes of unusable information. The divorce of education from application in the guise of scholarship had ill-prepared doctors for this ever-changing and occasionally hostile world. Now that we are armed with core and optional modules, blessed with an extended curriculum, and woken up to the calls from our doctors and the public on what is wanted and needed, there is no better time to address what medical education in Hong Kong can do and must do - to give birth to our unborn liberal arts, to graduate our students as a future class of *free man*.

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# Human Swine Influenza

## Dr. Vincent CC CHENG

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Dr. Vincent CC CHENG

*This article has been selected by the Editorial Board of the Hong Kong Medical Diary for participants in the CME programme of the Medical Council of Hong Kong (MCHK) to complete the following self-assessment questions in order to be awarded one CME credit under the programme upon returning the completed answer sheet to the Federation Secretariat on or before 31 August 2009.*

## Background

Influenza A virus belongs to the family Orthomyxoviridae. It is a single-stranded, negative sense RNA virus with 8 gene segments, encoding the surface glycoproteins of haemagglutinin (HA) and neuraminidase (NA), RNA polymerase (PA, PB1, PB2), nucleoprotein (NP), matrix protein (M), and nonstructural protein (NS). Based on the antigenic characteristics of HA and NA, they can be classified into 16 HA subtypes (H1-H16) and 9 NA subtypes (N1-9). Of the total 144 possible combinations, only three HAs and two NAs in 3 combinations (H1N1, H2N2, and H3N2) have been reported as human adapted viruses. These proteins not only mediate viral attachment and release from the susceptible host cells but also elicit immune responses to prevent infection or reduce viral replication. Therefore, when a new influenza virus emerges in the population without pre-existing immunity, it may cause a pandemic.

## History of Pandemic Influenza

In the past 100 years, there have been three major influenza pandemic events. The most severe one was human influenza A H1N1 (1918), and known as Spanish influenza. At that time, one-third of the world population was infected and 20 to 40 million persons died over a period of 18 months. Interestingly, the virus appeared to overcome the species barrier, transmitting from an avian source to humans and swine in 1918.

The next influenza pandemic was caused by H2N2 (1957), and known as the Asian influenza. This was the first time in demonstrating avian and human genetic reassortment. This new strain acquired 3 new gene segments from an avian source (HA, NA, and PB1) and maintained the other 5 gene segments from the 1918 influenza virus. This pandemic was considered moderate with a worldwide mortality of 2 to 4 million persons

Hong Kong was famous in the naming of the pandemic influenza, H3N2 in 1968. Avian and human genetic reassortment occurred once again. Two new gene segments (HA, PB1) were introduced from an avian source. This pandemic was considered mild because only 1 million people succumbed worldwide. This is double the global mortality due to seasonal influenza virus.

## Silent Evolution of Human Swine Influenza

Historically, pandemic influenza occurs once every 10 to 40 years. Therefore, when the outbreak of avian influenza H5N1 occurred in Hong Kong in 1997<sup>1</sup> and subsequently spread to the other parts of the world after the year 2000, many academic institutions focused their research in preparing for an avian influenza pandemic. However, a new triple reassortment swine influenza virus (with the genetic sources from swine, avian, and human origins) was silently emerging in the swine population of North America in 1998<sup>2</sup>. A recent phylogenetic estimate of the genetic surveillance further suggests that the reassortment of swine lineages from multiple genetic ancestries may have occurred 10 years before human emergence<sup>3</sup>.

The first human case infected with this new triple reassortment swine influenza virus was reported in a 17-year-old man who had epidemiological exposure to pigs at a slaughterhouse in Wisconsin. Since then, another 11 cases of human infection by this new triple reassortment swine influenza virus occurred between January 2006 and February 2009<sup>4</sup>.

## Outbreak of Human Swine Influenza in 2009

In mid-February, an outbreak of respiratory illness occurred in La Gloria, Veracruz, Mexico, followed by increased reports of patients with influenza-like illness in several areas of Mexico in March and early April 2009 (Table 1). The world was alerted when a novel influenza A virus (H1N1) was isolated in two children (aged 9 and 10) living in Imperial Country and San Diego Country in California on 15 April and 17 April 2009 respectively<sup>5</sup>. The infection rapidly spread from Mexico to North America, and 125 countries were involved as of 3 July 2009. The World Health Organization (WHO) raised the pandemic alert level gradually and declared influenza pandemic on 11 June 2009.

The clinical features of human swine influenza were similar to that reported in seasonal human influenza. An early study summarised the clinical characteristics of 642 confirmed cases in the US. Fever and cough were present in more than 90% of patients. However, gastrointestinal



symptoms such as vomiting and diarrhoea occurred in about 25% of patients, which were comparable to patients with avian influenza and SARS (Table 2)<sup>5-8</sup>. According to the early report from the WHO, the incubation period of human swine influenza ranged from 1-7 days with a median of 3-4 days. The clinical attack rate was particularly high (~ 33%) in school children in one outbreak. The reproductive number was estimated as 1.4 to 1.6 in a closed community in Mexico. Persons aged less than 30 year old were mostly affected<sup>9</sup>.

**Table 1. Timeline of human swine influenza virus outbreak**

Mid Feb	Outbreak of respiratory illness in La Gloria, Veracruz, Mexico
12 April	Mexican public health authorities report outbreak to PAHO
15 April	CDC identifies S-OIV in a boy from San Diego, California
17 April	CDC identifies S-OIV in a girl from Imperial, California
21 April	CDC alerts doctors to a new strain of H1N1 influenza virus
24 April	WHO issue Disease Outbreak Alert
27 April	WHO raise the pandemic alert from phase 3 to 4
29 April	WHO raise the pandemic alert from phase 4 to 5
1 May	Containment phase in HK (diagnosis of 1st imported case)
10 June	Onset of community outbreak in HK
11 June	WHO raise the pandemic alert from phase 5 to 6
13 June	Early mitigation phase in HK (opening of designated fever clinics)
18 June	Mitigation phase in HK (admission of confirmed case or severely ill)
29 June	Late mitigation phase in HK (admission of patients with severely ill)

**Table 2. Comparison of clinical symptoms of human swine influenza, avian influenza, and SARS**

Symptoms	Human swine influenza	Avian influenza	SARS
Fever	371/394 (94%)	58/59 (98%)	751/752 (99%)
Cough	365/397 (92%)	52/59 (88%)	460/702 (66%)
Sore throat	242/367 (66%)	17/33 (51%)	91/552 (17%)
Diarrhea	82/323 (25%)	19/49 (39%)	130/647 (20%)
Vomiting	74/295 (25%)	11/45 (24%)	8/30 (27%)
Abdominal pain	NM	9/39 (23%)	NM
Rhinorrhoea	9/30 (30%)	16/29 (55%)	50/362 (14%)
Headache	5/30 (17%)	9/32 (28%)	292/752 (39%)
Myalgia	10/30 (33%)	13/45 (28%)	365/752 (49%)
Dyspnea	13/30 (43%)	34/55 (62%)	282/614 (46%)
Pleurisy	NM	NM	47/210 (22%)

## Virulence of Human Swine Influenza

Complete genome sequencing revealed that the known molecular marker of pathogenicity (PB1-F2) was not expressed in the current strain of human swine influenza. PB1-F2 is a proapoptotic factor that compromised the ability of the host to mobilise adaptive immunity and resulted in secondary bacterial pneumonia in animal experiments<sup>10</sup>. PB1-F2 was consistently present in influenza viruses known to be of increased virulence in humans, including the viruses that caused the 1918, 1957, and 1968 pandemics, and the avian influenza virus H5N1 in 1997. Therefore, the clinical symptoms of human swine influenza remain mild in most patients, except for those acquiring infections in Mexico. In an early report from the WHO that summarised the first 3734 laboratory confirmed cases as of 20 May 2009, the overall case fatality ratio was 2%. The median time from symptom onset to hospitalisation and symptom onset to death was 6 days (1-20 days), and 10 days (2-33 days) respectively. In 45 of 74 fatal cases reviewed, 54% were healthy people mostly aged between 20-59 years<sup>9</sup>. Eighteen patients

hospitalised for viral pneumonia in Mexico between 24 March and 24 April 2009 was further analysed<sup>11</sup>. More than half of them were aged between 13 and 47 years, and only 8 had pre-existing medical conditions. Twelve (67%) patients required mechanical ventilation and 7 (39%) died. A more comprehensive analysis from the Mexican Ministry of Health revealed the mortality from severe pneumonia according to age group during 24 March to 29 April 2009, as compared with influenza seasons from 2006 through 2008, was about 10 times higher in the age groups of 10-14, 15-10, 20-24, and 25-29<sup>12</sup>. It seems that the clinical severity of human swine influenza is greater in Mexico than US and Canada. As of 3 July 2009, the mortality rate of human swine influenza is 1.16% in Mexico, whereas the mortality is 0.5% and 0.31% in the US and Canada respectively.

In view of the apparent discrepancy in clinical severity of human swine influenza in different populations, animal models using ferrets (*Mustela putorius furo*) have been attempted by two groups of scientists from the US and the Netherlands<sup>13,14</sup>. Both groups confirmed the new virus is more pathogenic than seasonal influenza but not as dangerous as the pandemic influenza H1N1 in 1918, or the avian influenza H5N1. In contrast to the seasonal influenza which only infects the nasal cavity, human swine influenza also infects the trachea, the bronchi, as well as the intestinal tract, which may explain the clinical manifestations of viral pneumonia and gastrointestinal symptoms and signs. However, both teams disagreed on the transmissibility of this new virus. One team found that the spread was as good as the seasonal influenza virus, whereas the other team found that it was less efficient in transmission. To date, the estimated reproductive number of human swine influenza is lower than that of the past influenza pandemics with a range of 1.8 - 2.5.

## Strategic Measures to Control Human Swine Influenza

With the advance of international air travel, it is extremely difficult to contain emerging infectious diseases nowadays<sup>15</sup>. Between March and April 2009, more than 2 million passengers flew from Mexico to 1018 cities in 164 countries (80.7% to US and Canada; 8.8% to Central America, South America, and Caribbean Islands; 8.7% to Western Europe; 1% to East Asia, and 0.8% to elsewhere). The number of confirmed cases was proportional to the volume of international passengers arriving from Mexico during the initial phase of the outbreak<sup>16</sup>. Therefore, during the containment phase of outbreak control in Hong Kong, tight border control and screening of passengers with fever or influenza-like illness, early isolation of suspected cases, tracing of close contacts, and prescription of post-exposure prophylaxis may have delayed the spread of the virus in the community. Prompt development of rapid molecular diagnostic tests is essential to prepare for the challenge<sup>17,18</sup>. On the first of May 2009, the first confirmed case diagnosed in Hong Kong was a 25-year-old man travelling from Mexico, which signified the beginning of our battle against human swine influenza. Over the next 40 days, both the government and the public health system maintained a high level of vigilance to contain human swine influenza and prevent the occurrence of nosocomial outbreaks.



However, as presymptomatic shedding of influenza virus has been well demonstrated in healthy volunteer studies, it would be impossible to interrupt the chain of transmission by identification and isolation of the symptomatic cases. A community outbreak of human swine influenza occurred in a secondary school on 10 June 2009, followed by an increasing number of locally acquired cases with no known source of infection. The government policy moved from the containment phase to the mitigation phase in order to reduce the total number of infections as well as delaying the peak of hospitalisation, while waiting for the availability of vaccination. As of 19 July 2009, there are 1810 confirmed cases of human swine influenza. One patient died of CA-MRSA coinfection and four immunocompetent adults were under critical condition.

## Infection Control Measures Against Human Swine Influenza

Human swine influenza, like seasonal human influenza, is transmitted via droplets and contact. Personal hygiene including cough etiquette, wearing masks while experiencing upper respiratory symptoms, and enforcing hand hygiene before touching our mucous membranes remain the key measures to prevent the community as well as nosocomial transmission of influenza viruses. Since the influenza virus can survive in inanimate objects for up to 48 hours and on our hands for 15 minutes, we may subconsciously transmit the virus from the environment to ourselves via our unclean hands. In the hospital setting, full personal protective equipment is to be worn (including eye protection, face shield, and N95 mask) upon performing aerosol generating procedures (intubation, cardiorespiratory resuscitation, bronchoscopy, surgery, and autopsy).

## Use of Antivirals Against Human Swine Influenza

Unlike seasonal human influenza H1N1 which has almost 100% oseltamivir resistance, human swine influenza remains susceptible to oseltamivir<sup>19</sup>. The drug can be reserved for high risk patients who may be at risk of severe complications and mortality. However, sporadic cases of oseltamivir resistance have been reported in human swine influenza isolated in Denmark, Japan, and Hong Kong. In Hong Kong, a 16-year-old girl who travelled from the US was confirmed to carry a de novo oseltamivir-resistant strain. This case serves as an important reminder that oseltamivir resistance can emerge with time.

## Conclusion

We are facing a new challenge of a human swine influenza pandemic due to a triple reassortment virus H1N1. The disease is apparently mild in the summer time. However, the most deadly influenza pandemic of 1918 also started with a mild disease but followed by a wave of greater impact during the winter time. In particular, recent animal studies have demonstrated the potential virulence of this new virus in causing lower

respiratory tract involvement. We must be continually vigilant in monitoring the epidemiological, clinical, and virological characteristics of this new virus.

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## MCHK CME Programme Self-assessment Questions

Please read the article entitled "Human Swine Influenza" by Dr. Vincent CC CHENG and complete the following self-assessment questions. Participants in the MCHK CME Programme will be awarded 1 CME credit under the Programme for returning completed answer sheets via fax (2865 0345) or by mail to the Federation Secretariat on or before 31 August 2009. Answers to questions will be provided in the next issue of The Hong Kong Medical Diary.

Questions 1-10: Please answer T (true) or F (false)

1. Influenza A virus is a segmental RNA virus
2. Surface glycoproteins of haemagglutinin (HA) and neuraminidase (NA) mediate viral attachment and release from the susceptible host cells
3. Pandemic influenza happens once every 20 years
4. Human swine influenza is emerging as a result of swine and human genetic reassortment
5. Gastrointestinal manifestation is the predominant clinical symptoms of human swine influenza
6. The reproductive number of human swine influenza is greater than that of seasonal influenza
7. Virulent factors are not well defined in human swine influenza
8. The clinical severity of human swine influenza is greater in Mexico than that in US and Canada
9. Human swine influenza is transmitted via airborne
10. Human swine influenza remains universally susceptible to oseltamivir

## ANSWER SHEET FOR AUGUST 2009

Please return the completed answer sheet to the Federation Secretariat on or before 31 August 2009 for documentation. 1 CME point will be awarded for answering the MCHK CME programme (for non-specialists) self-assessment questions.

## Human Swine Influenza

**Dr. Vincent CC CHENG**

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Specialist in Clinical Microbiology & Infection, Department of Microbiology,  
Queen Mary Hospital, The University of Hong Kong

1  2  3  4  5  6  7  8  9  10

Name (block letters): \_\_\_\_\_ HKMA No.: \_\_\_\_\_

HKID No.: \_\_\_\_\_ - \_\_\_\_\_ X X (x) HKDU No.: \_\_\_\_\_

Contact TelNo.: \_\_\_\_\_ CDSHK No.: \_\_\_\_\_

### Answers to July 2009 Issue

Recent Development in Minimally Invasive Colorectal Surgery

1 . F    2 . T    3 . F    4 . F    5 . F    6 . F    7 . T    8 . F    9 . T    10 . F

# Certificate Course on

**CME/CNE Course**

# Clinical Ophthalmology

Jointly organised by:

Course No. C148



**The Federation of  
Medical Societies of Hong Kong**



**The Hong Kong  
Ophthalmological Society**

Objectives: This course aims to provide an overview and update in the diagnosis and management of common and important eye diseases. After attending the course, attendees will learn how to deal with common ophthalmic conditions and when to refer patients to ophthalmologists.

Date	Topic	Speaker
2 September 2009	Cataract 白內障	Dr. Siu-Wah YUEN 袁紹華醫生
	Refractive Errors and Refractive Surgeries 屈光不正及手術	Dr. Kenneth W.H. NG 吳永浩醫生
9 September 2009	Squint 斜視眼	Dr. Joan S.K. NG 吳少琮醫生
	Corneal and External Eye Diseases 角膜及外眼疾病	Dr. Alvin L. YOUNG 楊樂叻醫生
16 September 2009	Common Ophthalmic Eye Drops 常用眼科滴眼液	Dr. Carol S. YU 余珊醫生
	Glaucoma 青光眼	Prof. Clement C.Y. THAM 譚智勇教授
23 September 2009	Paediatric Ophthalmology 兒童眼疾	Dr. Chung-Yin CHU 朱仲賢醫生
	Red Eyes, Ocular Trauma and Emergencies 紅眼, 眼部創傷及眼科急症	Dr. Suk-I CHIU 趙淑義醫生
30 September 2009	Diseases of Eye Lids, Lacrimal System and Orbit 眼瞼, 淚管及常見眼眶疾病	Dr. Pak-Man CHENG 鄭柏文醫生
	Neuro-ophthalmology 視神經眼科	Dr. Andy C.O. CHENG 鄭智安醫生
7 October 2009	Retinal Detachment and Diabetic Retinopathy 視網膜脫落及糖尿眼病	Dr. Barbara S.M. TAM 譚秀雯醫生
	Common Macular Diseases 常見黃斑點疾病	Dr. Alvin K.H. KWOK 郭坤豪醫生

Dates: 2 September 2009 - 7 October 2009 (Every Wednesday)  
 Time: 7:00 p.m. - 8:30 p.m.  
 Venue: Lecture Hall, 4/F., Duke of Windsor Social Service Building,  
 15 Hennessy Road, Wanchai, Hong Kong  
 Language Media: Cantonese (Supplemented with English)  
 Course Fee: HK\$750 (6 sessions)  
 Certificate: Awarded to participants with a minimum attendance of 70%  
 Enquiry: The Secretariat of The Federation of Medical Societies of Hong Kong  
 Tel.: 2527 8898 Fax: 2865 0345 Email: info@fmsmk.org

### CME / CPD Accreditation in application

A total of 9 CNE points for the whole course and the points will be awarded according to the number of hours attended.  
 Application form can be downloaded from our website: <http://www.fmsmk.org>

CERTIFICATE COURSE FOR NURSES AND  
ALLIED HEALTH PROFESSIONALS

# Certificate Course on Respiratory Medicine 2009

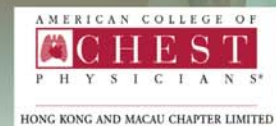
Jointly organised by :



The Federation of Medical Societies  
of Hong Kong  
香港醫學組織聯會



Hong Kong Thoracic Society  
香港胸肺學會



美國胸肺學院(港澳分會)

Date	Topic	Speaker
22 September 2009	Tuberculosis in HIV infected patients - the local perspectives	Dr. Chi-Kuen CHAN 陳志權醫生
29 September 2009	Fitness to fly in respiratory patients - trends in assessment	Dr. Kam-Cheung WONG 黃錦祥醫生
6 October 2009	Mechanical ventilation (i) Principles and practices (ii) Tracheostomy care	Dr. Chun-Wing LAU 劉俊穎醫生 Ms. Yuen-Ping LAM 藍婉平女士
13 October 2009	Influenza (i) An update including human swine influenza (ii) Infection control	Dr. Wai-Cho YU 余衛祖醫生 Ms. Wai-Chun TANG 鄧慧珍女士
* 20 October 2009	Non-pharmacological treatment of COPD (i) Pulmonary rehabilitation (ii) Smoking cessation	Dr. Thomas MOK 莫恩榮醫生 Ms. Doris TSE 謝笑芬女士
27 October 2009	(i) Postoperative respiratory failure (ii) Deep vein thrombosis and pulmonary embolism	Dr. Wai-Ming CHAN 陳惠明醫生

**Dates** : 22 September 2009 - 27 October 2009 (Every Tuesday)  
**Time** : 7:00 p.m. - 8:30 p.m.  
**Venue** : **The Hong Kong Council of Social Service**

Auditorium, 1/F., Duke of Windsor Social Service Building,  
15 Hennessy Road, Wanchai, Hong Kong

\* **The Boys' & Girls' Clubs Association of Hong Kong**  
Room 502, 5/F., 3 Lockhart Road, Wanchai, Hong Kong

**Language Media** : English (Supplemented with Cantonese)  
**Course Fee** : HK\$750 (6 sessions)  
**Certificate** : Awarded to participants with a minimum attendance of 70%  
**Enquiry** : The Secretariat of The Federation of Medical Societies of Hong Kong  
**Tel.** : 2527 8898  
**Fax** : 2865 0345  
**Email** : info@fmshk.org

## CME / CPD Accreditation in application

A total of **9 CNE points** for the whole course and the points will be awarded according to the number of hours attended.

Application form can be downloaded from our website: <http://www.fmshk.org>



Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
						<ul style="list-style-type: none"> <li>★ Charity Concert for Suicide Prevention Services</li> </ul>
<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>	<b>6</b>	<b>7</b>	<b>8</b>
<ul style="list-style-type: none"> <li>★ HKMA Certificate Course on Family Medicine 2009</li> </ul>	<ul style="list-style-type: none"> <li>★ HKMA - Shatin Doctors Network - Update on Asthma Management</li> <li>★ HKMA Orchestra Rehearsal</li> <li>★ HKMA/MPS Risk Management Workshop</li> </ul>	<ul style="list-style-type: none"> <li>★ HKMA/MPS Risk Management Workshop</li> <li>★ FMSHK Officers' Meeting</li> </ul>	<ul style="list-style-type: none"> <li>★ HKMA - Shatin Doctors Network - Update on Asthma Management</li> <li>★ HKMA Orchestra Rehearsal</li> <li>★ HKMA/MPS Risk Management Workshop</li> </ul>	<ul style="list-style-type: none"> <li>★ HKMA/MPS Risk Management Workshop</li> <li>★ HKMA Council Meeting</li> </ul>	<ul style="list-style-type: none"> <li>★ Joint Surgical Symposium - New Technology in Colorectal Operations</li> </ul>	<ul style="list-style-type: none"> <li>★ Refresher Course for Health Care Providers 2008/2009 - Role of Physiotherapy in General Practice</li> <li>★ HKMA/MPS Risk Management Workshop</li> </ul>
<b>9</b>	<b>10</b>	<b>11</b>	<b>12</b>	<b>13</b>	<b>14</b>	<b>15</b>
			<ul style="list-style-type: none"> <li>★ HK Neurosurgical Society Monthly Academic Meeting - Special Lecture: Brain Attack</li> <li>★ HKMA - Shatin Doctors Network - Certificate Course on Osteoporosis</li> <li>★ HKMA Orchestra Rehearsal</li> </ul>	<ul style="list-style-type: none"> <li>★ HKMA Structured CME Programme with Hong Kong Sanatorium &amp; Hospital Year 2009 - Treatment of Cancer in the Molecular Era</li> </ul>	<ul style="list-style-type: none"> <li>★ HKMA-Shatin Doctors Network CME Lecture Series on Type 2 DM Management</li> </ul>	<ul style="list-style-type: none"> <li>★ Certificate Course on Clinical Teaching and Assessment (Code no: TC-CTA-0903)</li> <li>★ Certificate Course on Interpretation of Electrocardiography (Code no: TC-ECG-0902)</li> <li>★ HKMA KE Network - Pain Management: Anaesthetist Perspective: (1) Neck and Back Pain(2) Post Herpetic Neuralgia</li> <li>★ HKMA HKE Network - Diabetes Mellitus Complications (DM II)</li> </ul>
<b>16</b>	<b>17</b>	<b>18</b>	<b>19</b>	<b>20</b>	<b>21</b>	<b>22</b>
			<ul style="list-style-type: none"> <li>★ HKMA Orchestra Rehearsal</li> </ul>	<ul style="list-style-type: none"> <li>★ HKMA Orchestra Rehearsal</li> <li>★ FMSHK Executive Committee and Council Meeting</li> </ul>	<ul style="list-style-type: none"> <li>★ HKMA Orchestra Rehearsal</li> </ul>	<ul style="list-style-type: none"> <li>★ HKMA-Shatin Doctors Network CME Lecture Series on Type 2 DM Management</li> <li>★ Certificate Course on Clinical Teaching and Assessment (Code no: TC-CTA-0903)</li> <li>★ Certificate Course on Interpretation of Electrocardiography (Code no: TC-ECG-0902)</li> <li>★ HKMA Orchestra 20th Anniversary Concert</li> </ul>
<b>23</b>	<b>24</b>	<b>25</b>	<b>26</b>	<b>27</b>	<b>28</b>	<b>29</b>
<ul style="list-style-type: none"> <li>★ HKMA Structured CME Programme with PMH Year 2009 (7) - i) Approach to Breast Mass ii) Management of Goiter</li> </ul>					<ul style="list-style-type: none"> <li>★ HKMA - Shatin Doctors Network CME Lecture When and How to Start Insulin</li> </ul>	<ul style="list-style-type: none"> <li>★ HKMA/MPS Risk Management Workshop</li> <li>★ Certificate Course on Clinical Teaching and Assessment (Code no: TC-CTA-0903)</li> <li>★ HKMA TSW Network - Certificate Course on Treating Alzheimer's Disease in Community (I) Case Based Discussion of Diagnosis of Early Alzheimer's Disease, and the</li> <li>★ Certificate Course on Interpretation of Electrocardiography (Code no: TC-ECG-0902)</li> </ul>
<b>30</b>	<b>31</b>					
<ul style="list-style-type: none"> <li>★ HKMA/MPS Risk Management Workshop</li> <li>★ Joint Professional Badminton Tournament</li> </ul>						





Date / Time	Function	Enquiry / Remarks
<b>1 SAT</b> 8:00 pm	<b>Charity Concert for Suicide Prevention Services</b> Organised by: The Hong Kong Medical Association Charitable Foundation, Chairman: Dr. P.C. CHOW, Venue: Concert Hall, Hong Kong Cultural Centre	Ms. Candy YUEN Tel: 2527 8285
<b>4 TUE</b> 6:00 pm (5,6,8,29,30) 8:00 pm - 10:00pm	<b>HKMA/MPS Risk Management Workshop</b> Organised by: The Hong Kong Medical Association, Speaker: Dr. Bronwyn HARTWIG, Venue: The HKMA Dr. Li Shu Pui Professional Education Centre, 2/F, Chinese Club Building, 21-22 Connaught Road Central, Hong Kong <b>FMSHK Officers' Meeting</b> Organised by: The Federation of Medical Societies of Hong Kong, Venue: Gallop, 2/F., Hong Kong Jockey Club Club House, Shan Kwong Road, Happy Valley, Hong Kong	Miss Viviane LAM Tel: 2527 8452 2.5 CME Points  Ms. Paulina TANG Tel: 2527 8898 Fax: 2865 0345
<b>5 WED</b> 2:00 pm 8:00 pm (12,19,20,21)	<b>HKMA - Shatin Doctors Network - Update on Asthma Management</b> Organised by: HKMA - Shatin Doctors Network, Speaker: Dr. Joseph LEE, Venue: Shatin <b>HKMA Orchestra Rehearsal</b> Organised by: The Hong Kong Medical Association, Venue: New Asia Middle School	Miss Alice TANG Tel: 2527 8285 1.5 CME Points Ms. Candy YUEN Tel: 2527 8285
<b>6 THU</b> 8:00 pm	<b>HKMA Council Meeting</b> Organised by: The Hong Kong Medical Association, Chairman: Dr. H.H. TSE, Venue: HKMA Head Office, 5/F., Duke of Windsor Social Service Building, 15 Hennessy Road, Wanchai, Hong Kong	Ms. Christine WONG Tel: 2527 8285
<b>7 FRI</b> 8:00 am - 9:00 am	<b>Joint Surgical Symposium - New Technology in Colorectal Operations</b> Organised by: Department of Surgery, The University of Hong Kong & Hong Kong Sanatorium & Hospital, Chairman: Dr. Angus C.W. CHAN, Speakers: Prof. LAW Wai-Lun & Dr. Jensen POON, Venue: Hong Kong Sanatorium & Hospital	Department of Surgery, Hong Kong Sanatorium & Hospital Tel: 2835 8698 Fax: 2892 7511 1 CME Point (Active)
<b>8 SAT</b> 2:30 pm	<b>Refresher Course for Health Care Providers 2008/ 2009 - Role of Physiotherapy in General Practice</b> Organised by: The Hong Kong Medical Association and Our Lady of Maryknoll Hospital, Chairman: Dr. LO Wai Hon, Speaker: Mr. Robin TSIM, Venue: Training Room II, 1/F., OPD Block, Our Lady of Maryknoll Hospital, 118 Shatin Pass Road, Wong Tai Sin, Kowloon, Hong Kong	Ms. Clara TSANG Tel: 2354 2440 2 CME Points
<b>9 SUN</b> 2:00 pm	<b>HKMA Certificate Course on Family Medicine 2009</b> Organised by: The Hong Kong Medical Association, Speakers: Dr. CHAN Tat Eddie & Prof. WONG Chi Sang Martin, Venue: Queen Elizabeth Hospital, Kowloon	Miss Viviane LAM Tel: 2527 8452 3 CME Points
<b>12 WED</b> 7:30 am 2:00 pm	<b>HK Neurosurgical Society Monthly Academic Meeting - Special Lecture: Brain Attack</b> Organised by: Hong Kong Neurosurgical Society, Speaker: Prof. Lawrence WONG, Venue: Seminar Room, G/F., Block A, Queen Elizabeth Hospital, Kowloon <b>HKMA - Shatin Doctors Network - Certificate Course on Osteoporosis</b> Organised by: HKMA - Shatin Doctors Network, Chairman: Dr. Carl WONG, Speaker: Various, Venue: Royal Park Hotel, Shatin	Dr. Y.C. PO Tel: 2990 3788 Fax: 2990 3789 2 CME Points  Miss Alice TANG Tel: 2527 8285 1.5 CME Points
<b>13 THU</b> 2:00 pm	<b>HKMA Structured CME Programme with Hong Kong Sanatorium &amp; Hospital Year 2009 - Treatment of Cancer in the Molecular Era</b> Organised by: The Hong Kong Medical Association, Dr. KWAN Wing Hong, Venue: The HKMA Dr. Li Shu Pui Professional Education Centre, 2/F, Chinese Club Building, 21-22 Connaught Road Central, Hong Kong	Miss Viviane LAM Tel: 2527 8452 1 CME Points
<b>14 FRI</b> 2:00 pm (22)	<b>HKMA-Shatin Doctors Network CME Lecture Series on Type 2 DM Management</b> Organised by: HKMA-Shatin Doctors Network, Speaker: Mr. Derek POON, Venue: Royal Park Hotel, Shatin	Ms. Mabel CHOW Tel: 3189 8770 1.5 CME Points
<b>15 SAT</b> (Aug 22,29, Sep 2,9) (Aug 22,29, Sep 2,9,23) 1:30 pm 2:00 pm	<b>Certificate Course on Clinical Teaching and Assessment (Code no: TC-CTA-0903)</b> Organised by: College of Nursing, Hong Kong <b>Certificate Course on Interpretation of Electrocardiography (Code no: TC-ECG-0902)</b> Organised by: College of Nursing, Hong Kong <b>HKMA KE Network - Pain Management: Anesthetist Perspective:(1) Neck and Back Pain(2) Post Herpetic Neuralgia</b> Organised by: HKMA KE Network & UCH, Chairman: Dr. AU Ka Kui Gary, Speaker: Dr. LIM Huey Sing, Venue: Lecture Theatre, G/F, Block P, UCH <b>HKMA HKE Network - Diabetes Mellitus Complications (DM II)</b> Organised by: HKMA HKE Network & HA HKE Cluster, Chairman: Dr. YIP Yuk Pang Kenneth, Speakers: Various, Venue: Lecture Theatre, Ruttonjee Hospital, Wanchai, Hong Kong	Secretariat Tel: 2572 9255 Fax: 2838 6280 24 CNE Points Secretariat Tel: 2572 9255 Fax: 2838 6280 24 CNE Points  Miss Alice TANG Tel: 2527 8285  Miss Alice TANG Tel: 2527 8285
<b>20 THU</b> 7:00 pm - 10:00 pm	<b>FMSHK Executive Committee and Council Meeting</b> Organised by: The Federation of Medical Societies of Hong Kong, Venue: Council Chamber, 4/F., Duke of Windsor Social Service Building, 15 Hennessy Road, Wanchai, Hong Kong	Ms. Paulina TANG Tel: 2527 8898 Fax: 2865 0345
<b>22 SAT</b> 8:00 pm	<b>HKMA Orchestra 20th Anniversary Concert</b> Organised by: The Hong Kong Medical Association, Venue: Concert Hall, Hong Kong Cultural Centre	Ms. Candy YUEN Tel: 2527 8285
<b>23 SUN</b> 2:00 pm	<b>HKMA Structured CME Programme with PMH Year 2009 (7) - i) Approach to Breast Mass ii) Management of Goiter</b> Organised by: The Hong Kong Medical Association, Speakers: Dr. HO Leung Sing & Dr. LUK Hung To, Venue: G8 Hall, PMH	Miss Viviane LAM Tel: 2527 8452 2 CME Points
<b>28 FRI</b> 1:30 pm	<b>HKMA- Shatin Doctors Network CME Lecture When and How to Start Insulin</b> Organised by: HKMA-Shatin Doctors Network, Speaker: Dr. LO Kwok Wing, Venue: Shatin	Ms. Sandra CHU Tel: 2387 8555 1 CME Point
<b>29 SAT</b> 2:00 pm	<b>HKMA TSW Network - Certificate Course on Treating Alzheimer's Disease in Community (I) Case Based Discussion of Diagnosis of Early Alzheimer's Disease, and the Application of Office Clinical Tools</b> Organised by: The Hong Kong Medical Association & Hong Kong Alzheimer's Disease Association, Speaker: Dr. DAI Lok Kwan David, Venue: Ballroom C & D, Harbour Plaza Resort City, Tin Shui Wai,	Ms. Jaclyn LEE Tel: 2877 1106
<b>30 SUN</b> 12:00 pm	<b>Joint Professional Badminton Tournament</b> Organised by: The Hong Kong Medical Association, Venue: Shatin College	Ms. Dora HO Tel: 2527 8285



## Meetings

31/10/2009 - 1/11/2009	<b>3rd Joint Scientific Meeting of The Royal College of Radiologists and Hong Kong College of Radiologists and 17th Annual Scientific Meeting of Hong Kong College of Radiologists</b> Organised by: The Royal College of Radiologists & Hong Kong College of Radiologists, Venue: Hong Kong Academy of Medicine, Jockey Club Building, 99 Wong Chuk Hang Road, Aberdeen, Hong Kong, Enquiry: Secretariat, Tel: 2871 8788, Fax: 2554 0739, Email: enquiries@hkcr.org, Website: <a href="http://www.hkcr.org">http://www.hkcr.org</a>
8/11/2009	<b>International Symposium on Hepatology 2009 / 22nd Annual Scientific Meeting</b> Organised by: The Hong Kong Association for the Study of Liver Diseases, Venue: Hong Kong Convention and Exhibition Centre, Enquiry: Ms. Melissa LEUNG, CMPMedica Pacific Limited, Tel: 2116 4348, Email: melissa.leung@asia.cmpmedica.com

## Courses

11-13/9/2009, 20-22/11/2009	<b>Advanced Trauma Life Support (ATLS) Student Course</b> Organised by: Department of Surgery, Queen Mary Hospital & Hong Kong Chapter of the American College of Surgeons, Venue: The Jockey Club Skills Development Centre, C3, Main Block, Queen Mary Hospital, Pokfulam, Hong Kong, Enquiry: Course Administrator, Tel: 2855 4885 / 2855 4886, Fax: 2819 3416, Email: hnsrg@hkucc.hku.hk, Web site: <a href="http://www.hku.hk/surgery">http://www.hku.hk/surgery</a>
11-12/9/2009, 20-21/11/2009	<b>Advanced Trauma Care for Nurses (ATCN) Provider Course</b> Organised by: Department of Surgery, Queen Mary Hospital & Hong Kong Chapter of the American College of Surgeons Venue: The Jockey Club Skills Development Centre, C3, Main Block, Queen Mary Hospital, Pokfulam, Hong Kong Enquiry: Course Administrator Tel: 2855 4885 / 2855 4886 Fax: 2819 3416 Email: hnsrg@hkucc.hku.hk Web site: <a href="http://www.hku.hk/surgery">http://www.hku.hk/surgery</a>
3-7/10/2009	<b>PALS Course 2009</b> Organised by: Hong Kong College of Paediatricians, the Heart Institute for Children, Hope Children's Hospital, Illinois, USA & Hong Kong Paediatric Nurses Association, Speakers: Various, Venue: A & E Training Centre, Tang Shiu Kin Hospital, CME Accreditation: 12 Points for Provider Course, Enquiry: Ms. Vanessa WONG, Tel: 2871 8773, Fax: 2785 1850, Email: enquiry@paediatrician.org.hk, Website: <a href="http://www.paediatrician.org.hk/entcnews.htm">http://www.paediatrician.org.hk/entcnews.htm</a>
12-13/12/2009	<b>Advanced Medical Life Support (AMLS) Provider Course</b> Organised by: Department of Surgery, Queen Mary Hospital & Hong Kong Chapter of the American College of Surgeons, Venue: The Jockey Club Skills Development Centre, C3, Main Block, Queen Mary Hospital, Pokfulam, Hong Kong, Enquiry: Course Administrator, Tel: 2855 4885 / 2855 4886, Fax: 2819 3416, Email: hnsrg@hkucc.hku.hk Web site: <a href="http://www.hku.hk/surgery">http://www.hku.hk/surgery</a>

## Upcoming Certificate Courses of the Federation of Medical Societies of Hong Kong

Date	Course No	Course Name	Target Participants	CME/CNE
6 Aug 09 - 10 Sep 09 (Every Tur)	C141	Certificate Course on Wilderness Medicine	Healthcare Professionals	9 CNE Points / CME Accreditation in application
2 Sep 09 - 7 Oct 09 (Every Wed)	C148	Certificate Course on Clinical Ophthalmology	General Practitioners & Allied Health Professions	9 CNE Points / CME Accreditation in application
4 Sep 09 - 9 Oct 09 (Every Fri)	C151	Certificate Course on Dental Nursing in Oral Surgery	Dental Nurses	9 CNE Points / CME Accreditation in application
12 Sep 09 - 26 Sep 09 (Every Sat)	C147	Certificate Course on Clinical Ethics in Practice	Professionals in Clinical Practice	6 CNE Points / CME Accreditation in application
22 Sep 09 - 27 Oct 09 (Every Tue)	C150	Certificate Course on Respiratory Medicine 2009	Nurses and Allied Health Professionals	9 CNE Points / CME Accreditation in application



## Society News

## News from Member Societies

**Hong Kong Thoracic Society Limited**

Updated office-bearers for the year 2009-2010 are as follows: President: Dr. Cheuk-yin TAM; Honorary Secretary: Dr. James Chung-man HO; Honorary Treasurer: Dr. Wai-san KO

The FMSHK would like to send its congratulations to the new office-bearers and look forward to working together with the society.

The Federation, in cooperation with Kingsway Concept Limited, offers a discount on petrol and diesel purchases of HK\$0.9/litre from **Caltex, Shell, Esso and Sinopec** to members and their families of all Ordinary and Associate member societies under the Federation. Please contact our Secretariat on 2527 8898 and [info@fmskh.org](mailto:info@fmskh.org) or Kingsway Concept Limited on 2541 1828 and [kingswayconcept@yahoo.com](mailto:kingswayconcept@yahoo.com) for further details and terms for this offer.



## Answer to Radiology Quiz

### Answer: Osteopathia Striata and Osteopoikilosis

#### Radiographic Findings:

1. Dense longitudinal streakings are noted at the metaphyseal region of the femurs and tibias, more prominent on the right side.
2. Small round foci of bone sclerosis are seen in the metaphyses and epiphyses of the femurs.

#### Discussion:

Osteopathia striata is a rare bone disorder involving an error in internal bone modelling and characterised by dense longitudinal bone striations. The aetiology is unknown. Laboratory values are normal. The patient is asymptomatic.

Osteopoikilosis is also a rare bone disorder characterised by the presence of multiple small circumscribed round areas of increased bone density caused by local condensations of the spongiosa. In the long bones, the lesions are seen in the metaphyses and epiphyses but not the shaft. The aetiology is unknown and laboratory studies show no abnormalities. The patient is asymptomatic.

These two entities are usually detected incidentally and coexist in this patient.

### Dr. WK TSO

Consultant, COS of Department of Radiology,  
HKWC and Queen Mary Hospital

#### The Federation of Medical Societies of Hong Kong

4/F Duke of Windsor Social Service Building,  
15 Hennessy Road, Wanchai, Hong Kong  
Tel: 2527 8898 Fax: 2865 0345

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# Certificate Course on Dental Nursing in Oral Surgery

Jointly organised by



The Federation of Medical  
Societies of Hong Kong  
香港醫學組織聯會



The Hong Kong Association of  
Oral and Maxillofacial  
Surgeons Limited

## Objectives

Modern dentistry has been continuously evolving. Oral surgical procedures are commonly performed nowadays in the dental office. Good dental nursing is a key component to success in this setting. Our course aims at introducing contemporary concept on dental nursing in oral and maxillofacial surgery.



Date	Topic	Speaker
4 September 2009	Common oral diseases	Dr. Winnie CHOI
11 September 2009	Implant surgery and Dentoalveolar surgery: Basic principles and various modes of anaesthesia	Dr. Ian YIP
18 September 2009	Perioperative nursing I	Ms. Julie CHOW Ms. Wai-Yi KONG Ms. Phenita LI Ms. Pui-Shan WONG
25 September 2009	Perioperative nursing II	Ms. Julie CHOW Ms. Wai-Yi KONG Ms. Phenita LI Ms. Pui-Shan WONG
2 October 2009	Dental emergencies and their management	Dr. John LO
9 October 2009	Medical Emergencies and their management	Dr. Alfred S.L. LAU

**Dates:** 4 September 2009 – 9 October 2009 (Every Friday)

**Time:** 7:00 p.m. – 8:30 p.m.

**Venue:** Lecture Hall, 4/F.,  
Duke of Windsor Social Service Building,  
15 Hennessy Road, Wanchai, Hong Kong

**Language Media:** Cantonese (Supplemented with English)

**Certificate:** Awarded to participants with a minimum attendance of 70%

**Course Fee:** HK\$750 (6 sessions)

**Enquiry:** The Secretariat of The Federation of Medical Societies of Hong Kong

**Tel.:** 2527 8898

**Fax:** 2865 0345

**Email:** [info@fmshk.org](mailto:info@fmshk.org)

## CME/CPD Accreditation in application

A total of 9 CNE points for the whole course and the points will be awarded according to the number of hours attended.  
Application form can be downloaded from our website: <http://www.fmshk.org>