The Hong Kong Geriatrics Society Newsletter

The Hong Kong Geriatrics Society

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Editorial

We have very interesting articles and local news in the present issues. Besides the current hot topics of prevention of falls, prevention of other accidents in older people is also important as apparently Hong Kong is not a very safe place for older people to live in. We have two important reports published here: the HKGS response on the Advance Directive issue and a conference report on Nutrition. HKGS has developed a number of SIGs and many have function well in the development of knowledge or provision of service in their particular area of interest. Members are welcome to join in and develop them further. Looking forward to seeing you in the annual outing of our Society on 5/12/04.

Mok CK, Editor

President's Message
Integration, disintegration, re-integration
Dr TK Kong

This headline was used in the September 1998 issue of the BGS Newsletter in an article by Professor Grimley Evans in response to the concern of Dr. Arup Banerjee (the BGS President then) that the outcome of the "integrated" practice would be "many elderly patients with complex needs being cared for by physicians not accredited in geriatric medicine."

Structural integration of Geriatrics with Medicine started in 1994 in Hong Kong, and its completion is indicated by such names as "Department of Medicine and Geriatrics", or "Department of Integrated Medical Service." Have we achieved the vision of Professor Grimley Evans, the originator of the integrated model? He argued that the concept of the integrated model was to ensure that the increasing numbers of older people referred to hospital general medical services had immediate access to the full range of modern medicine including geriatrics, and that acute geriatric service should be an integral part of the complete spectrum of geriatric services, including geriatric rehabilitation, day hospital, out-patients, long-stay care and community liaison. However, Professor Grimley Evans lamented that disintegration had occurred when the integrated model was driven by cost-saving incentive, with deprivation of the frail old from the full spectrum of geriatric services.

Are our frail elderly patients missing out in the current service organization? How many of the frail elderly patients hospitalized acutely with the "geriatric giants" have these problems identified and have access to geriatricians? Are the individual rehabilitative needs of frail elderly patients recognized or are they sent randomly to "convalescent" hospitals or aged homes because of bed pressure in acute hospitals? In an interview about the early days of geriatric service in Hong Kong, Dr. Chan Sik, the first consultant geriatrician in Hong Kong and the first President of our Society recalled, "People thought then that geriatric wards were simply convalescent wards for older patients, a place where they waited to recover, or to die." How many are still holding such views? Recently, I heard of the term "acute convalescence."

Since the inception of the specialty of Geriatrics in 1975, the number of specialists in Geriatric Medicine in Hong Kong have risen to 120 in 2004, with a growth spurt for the years 1997 to 2000 (Figure 1). There is however no place for complacency. The growth is retarding. The proportion of time spent in Geriatric Medicine for geriatric specialists working in public hospitals are decreasing: 42% of them work half-time in geriatric medicine, 34% work more than half-time, and 24% work less than half-time; so that the full-time equivalents of geriatric specialist take a downturn in 2004 despite an apparent increase in the number of geriatric specialists. The gap between demand (based on the RCPL/BGS recommended ratio of 1 FTE geriatric specialist to 4000 elders aged over 75) and supply is diverging after the convergence during the growth spurt (Figure 1). How are we going to meet the population challenge in the next 10 years?

Since June this year, I have been voicing out my concern to key managers and policy makers in various committees of the Hospital Authority on the current disintegration of geriatric services in the majority of hospitals, and the consequent undesirable impact on service, trainingand manpower with regard to the care of the frail old.

The four stages of a group are forming, storming, norming and performing. We have gone through the stages of forming and storming (I hope!). The ultimate effective performance of us as a group depend very much on our commitments (norming).

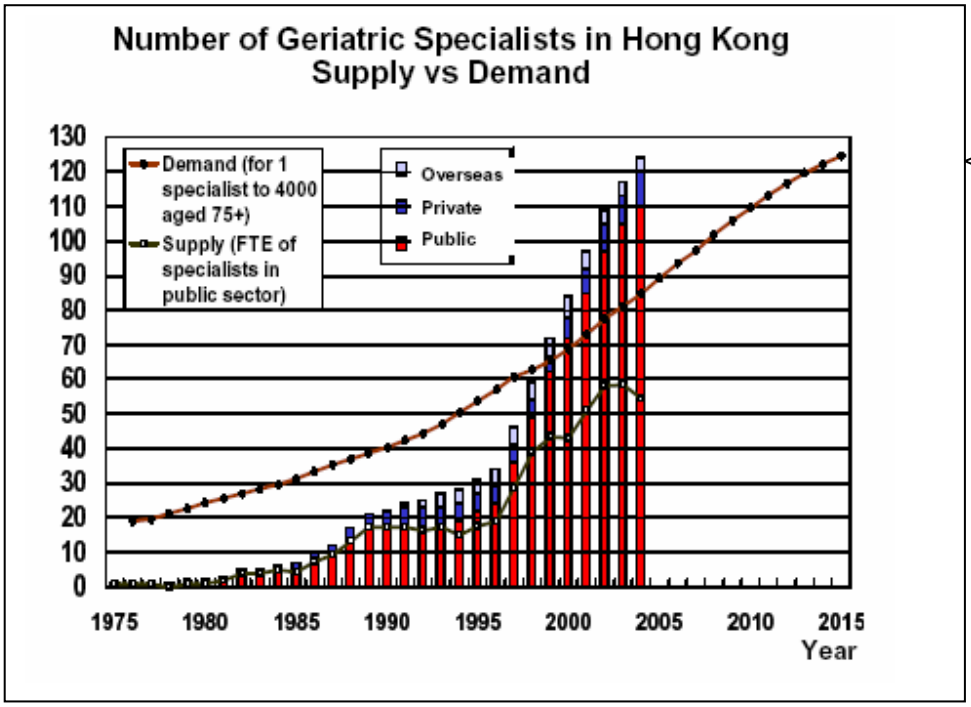

Fig 1

Letter to editor: Report from sponsored meeting PENSA

Ho Wency, Ip CY, Ko CF, Lum CM

We were sponsored by the Hong Kong Geriatrics Society to attend the 10th Parenteral and Enteral Nutrition Society of Asia (PENSA) meeting at Pattaya, Thailand on 27-29 October 2004. The meeting updated the recent advances in nutritional therapy in the past few years. We would like to share our inspiration at the meeting to our colleague members of HKGS.

Because this year is the 10th Anniversary of the PENSA, the conference started with a review on the progress on nutrition support and shone light to the future. In particular, it was stated by Professor Rombeau from the States that one of the foci would be on nutritional support to the elderly. It cannot be over-emphasized on **nutrition intervention to prevent / reverse sarcopenia**. At the other end, obesity is increasing among elderly patients. **Obesity may induce chronic inflammation** and in turn lead to progressive loss of lean tissues and impaired immune function. This may have adverse outcome and is an area to be explored. The understanding of and the possible nutrition intervention on sarcopenia and chronic inflammatory responses are underway.

Much has been presented and discussed on the importance of **early re-feeding the patients**, including patients who had undergone GI operation. Evidence is emerging that enteral feeding is preferred to parenteral feeding in patient outcome. The questions are: how early is early and what / how much to feed? The consensus appears to start re-feeding within 72 hours (48 hours preferred) with glucose solution. As little as 10 ml per day can maintain the microvilli functioning.

A whole session was devoted to **anti-oxidative therapy and trace elements deficiency.** A number of anti-oxidants were discussed. These included: vitamins C&E, provitamin A, N-acetylcysteine and glutathione. Evidence is there that early administration of anti-oxidants supplements reduced the incidence of organ failure among critically ill patients nursed in ICU. It was also highlighted that elderly at long term care facilities was more prone to deficiency of trace elements.

We think that the conference was most appropriate for us. Nutrition is an important aspect in Geriatric Medicine, yet often neglected. Several areas can be developed along the direction:

a) nutrition intervention to **prevent sarcopenia;**
b) nutrition **intervention in aspiration pneumonia**;
c) nutrition **intervention in specific organ diseases** (e.g. chronic renal failure) which are common among elderly;
d) nutrition intervention **against oxidative stress**;
e) nutrition status (in particular, trace elements) and **intervention among elderly at long term care facilities**.

The above can also be potential areas / dissertation topics for our HPTs! Anyone who is interested in the area can contact Dr. C M Lum (lumcm@ha.org.hk) directly for discussion.

HKGS Response to the Consultation Paper on Substitute Decision-making and Advance Directives in relation to Medical Treatment
(published by The Law Reform Commission of Hong Kong on 13 July 2004)

Dr. TK Kong

(on behalf of HKGS Special Interest Group on Medical Ethics and HKGS Council , 21/9/04)

The Hong Kong Geriatrics Society is a specialist Society of over 100 doctors responsible for the management of acute illness, severe disability and terminal conditions in elderly people. Together with their multidisciplinary teams they are experienced in the management of disease in old age and in meeting the related ethical challenges.

The HKGS is pleased to have the opportunity to respond to the Consultation Paper and makes the following points:

1. In principle, the Society welcomes the use of Advance Directives (AD, a mechanism whereby competent people can make decisions about their health care should they become incompetent in the future) to help patients to state their preferences so as to enhance their autonomy and to improve communication between patients and the health care team. However, the Society is aware of the limitations of AD when applied to the medical care of elderly people (see paragraph 15 below), and that the concept of AD is not easily understood by the general public, especially elderly patients. Thus, the Society recommends that AD to be implemented through non-legislative means (Option E (p. 153) and recommendation 1 (p.155) of Ref. 1).

2. The context of AD should be confined to living will. Expanding the current coverage of the Enduring Power of Attorney to health issue is inappropriate as abuse is difficult to avoid. Moreover, studies have shown that proxies may not actually understand the patient's wishes even when that proxy is someone the patient thinks will understand him or her (Ref. 2). The Society is of the opinion that it is inappropriate for relatives to act as second witness in the signing of AD. This does not imply, however, that relatives are to be excluded from the process of making the health care plan for a patient facing terminal illness (see paragraph 7 below).

3. The objective of AD should be explicitly stated in the AD form. That of the BMJ (p. 179 of Ref. 1, Ref. 3) is a good example: "The object of this directive is to minimise distress or indignity which I may suffer or create during an incurable illness, and to spare my medical advisers or relatives, or both, the burden of making difficult decisions on my behalf."

4. AD should only be basically used to indicate the refusal to use medical means to prolong life in terminal illnesses including cardiopulmonary resuscitation, artificial ventilation, artificial hydration & nutrition except to relieve obvious suffering (p. 178 of Ref. 1, Ref. 3). "Long-term physical restraining as medical management" is suggested to be added to the list of refusal as this is a common problem faced by our elderly patients in Hong Kong.

5. While AD could be used to indicate other requests from the patient, he/she should understand that only treatments available in the health facility and considered to be for the "best interests" of the patient by the attending doctor could be given. Euthanasia should never be accepted as a request.

6. AD should mainly be used for terminal illness situation. Whether dementia or other degenerative brain disorders should be included is controversial. The present Guardianship board mechanism appears to be effective and safe. Writing a living will beforehand can act as a supportive evidence of one's authentic view for the board's consideration. As many such patients are of old age, geriatric input to the board's decision should be enhanced.

7. The writing of AD should be initiated during the process of making the health care plan for a patient facing terminal illness. As the basic requirement for good health care planning, the patient's psychosocial status should be well considered. Multi-disciplinary and multi-party input, including those from formal and informal caregiver, should be taken when appropriate.

8. AD should be regarded as a formal tool to facilitate communication between patient and doctors. It should never become a "duty" for every patient to consider nor such culture be allowed to develop. Everyone's right of "Not to decide" should always be respected. This is to avoid the development of implicit coercion to force everyone, especially the old and the chronically ill, to write AD for the sake of relieving the burden of the family and/or the health care system.

9. The threshold for revoking AD should be very low. A patient should be allowed to revoke the AD at any time by any means (verbally to the attending doctor should be good enough). This is especially so if writing AD is extended to dementia patients. This forms a safety net for everyone. A "wrong" revoking would only allow the doctor to offer "extra" medical treatment to the patient based on the principle of "best interests" for the patient in general. Too demanding criteria on revoking may result in a tragedy whereby the patient actually changes his/her mind and wants the

treatment but is deprived of it and dies as a consequence. The study by Danis (Ref. 4) revealed that some patients' wishes were unstable and suggested that an instruction for future care cannot be assumed to be permanent wish in future.

10. Whenever there is reasonable doubt on the validity of the AD by the medical staff, the principle of "medical management for the best interests of the patient" should prevail. It is better to err on over-doing than under-doing. This is to safeguard the patient's benefit (benefit of doubt), and to protect the medical staff from unnecessary legal liability.

11. When writing an AD, the element of depression should be considered. A very good explanation to the patient (preferably to relatives also, within the context of health care planning) should be offered especially to older patients. Thus, it is mandatory to have a medical doctor to sign as witness, preferably not the doctor providing the immediate care. The doctor should make a clinical judgement that the patient is having a sound mind and not obviously depressed.

12. The Society is against setting up a central registry for AD. The formality of central registration may deter patients writing AD as it appears to be something very official, and would give undesirable pressure for the frontline medical staff to search for its presence. Elderly patients may have the unnecessary fear of having difficulty to revoke the AD if kept away from him/her in a central registry. The Society opines that it is sufficient for the AD form to be kept by the patient or the relatives and then shown to medical staff which situation arises.

13. The government and the health authorities should pay major effort in educating the public on the proper usage of AD. The older patient should not be deprived of the benefit of using AD but also be protected from any exploitation and abuse.

14. It is difficult for one to imagine the situation when one is having terminal illness in the future. To make a properly informed advanced directive, the patient will be required to make decisions about potential quality of life and a range of complex possible medical interventions. Patients should be well informed before they are more likely to make a non-regrettable decision about any refusal in medical management. The Society advocates that the government and the health authorities should make every effort to produce guidelines for professional staff to offer adequate explanation, illustrative videos for explanation of conditions etc. This is particularly important for our elderly patients who may not be familiar with the medical terms, equipment and procedures.

15. The Society would like to alert the public and the medical profession of the following limitations of AD in order that quality care of elderly patients would not be compromised:

15.1 Goal-setting is of utmost importance in geriatric care, rehabilitation and palliative care. The listing of potential procedures in AD may divert attention from the overall treatment goals and may give rise to inappropriate care (Ref. 5).

15.2 Confusion (and thus mental incapacity) may arise from treatable conditions like constipation and urinary tract infection. Thus AD should not be activated simply based on mental incompetence, which could be transient and reversible.

15.3 The elderly patient frequently presents with multiple illness, acute on chronic symptoms, and a combination of illness and underlying frailty. And the extent of impairment, the potential for treatment and rehabilitation, vary significantly with each individual. The complexity of illness in old age means that the potential patient often cannot be adequately informed so as to tailor the AD to the circumstances that will prevail at the time the directive has to be implemented. The difficulty in relating an AD to the conditions prevailing at the time a decision has to be taken had led to reported cases of misapplication in other countries (Ref. 6).

References

1. The Law Reform Commission of Hong Kong. Decision-making and advance directives sub-committee consultation paper. Substitute decision-making and advance directives in relation to medical treatment, July 2004.

2. Ouslander JG, Tymchuk AJ, Rahbar B. Health care decisions among elderly long-term care residents and their potential proxies. Arch Int Med 1989;149:1367-72.

3. Robertson GS. Making an advance directive. BMJ 1995;310(6974):236-238.

4. Danis M, Garrett J, Harris R & Patrick D. Stability of choices about life-sustaining treatments. Ann Intern Med 1994;120:567-73.

5. Brett AS. Limitations of listing specific medical interventions in advance directives. JAMA 1991;266:825-8.

6. Millard P. Advance Directives. BGS Newsletter, British Geriatrics Society, May 1995.

City Hazards

Quick Traffic Light – 81 years old gentleman was killed because he could not catch up with the 23 seconds safe green pedestrian traffic light and knocked down by a car at Prince Edward Road West. That segment of Prince Edward Road West has 6 lanes and the normal duration of safe green pedestrian light is 23 seconds for normal hours and 25 seconds for rush hours (6:30am to 7:30am). Calculations from the Polytechnic University, Department of Mechanical Engineering showed that normal adults need about 25 seconds to cross 5-6 lanes road, while the elderly need 50 seconds. (Oriental Daily News, 4/9/2004)

Steep Escalator – A 78 years old lady was injured as she fell down from a public escalator linking to a pedestrian bridge. That escalator was in Yuen Long area and was quite long and steep. The elderly lady suddenly lost balance and fell backwards in the middle of the way while using the escalator. (Oriental Daily News, 10/10/04)

Crowded Area – A 66 years old lady was injured during the charity distribution of "blessed rice" at the Chinese Ghost Festival. Many elderly were queued up in the central park in Tsz Wan Shan for the free "blessed rice". The crowd was out of control with iron fences fell down and injured that lady. Another elderly lady felt sick while queuing at Ngau Tau Kok area for the "blessed rice". (Oriental Daily News, 22/8/2004)

Nursing Home

In 2001, the Department of Community and Family Medicine of the Chinese University of Hong Kong had conducted a study in 14 nursing homes and found that **a quarter of the nursing home elders had malnutrition**. A total of about 1500 elders were recruited and their body weight, body height and body mass index were analyzed. About one quarter of the nursing home elders had their body weight below standard. Also, the lower the staffing ratio in the nursing home, the more chance of elderly malnutrition was noted. (Oriental Daily New, 2/8/2004)

A study conducted by the Faculty of Dentistry of the University of Hong Kong showed that **nursing home elders had poor dental condition**. More than 3,000 nursing home elders were studied and they found that 20.3% of them was edentulous. On average each nursing home elders only had 9 healthy teeth and 2.9 teeth were decayed. Also, 19.8% of the nursing home elders had severe gum disease. 51.8% of the nursing home elders had no dental checkup in the recent 5 years and the reasons being dental condition not severe (27.6%), financial problem (25.7%) and mobility problem (19.6%). (Hong Kong Economic Daily, 27/10/2004)

Local News

Depression

A local cross-sectional descriptive study was done to determine the **prevalence of depression symptoms in private nursing homes residents** was published in the International Journal of Geriatric Psychiatry (2004;19:734-740). The study involved 20 private nursing homes at Hong Kong East with 245 subjects aged 65 or more. It was found that **29%** of the residents had significant depressive symptoms with a Geriatric Depression Scale-Short Form of point 8 or more. Swallowing problems, currently non-CSSA recipient and low levels of basic activities of daily living were found to be independent risk factors for depression. The study showed that the prevalence of depression among nursing home residents are much higher than their community dwelling counterpart, where previous studies showed that the prevalence was around 10-20%. (Mingpao Daily News 12/9/2004)

Elder smokers had 50% higher risk to have depression than elder non-smokers as reported by a study from the Faculty of Medicine, University of Hong Kong and the Department of Health. Fifty-six thousand elders were recruited from the 18 Elderly Health Centers from the year 1998 to 2002. 20.3% of the male and 4% of the female were smokers and the risk of having depressive symptoms was 50% higher in the smoking group than the non-smoking group. Also, the group of quitters had 20% less risk of having depression than the smokers. (Hong Kong Economic Daily, 25/9/2004)

A study from the Department of Community and Family Medicine of the Chinese University of Hong Kong showed that **8.5% of our elderly man (65 years old or above) had depression** and the **depressed group had poorer health status**. 42.6% of the depressed elders had osteoporosis compared to 31.0% in the control. The depressed elders also had more coronary artery disease, falls, fractures, respiratory diseases, diabetes and smoking than the control group. (Oriental Daily News, 23/10/2004)

Council News

Dr. Bernard Kong, Hon Sec, HKGS

1. HKGS participating in RTHK Radio One Health Talk 精靈一點
HKGS is providing a series of health talks on geriatric problems (total 8 sessions) to the public via RTHK One every Tuesday from 5/10/04 to 30/11/04 as below:

5/10/2004	柏金遜症	江德坤醫生
12/10/2004	心/肺及呼吸問題	江明熙醫生
19/10/2004	失禁	梁萬福醫生
26/10/2004	老年記憶問題	朱亮榮醫生
2/11/2004	安全藥物使用	陳銘洪醫生
9/11/2004	視聽問題	陳漢威醫生
16/11/2004	跌倒, 骨/肌問題	莫俊强醫生
23/11/2004	老人性健康, 抗衰老	王春波醫生
30/11/04	口腔/營養問題	郭志銳醫生

2. There is an expansion and formation of SIGs under HKGS with the aims to arouse the academic atmosphere, fraternity and active participation among HKGS members, and ultimately to raise the professional image of HKGS. HKGS members are encouraged to join one or more of the SIGs.

SIGs	Chairman	Secretary
Cognition and Cerebral Ageing SIG	CHU Leung Wing	
Chinese Medicine	CHAN Ming Houng	
Continence SIGs	LEUNG Man Fuk	TONG Bing Chung
Falls SIG	MOK Chun Keung	KO Chi Fai
Infectious Disease SIG	KONG Ming Hei, Bernard	
Medical Ethics SIG	KONG Tak Kwan	WU Yin Ming
Nutrition SIG	KWOK Chi Yui, Timothy	
Sexuality and Older Adults SIG	WONG Chung Por	

3. Dr. Kong TK (our President) and Dr. Au SY will be visiting Royal Colleges of Physicians and Surgeons of Glasgow and Chinese Geriatrics Society from 15/11/04 to 23/11/04 on behalf of HKGS.

4. The HKGS Medical Ethics SIG has drafted a feedback on the consultation paper on Advance Directive. Dr TK Kong has replied to the Law Reform Commission's Decision-making and Advance Directives Sub-committee. The Council would like to thank those who have contributed in the discussion. (The report is published in this issue of Newsletter)

5. DGM (Glasgow) will be held in the 3rd week of June 2005 in the first time in Hong Kong. The Postgraduate Diploma in Community Geriatrics clinical examination will be in the same week as DGM. PMH and KWH are the examination centres.

6. Dr. MH Chan will lead a delegation to attend the **中華醫學會第七屆全國老年醫學大會** and a formal exchange with the Chinese Geriatrics Society will be arranged. Four papers of HKGS members have been accepted and 7 members will attend the Conference.

7. Dr. F Chan has agreed to chair the ASM of HKGS 2005. The previous working group will stay to prepare for the meeting. Prof. David Stott will be invited to be the keynote speaker.

8. Dr CY Ip has prepared a program for our annual outing on 5/12/04. 9. There will be two symposiums coming: a/. Coummunity Falls Prevention Symposium on 30/11/04 (Excelsior Hotel, Causeway Bay) and b/. COAD in Elderly 13/12/04 (Langham Place Hotel, Mongkok)

Dear Members,
Please kindly update your personal email address (if any) to the Dr Bernard Kong (kongmh@ha.org.hk) for communication between society and members.

Vitamin D Supplementation Improves Neuromuscular Function in Older People who Fall
Age and Ageing 2004 33(6):589-595

A randomized double-blind placebo-controlled study to determine the effects of vitamin D supplementation on aspects of neuromuscular function known to be risk factors for falls and fractures. 139 ambulatory subjects (≥65 years) with a history of falls and 25-hydroxyvitamin D (25OHD) ≤12 µg/l were randomised to receive a single intramuscular injection of 600,000 i.u. ergocalciferol or placebo. They found that with vitamin D supplementation, in fallers with vitamin D insufficiency, has a significant beneficial effect on functional performance, reaction time and balance, but not muscle strength. This suggests that vitamin D supplementation improves neuromuscular or neuroprotective function, which may in part explain the mechanism whereby vitamin D reduces falls and fractures.

Fall incidence in frail older women after individualized visual feedback-based balance training.
Gerontology 2004;50:411-416.

This randomized study focused on fall prevention in residential home elders. Twenty-seven ambulatory subjects were randomized into exercise (20 subjects) and control (7 subjects) groups. Exercise group subjects underwent a 4-week computeraized visual feedback balance training and both groups were encouraged to continue their usual activities. At 1 year follow up, the monthly fall risk was significantly lower in the exercise group (OR 0.40). In addition, the exercise group had less fear of fall and higher physical activities after training.

Just one look, and fractures and death can be predicted in elderly ambulatory women.
Gerontology 2004;50:309-314.

This interesting study recruited 1004 ambulatory 75-year old women from a larger community prospective risk assessment project. A visual scoring on the biological age, or frailty (a scale from 0 to 100), was performed by 2 nurses and 2 physiotherapists within 15s of their first sight on the subject. All subjects were following up for a mean of 4.6 years. Those women in the highest tertile had more fractures and deaths than other elders. The study concluded that without considering specific comorbidity, a subjective estimate on the frailty was already predictive of future health outcomes. Many of us probably had similar experiences in our daily practice.

Prevention of late complications by half-solid enteral nutrients in percutaneous endoscopic gastrostomy tube feeding.
Gerontology 2004;50:417-419.

This case report described an 85-year old lady who suffered repeated aspiration pneumonia after feeding through PEG. The authors thickened the milk formula into half-solid form and injected into the PEG through a 50ml syringe. After this intervention the patient was free of feeding related symptoms in the subsequent 6 months. Their experience gave us a new option in managing PEG related gastro-oesophageal reflux complications.

Editor's choice

Faecal incontinence in adults
Lancet 2004;364:621-32

A comprehensive review on faecal incontinence which includes its epidemiology, aetiology, assessment and recent advances in therapy.

Acupuncture as a complementary therapy to the pharmacological treatment of osteoarthritis of the knee: randomized controlled trial
BMJ. 2004 Oct 19 [Epub ahead of print]

A Spanish randomized, controlled, single blind trial with blinded evaluation and analysis of results. 97 outpatients with osteoarthritis of knees were randomized into treatment group: acupuncture plus diclofenac Vs control group: placebo acupuncture plus diclofenac. The results showed that acupuncture plus diclofenac were more effective in improving physical capability and psychological functioning. The side-effects were bruising after the acupuncture sessions.

Alcohol drinking in middle age and subsequent risk of mild cognitive impairment and dementia in old age: a prospective population based study
BMJ 2004:329;539

A prospective population based study that was done in Finland involving 1464 subjects aged 65-79 years. The alcohol consumption in their middle age was surveyed in questionnaire done in 1972 and 1976 and they were re-examined in 1998. Alcohol drinking in middle age showed a U shaped relation with risk of mild cognitive impairment. Prticipants who drank no alcohol at midlife and those who drank alcohol frequently (several times per month) were both twice as likely to have mild cognitive impairment as those participants who drank infrequently (less than once a month). The effect of drinking on development of dementia was also modified by the presence of the apolipoprotein e4 allele. Carriers of apolipoprotein e4 had an increased risk of dementia with increasing alcohol consumption

SIG membership application

To **Dr. Kong Ming Hei, Secretary, HKGS**
c/o Cinical Services Division, Wong Chuk Hang Hospital, No.2, Wong Chuk Hang Path, Wong Chuk Hang, Hong Kong. Tel: (852) 24178383 Fax : (852) 24116536

I am interested in joining the following SIG of HKGS:

[ ] Cognition and Cerebral Ageing SIG
[ ] Chinese Medicine SIG
[ ] Continence SIG
[ ] Falls SIG
[ ] Infectious Disease SIG
[ ] Medical Ethics SIG
[ ] Nutrition SIG
[ ] Sexuality and Older Adults SIG

My personal details are:

Name:
Place of work:
Contact: e-mail phone

Please notify the corresponding Chairperson of the SIG to contact me for future activities.

Foreign News

Nosokinetics News Oct 2004 issue is now available. If interested, please go to www2.wmin.ac.uk/coiec/nosokinetics.htm for the details.

An interesting model of population stratification in chronic disease management was published in BGS Newsletter Sep04 issue in the report of the 2004 study day on chronic disease management. You can go to the website for further details: www.dh.gov.uk/organisation.

BGS also reported a close collaboration with BOA (British Orthopaedic Association) on various occasions recently – mainly in the areas of falls, osteoporosis and fracture management. They are looking forward to further joint development in the "political, clinical, educational and academic" arenas of caring the older people who fall and are unfortunate enough to sustain a fracture (BGS Newsletter Sep 04). Similar occasions had occurred in our local scene. Let's see how much fruit it can bear.

Publication subcommittee:

Dr. Mok Chun Keung
(Chairman)
Dr. Leung Ho Yin
Dr. Pang Fei Chau
Dr. Yu Kim Kam
Dr. Tsui Chung Kan
Dr. Ip Pui Seung
Dr. Sheng Bun

NTE Cluster news

The Community Geriatric Assessment Team of the NTE Cluster had started an enhanced geriatric outreach service to 11 old age homes at the NTE region since August 2003. The enhanced service include nursing visits to the homes which vary from 2 to 6 times a week and designated doctor visits 1 to 3 times a week. The attention of these visits was on those recently discharged from hospitals, the frail elderly and those with recurrent admission. Preliminary data showed that this mode of enhance support is effective in reducing AED attendance, hospital admission and unplanned readmission.

Local and Overseas Scientific Meetings

Name	Time & Place	Organizer	Contact
International Conference on Geriatrics and Gerontology	27/11/04-28/11/04 New Delhi India	Geriatric Society of India	www.geriatricindia.com
12th Annual Congress of Gerontology	27/11/04 Langham Hotel Kowloon	Hong Kong Association of Gerontology	www.hkag.org
"Falls Symposium" by HKGS	30/11/04 Hong Kong	Hong Kong Geriatrics Society	http://medicine.org.hk/hkgs/
Dignity & Older Europeans Conference	2/12/04-3/12/04 Cardif,UK	Dept of Geri Med Cardiff University	Doe-project@cf.ac.uk
Phoenix conference on longevity health sciences	9/12/04-11/12/04 Scottsidale, Arizona USA	ISHARE KRLK O2SA	www.phoneixconference.org
Faculty of Psychiatry of Old Age and International Psychogeriatric Association regional meeting	4/4/05-8/4/05 Rotorua New Zealand	Faculty of Psychiatry of Old Age (RANZCP) and International Psychogeriatric Association	www. ipa-online.net
BGS Spring meeting	14/4/05-15/4/05 Birmingham,UK	British Geriatrics Society	www.bgs.org.uk
2005 Annual scientific meeting	20/6/05-22/6/05 Brisbane, Australia	Australian Society of Geriatric Medicine	www.asgm.org.au
IPA's 12th International Congress	14/8/05-19/8/05 Stockholm, Sweden	IPA	www.ipa-online.net
BGS Autumn meeting	5/10/04-7/10/04 Harrogate, UK	British Geriatrics Society	www.bgs.org.uk

Inter-hospital Geriatrics Meeting (04-05) 6:00 pm – 8:00 pm

Venue: HAHO Room 205S (Light meal provided)

Date	Topic	Organiser
29.10.04	6:00-7:00pm CMC 7:00-8:00pm FYKH	Dr Mak WP Dr Chan HW
26.11.04	6:00-7:00pm WTSH 7:00-8:00pm PMH	Dr Au LK Dr BC Tong
17.12.04	6:00-7:00pm SH 7:00-8:00pm RH/TSKH	Prof J Woo Dr Wong CP
28.01.05	6:00-7:00pm TMH 7:00-8:00pm PWH	Dr Au SY Dr Dai LK
25.02.05	6:00-7:00pm UCH 7:00-8:00pm HHH	Dr Leung MF Dr Wu YM
25.03.05	6:00-7:00pm KWH 7:00-8:00pm PMH	Dr Chan MH Dr Kong TK

Hong Kong Geriatrics Society – Membership application / Information update Form

A). Personal information for *membership application* or *information update*

Name	
Corresponding Address	
Current Practice (HA - Hospital Authority/ DH - Department of Health / PR - Private practice / HS - Hospital Service Department / HK - HKU / CU- CUHK / OT - Others)	"√" one of the following : □ HA □ DH □ PR □ HS □ HK □ CU □ OT
Present post (e.g. MO, Cons, Prof. etc.)	
Hospital (working at)	
Department (working at)	
Home Address	
E – mail address	
Home Telephone	
Office Telephone	
Fax Number	
Basic Qualification (basic degree) and year	
Higher Qualifications and year	
Membership status to apply for or change	Please "√" either one below
□ a) I am an accredited **Geriatric Specialist** according to the criteria of HK Academy of Medicine □ b) I am currently under **higher specialty training in Geriatric Medicine** according to HKAM □ c) I am a registrable medical practitioner in HK who is interested in Geriatric Medicine but the above two conditions do not apply.	
Membership: (Official Use)	**Regular/Associate**
Approved by council at: (Official Use)	

Category a or b (Annual fee : **$200) - Regular member*
*Category c (Annual fee: **$100**) - Associate member (No voting right nor right to be elected as council member)*

For new application of membership, one has to be proposed by a **Regular Member of the Society:

Name of Proposer: _____ (Signature: _____)

B). I have the following publication/presentation of local studies / surveys in Geriatrics:

Title (Summary can be sent separately)	Journal index/ Name of meeting or seminar & dates

Please send this form to the following:

Dr. Kong Ming Hei
Honorary Secretary, c/o Cinical Services Division, Wong Chuk Hang Hospital, No.2, Wong Chuk Hang Path, Wong Chuk Hang, Hong Kong

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C). **Annual Fee for 2004/2005**
Please send a cheque payable to "The Hong Kong Geriatrics Society"
(Regular member: $ 200 – 1yr; Associate member: $ 100)

**Please tick if your want a receipt □ & your address: _____

Name : _____ Signature: _____ Date : _____

E-mail address: _____

Please send to : **Dr. Wong Tak Cheung, Honorary Treasurer, Hong Kong Geriatrics Society, c/o Dept. of Medicine, 1/F, Tseung Kwan O Hosp., 2 Po Ning Lane, Tseung Kwan O**