The Hong Kong Geriatrics Society Newsletter

May 2006

The Hong Kong Geriatrics Society
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Editorial

I think it is no mere coincidence that the British (at the Royal Society of Medicine evening debate as reported in the BGS Newsletter March 06 issue), the Asian (at the Asia Pacific Geriatric Conference at Kuala Lumpur in April which many Hong Kong colleagues attended) and we (at a focused discussion forum reported in this issue) discussed on "the future of Geriatrics". People used very alarming titles such as "Geriatric medicine has no future" (British) and "Geriatricians are not needed for elderly care" (Asian). It seems that the enthusiasm of Geriatrics is coming to a plateau and many of us are eager to know what should be the next leap – going up or down! HKGS is celebrating her 25th anniversary and it is a good time to sit down, look back and plan forward. The focused group discussion as reported well reflected this process. We are going to have our AGM cum ASM on 17/6/06 together with the celebration dinner of the 25th anniversary of HKGS. As Dr. Kong TK, our current President, has decided to step down, new president and new council members will be elected in this important event. So you cannot and should not miss it.

I have served as the HKGS Newsletter Editor for seven years. New breath, new insight and new energy are needed to help us to go forward and leap to a higher ground. I consider it the appropriate time now for me to hand over to the new Editorial board and Editor and wish them every success in the future. I also wish to express my greatest gratitude to the past and present editorial board members. Without their great contribution and effort, we cannot keep the record of not breaking the continuity of publishing four issues of our Newsletter per year till now.

I wish to quote the words of Prof. John Gladman, talking about the future of British Geriatrics, as a blessing to HKGS: " I have seen the future and it looks wonderful".

Mok CK, Editor

President's Message
From recognizing "dis-ease" to detecting disease: Geriatricians' role in cure and care

Dr. TK Kong

In the recent "Young Geriatricians' Forum" of our Society, some members opined that geriatricians' role should be more than care of elders of residential care homes, and that geriatricians should go beyond assessment to detect and cure diseases by acquiring skills in technological investigations.

The term "disease" originated from "dis-ease."[1] Advances in medicine in elucidating the aetiolgoies of "dis-ease," often to microscopic and molecular levels, led to the emergence of objective, scientific concept of "disease" from earlier subjective ideas of "dis-ease," so much so that patients are nowadays more often referred to by disease labels rather than as persons with "dis-ease." Thus, the sick man "disappeared" in the modern society as "doctors directed their gaze not on the individual sick person but on the disease of which his or her body was the bearer." [2]

However, a list of multiple diagnostic disease labels attached to an elderly patient may not bear any relevance to the "dis-ease" for which an elderly patient seeks medical attention, e.g. dyspnoea and reduced effort tolerance in an elder labeled as COAD may be due to unnoticed and uninvestigated anaemia rather than

COAD; functional decline and fever in another elder labeled as "UTI" may be due to undiagnosed gouty arthritis precipitated by diuretics used in treating heart failure. Mis-labelling and mismatching of the relationships between "dis-ease" and disease may deny an elder a chance of cure, e.g. an elderly lady with instability and impaired cognition being denied an operation for subdural haematoma because of the diagnostic label of dementia, ignoring that subdural haematoma could be a reversible cause of cognitive decline. "Dis-ease" in an elder may remain hidden from the attending doctor because of lack of appropriate attitude, knowledge and skills in geriatric medicine, e.g. problems of incontinence, instability and falls, and insomnia are ignored or just treated palliatively. It is often forgotten that such geriatric problems can have reversible causes and can at times be cured through detection and treatment of underlying diseases. [3] If "dis-ease" is not recognized, a diagnostic pathway won't occur, and an elder might be labeled as "social problem," and the solution thought to be social or institutional care. The dichotomous view of an elder with "dis-ease" as either "medical" or "social" would not fit into her fragile ecosystem of diseases, drugs and adverse social factors with complex interactions. In the words of Bernard Isaacs, "Elderly patients are admitted to hospital not because of social problems, but because of medical problems with social consequences, or social problems with medical consequences." Geriatric assessment is a process of knowing the elderly person: recognizing "dis-ease"; detecting causative diseases and environmental factors (drugs, social); matching "dis-ease" to diseases; in order that "dis-ease" can be reversed or reduced through appropriate interventions, thus protecting a frail elder from functional decline and institutional placement. But all these will be largely theoretical if our health care system and evidence-base remains biased towards singular disease and fragmented into single organ-system approach. [4-6]

Health professionals who have, or are caring for, parents with acute and chronic "dise-ease," often experiencing heartache and hardship, understand the limitations of our current health care system as applied to elderly patients. [7-11] Scarred by the undignified hospital experience of his mother, a doctor wrote, "It has something to do with lack of resources, but I suspect more to do with lack of professional self worth and care by isolated individuals rather than a coherent team." [7] Frustrated and inspired by their own experience of being caregivers of parents, [9] Robert and Rosalie Kane, themselves knowledgeable geriatrician and gerontologist, formed the lobbying organization, "Professionals With Personal Experience in Chronic Care" in the U.S., and voiced out to policymakers, *"If professionals working within the health care system are having serious problems with getting care for themselves and their families, then the system is failing in a major way."* [12]

There is much that we can do as geriatricians, by education and by examples, to strive for a better model and system of medical and social care to match the needs of elderly people with "dis-ease."

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Provisional draft program of
the Hong Kong Geriatrics Society 25th Anniversary cum Annual Scientific Meeting
17th June 2006, Sheraton Hotel

12:30-14:00	Registration and Lunch
14:00-15:00	Free Paper Presentation (Competition for Chan Sik, YY Ng & NS Ng Prizes)
15:00-15:30	Annual General Meeting
15:30- 16:00	Health Break
16:00-17:30	Old Age Psychiatry Symposium on Dementia, Delirium & Depression
	Prof. Roy Jones (Bath), Dr. Jim George (Carlisle)& Prof S W Tang (HKU)
17:30-17:45	Opening ceremony and welcome addresses
	Hon Dr Leong Chi Hung, Dr. TK Kong, Dr. Felix Chan
17:45-19:15	Plenary Symposium on Geriatric Medicine: Past, Present and Future
	Prof. David Stott (Glasgow), Dr. HC Tam (Australia), Dr. YC Lee (NewZealand)
19:15-22:00	Jubilee Annual Dinner
	Gold Medal Awards and Outstanding Free Paper Awards Presentation / Performances/Games/Lucky Draw

Council news

Dr Bernard Kong

1. ***"Hong Kong Geriatrics Society Curriculum in Geriatric Medicine"*:** 2000 copies have been printed and sold at HK$300 in the McBarron bookshop for non-members. Members can get a copy at HK$100 from HKGS.
2. DGM will be held in SH on 15/6/06 and PDGM in KWH & TKOH on 13-14/6/06. The PDGM examination format in June 06 will change to that similar to the DGM.
3. Asia Pacific Geriatric Conference in April 2006: TK Kong, MF Leung, J Woo and B Kong were invited as speakers representing Hong Kong (photo 1). It was well organized with sharing between specialists from Australia, NewZealand, Malaysia, Singapore, Thailand and Indonesia. An Asia Pacific Network in Geriatric Medicine has been set up with a web site run by Australian Society For Geriatric Medicine. The next APGC will be held in Beijing in October, 2007. It is planned to have parallel conference with the Asian/Oceania Congress of Gerontology meeting.
4. Annual Outing on 5/3/06: members and their families enjoyed a good day.
5. ASM/AGM 2006 – see separate notice.
6. Dr. TK Kong will step down from Presidency in June. A five-member election committee was set up for the AGM – TK Kong (Chairman), F Chan, B Kong,, TC Wong and CP Wong.
7. HKGS 25th Anniversary: Jubilee Dinner – core group led by B Kong for the logistics. An editorial board with CM Lum as editor in chief will publish a book to commemorate the occasion. Board members are: KS Au, F Chan, PS Ko, B Kong, KK Mo, CK Mok, FC Pang, B Sheng.
8. Progress on Combining JHKGS and JHKAG: T Kwok and MF Leung are co-editors of the new "Asian Journal of Gerontology and Geriatrics" – planned for 3 publications in 2006, then 4 per year from 2007 onwards. The first issue will be out by end of May. The 1st inaugural issue will be free to members of HKGS, HKCP, HKCFM and Psycho-geriatricians.
9. Three council members (TK Kong, T Kwok, TC Wong) together with Prof. J Woo met Professor Finbarr Martin (consultant physician at the elderly care unit at Guy's and St.Thomas' NHS Foundation Trust in London, Chair of the BGS Section on Fall and Bone health.) on 25/4/06 at Regal Seafood Restaurant, Regal Riverside Hotel (photo 2).
10. NS Ng, F Chan and a team of geriatricians attended the Canadian Geriatrics Society 25th Anniversary cum Annual Scientific Meeting in Vancouver (photo 3). On behalf of HKGS, NS Ng presented a souvenir (the Hong Kong Geriatrics Society Curriculum in Geriatric Medicine) to the Canadian Geriatrics Society.

Future of HK Geriatrics Forum

Reported by Mok CK,Moderator of the Forum

A forum on "Future of Hong Kong Geriatrics – 20 years forward" was held on 16/3/06 at Ruttonjee Hospital by HKGS. This is part of the celebration activities of the 25th anniversary of HKGS. 17 HKGS members attended the meeting with a good mix of "old" and "young' colleagues working in geriatrics. A few who could not come had expressed their points through e-mail. The following is a brief summary of the points noted in the meeting. Some viewpoints are very different or even contrasting to each other. However, they reflected the diversity of our members' view on our specialty.

Image of Geriatrics

- Geriatrics has a general good image & is trusted by both formal and informal care-givers.
- Some doctors have a low image of Geriatrics including geriatric colleagues themselves.
- Some equate 'Geriatrics" to "Old Age Home" medicine – considered as a negative image.
- Some have positive regards towards the Geriatrics specialty; geriatricians are no less capable than general medical colleagues and geriatrics have her special contribution to frail elderly patients.
- Some successful colleagues thought that image was built up by effort – contribution to difficult case management, hospital service planning & administration etc.
- Some have the impression that the current geriatric service pays too much emphasis on population health, policy making and public health service provision.
- A proposal to promulgate the image of Geriatrics: the mission of geriatric training is to train CARING doctors to be the BEST physicians for FRAIL elderly persons in DIFFERENT medical settings; Geriatricians are the best physicians for frail older patients.
- Propaganda in the media is needed to spread our knowledge and message to the public which in turn can uplift our public image; need to uplift the image of Geriatrics to both the professional (Geri & non-Geri) and lay people.
- Geriatricians, with a strong background of holistic approach to disease management, should take up active roles in service planning, administration and monitoring in hospitals which in the long term can build up the prestige of Geriatrics.
- Role models (academic, administration, service provision) are always in need to boost up the morale of a specialty.
- A strong knowledge basis of general medicine is a strong promoter of self-image & respect from others; "Knowing something of everything" is important.
- Some considered Geriatrics taking a passive role in hospital service. But some commented that actually one could be very active e.g. running A&E liaison, orthogeriatric services etc. Whether the specialty is active or not depends on the attitude of the team and their relationship with other specialties.

Public Private interface

- Survival in private market – as in many specialties, private specialists need to do general medical. For Geriatrics, just doing assessment is not enough, need to run disease model and treatment model for business.
- Public service support (multidisciplinary support) to private geriatricians can be very helpful e.g. direct referral to GDH, admission right (bypass the long queue of specialist OPD new case booking) etc.
- Recognition of the geriatric specialty by both HK people and professional colleagues of other specialties is crucial for successful private practice.
- Group practice is a trend in the private market; this can be a better model of geriatric practice in private.

Training and staff recruitment

- Centralized training program was suggested, using inter-hospital meeting as a possible means. Our HPT curriculum could be used as the backbone of the presentations including basic knowledge and current updates; sharing of service delivery models and experience to young geriatricians was also suggested e.g. how to set up dementia clinic, continence clinic etc.
- Some thought that the current low image of Geriatrics in some hospitals deterred recruitment of new staffs/trainees.
- Hi-tech and Hi-skill are not the characteristics of Geriatrics; Geriatrics requires a different set of skill-mix.
- For some low risk investigation & procedures e.g. dysphagia assessment, PEG insertion etc., geriatricians may be at a good position to pick up the skills and deliver the service. This is to be considered with the local settings in individual hospitals and the relationship with other subspecialties.
- For technical skill training, inter-departmental transfer of staff for attachment is to be encouraged & facilitated.
- Some considered that the knowledge on the core business of Geriatrics is probably not thoroughly known by many geriatric doctors (even trained ones) – further improvement in this situation is needed.
- Some suggested 3rd specialty training but most thought that Geriatrics + AIM is good enough; a 3rd specialty just diverge the attention & effort from Geriatrics.

- Our holistic approach to elderly health problems is never to be compromised. Such approach actually helps us to make quick and good clinical judgment and decision in our daily practice e.g. discharge planning, appropriate Ix and Mx etc.
- For trained geriatricians, more chance to take up supervisory role in service development and delivery is important for staff development.
- Good role models seen by medical students have big influence in their future choice of clinical subspecialties.
- As geriatric service has many faces, multiple types of geriatricians are needed. The geriatric specialty is probably more diversified than others. This is the challenge but also the attractive point of Geriatrics. Diversification is actually welcome by the modern society.
- The innate instability of contract MO affects the recruitment of staffs. Contract staffs are at a difficult position to choose subspecialty training. They usually choose those skills that are useful in private practice and would consider Geriatrics as a lower priority.

Academic Geriatrics

- Development of academic prominence depends on the availability of suitable candidates and political environment; many expressed a deficiency in this aspect in HK.
- Lack of prominent figures in the academic field except a few in CUHK.
- Training in research is lacking during our HPT in service hospitals; possibility of HKGS to contribute was suggested.
- Meaningful research on the big "I"s of Geriatrics is still in need.
- Biomedical research may not be the best way for Geriatrics; service related, population need or local epidemiology studies are much in need and also easier for geriatricians to conduct. These answers are instrumental to understand the elderly health issues of our local setting.
- Joint research project (multi-centered) can be a direction to go; HKGS may take an active role in this.

Future development

- NGOs are very good allies of Geriatrics. Current strong linkage should be further strengthened. They are very good spokesman for us in the public.
- Developing special clinics for elderly patients e.g. syncope clinic, memory clinic etc. worked well; can be tried in private market so that other medical colleagues know when to consult a geriatrician.
- Some consider "Nursing Home" medicine is something Geriatrics should be proud of. It is the comprehensive care that is needed that shows our skills. This is indispensable and should be further developed e.g. supervision of OAH VMO. As such, one being trained to provide an independent service to OAH is a very important skill.

Visit to Acute Care for Elders Unit in Vancouver General Hospital

Dr. TY Chan, KWH

A group of geriatricians made a pre-conference visit to the Acute Care for Elders Unit (ACE) in Vancouver General Hospital (VGH) on April 19, 2006 (photo 3). The delegate was led by Dr. Ng Ngai Sing, and included Drs. Felix Chan, James Luk, TY Chan, Wancy Ho, and Noble, wife of James. The visit was hosted by Dr. Roger Wong, Medical Manager and Consultant Geriatrician of ACE. The unit is located at the 11th floor of Jim Pattison Pavillion of VGH and comprises 22 beds. It provides acute medical care to patients aged 75 and over, who are admitted through the emergency department. The ward is very spacious with main desk located in center. All the rooms are either single or double en suites with ceiling hoist and fabulous view. There are signage with large fonts and matte finish of flooring. Majority of the physiotherapy is undertaken within the room or hallway. The unit is staffed by full time internists or hospitalists (family physicians), nurses, physiotherapists, occupational therapists, social workers, pharmacists and dietitian. Geriatric and geriatric psychiatrist consultations are readily available. The unit emphasizes multi-disciplinary care, early rehabilitation and discharge planning. Interdisciplinary rounds are held twice weekly for each patient. The average length of stay was 5.2 days. A retrospective study showed that ACE reduced ALOS when compared to an acute medical unit and most of the patients were discharged home.

An informal meeting between the delegates and Roger was held after the tour. Various aspects of elderly care in Canada and Hong Kong were discussed.

Shortly afterwards, the group paid a visit to Dr. Ng's home in Coquitlam. All of us were warmly greeted by him and his family, including their lovely dog, Icy. In the evening, the whole party went to a dinner hosted by Dr. Ng in a Chinese restaurant. The dinner featured Alaska King Crab (cooked in four styles), roasted pigeons and other delicious dishes.

Mild cognitive impairment
Lancet 2006; 367:1262-70
This was a comprehensive review on mild cognitive impairment written by the participants of the International Psychogeriatric Association Expert Conference on mild cognitive impairment.

Donepezil in patients with severe Alzheimer's disease: double-blind, parallel-group, placebo-controlled study
Lancet 2006; 367:1057-65
A double blind placebo-controlled study in 248 patients with severe Alzheimer's disease (MMSE 1-10) who were living in nursing home. Donepezil 10 mg daily was compared with placebo. After a 6 month period patients given donepezil were found to improve more in the severe impairment battery and declined less in the modified Alzheimer's Disease Cooperative Study activities of daily living inventory for severe Alzheimer's disease. The authors concluded that donepezil improved cognition and preserved function in individual with severe Alzheimer's disease who live in nursing homes.

Oral melphalan and prednisolone chemotherapy plus thalidomide compared with melphalan and prednisolone alone in elderly patients with multiple myeloma: a randomised controlled trial Lancet 2006; 367: 825-31

A randomized controlled trial with 255 elders with newly diagnosed multiple myeolma who were randomized to either oral mephalan plus prednisolone (MP) or mephalan plus prednisolone with thalidomide 100 mg daily (MPT) for six 4-week cycles. Patients treated with thalidomide had higher response rates and longer event free survival. Combined complete or partial response rates were 76% for MPT and 47.6% for MP alone. 2-year event free survival rates were 54 % for MPT and 27 % for MP (HR 0.51 95% CI 0.35-0.75 p=0.0006). The MPT group also had lower rates of grade 3 or grade 4 adverse events. However there was no statistically significant difference in the 3-year event free survival rate. The authors concluded that MPT is an effective first line treatment for elderly patients with multiple myeloma.

Editor's choice

Medical illnesses are more important than medications as risk factors of falls in older community dwellers? A cross-sectional study
Age and Ageing 2006 35(3):246-251
The hypothesis that underlying medical illnesses are the cause of falls rather than medications was tested. This was a cross-sectional study involving 4,000 ambulatory urban Hong Kong community-dwelling men and women aged 65 years or over. Demographic data, fall history in the previous 12 months, medical diagnoses, current medications and self-rated health were recorded. Medical diagnoses and their corresponding medications were tested simultaneously in a multivariate model. 789 (19.7%) subjects reported at least one fall and 235 (5.9%) experienced two or more falls. After adjustment for age and sex, medications associated with any falls were aspirin, diabetic drugs, nitrates, NSAIDs, and paracetamol, and those associated with recurrent falls were calcium channel blockers, diabetic drugs, nitrates, NSAIDs, aspirin and statins. Only anti-diabetics and nitrate showed moderate and borderline significance in multivariate analyses for recurrent and any falls respectively. Other medications failed to show significant relationship with falls, while eye diseases, heart diseases and musculoskeletal pain showed variable associations. The apparent association between many medications and falls was mediated through the underlying medical diagnoses and neuromuscular impairment. Anti-diabetics agents were associated with falls.

Effectiveness of hip protectors for preventing hip fractures in elderly people: a systemic review
BMJ 2006: 332: 571-4

This was a systemic review with meta-analysis of the evidence for the effectiveness of hip protectors. Databases including Cochrane, Medline, Embase and CINAHL were searched. Data from 11 trials carried out in nursing or residential care settings and 3 randomized trials of 5135 community dwelling elders were review. Results from the nursing or residential care settings showed a marginally statistical significant reduction in the incidence of hip fracture (RR 0.77 95% CI 0.62 to 0.97) whereas that of community dwelling elders showed no reduction (RR 1.16 95% CI 0.85 to 1.59). Long term compliance of the hip protectors was poor. The authors concluded that hip protectors are an ineffective intervention for those living at home and their effectiveness in an institutional setting is uncertain.

Calcium plus Vitamin D supplementation and the risk of fracture in community subjects (& risk of colorectal cancer)
NEJM 2006: 354(7): 669-83

This was a randomized placebo-controlled trial of 36282 healthy postmenopausal women aged 50 to 79 year (from the Women's Health Initiative trial). Intervention group was given 1000mg of elemental calcium as calcium carbonate plus low dose of vitamin D3 (400 IU) daily. Fractures were ascertained for an average follow-up period of 7.0 years. The intervention group had a significant higher hip bone density (1.06%) than that of placebo group. But there was no significant difference in hip fracture or total fracture. The risk of renal calculi increased with treatment (hazard ratio 1.17). If data were excluded at the time a woman's adherence to therapy below 80%, the risk of hip fractures was significantly reduced (hazard ratio 0.71). It was noted that more than half of all participants in both groups were currently receiving hormone-replacement therapy. The secondary outcome of this study is the incidence of pathologically confirmed colorectal cancer. The incidence of invasive colorectal cancer did not differ significantly between intervention and placebo groups (168 case and 154 cases respectively).

Local News

As the population of Hong Kong is ageing, elderly health care has been a growing problem. Just a yearly membership fee of $110, the elderly can enjoy health assessment and body check service in the 18 **Elderly Health Centers** under the Department of Health. Because of the low cost, the number of members of the Elderly Health Center has grown to thirty-eight thousand with twenty-five thousand being on the waiting list with a **long waiting time of about two years**. But in view of the tight budget, the Department of Health has not planned to subsidize directly to the service but the department will continue to cooperate with the private sector and non-government organizations to improve the basic health care of our older citizens. (Sing Pao 23/3/2006)

The Hong Kong East Hospital Cluster of the Hospital Authority is planning to establish seven high risk patients databases which will serve as a **shared platform of patient information** between the Hospital Authority, Non-government Organization and the private sector. The NGO and private doctors can use the shared information in providing shared care to the patients. The Cluster is also planning to lease out empty premises located at the Tang Shiu Kin Hospital to the NGOs to provide social services so as to increase the income of the Cluster. (Mingpao Daily 3/4/06)

The "Against Elderly Abuse of Hong Kong" had received 911 **elder abuse** referrals from June to December 2005. The types of elderly abuse in the order of frequency were financial abuse (45%), psychological abuse (27.4%), physical abuse (17.5%), mixed abuse (9.3%) and sexual abuse (0.1%). Among those cases of financial abuse, 40% of the abused elderly had their wages or CSSA being taken away by their family. The "Against Elderly Abuse of Hong Kong" urged the Government to put in more resources to improve the situation. (Hong Kong Economic Times 20/3/2006)

The "Against Elderly Abuse of Hong Kong" received more than 800 referrals or complaints about **transportation difficulties to hospital follow-up of our senior citizens**. They interviewed about 3000 CSSA elderly recipients with mobility problems and chronic medical illnesses and 85% reported that the present NEATS, easy access transport and rehabus services were not enough. 70% reported that they frequently could not get the above transportation service and among them 15% could not go to hospital follow-up because of transportation difficulties. The "Against Elderly Abuse of Hong Kong" urged the government to put in more resources to improve the transportation services for our elderly. (Oriental Daily News 24/4/2006)

Foreign news

A very interesting debate was reported in the March 06 issue of BGS Newsletter. It was the Royal Society of Medicine evening debate. The motion was "Geriatric medicine has no future". Some sayings were quoted below:

- Compared to less acute, often nurse-led services, consultant geriatricians and hospital teams are an expensive resource. Consultant geriatricians are paid twice as much as nurse consultants but are they twice as effective? – from a nurse consultant
- The original rationale for Geriatric existence is fast disappearing if we actively eschew, or are neither asked nor funded by primary care trusts or local authorities to serve in community or continuing care roles – from a community geriatrician
- Time and again, it is precisely the involvement of a geriatrician which solves (often quickly) problems which have lain unrecognized or untreated by primary care staff, nurses or other hospital specialists – from a Professor of Geriatrics
- Those targets such as person-centred or intermediate care, with less medical input are those against which progress is slower. We are world leaders in falls services and are still seen as a model from which other countries actively seek to learn – from another Professor of Geriatrics
- In the end, I was left feeling that both parties are arguing that geriatric medicine has no future – as initially envisaged and practiced – from Secretary of BGS

A BGS policy paper on Geriatric Day Hospitals was also published in the same issue of BGS Newsletter.

(BGS Newsletter Mar06)

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.

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The April issue of Nosokinetics News is released at: http://www2.wmin.ac.uk/coiec/nosokinetics.htm, http://www.iol.ie/~rjtechne/millard/nsk61/indx61.htm

Symposium on advances in Aged Care will be held on 7 July 2006 (Friday). The symposium is organised by the HK Association of Gerontology. Among many prominent speakers, Prof. Raymond Tallis from UK, Prof. Sang Chul Park from Korea, Prof. Linda Lam from HK will present.

Congratulation to Dr. Brian O. Williams for taking up Presidency of the Royal College of Physicians and Surgeons of Glasgow from December 2006 for 3 years

Dr. Brain O. Williams has a long association with the HKGS since 1983, and is well known among our local geriatricians. He has been the mentor of a number of our geriatricians, visiting professor in our annual scientific meetings, honorary advisor of our Journal, external advisor of the Postgraduate Diploma in Community Geriatric Course, and is the key person in facilitating the setting up an overseas examination centre in DGM(Glasgow) in Hong Kong. We sincerely hope that he enjoys the Presidency and leads the College forward to its highest academic standard, and strengthens further the relationship with Hong Kong.

Photo 1: Geriatricians from Asia Pacific countries gathered on 8 April 2006 to discuss on the formation an Asia Pacific Network in Geriatric Medicine during the Asia-Pacific Geriatric Conference held in Kulala Lumpur, Malaysia.

Photo 2: Hong Kong geriatricians attended the Canadian Geriatrics Society 25th Anniversary cum Annual Scientific Meeting in Vancouver

Photo 3 : Dinner meeting on 25 April 2006 with Dr. Finbarr Martin (centre of front row) during his brief stop in Hong Kong after lecturing in Taiwan. Fruitful sharing was made on the geriatric scene and fall service between the two countries.

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

Inter-hospital Geriatrics Meeting (06-07) 6:00 pm – 8:00 pm

Date	Host hospital	Venue
26.05.06	6:00-7:00pm TPH 7:00-8:00pm UCH	HAHO 205S
17.06.06	AGM cum ASM / 25th anniversary dinner	Sheraton Hotel
28.07.06	6:00-7:00pm RH/TSK 7:00-8:00pm CMC	HAHO 205S
25.08.06	6:00-7:00pm PYNEH 7:00-8:00pm SH	HAHO 205S
29.09.06	6:00-7:00pm HHH 7:00-8:00pm TWEH	HAHO 205S
27.10.06	6:00-7:00pm WCHH 7:00-8:00pm KWH	HAHO 205S
24.11.06	6:00-7:00pm RH 7:00-8:00pm PMH	HAHO 205S
22.12.06	X'mas	
26.01.07	6:00-7:00pm TMH 7:00-8:00pm PWH	HAHO 205S
23.02.07	6:00-7:00pm RH 7:00-8:00pm FYKH	HAHO 205S
30.03.07	6:00-7:00pm QEH 7:00-8:00pm HHH	HAHO 205S

Local and Overseas Scientific Meetings

Name	Time & Place	Organizer	Contact
HKGS 25th Anniversary AGM cum ASM	17/6/06 Sheraton Hotel Hong Kong	HKGS	www.hkgs.org
11th Conference on Osteoporosis UK	25/6/06 – 28/6/06 Harrogate UK	UK National Osteoporosis Society	www.nos.org.uk
Symposium on Advances in Aged Care	7/7/06 Christian Family Service Centre Hong Kong	HK Association of Gerontology	www.hkag.org
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/
4th Congress of the European Union Geriatric Medicine Society	23/8/06 – 26/8/06 Geneva Switzerland	European Union Geriatric Medicine	www. Eugms2006.org
8th Scientific Meeting Society for Geriatric Medicine, Singapore	16/9/06 – 17/9/06 Singapore	Society for Geriatric Medicine, Singapore	www. Geriatrics.org.sg
BGS Autumn meeting 2006	4/10/06 – 6/10/06 Harrogate UK	British Geriatrics Society	www.bgs.org.uk

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 2006/2007**
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**