The Hong Kong Geriatrics Society Newsletter

The Hong Kong Geriatrics Society

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Nov 2005

Editorial

The HKGS's response to the HMDAC Discussion Paper on "Building a Health Tomorrow" is a fairly lengthy document but is a very detailed account of Geriatrics in Hong Kong - its development, objectives and perspectives on management of elderly health issues. Dr. Kong has summarised it in the President's address column for your grasp of the important points. It can be read in full on our website. It is quite a coincidence that the BGS President commented that politicians in UK, while understanding the defeats of the medical model for caring the elders, turned to a social model rather than the geriatricians. We and our elders are probably facing a similar threat here. HKGS has made another big step – we have our own book on Geriatrics! Initially written for the Diploma course, it turned out to be a very readable text on Geriatric practice, especially related to the local practice in Hong Kong. Look out for its selling announcement. As a member of HKGS, you would certainly receive a good discount on this. In this issue of Newsletter, you are updated on some local news on the future policy of elderly care and new information on drug management on some common elderly diseases. The end of 2005 is coming. Wish us all a Merry X'mas and Happy New Year … and free from flu, especially the bird one.

Mok CK, Editor

Will You Still Cure Me, Will You Still Care For Me, When I'm 75?

HKGS's Response to the HMDAC Discussion Paper on "Building a Healthy Tomorrow"

Dr TK Kong

Following the release of the Discussion Paper "Building a healthy tomorrow" of the Health and Medical Development Advisory Committee (HMDAC) in July 2005,[1] the Hong Kong Geriatrics Society has set up a working group to study and discuss on the Paper, as well as soliciting the views and comments of our members. On behalf of the Society, I have responded to Dr. York Chow of the Health, Welfare and Food Bureau on our stand and views on the Discussion Paper on 29 October 2005. The full response can be read at our Society website[2] and the summary is as follows:

- While the Discussion Paper realizes the need for future planning of hospital bed provisions to take into account the growing elderly population, it falls short of giving a clear **direction on how hospital geriatric care is to be provided** and is deficient in the area of acute care of elders.

- The proposed future **health care delivery model of primary, secondary and tertiary divisions** is not necessarily appropriate to the health care needs of many elders that depend on the full spectrum of progressive care from acute to rehabilitation to long-term care, as well as the continuum from hospital to community for the delivery of comprehensive effective and efficient geriatric care.

- The proposed **primary care model** of "family doctor and visiting medical officer" as gatekeeper can be ineffective and costly when applied indiscriminately to all elderly people without the direct participation of geriatricians. Elders with multiple illnesses, multiple pathologies, multiple aetiologies, multiple medications and multiple disabilities need seamless healthcare without primary and secondary divisions.

- The current and proposed acute hospital service ("**secondary care**"), designed for people who have only one thing wrong at once, is inadequate to meet the needs of frail elders with many things wrong,

who turn out to be major users of hospital service.

- It appears from this Paper that the Government has not considered properly the **role of geriatric medicine and of geriatric specialists** in meeting the needs of the ageing society.

- Since the origin of the specialty of **geriatric medicine** in UK 70 years ago, an impressive knowledge base has been accumulated, and research has confirmed its **effectiveness** in both hospital and community settings in improving the outcomes of elderly people with multiple pathologies and functional problems.

- **Elders predominate hospital populations. Future hospital planning for elderly services should target at the 75+ age group** because they represent most of the **frail elders** with complex problems and multiple illnesses, often presenting as the "geriatric giants" (falls, immobility, confusion, incontinence) instead of singular presentations that can be explained by one single disease as in younger adults.

- The **single organ-system approach has its limitation** in the hospital care of frail elderly patients. Pitfalls in diagnosis, investigation and management, including iatrogenesis and adverse drug reactions, are prone to occur in the absence of a geriatrics perspective and knowledge base.

- **Inadequacies of acute care and rehabilitation services cause inefficient and expensive care**. Making progress will need action in many areas. It is important for the Government to have commitment to the care of elderly people in both the preventive and the remedial aspects.

- **Early access to geriatric care in the acute phase could help reduce morbidity and optimize use of hospital resources**. For an effective, efficient service and continuity of care, a structural and functional geriatric service is essential. However, there is a **lack of acute geriatric beds/wards** for the proper provision of geriatric service and the conduction of training in geriatric medicine to doctors and nurses.

- Implementation of the proposed **acute geriatric care model** would be cost-neutral to start with, by striking a balance between geriatric commitments and non-geriatric commitments of geriatricians. There is potential for cost saving in terms of optimal use of hospital resources; improving flow between the acute, rehabilitation, and long-stay compartments; reducing iatrogenesis and multiple medication problems; reducing disability; and reducing institutionalization.

- **Geriatricians can contribute to the care of elderly patients in the community by** providing direct specialist medical care, advising primary health care, working with a community based or outreach multi-disciplinary team, geriatric specialist assessment prior to entry to residential care homes for the elderly (RCHEs) or other community care packages, and giving advice about services.

- **Predictors of admission to RCHEs are overwhelmingly health-related (including undiagnosed medical conditions)**, rather than social. By optimizing an individual's health and functional capacity, their need of future expensive hospital and long term care services can be minimized. This is also in line with the **preference of most elders for living at homes rather than in institutions**.

- **Elders admitted to RCHEs** often have multiple chronic illnesses and complex medical problems, management of which **require the specialist input of geriatricians** in partnership with primary care doctors, nursing and allied health professionals. Augmentation of this is required to meet these needs.

- **Elderly patients should have access to the particular skills and experience of a physician trained in geriatric medicine and special services of a multi-disciplinary team**. As the population grows and demands both on emergency acute take for elders grow and the care provided within the community develop this is likely to require an **increase in geriatric specialists**. We do need to **maximize the 'division of labour'**, to including primary care doctors with the appropriate experience, competency and commitment, psychogeriatricians, geriatric nurse specialists and therapists in providing comprehensive services.

- Pertinent questions on **health care financing** have to be solved to bring about reform for sustainability, affordability, accessibility and quality health care for elders. The majority of the present generation of low income and under-privileged elders in Hong Kong will continue to rely on social security or the good will of their children for subsidy of their health care services. Workable health care financing models for the "to-be" old, especially the baby-boomers, have to be explored to meet the future escalating health needs of the elders.

- The Government should take on the lead to rekindle the Chinese virtue of **filial piety,** and that **"longevity" is to be viewed positively** as an opportunity for the young to pay tributes to the old rather than negatively as a burden; and to **dispel ageism**.

- The HKGS proposes that **geriatric medical care should be explicitly considered in the context of hospital and community care**, and that geriatricians be facilitated to contribute substantially to future hospital and community care of elders.

- The HKGS is ready to **contribute to the planning for the future health care of elderly people** and would be happy to see the establishment of a **communication channel** with the Health, Welfare and Food Bureau for future continuous consultation and dialogue.

References

1. Health and Medical Development Advisory Committee, Health, Welfare and Food Bureau. Building a healthy tomorrow – Discussion paper on the future

service delivery model for our health care system. Hong Kong SAR Government, July 2005. Online. Available: http://www.hwfb.gov.hk/hmdac/english/dis_papers/dis_papers.html Accessed 20 July 2005.
2. Will You Still Cure Me, Will You Still Care For Me, When I'm 75? HKGS's Response to the HMDAC Discussion Paper on "Building a Healthy Tomorrow". Hong Kong Geriatrics Society, 29 October 2005. Online. Available: http://www.hkgs.org.hk/HKGS-PS051029-HealthyTomorrow.pdf Accessed 29 October 2005.

Photo of recent reunion (on 27 Oct 05) with our old friend Dr. YC Lee on his way back from Glasgow via Hong Kong to New Zealand.
From left to right:
Back: TK Kong, BC Tong, CM Lum, SW Li, SY Au, YY Ng
Front: NS Ng, ML Szeto, YC Lee, S Chan, WT Law

Dr. YC Lee is the key person who catalyzed the strong ties between Glasgow and Hong Kong in the geriatric field, the first Honorary Secretary and first editor of the Hong Kong Geriatrics Society. He is now a senior consultant geriatrician in New Zealand. All our past and present presidents (Drs. Chan Sik, Ng Yau Yung, Ng Ngai Sing, Au Si Yan, Kong Tak Kwan) are here to welcome him back!!

Council News:

Dr Bernard Kong, Hon. Secretary HKGS

1. Survey and HKGS' response on the Paper of HMDAC on Health Care Reform - findings of the survey was attached (appendix 1). HKGS had submitted a response paper to the government.
2. HKGS Curriculum in Geriatric Medicine: the book was close to completion and ready for use for the PDGM program. HKGS had the ownership of the book and it would be sold at HK$300 each. Contributors of the book and lecturers of the Course would receive a copy for free from HKGS and HKU respectively. HKGS members' price was proposed to be HK$100 including posting.
3. Dr. A Yuen was elected as the social convener and would arrange the Autumn Annual Outing.
4. Membership updates: e-mails have been sent out to alert members to updates their information.
5. The publication of the Journal of HKGS was in progress. HKGS proposed to HK Asso. of Gerontology to combine the two journals to improve the quality, increase the no. of issues annually and attract more submission.
6. Prof. Stephen Allen of Bouremouth Hospital, UK who was also ex-chairman of BGS Training Committee, visited HK and was invited as honorable speaker in the interhospital geriatric meeting on 23 Sept 05. The title was: "Determinants of Adequate Inhaler and Spirometry Techniques in Elderly Patients". HKGS also hosted a dinner reception with Prof, Allen after the meeting.
7. Dr. J Luk attended the 2nd QoLDem meeting on behalf of HKGS on 30 Sep 2005. (a separate report was published in the Newsletter)
8. Meeting of geriatricians of Asian Region: the tentative inaugural meeting would be held in Apr 6-9 2006 KL Malaysia. A number of Geriatricians would be invited to give presentation on the occasion.
9. Examination centres: for DGM, PWH/SH will be the examination center on June 15, 2006; for PDGM, KWH and TKOH will be the examination center on June 13 &14 respectively. FYKH will be the standby.
10. Annual Scientific Meeting 2006: Dr. F Chan will be the chairman again; tentative date is 17 June 06. Dr. Leong CH has accepted our invitation to be the guest of honour. Dr. J George from UK, who is involved with developing the new BGS Guidelines on Delirium, has also accepted our invitation to lecture on 17 June 06 in our ASM.

Foreign news

The President of BGS commented that despite a clear reaction against the medical model of caring for older people, politicians by and large did not look to geriatricians for solutions, but to nurses running managed care, privatization of long stay care and a radical shift from the medical model to the social model… BGS was looking forward to recruit consultant nurses to be members and formed a special interest group in nursing the elderly. This was considered to be a major step for BGS to become a truly multidisciplinary society.

BGS responded to a consultation process on future older people's housing and care with the following suggested standards: walk in showers, adjustable height work surfaces and equipment, accessible local facilities including shops, pharmacy, health and social care facilities, cable television and internet access, economical heating and cooling systems with energy conservation schemes, secure entry systems, easy to use waste disposal facilities. It was hoped that re-housing or relocation would be minimized if functional abilities of the older people changed. BGS also supported the development of extra-care housing schemes as an alternative to traditional residential care or sheltered housing, to allow support to be increased (or reduced) as needs change, without relocation. It is important to ensure support staff receiving appropriate training in health related issues including dementia, Parkinson's disease, stroke, continence promotion, arthritis and in ethical issues of respect and autonomy. (BGS Newsletter Sep 05).

Nosokinetics News

October 2005 Nosokinetics News is published on line as follows:
http://www2.wmin.ac.uk/coiec/nosokinetics.htm
http://www.iol.ie/~rjtechne/millard/index0.htm (on-line archive)

SIG membership application

To Dr. Kong Ming Hei, Secretary, HKGS

c/o Department of Medicine, Pamela Youde Nethersole Eastern Hospital, 3 Lok Man Road, Chai Wan., Hong Kong. Tel: (852) 25956899 Fax : (852) 25153182

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.

Publication subcommittee:

Dr. Mok Chun Keung (Chairman)
Dr. Leung Ho Yin
Dr. Pang Fei Chau
Dr. Yu Kim Kam
Dr. Tsui Chung Kan
Dr. Sheng Bun
Dr. Lam Wai Sing

Report on QoLDEM -The Consensus Programme on Improving the Quality of Life for Asian People with Dementia

Dr James Luk, Council Member, HKGS

The number of people with dementia is rising exponentially, but dementia care is not well developed in many countries in Asia, public awareness of dementia is low and policy on dementia care is deficient. A 3-year program of consensus meetings on dementia care has been established. Prof. Edmond Chiu, Past President of IPA and Chair of the World Psychiatric Association Section on Old Age Psychiatry is Chair and Prof. Helen Chiu is Deputy Chair of this program.

The QoLDEM program was organized under the auspices of three international organizations: the International Psychogeriatric Association, the Pacific Rim College of Psychiatrists and the World Psychiatric Association, Section on Old Age Psychiatry. The first consensus meeting was held in Hong Kong on April 29, 2004. The Jockey Club Centre for Positive ageing, played host to this consensus project. Experts from various parts of Asia, including China, Japan, Indonesia, South Korea, Singapore, Malaysia, Philippines and Thailand attended the meeting. The group identified the problem areas and discussed on the issues important for quality of life for elderly with dementia in this region. A Consensus Statement on Improving the Quality of life of Asian people with dementia was developed.

In the next 2 years, the QoLDEM group will develop a set of detailed care guidelines, establish Outcome Measures in Quality of Life domains, as well as Key Performance Indicators for evaluation of dementia care services. On behalf of the HKCS, I attended the focus group meeting II of QoLDEM which was held on 20 September 2005 in Holiday Inn Golden Mile Hotel, Tsim Sha Tsui. It was moderated by Dr. S W LI, Chief of Service, Psychogeriatric Department, Castle Peak Hospital. During the meeting, 2 themes were discussed. The first theme was Consensus on the Performance Benchmarks for quality dementia care in RCHEs. The second theme included issues on Staff Training, Funding and Performance Audits.

After the meeting, working groups were formulated to further discuss on the Consensus on the performance benchmarks with a view to formulating a recommendation on the guidelines for quality dementia care in the RCHEs.

When asked what attracts him to this area of medicine, Dr. Sahota said: "You can make a big difference by doing something very simple".

Dr. Sahota from Queen's Medical Centre, Nottingham has been named Hospital Doctor of the Year in the East of England and the Midlands for his contribution in fall prevention and osteoporosis assessment for fracture hip patients.
(BGS Newsletter Sep 05)

Geriatrics is not just the largest specialty in general medicine – there are currently 1200 consultant geriatricians in the UK – and the fastest growing, it is also, according to a recent survey led by Dr. Sally Briggs, the happiest.

(BGS Newsletter Nov 05)

The discussion paper on "Building a Healthy Tomorrow" recommended the Government to consider changing the licensing condition of Residential Care Home for the Elders (RCHE) to require them to engage doctors to take care of their residents' medical needs on a regular basis. Secretary of Health, Welfare and Food, Dr. York Chow said that in the new system, the doctor looking after the residential elders would not need to be stationed in the home but need to be available when on call and need to know the conditions of the elders. He also commented that in the new system, when the treatment to the elders was proven to be failed, and with the agreement of the elders and their families, the **elder could choose to die in their residential home in their wish** instead of rushing into the hospital. (Oriental Daily News, 28/7/2005)

The Social Welfare Department will issue a **new Code of Practice for Residential Care Homes (elderly persons)** in Hong Kong. The new guideline recommended that residential care home should arrange scheduled visits by a registered medical practitioner for health inspection or medical consultation or follow-up treatment at regular intervals to the residential care elderly, which is advised to be one to two times in every two weeks and when necessary. Also, residential home doctors need to review their physical restrain decision for elders every half yearly instead of yearly. Moreover, the new Code of Practice recommended the residential home in-charge to keep their staff duty list/roster and attendance records. (Oriental Daily News, 5/8/2005)

The rapidly ageing Hong Kong population has posted a heavy burden to the public health expenditure. The Government plans to **change the current practice of budget allocation** according to the expected 1% population grow rate. According to estimation from the Census and Statistics Department, the growth of the elderly population outgrows that of the general population and therefore there is a need for the proposed change in budget allocation. (Mingpao Daily News 5/9/2005)

Local News

The new chairman of the Elderly Commission, Dr. CH Leong said that the Commission's working priorities would be long term care model for elderly service, active ageing and financial securities for elders. He suggested the concept of "**Money goes with the elders**" to let elders have the power of choosing the services they like. (Oriental Daily News, 12/9/2005)

The Department of Health together with the School of Public Health of the Chinese University of Hong Kong has done a **survey on 1002 Hong Kong citizen of 18 to 64 years old on their knowledge, altitude and experience with dementia patients**. They found that about 80% of the respondents claimed to know what dementia was but the result showed that majority has misconception about dementia. About 60% of the respondents misunderstood that dementia only involves cognition; 90% thought that loss of way was an early symptom and within which 30% thought that losing way elders did not need any medical attention. Moreover, they found that 15% of the respondents had close relatives with dementia and majority (80%) claimed that their family was disturbed. (Metropolis Daily, 21/9/2005)

The Chairman the Elderly Commission, Dr CH Leong, suggested that a **24 hour doctor on call system at the old age homes** may help to reduce the need of hospital admission of the elders. He proposed that resident doctors should be available at the old age homes and help to settle the minor medical problem of their residents on a 24 hour basis. However the proposal may face problem and manpower allocation and there must be incentive for the old age homes to employ resident doctors. (Mingpao Daily News 11/10/2005)

Sexuality in older adults: behaviours and preferences
Age Ageing 2005; 34: 475-480

The purpose of this study was to assess a sample of lower-income older adults, to describe a full range of sexual behaviours and to identify the degree to which they are satisfied with their sexual activities. Subjects were 179 people (60 and older) who were residents of subsidized independent-living facilities, recruited during a lecture or in public areas in the building. Thirteen of 179 were excluded due to age. Most were white (82%), living alone (83%) and female (63%). Overall, the majority reported to have had physical and sexual experiences in the past year such as touching/holding hands (60.5%), embracing/hugging (61.7%) and kissing (57%) daily to at least once a month; mutual stroking, masturbation and intercourse were experienced 'not at all' by 82% or more. For all activities except masturbation, participants wanted to participate in sexual activities more often than they did. The most important barrier to sexual activity was lack of a partner. Self-reported health was related to sexual activities wanted, with age also related to some preferences. Most of the elderly surveyed want to maintain a sexual relationship which includes touching and kissing, and they would like to have more sexual experiences than they have accessible.

Functional disability related to diabetes mellitus in older Hong Kong Chinese adults
Gerontology 2005; 51:334-339.

Investigators drew a random sample of 6000 households from the 1996 Hong Kong Census and identified 2502 senior citizens age 60 or above. They successfully interviewed 2003 of them face-to-face using standard questionnaires on basic ADL, instrumental ADL and mobility, and correlated the disability with their self reported diabetes status. 12.3% of the sample had DM, and diabetic elderly reported higher disability over a wide range of items in self care, high functional task and mobility, independent of education, marital status, gender and age. Investigators concluded that DM was strongly related to a wide range of disabilities in older Hong Kong adults, underlying mechanism might be different for different categories of disability.

Editor's choice

Effectiveness of antipsychotic drugs in patients with chronic schizophrenia
NEJM 2005; 353: 1209-1223

1493 US patients with chronic schizophrenia participated in this Multi-centre double blind trial. The study aimed to compare second generation antipsychotics (olanzapine, quetiapine, risperidone, ziprasidone) with first generation antipsychotic perphenazine (chosen because of lower potency and moderate side effect profile)
The primary outcome was "time to discontinuation" of the drug for any causes, which was readily definable and avoided the subjective description by subjects. The result show that 74% patients discontinued the study medication before 18 months: 64% of those assigned to olanzapine, 75% of those assigned to perphenazine, 82% of those assigned to quetiapine, 74% of those assigned to risperidone, and 79% of those assigned to ziprasidone. Most subjects discontinued the medications out of inefficacy or intolerable side effects. The time to discontinuation of treatment for any cause was significantly longer in the olanzapine group than in the quetiapine or risperidone group. The time to discontinuation because of intolerable side effects were similar among the groups, but the rates differed; olanzapine was associated with more discontinuation for weight gain or metabolic effects, and perphenazine was associated with more discontinuation for extrapyramidal effects.

Roflumilast – an oral anti-inflammatory treatment for chronic obstructive pulmonary disease: a randomized controlled trial
Lancet 2005; 366: 563-71

A phase III, multicentred double-blind RCT in 1411 COPD patients with 3 arms: roflumilast 250ug, 500ug or placebo given orally once daily for 24 weeks. Primary outcomes were postbronchodilator FEV1 and health-related quality of life. Secondary outcomes included other lung function parameters and COPD exacerbations. Both roflumilast groups showed significant improvement in postbronchodilator FEV1 compared with placebo ($p<0.0001$). Improvement in quality of life was not significant. The mean numbers of exacerbations per patient were reduced in the roflumilast groups. Roflumilast is considered as a promising candidate for anti-inflammatory COPD treatment.

Secondary prevention of macrovascular events in patients with type 2 diabetes in the PROactive Study (PROspective pioglitAzone Clinical Trial in macroVascular Events): a randomized controlled trial
Lancet 2005; 366: 1279-89

A prospective controlled trial in 5238 patients with type 2 diabetes who had evidence of macrovascular disease with two arms: oral pioglitazone (15mg to 45mg) Vs matching placebo, in addition to glucose-lowering drugs. No statistical significant difference was shown for the two groups in 3 yr observation for the primary endpoint (composite of all-cause mortality, non-fatal myocardial infraction, stroke, acute coronary syndrome, endovascular or surgical intervention in coronary or leg arteries and amputation above the ankle). However pioglitazone group had significantly less events (0.84, 95% CI 0.72-0.98, p=0.027) in the secondary endpoint (composite of all-cause mortality, non-fatal myocardial infarction and stroke).

Prevention of cardiovascular events with an antihypertensive regimen of amlodipine adding perindopril as required versus atenolol adding bendroflumethiazide as required, in the Anglo-Scandinavian Cardiac Outcomes Trial-Blood Pressure Lowering Arm (ASCOT-BPLA): a multicentre randomized controlled trial
Lancet 2005; 366:895-906

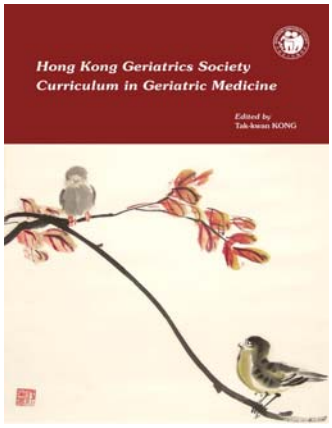
A multicentre RCT in 19257 hypertensive patients (age 40-79) having at least 3 other cardiovascular factors with two arms: amlodipine (5-10mg) adding perindopril (4-8mg) as required Vs atenolol (50-100mg) adding bendroflumethiazide (1.25-2.5 mg) as required. The primary endpoint was non-fatal MI and fatal CHD. The study was stopped prematurely after 5.5 years' median FU because amlodipine-based regimen had fewer (though not statistically significant) primary endpoints (HR 0.90, 95% CI 0.79-1.02, p= 0.1052), fatal and non-fatal stroke (0.77, 0.66-0.89, p= 0.0003), total cardiovascular events and procedures (0.84, 0.78-0.90, $p<0.0001$), all-cause mortality (0.89, 0.81-0.99, p=0.025) and diabetes development (0.70, 0.63-0.78, $p<0.0001$). The amlodipine based regimen was shown to prevent more major cardiovascular events and induced less diabetes than the atenolol-based regimen which have implications with respect to optimum combinations of antihypertensive agents.

Editor's choice

Efficacy and effectiveness of influenza vaccines in elderly people: a systematic review
Lancet 2005; 366: 1165-74

A total of 64 studies up to December 2004 were recruited for analysis. Effectiveness of vaccines against influenza-like illness (ILI) was significant but against influenza was non-significant. However, well matched vaccines prevented pneumonia, hospital admission and deaths. For elders living in community, vaccines were not significantly effective against influenza, ILI or pneumonia but did prevent hospital admission and all-cause morality. It was concluded that in long-term care facilities, the aims of vaccination campaign are fulfilled, at least in part. However, the usefulness of vaccines in the community is modest.

Hong Kong Geriatrics Society Curriculum in Geriatric Medicine



edited by Tak-kwan KONG

ISBN: 988-98727-1-4
Published: December 2005
Price: HKS$300

HKS$100 (for HKGS members)

"This practical book will definitely help most doctors to improve their knowledge, confidence and competence to cope with the many common problems encountered in our daily practice."
Yau-yung Ng

Past President, The Hong Kong Geriatrics Society

"This important textbook has now emerged providing a full spectrum of world knowledge on the subject, as well as considering its special application to Hong Kong. As a comprehensive textbook of geriatric medicine, it is relevant to all doctors whose practice includes elderly patients."
John C. Brocklehurst

Professor Emeritus, Geriatric Medicine, University of Manchester
Past President, The British Geriatrics Society

Why should I buy this Book?
This 32-authored book provides a comprehensive, locally relevant, and up-to-date coverage of common medical problems in old age. It aids the doctor in the day-to-day management of elderly patients, and is a useful reference for those preparing for examinations in geriatric medicine. It includes 35 chapters in 3 sections:

Geriatric Services & Approach	*Geriatric Syndromes*	*Common Geriatric Diseases*
• Development & practice of geriatric	• Constipation & faecal	• Infection control in residential care
• Organization of geriatric services	• Urinary incontinence	• Urinary tract infections
• Community geriatric care	• Falls	• Respiratory tract infections
• Geriatric rehabilitation	• Dizziness & syncope	• Musculoskeletal disorders
• Preventive geriatrics	• Dementia & delirium	• Parkinsonism
• Psychogeriatric services	• Depression	• Stroke
• Indications & interpretations of	• Anxiety syndrome	• Chronic obstructive pulmonary disease
• Use & abuse of drugs	• Sleep disorders	• Cardiovascular disorders
• Social gerontology	• Impaired vision & hearing	• Atrial fibrillation
• Ethical & legal aspects	• Impaired immunity &	• Anaemia
• Palliative care	• Malnutrition	• Common skin problems
		• Diabetes mellitus
		• Gastrointestinal disorders

How can I order a copy of the Book?

For HKGS members, please send a cheque of HK$100 payable to "The Hong Kong Geriatrics Society" and write on its back "HKGS Curriculum in Geriatric Medicine", and mail to Dr. Wong Tak Cheung, Honorary Treasurer, Hong Kong Geriatrics Society, c/o Department of Medicine, 1/F, Tseung Kwan O Hospital, 2 Po Ling Lane, Tseung Kwan O. Non-members please click this link http://www.hkgs.org.hk/publication_contents.html to be taken to the publication page of the HKGS website. Will let you have the book today.

The Hong Kong Geriatrics Society

www.fmshk.com.hk/hkgs

www.hkgs.org.hk

Inter-hospital Geriatrics Meeting (05-06) 6:00 pm – 8:00 pm

Date	Host hospital	Venue
25.11.05	6:00-7:00pm RH/TSK 7:00-8:00pm KWH	HAHO 205S
16.12.05 - Cancel (postpone to Jan 06)	6:00-7:00pm PYNEH 7:00-8:00pm HHH	HAHO 205S
20.01.06	6:00-7:00pm ANHH 7:00-8:00pm FYKH	HAHO 205S
24.02.06	6:00-7:00pm PWH 7:00-8:00pm QEH	HAHO 205S
31.03.06	6:00-7:00pm TMH 7:00-8:00pm WCHH	HAHO 205S
28.04.06	6:00-7:00pm UCH 7:00-8:00pm TPH	HAHO 205S
26.05.06	6:00-7:00pm RH/TSK 7:00-8:00pm KWH	HAHO 205S

Local and Overseas Scientific Meetings

Name	Time & Place	Organizer	Contact
13th Annual Congress of Gerontology HK	26/11/05 Langham Hotel , Hong Kong	Hong Kong Association of Gerontology	www.hkag.org
Geriatrics Clinical Management in Europe 2006	16/2/06 – 18/2/06 Ostend, Austria	International Association of Gerontology	www.iag-er.org
Birmingham movement disorders course 2006	15/3/06 – 17/3/06 Birmingham, UK	Department of Neurology City Hospital Birmingham	susan.pope@swbh.nhs.uk
International Congress of Elderly Health 2006	2/4/06 – 6/4/06 Istanbul, Turkey	International Congress of Health	www.geriatrics2006.org
BGS Spring meeting 2006	5/4/06 – 8/4/06 Newcastle upon Tyne, UK	British Geriatrics Society	www.bgs.org.uk
International Conference On Health and Social Care Modelling and Applications 2006	19/4/06 – 21/4/06 Adelaide, Australia	Noskinetics News Group	www.psychology.adelaide.edu.au/hscm2006/
CGS Annual Scientific Meeting 2006	20/4/06 – 22/4/06 Vancouver BC, Canada	Canadian Geriatrics Society	www.canadiangeriatrics.ca
AGS annual meeting 2006	3/5/06 – 7/5/06 Chicago, USA	American Geriatrics Society	www.americangeriatrics.org/
11th Conference on Osteoporosis UK	25/6/06 – 28/6/06 Harrogate, UK	UK National Osteoporosis Society	www.nos.org.uk
8th International symposium on neurobiology and neuro-endocrinology of Aging	23/7/06 – 28/7/06 Bregenz, Austria	Geriatrics Initiative, Southern Illinois University School of Medicine	www.neurobiology-and-neuroendocrinology-of-aging.org/
BGS Autumn meeting 2006	4/10/06 – 6/10/06 Harrogate, UK	British Geriatrics Society	www.bgs.org.uk

Appendix 1: A Study of the Response of Primary Care Doctors & Geriatricians to the Discussion Paper on the Future Health Service Delivery Model for Residential Care Homes for the Elderly

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Objectives:

•To study the response of primary care doctors and geriatricians to the recommendations made by the Health, Welfare & Food Bureau in the "Building a Healthy Tomorrow – Discussion Paper on the future service delivery model for our Health Care System"

• To explore the feasibility of engaging primary care physicians in looking after the basic medical needs of residents in RCHEs on a regular basis

• To determine the support needed to enable primary care doctors to take up the role as "gate-keepers"

Results

- No. of questionnaires posted – 404
- Overall response rate – 42.3% (171/404)
- Primary Care doctors' response rate 42.6% (113/265) , 56% have been a VMO
- Geriatricians' response rate 41.7% (58/139)

Willingness/ Commitment of taking up VMO's duty

1. Will you be able to devote your time to look after the medical needs of a home for the elderly on a regular basis ?
   84.7% primary doctors able to devote more time, 50% geriatricians able to devote more time
2. How many hours in a week will you be able to devote your time as a VMO ?
   50.5% Primary doctors able to devote 2-3 hours & 24.2% able to devote 1-2 hours
3. Will you be able to provide 24 hour medical support to the homes for the elderly on a regular basis ?
   16.7% primary doctors – Yes, 10.7% geriatricians - Yes

Views on Recommendations made in the HMDAC Paper

1. Engaged VMOs should attend to the basic medical needs of the RCHEs on a regular basis
   Almost all doctors agreed
2. Social Welfare Department should revise the Code of Practice for RCHEs to engage doctors to take care of their residents' medical needs on a regular basis
   95.3% doctors agree
3. Geriatricians in HA should focus more in hospital work rather than RCHEs
   64.2% geriatricians disagree or strongly disagree,70.9% primary doctors agree or strongly agree
4. CGAT should concentrate on discharge planning and provide support to doctors engaged by RCHEs through consultations and joint conferences
   19.3% geriatricians strongly disagree or disagree, 97.3% primary doctors strongly agree or agree
5. Private doctors can act as gatekeepers of A & E attendance and hospitalization for all RCHE residents
   94.6% primary doctors strongly agree or agree, 43.9% geriatricians strongly disagree or disagree

Success elements for VMO - in order of importance

- Time that the VMOs can spend in RCHEs for consultation on each visit
- Frequency of VMOs' visit
- VMOs' financial return from RCHEs work
- Experience of working with CGATs
- Possession of a PDCG/DGM qualification

Support required by VMOs - in order of importance

- Access to HA Clinical Management System (CMS) record
- Referral rights to HA community nursing and allied health professionals
- Right of ordering investigations in HA laboratories
- Right of prescription in HA pharmacy
- Right of admission to HA hospitals

Discussion

- 73.1% of doctors are willing to look after the medical needs of residents of RCHEs
- 15.3% are willing to provide 24 hr support to RCHEs (84.7% unwilling)
- 64.2% geriatricians disagree or strongly disagree that geriatricians should focus more in hospital work
- 43.9% of geriatricians do not think private doctors can act as gate-keepers of A&ED attendance & hospitalization
- Medical care for RCHEs is considered as mixture of both primary & secondary care
- VMO's time/frequency spent in RCHEs & financial return are considered important elements of success to implement HWFB's recommendation
- Access to HA's medical record system & referral rights to community nursing / allied health service are essential support to VMOs

Limitations

Response rate

- Selection bias
- Definition of VMOs
- Keep goals of geriatric care in mind rather than just gate-keeping

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- Dr. P S Ko (AHNH)

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**