Newsletter
January 2013

The Hong Kong Geriatrics Society
香港老人科醫學會

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President's Message

What a wonderful year 2012 must have been for the Hong Kong Geriatrics Society!

On a fine chilling morning in Jan 2012, Professor Jean Pierre Michel representing the International Association of Gerontology and Geriatrics (IAGG) visited me at my office. We were discussing about the possibility of hosting a Master Class on Ageing in Hong Kong. In August, the event was held at the Faculty of Medicine, Hong Kong University with more than 30 trainees and junior fellows from 6 countries attending 9 state of the art lectures with active interactive poster discussions in between. The event was a great success thanks to the support of local and overseas experts who acted as tutors. MCA Hong Kong will never be possible without the full support from HKU and IAGG. I wish to give special thanks to Prof Karen Lam, Prof LW Chu, Prof Alain Franco - Vice President of IAGG and Prof Jean Michel - President of the European Union Geriatric Society for their collaboration.

The highlight of the year has to be the 2012 Asia Pacific Geriatrics Conference hosted by HKGS in October. It was well attended by more than 350 participants with more than half from overseas. It was the first time that HKGS hosted an International Conference on her own and we received very positive feedbacks from all the eminent speakers, experts in the field of geriatrics and participants. I must thank Prof Jean Woo as the chairlady of the scientific committee and Dr Au Yeung Tung Wai as the chairman of the organizing committee for their leadership and devotion in making APGC 2012 a huge success.

It has been more than 30 years since the founding of the HKGS and members are getting more involved and all working towards a common goal –striving for excellence in the care of the elderly.

It is a most fulfilling career for me being the president of the HKGS and I am sure our society will continue to network with Asia Pacific, European and other Geriatric Societies to build a strong professional body.

Dr Bernard Kong
President
The Hong Kong Geriatrics Society

Editor's Notes

It is my great pleasure to take up the role of the Editor in the HKGS Newsletter this year. Being busy with the Asia Pacific Geriatrics Conference 2012 a few months earlier, I have taken the liberty to postpone the first issue of the Newsletter till now so that our team of editors can concentrate on the preparation of this international event.

We have decided to give a face-lift to our Newsletter this year by adding in a wider variety of "columns". Apart from the usual information about our Continuous Medical Education activities, we have added in the "Training and Trainees" column with a personal touch from our newest Fellow, and the "Continuous Medical Education (CME) Activities – a young Fellow's perspective" column, written by another young Geriatrician. In particular, we have the "Perspectives" column for the first time, featuring Dr TK Kong, one of our most senior geriatricians in hospital service and a regular panel member in many of our Board exams including mine.

The "SIG news" serves to highlight the activities and achievements of our various SIGs, and the Specialty Board has also put in a few kind reminders to our trainees in this issue. The new "Members' publications" column was added to promote an atmosphere of academic research and collaboration.

On the soft side we of course have the announcement of our annual outing, plus a new column on happy sharings and changes ("Congratulations!"). We also hope to help our members to plan ahead with the "Upcoming conferences and courses" section.

I would take this chance to acknowledge all our new editorial team members (in no particular order but ladies first): Catherine Chui, Winnie Ng, Stanley Tam, Kenny Wong and Chun Keung Shum.

Jenny Lee, Editor

Editorial Board
Editor: **Jenny Lee** ▪ SIG News: **Catherine Chui** ▪ Outing and Congratulations: **Winnie Ng** ▪ Professional Development: **Stanley Tam** ▪ Council News: **Kenny Wong** ▪ CME activities: **Chun Keung Shum**

Perspectives - Why geriatric medicine?

Tak Kwan KONG

Consultant Geriatrician, Princess Margaret Hospital

Q: "I am just waiting for a post in internal medicine," a green medical officer (who had no exposure to geriatric medicine in his undergraduate curriculum) frankly told the consultant geriatrician in-charge of a geriatrics unit during a recruitment interview.

A: "Never mind, just stay on and see if you like the specialty. Some doctors may not like working with elderly patients who are incontinent of urine and faeces…... We see and care for elderly patients as a multidisciplinary team." Having witnessed how geriatric medicine was practised and how elderly patients were cared for and helped in the geriatric unit, the doctor stayed on, finding the specialty both intellectually challenging and emotionally rewarding.

Q: "Why Geriatric Medicine?" A geriatrician was asked to speak on behalf of his Society to invite trainees to consider a career in specialty of geriatric medicine upon their success in passing the MRCP.

A: "Geriatric medicine certainly keeps you humble. Be prepared for unexpected passionate kisses…. It is a "whole person" specialty considering psychological, social and spiritual dimensions, together with functional and environmental assessments….To be successful in Geriatric Medicine you need to be a detective and enjoy taking time to tease out key clinical features. We rejoice in complexity. Many of our patients have much co-morbidity, and assessing and prioritising their problems can be intellectually fulfilling. A survey of 12,000 American clinicians from 33 specialties found that geriatricians, belonging to 'cognitive' specialties, were the specialists most satisfied with their career choice, whereas prestigious 'procedural' specialties scored badly in terms of job satisfaction." [1]

Q: "Why Geriatrics as a career choice?"

A: "Geriatrics is the most challenging and exciting area of patient care. The patients are the most ill, most complex and most dependent on our skills and wisdom for their persistence as independently living people. The opportunities for research in geriatrics are essentially unlimited." [2]

Q: "Is there was any difference between geriatrics and general internal medicine?" a geriatrics trainee, pondering whether he should continue to pursue geriatrics in his career, asked a visiting professor in geriatric medicine.

A: "It depends on whether you are happy to stay on in geriatrics…..There has been much discussion on whether geriatrics is just general internal medicine and nursing, or whether it is a specialty in its own right. The question will become superfluous when all doctors and nurses are confident of managing the Giants of Geriatrics as they are of dealing with other diseases and disabilities which they encounter….The 'Giants of Geriatrics' embrace the 'common final pathway' of the clusters of acute and chronic diseases which frequently afflict very old people, with gigantic impact but yet often ignored." [3]

Q: "But we have been attending to so many elderly patients. We are all geriatricians." A general physician and endocrinologist exclaimed.

A: "Are you implying there is no need for specific geriatrics services? It boils down to how responsibilities should be divided between geriatricians and general physicians. Geriatricians should focus on the biologically aged elderly with whom they have most experience and whom they manage best. Integration may lead to the neglect of older patients as geriatricians are 'seduced' by younger ones. Having said this, it is important not to pretend that there can be single blueprint for the division of responsibilities between geriatricians and general physicians. The pressure on services (which will depend on the age structure of the population, levels of morbidity and social variables), the allocation of resources (beds, medical, nursing and paramedical staff) between geriatrics and general internal medical services and (above all) personal relationships will be important local determinants of successful collaborative working…. It is important also to appreciate that geriatric patients are present in many other settings than medical wards: a successful geriatric service should be able to reach patients in surgical wards (general, orthopedic and gynecological) and also those who are managed in the accident and emergency department without being admitted." [4]

Q: "In one word, what are you trying to get across to medical students about health-care of older adults?" a consultant geriatrician asked during a recruitment interview for senior registrar in a University Hospital.

A: "Enthusiasm," replied the candidate and he got the senior registrar post. He later wrote, "One needs more than enthusiasm to be a geriatrician. One needs expertise – and I carefully distinguish that from experience; however, without enthusiasm, without fire in the belly, we won't do the job as well as we could, and our patients will suffer." [5]

Q: "Are there any interesting procedures to learn in geriatric medicine?"

A: "For the wavering medical student or resident coming to grips with the often merciless optimism of procedure-focused medicine, there is much in the book 'Blue Nights' to show how our patients gradually come to know better than to believe what we tell them, no matter how artfully we might hedge the final outcome….. Didion describes how the evaluation of a seemingly straightforward syncope resulting in an injurious fall can demoralise the patient even as it frustrates the staff. She suffered a sudden loss of consciousness, and then was caught up in the medical machine. She noted the resentment of some healthcare team members when 4 days of heart monitoring failed to reveal a cardiac cause for her syncope; their view was that 'because I had been given a bed on the cardiac unit I must have a cardiac problem'. To a Canadian sensibility, the ensuing level of investigation (four days of cardiac monitoring, MRI, MRA, PET) seems extravagant. That it proved unrevealing did not surprise. Didion described a sudden fear of falling as she tried to arise from a folding chair at a rehearsal of the off-Broadway play based on 'The Year'." [6]

Q: "Ah, you are a geriatrician. What do you specialize in?" a dermatologist asked.

A: "Geriatrics offers a wide range of clinical interests. To be a good geriatrician, we geriatricians should know something about everything and everything about something. The something we need to know everything about might be stroke, syncope and falls, Parkinsonism and other movement disorders, dementia, incontinence, or orthopaedic geriatrics." [1]

Q: "Are geriatricians those doctors who care for residents of aged homes?" asked a home-dwelling elderly person who heard about 'geriatrics' for the first time.

A: "A parent wishes his child to be treated by an expert paediatrician. A child wishes his parent to be treated by an expert geriatrician." [3]

A: "Specialised geriatric medicine with multidisciplinary care can prevent functional decline and reduce nursing home utilization for frail older patients in their own homes and in the acute hospital setting….However, instead of getting to grips with how service is provided to complex patients, modern health care system wants the frail old people to go away, to some more 'appropriate' place." [7]

Q: "Why Geriatric Medicine? How should we 'package' the consultant post in the vacancy notification? " a Hospital Chief Executive asked when urged to fill up the vacancy upon the resignation of a consultant geriatrician.

A: "G-E-R-I-A-T-R-I-C-S: G for general, E for excellent, R for restorative, I for individualistic, A for artistic, T for total, R for respectable, I for intelligent, C for caring, S for scientific!" [8]

Q: "Geriatrics has become a 'convalescent' specialty nowadays", a Hospital Chief Executive said during a board interview for recruitment of a consultant geriatrician.

A: Geriatric medicine is the treatment of underprivileged patients by underprivileged doctors in underprivileged buildings…..A geriatrician is a doctor with a soft heart, a hard head, a thick skin and a chip on the shoulder. With his soft heart he feels, with his hard head he decides, with his thick skin he fights, with his chip on the shoulder he suffers." [3]

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