

為香港做個好醫生

BE A GOOD DOCTOR

for Hong Kong

2011

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"...I urge you to live a life worthy of the calling you have received..." (Ephesians 4:1)

CDN Christian Doctor Network



為香港做個好醫生

CDN

我們是Christian Doctor Network (CDN) · CDN是一個聯繫公共和私營的基督徒醫生網絡，一起為香港醫療服務。我們希望編製一本書，名為“為香港做個好醫生”，旨在引導本港醫科畢業生如何選擇一個專科，為香港做個好醫生作準備。

辦好醫學教育就是做好病人服務，有見及此，我們一直很關心醫學教育，自2000年以來，我們每年也舉辦“Housemen Career Conference and Gospel Meeting”，邀請來自不同專科的醫生，分享他們的個人經驗。在香港，指導醫科畢業生如何選擇一個專科的幫助較少，市面上有些類似的書，如“*How to choose a medical specialty*” by Dr Anita Taylor · “*A career in medicine: do you have what it takes?*” by Harvey White和“*The ultimate guide to choosing a medical specialty*” by Brian Freeman，可惜都是外國寫的。

我們邀請了本地一些不同專科的資深醫生，分享自己的職業生涯、神的呼召，做基督徒醫生的經歷，選擇這個專科的原因，該專科的特色，在香港的發展情況，獨有風格及需要，該專科需要甚麼特質的準醫生及訓練內容，實習醫生應該如何準備自己等。

我們希望這本書可以宣揚正面的信息，讓新一代的醫生不再只問我想做什麼專科，我喜歡什麼專科，我可以賺多少錢，這專科有什麼前途，我唔想call等等。鼓勵大家拋開自我中心，多去了解本地的醫療情況，香港現今的醫療制度需要什麼人材？我可以怎樣去貢獻社會？讓我們學習以病人為中心，讓我們為香港做個好醫生。

願 神 祝 福 你 ！



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麻醉科

ANAESTHESIOLOGY

麻醉科，可說是一個不大顯眼的專科。由於長時間是載著口罩、帽子、並穿著手術室的制服，在手術室中默默耕耘，故此，直到今天，仍有很多人對此專科存在著很多的誤解。

作為麻醉科醫生，最反感的是別人稱呼我們作「麻醉師」。如此的稱呼常會令病人誤以為我們不是醫生。事實上，麻醉科是眾多專科的其中一個，在香港，與其他專科一樣是要經過至少六年的臨床培訓，才正式成為專科醫生。

很多人以為麻醉科醫生工作沉悶，甚至以為他們在手術室中十分清閒。我雖然已在這專科十一年多的時間，卻一點也不覺得沉悶。反之，此專科是工作有時、休息有時，此外，更是充滿挑戰，並仍有很多發展的空間。

麻醉科醫生的工作範圍

麻醉科醫生的工作並非只在手術室中麻醉病人。如何給病人麻醉是一個需用心去策劃的計劃，因為每一個病人都是獨特的，每一個手術也有其特色，即或是不同外科醫生作同一類型的手術，所用的方法和程序也可不同。所以，麻醉科醫生的職責是從手術前評估病人開始，直至手術後確保病人甦醒後穩定，此外，也會跟進某些病人手術後的止痛情況，因為麻醉科醫生會按不同手術的需要，安排不同的止痛方法，如患者自控式止痛 (Patient controlled analgesia)、脊椎硬膜外止痛法 (epidural analgesia)、連續外周神經阻滯 (Continuous peripheral nerve block) 等。

事實上，完成麻醉科的專科考試後，更可深造疼痛醫學，幫助急性及慢性的痛症病人。此外，受訓的醫生也可參與由麻醉科醫學院提供的危重病學院的院士培訓，在深切治療部中發展其專業。

每一天，不同的人正看著我們如何與病人、家屬、護士們、支援員工們、醫生們、上司下屬們相處。我們始終是人，縱有軟弱的地方，但只要堅心倚靠主，不斷在主面前更新自己，才能活出「行公義、好憐憫、存謙卑的心與神同行」的生命。我的禱告是：「求神幫助我成為一位有才能又有愛心的醫生，並願在病人的苦痛中成為他們一點點的燭光。」



麻醉科醫生如何看自己

曾聽過不少麻醉科同事會用不同的比喻幫助別人明白自己的工作，其中最常聽到的比喻是以飛機師來形容麻醉科醫生的工作。飛機的起飛與降落，就好像使病人進入麻醉狀態及從麻醉中復甦的時間；飛行期間除要緊密監察飛行狀況，更會遇上氣流等不穩定的時候、甚至罕見的嚴重事故。類似地，麻醉期間也需要緊密監察病人的情況，病人也可以有不同程度不穩定的狀況發生，如受病者本身的病況影響，對麻醉藥物的反應，也可以是手術因素的影響等等，最嚴重的甚至是會影響病人生命的危機。所以，麻醉科醫生必須在手術期間隨時作好準備應付不同的處境，好如守門員要有長時間的專注力，預備迎接投向龍門的每一球。

也曾聽過麻醉科同事說施予麻醉最重要的考慮因素，第一是安全，第二是安全，第三也是安全。我十分認同其說法，因為麻醉期間病人會失去了好些自我照顧的能力，麻醉科醫生要照顧很多細微的事情，如確保病人被擺放的姿勢是不會受傷。此外，做手術時外科醫生主要的專注是要接受施手術的器官，而麻醉科醫生則看重病人整體的安全。例如手術期間有大量出血時，除了外科醫生要作止血工作外，麻醉科醫生更要確保病人得到足夠的流體、血液及凝血因子的補充等，維持病人穩定的生命體徵，減少因大量出血引致不同器官可出現的併發症。

只要安全的大前題滿足了，在我看來，讓病人在過程中舒適也是很重要的。所以，我通常會告訴病人麻醉的目的是讓他們能舒適並無痛地完成手術，更會在整個過程緊密監察他們的情況，確保他們在安全的情況下完成手術。

對我來說，麻醉科是充滿挑戰的，因我們照顧的病人，可以是剛出生甚至早產的嬰孩，也可以是年逾百歲的長者；可以是只有幾百毫克的生命，也可以是超過百多公斤的病態肥胖者。此外，所接觸的專科也甚廣，因病人可以是接受外科、婦產科、腦外科、耳

鼻喉科、骨科等不同的手術，病者本身也可有不同的內科毛病。此外，過往不少需要在全身麻醉情況下進行的手術，現在可以在區域麻醉下進行。所以，只要用心去作，每一天都是新的一天。

什麼樣的人適合作麻醉科醫生呢？

其中一樣的質素，是不怕讀書和考試。雖然在整個專科培訓中，只有二次的專業試，但所包含的深度和闊度一點也不少。未能通過專科考試，正是其中一個重要原因帶來受訓期間不少的壓力。

除此之外，懂得與人溝通和與別人合作也是很重要的，別以為麻醉科醫生躲在手術室中不用接觸病人，其實在手術前與病人正面的接觸是能減輕病人對手術的恐懼，我們更需要把握在很短的時間內建立病人與醫生的關係及病人對我們的信心。在手術室內，麻醉科醫生更需與不同科系作手術的醫生溝通，及一同合作的護士和手術室助理們工作。

此外，面對危機時要有處變而不驚並臨危不亂的態度和能耐，才能在病人危急時施予急救和帶領護士、助手們一同幫助病人離開危急的關頭。當病人遇上危急情況時，麻醉科醫生更需要能同時處理不同的任務，因施行急救的同時，需要儘快找出病人不穩定或危險的原因並加以治療。

當然，大部份的手術都能無驚無險順利完成，故麻醉科醫生也很需要有長時間照顧細節的專注力。正如前文所說，接受麻醉的病人會失去一定程度上自我照顧的能力，若不小心並細心地去照顧麻醉中的病人，病人是有機會受到傷害的。

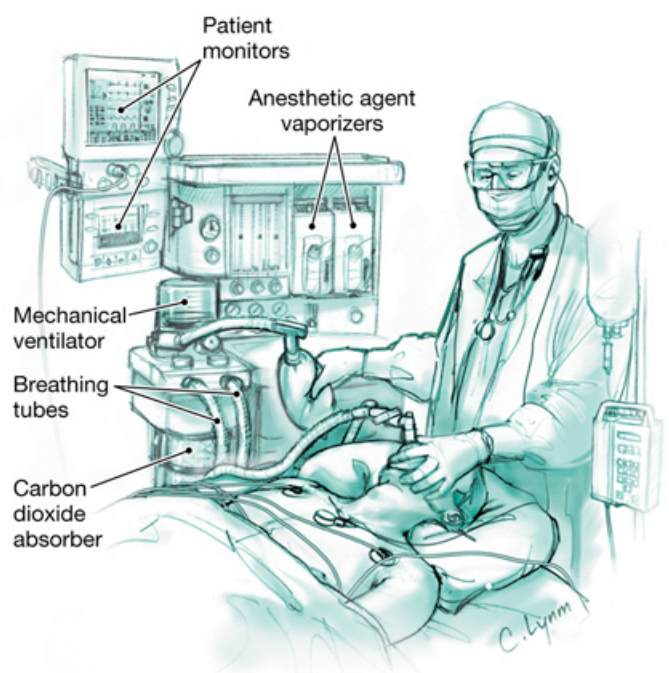
最後，就是要有好好計劃的能力，因為病人可以是本身有很多不同的身體毛病去進行不同類型的手術，這會帶來在策劃如何施行麻醉時不同的考慮。例如，在術前評估病人時要預計病人在手術過程中可能出現的異常反應，以便在手術前準備適當監察的儀器、使用的藥物和麻醉的方法、手術後的照顧等，以策萬全。

專科培訓的途徑

選擇了麻醉專科後，在香港主要參與的專科學院為香港麻醉科醫院 (Hong Kong College of Anaesthesiologists) www.hkca.edu.hk 及澳紐麻醉科醫學院 (Australian and New Zealand College of Anesthetists) www.anzca.edu.au。麻醉科的臨牀培訓特色有二，首先，是開始時全是一對一的培訓，以確保病人的安全及受訓的醫生掌握基本的麻醉知識和技巧。其二就是要到不同的醫院輪流受訓，以確保每位受訓者學習到處理不同類型手術的不同方法。第一次的專科試通常在第二至三年的受訓期間進行，範圍主要是生理學、藥理學和臨床監測的原理和應用。第二次的專科試多在第五至六年間進行，範圍涉及所有不同麻醉情況的臨牀處理，詳情可溜灑麻醉專科學院的網頁。

對有興趣選擇麻醉作為專科者的建議

若干年前，麻醉科是較少人選擇的科目，但隨著其發展空間的擴大，今天已成為不少醫學生、實習醫生希望選擇的專科，故競爭也越來越大。若有心進入此專科，不妨在醫學院選修科時選擇在香港或香港以外的麻醉科部門中學習，並與不同的麻醉科醫生傾談，以了解自己是否真的喜歡和適合在這專科上發展。此外，要留意的是，年資越高責任越大的道理。在香港有





不少醫院的麻醉科副顧問醫生是要駐院當值的，因麻醉科的專長是氣道管理和心肺功能的支援，這些都是可突然發生而需儘快處理的問題，故此安排在某些醫院是有其必要。而筆

者工作的部門更是連部門主管及顧問醫生也會駐院當值的，確保病人得著最適時和適切的幫助。

筆者的職業生涯和召命

起初選擇麻醉科時，並非十分了解此專科，只知自己一定不會選擇要動手術的科目，因自知操刀不是我的專長。曾想過作內科，因在醫學院考試時內科是其中取得

優異成績的科目。但神卻很早已給我開了作麻醉科醫生的門，直至今今天，我都沒有後悔如此的選擇。

如前文所分享，這個專科工作有時、休息有時，受訓初期又真的有上司作近距離的教導，即或在受訓後期，上司們仍會十分樂意提供協助和意見。考試雖然辛苦，但認真地面對考試絕對能幫助我成為有知識的麻醉科醫生。在工作上與病人建立長久關係的機會的確是稍遜，但只要願意付出額外的時間，仍能關心很多病者的需要，尤其在大部份人眼中作手術是「大件事」，且有一部份的病人是因有癌症或其他重要的疾病才要作手術。

醫生的專業訓練始終在於照顧病人身體的需要多於心靈的需要，但對病人說正面鼓勵性並關心的說話，卻是在怎樣忙的情況下也是可以的。此外，香港醫院的院牧服務實在是很好，若適合，是可將有需要的病人轉介給他們跟進，無論是更多心靈的關顧，甚或是信仰的追尋和決志的跟進。

而我，完成了六年的專科培訓成為了合資格的麻醉專科醫生後，便轉往當時的葛量洪醫院深造心臟的麻醉，也曾往澳洲墨爾本的兒童醫院學習兒科的心臟麻醉，並考獲美國超聲心動圖的國家委員會的高級PTE EXAM。2008年又隨部門轉到瑪麗醫院工作，繼續作心肺麻醉科醫生。作心肺科手術一點也不悶，因瑪麗醫院的心胸外科，除了作成人的心胸手術外，也做了差不多全港所有的兒童心臟科手術、所有的心肺移植手術、並不斷有新的手術發展，如人工心，導管主動脈瓣置換等。

麻醉的管理是要配合手術的發展，才能成為病人最大的幫助。工作上的挑戰會令人興奮，在工作間與不同部門同事的關係也十分重要。我們見證神，莫過於以身體力行去見證祂。口要講，但在工場中生命的質素更重要。每一天，不同的人正看著我們如何與病人、家屬、護士們、支援員工們、醫生們、上司下屬們相處。我們始終是人，縱有軟弱的地方，但只要堅心倚靠主，不斷在主面前更新自己，才能活出「行公義、好憐憫、存謙卑的心與神同行」的生命。我的禱告是：「求神幫助我成為一位有才能又有愛心的醫生，並願在病人的苦痛中成為他們一點點的燭光。」

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CLINICAL ONCOLOGY

Specialty Overview

Clinical Oncology is a specialty which specializes in the treatment of cancer in adult patients. It provides treatment modalities including radiation therapy, chemotherapy, targeted therapy and palliative / supportive therapy. Similar to the UK system, clinical oncology in Hong Kong was under the Hong Kong College of Radiologists. Due to both aging population and the rapid advancement in oncology treatment in the past decades, there is tremendous development in the specialty.

Specialty Status in Hong Kong

There are altogether six cancer centers under Hospital Authority, including Hong Kong West Cluster by Queen Mary Hospital, Hong Kong East Cluster by Pamela Youde Nethersole Eastern Hospital, Kowloon Central Cluster by Queen Elizabeth Hospital, Kowloon West Cluster by Princess Margaret Hospital, New Territories East Cluster by Prince of Wales Hospital and New Territories West Cluster by Tuen Mun Hospital. Several private hospitals also provide oncology services but they do not provide training to oncology trainees. Private market is active, however, due to the high treatment cost, most patients attend public services.

Training Structure

In general the specialty puts much emphasis on training and staff development. Training for oncology trainee con-





sists of three stages which last for at least 6 years. Details can be found at College homepage (www.hkcr.org). In summary,

- 1) Basic Training - trainees have to complete basic scientific subjects on physics, cancer biology, radiobiology, pharmacology and statistics. The College provides structured training with lectures on Saturday morning. Trainees have to pass examinations on all these subjects, known as the "part I exam", in order to proceed to intermediate training. Part I exam was held twice every year in Hong Kong.
- 2) Intermediate Training - trainees are expected to acquire broad background knowledge and skills on oncology treatment. This examination, commonly called as "part II exam", is considered to be the most challenging one by trainees. It consists of written exam (all MCQs), VIVA and OSCE. The examination is conjointly held by the Hong Kong College of Radiologists and the Royal College of Radiologists. The College provides structured training with lectures on Saturday morning. The College also started to arrange mock examination for trainees since 2010. Trainees have to pass the part II exam before proceeding to higher training.
- 3) Higher Training - trainees are expected to acquire administrative, research and organizational skills during the last phase of training. Trainees are expected to publish papers, do scientific presentations, attend conferences and make contributions to service improvement in their own department. They will be interviewed by the board of the College before obtaining a pass in the final examination, which will grant trainees a formal fellow status.

4) Post-graduate Training - the college arrange palliative care training as a post-fellowship diploma course. Besides training for examination, the college also arranges regular sessions of commissioned training. There are also numerous opportunities for trainees to attend local and overseas conferences.

Typical Daily Schedule and Activities of Residents

Modern oncological treatments are complicated, which involve multi-modalities approaches and multi-disciplinary input. Daytime clinics are extremely busy for all the oncology centers during weekdays. Most of the patients receive their treatment as outpatient basis, yet a proportion of patients undergoing intensive treatment or those with severe symptoms are admitted for inpatient care.

Daytime clinics:

1) New case clinic: Patients are referred to oncology department after being diagnosed to have malignancy. Patients and their families are first seen in the new case clinic.

2) Chemotherapy clinic: Patients undergoing chemotherapy or clinical trial are followed-up regularly at chemotherapy clinic to check their blood counts and receive regular cycles of treatment.

3) Radiotherapy planning clinic: Patient arranged for radiotherapy are seen at the clinic to explain the efficacy, procedure and side effects of the treatment. Patient then undergo various procedures before proceeding to radiotherapy. Doctor's role is to collaborate with physicists, ra-

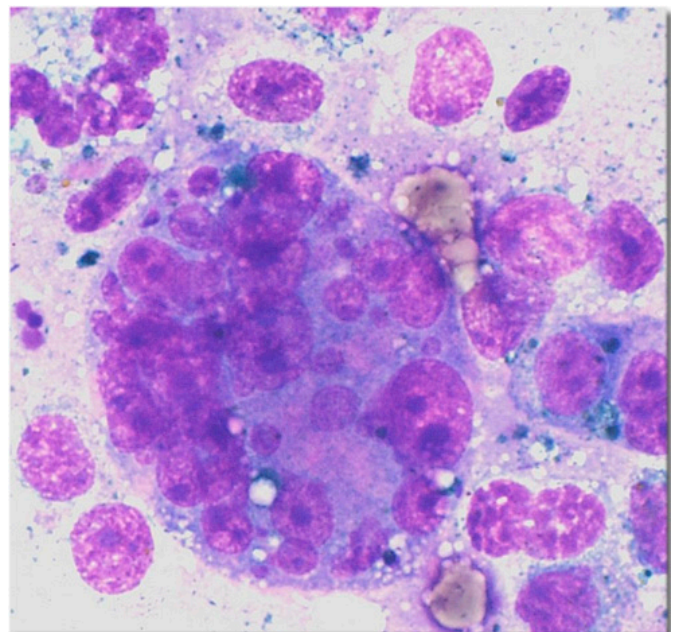
diographers and other technicians to deliver accurate and appropriate radiation dose to patients.

4) Radiotherapy treating clinic: Patients undergoing radiotherapy are assessed regularly at clinic to monitor acute side effects

5) Multidisciplinary clinic: Many disease sites involve multidisciplinary treatment, for example head-and-neck cancers, thoracic tumors, breast cancer, urological cancers, gynecological cancer. Complicated cases are referred to multidisciplinary clinic for combined assessment by doctors from different departments.

6) Follow-up clinic: Cancer survivors are followed up in clinic to detect recurrence or late side effects of treatments.

7) Palliative care clinic: Patients who suffered from incurable disease are followed up in the clinic to provide symptom control and psychosocial support.



Ward round

Every oncology centers run their own ward, mainly for chemotherapy, radiotherapy and symptom control of patients with advanced malignancy. Residents are usually assigned the work to look after in-patients under supervision by specialists.



Serving Cancer
Patients Beyond
Anticancer Drug

On-call system

The system varies among different oncology centers, but in general residents need to be on-call 2-4 times per month. Admission rate to oncology ward is usually lower than general medical ward but emergency care and resuscitation cases do occur in oncology ward. Post-call half-day compensatory leave is available in most cancer centers.

Future Development and Challenges of the Specialty

Sustainability of development

New technologies bring new treatment options to various kinds of cancers. However, cost exponentially increases and benefit is very limited for some of these new treatments. These treatments can also bring harm to patients and drains limited resources from other disciplines of medicine as well. Financial constraint may even poses an impression to some patients that only the wealthy ones can receive better care. This is a global problem to every health care system, but the problem is even made more prominent in Hong Kong as many cancer drugs are not subsidized by the Government. Health care reform has not reached consensus either.

Manpower shortage

Increasing complexity of treatment, increasing number of patients and increasing demand from more empowered patients and their families pose great pressure on the system. Working hours is ever increasing for every oncology centre.

Sub-specialization

With explosion of knowledge and information, sub-specialization of the discipline and more interactions between different specialties will be unavoidable.

What Abilities and Qualities are Important in Clinical Oncology?

Patience and compassion: Being oncologists, we almost need to break bad news daily. Such news is the “same” to us as oncologist but is hugely traumatic to patients and their families. It is not uncommonly heard from patients and their relatives that oncologist is “cold-blooded” . To keep the compassion alive throughout the years is beyond a professional quality but a spiritual commitment.

Communication skills: Good communication skills are important to every frontline health care worker, especially during the discussion of life and death issues and approaching end-of-life stage. It is also important for facilitation of team work, which is essential in many oncological treatments.

Deep thoughts in sufferings and death: Compassion and communication skills both help to establish trust between doctors and patients. But what next? How can we help them?



How can we stand the emotional trauma every time when the patients whom we treasure die? This is not answered in oncology textbooks or journals but is indeed the deepest mourning of our spirit. Everyone, including ourselves will eventually die. Are we prepared?

Keen on academic study: The need of life-long learning is obvious in oncology field as treatment principle is kept on evolving, especially in the last decade. Study is not for examination only, but is the basic requirement of being a responsible oncologist.

Suggestions to Interns Who are Interested in Clinical Oncology

As oncology treatment, especially radiation oncology is not included in under-graduate curriculum; medical graduates interested in oncology are strongly advised to apply for clinical attachment at oncology centers. Clinical attachment should preferably last for 1-2 weeks, which will give you valuable exposure to oncology practice.

Why and How I Became a Clinical Oncologist?

During my years in medical school, I made good friendship with several cancer patients. All of them eventually died of recurrence. Yet their lives during the final months inspired me a lot. Their physical condition all declined but some of them were able to achieve transformation of their lives and reconciliation with other family members. The strength behind their transformation was undeniably related to their Christian faith.



Unfortunately some of them died in miserable sufferings. The suffering was not due to physical pain but the fear of death. I witnessed how desperate patients could be at the end-of-life period despite how strong and positive they had been during their fight against cancer. I hoped I could serve this group of patients with love and hope.

The job market was poor in the year 2004 when I looked for job after internship. Thankfully TMH oncology offered a training post to me. I had never thought of working in Tuen Mun District before but once I worked in it, I understood that it was God' s mercy. TMH oncology was special in the sense that it offers a holistic approach to all patients. The department offers curative treatment to suitable patients and it also promises taking care patients till the very end even the disease was not curable. I learned much from my seniors and gradually developed my clinical skills there. I also learned to practice medicine according to biblical principles - I found this was not only practicable but indeed was the best way of practicing medicine. Our patients and colleagues may have heard Jesus, but few of them have met Him. It is our calling to be a Christian doctor to practice with Jesus.

Besides daily frontline work in which I find lots of opportunity to serve, serving in public hospital has a special calling as we have an important role to serve the grass-root public. Nowadays anticancer treatment can be very expensive. Palliative treatment may slightly prolong survival but the cost can be prohibitive. It is not uncommon that some families run into heavy debt or even need to sell their only properties for private treatment. Quality and cost-effective care from public center has a justifiable role in this group of patients. Serving the disadvantaged is an irresistible calling to all Christian health care workers.

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回想起那些年，我們同學仔還不知道會去哪一專科、哪一科的前途最好、哪一科最賺錢，起碼我不是這樣想，我只是想哪一科我最喜歡和最適合我。

起初我以為自己最想做兒科，因為喜歡小朋友，就算病人是小朋友，他們也是最可愛的，心想將來每天見到這樣可愛的病人，工作也不會沉悶。我記得有一個約兩歲的病人，他叫小B，是一個孤兒，因他有脊柱裂而導致下身癱瘓和小便失禁，所以父母把他遺棄，留他在醫院，他需要每兩小時插尿管放小便，這個小B當然不太喜歡，要我們想盡辦法去哄他，如給他包紮用品當玩具，開電視給他看最喜愛卡通片，他真是很聰明，總把我們一班醫生、護士和姐姐玩弄一番。但他最後都會乖乖地合作，完成放小便的工作。後來，我們得悉小B得到領養，不用再長留醫院，消息真令人快樂。

在兒科就是時常都可以聽到好消息，但最後我都沒有選擇兒科，因為當我做實習的時候，有機會去照顧初生深切治療的早產嬰兒，他們真的很脆弱，有的大概只有一公斤重，我要在他們的細小身軀上抽血，實在太嚇人，而他們的變化可以很大，併發症也很容易出現，我不是一個可以抵受大壓力的人，完了實習，我只有和那些醫院的小朋友說再見。

另一個心儀的專科是家庭科，也是我現在仍要努力學習的一科，也許不會有太多人一早有心想入家庭科，只是其他專科沒有位的阿二或阿三選擇，但我被它迷倒了，而且是越做越有味道。

還記得在醫學院時跟過一個家庭醫生，他看病人總臉帶笑容，他不單細心地醫治病人的疾病，還很清楚他各家人的狀況，現在我當然知道，病人記錄上的家譜圖幫他知道這些資料，當時我覺得這就是我想當的醫生，病人非常滿足地離開房間，而這個醫生也得到從滿足感而來的快樂，這不是一個很美好的畫面嗎？

於是我就開始去尋找訓練家庭科的機構。回想起當時的路真是神的安排，因為我是在播道醫院訓練家庭科，而播道醫院是香港第一個基構訓練家庭科醫生。他們有資深的家庭醫生，並且以「病人為本、全人醫治」為宗旨，這正是家庭科

的宗旨。但當時他們沒有空缺，我只好把求職信寄上，心想機會渺茫，但想不到，在醫管局面試之後，我就收到他們的電話叫我去面試，因他們剛剛有醫生離職，我就這樣進入了這個「家庭科的搖籃」完成了我四年的基本訓練。在播道醫院，我學了畢生受用的診症溝通技巧，更學習到要給病人一份同理心，給了我做醫生的重要核心，不至給物質的世界有所動搖。我也在我的病人那裏得到很多，他們的關懷（有個病人見我忙到沒有時間吃午飯，就買了一份麥當勞給我，讓我可以先吃兩口包，再繼續睇病人），以及在他們身上學到的種種經歷（例如：我不需要有小朋​​友就知道做媽媽的擔心，不用到老就知道老人家的困難），這一切都給了我很大的滿足感和動力。

現在我在衛生署的長者健康服務中心工作，進入政府的路也是誤闖誤撞的。由於之前政府工的待遇很差（當然已沒有長俸），所以大多數同事都沒有選擇。和我一同訓練的戰友告知我，政府正招聘公務員（不是合約），當時我也想轉工，所以交了求職信，但心想不知道自己適不適合。我除了實習的時候，沒有做過政府或醫管局，我打算出私家診所打工。寄出信件之後，一路都沒有收到回音，直到九個月後，終於收到他們的確認信，通知我再等他們回覆面試。初時，都心大心細，不知去不去政府好，因他們不會給你選擇上班的部門和工作地點，見工的時候，只可選擇一個大方向，例如我選擇了家庭科，但我不確定會去公務員診所或長者健康服務，你更不知道會去哪一區上班，因政府部門遍佈港九新界，好像沒有把握。起初我要求去公務員診所工作，但他們安排了我去長者服務。最終我選擇了去政府，因入政府工作的機會不多，而我就算做完政府之後覺得不適合，也可再出去私家診所工作。這樣，我就「打政府工」了。最初，在長者健康服務工作需要四處去替假，也令我熟悉了香港很多的地方和車路，雖然我現在還是路盲。

至於政府的招聘，可以在政府網站瀏覽職位空缺(www.dh.gov.hk/english/vacancies/vacancies.html)，但都是最好問內行朋友，因政府空缺是中央聘請的，今次可能需要兒科醫生做兒童體能智力測驗服務，下次可能需要家庭科做公務員診所，所以在求職網站你並不會知道他們要什麼科的醫生。不過，如果有興趣做衛生署，而又見到有職位空缺，不妨先交上求職信，再等他們消息。

衛生署的醫生主要分兩個範疇，一是公共衛生 (Public Health)，另一組是臨牀醫生 (Clinical)，我是屬於後者，主要醫治病人。而公共衛生醫生的工作主要協助推行基層的醫療政策和疾病的監察。現在政府對於招聘醫生大都需要完成基本專科訓練才聘用。有一些同事有興趣投身公共衛生，可以在職培訓，考公共衛生的專科試，有助晉升。而公務員診所也是訓練家庭科的好地方，現在大數的同事入職前已考完 Conjoint Exam，然後在衛生署做 Higher Training 和 Exit Exam。這也是很好的選擇。不過，我就不太建議完了實習就立即進入衛生署，因在衛生署除了公共衛生，就沒有其他專科的全面訓練，不像在醫管局有住院病人給你各種病症的訓練。

現在我的病人由最初想做的兒科轉到老人家，我相信這也絕不是我自己安排，是神讓我去照顧一班有需要的老人家，其實他們也好像小孩般可愛，需要人哄和別人的了解和照料。我在這裏為他們做身體檢查，及早發現疾病，給予健康教育，並為他們的疾病治療或轉介。我現在見的都是一些不太富裕的老人家，學識也不多，但他們很懂得去感謝，這是我覺得他們最可愛的一面。

我會「做好呢份工」，是天父托付我們的工，我相信神放我們在任何一個專科，總有祂的心意，相信祂也會為你安排一個最適合的專科。感謝天父，願一切榮歸與天上的父親。阿們。

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急症科

EMERGENCY MEDICINE

急症科好輕鬆？

在我加入急症室的時候，急症室是一個「沒有什麼規模」的地方。病人是「入院」、「出院」、「打針」、「到外面等等」；如果再痛、再暈、血還未止、呼吸還欠順暢便入醫院。所以，那時候做急症室好像很簡單，一直以為沒有什麼可以做。你說好輕鬆也可以，好緊張也可以，因那些年代只需要簡單的臨床決定。

在1986年考試後，醫務處打電話邀請我轉到急症室去。我本來沒有想過選擇急症科的，最初不太願意，現在回想起才發覺，其實急症科有太多項目需要處理。

急症室是醫院的大門，需要與各樓層病房的配合和與外界聯絡。急症科醫生除了要把書讀好外，不斷進修，還要有良好的操守，正直誠實，關心病人及其家人，工作有效率。病人來到自己面前，就負起專業精神處理，醫生不能選擇病人。」

「好多東西要做」，代表什麼呢？以前，很多不用我們處理的，例如：嚴重創傷、中風處理、為突發心臟病注射血栓溶解劑、安排「通波仔」、安排深切治療部、以至安排社康、社工、復康、物理治療等，現在很多都需要和可以在急症室處理。以前嚴重創傷是不會留在急症室治理的。現在嚴重創傷全部都以急症室作為一個中心點，所有的安排、例如電腦素描、超聲波、統籌外科、骨科、腦外科、深切治療科醫生、配血等，全部都是急症室的即時工作。這反映了急症室三十年來重要的進步，我們需要擔當的急症崗位和範圍也會越來越重，挑戰也越來越大。

怎樣才是好的急症科醫生？

其實急症科醫生要做得好，是很難的事。困難在於急症室所有東西也是需要「立刻」——當危急的病人被送到來，你要立刻放下手上的工作，處理這危急的病人。如果你爽快聰明，基本功掌握得好，對病例熟識，便不會感到太大壓力。反之，就會感到很大壓力。

為何會感到那麼大壓力? 因為愈快便愈有機會出錯，愈容易錯便愈會過份小心(驚)，愈驚最終會導致「保衛式醫療 (defensive medicine)」出現，即全部都做。而困難之處在於要用很短的時間，掌握準確病歷，快速做一個選擇性的身體檢查，便要拿到最合適的答案。這樣的情況下，如果你靈活、基礎好，和有clinical sense，恰當診斷的機會很高和很有把握。如你的clinical sense不太好，就會很危險。「inappropriate」的診斷不一定是「錯」，但這也不是太好。

作為急症室醫生，你的臨牀經驗必須要很好。因為診症時病人在痛、血壓下降、心律不正、呼吸不好，驗血報告未在手，X光超聲波還未有，那個時刻，你若要達致合適的診斷和治療，你的知識基礎和臨牀經驗最為重要。所以，在初級醫生的日子，必需努力學好bedside clinical work作為一輩子的基礎。

以前我們當初級醫生，很少會感到不安。因為那時很少人投訴、也不會有人看著你做事情。總之，好像做什麼也是對的，也難以看到自己的錯誤或不足的地方。所以，我們以前工作上沒有太大壓力。在沒有太大壓力的情況下做事，自然不會感到很吃力。

但是，現在做醫生，特別是做急症科醫生，壓力則頗高。面對和適應壓力的能力，則因人而異。其實太大的壓力，是十分不健康的。我最近看到一篇醫學文章，題目關於「保衛式醫療可否可以繼續下去?」。我估計這情況只會愈來愈嚴重。在美國已變得十分嚴重，香港已漸趨嚴重。其實「Defensive medicine is harmful to the patient and harmful to the doctor」。「Harmful to the patient」是因為我們不時做了一些不需要和不切實際的工作和檢驗。「Harmful to the doctor」也是同樣意思。一些醫生明知不需做的工作和檢驗，有時為了保護自己，避免病人及其家人的投訴，也迫著照樣去做。本着那個忙起來便有機會錯的心態，如果自己不多做保衛式醫療，當人人都這樣做，自己不做，則會感到很不安樂。也因為這樣，工作量也間接增加了許多。



這樣，也出現了「工作效率」的問題，做了很多不需要的檢查，把流程和進度都拖慢了。反之，在追查仔細的病歷和臨牀身體檢查卻被忽略了。其實如果缺乏良好的臨牀敏銳度，結果也是會出錯的。雖然這樣可以「保護」到醫生，但對醫學專業來說，卻是相當可惜的。這個情況，連我也很想在中間找個平衡。最好的辦法，還是訓練一個好醫生，以免出現「Harm to the patient, harm to the profession」的情況。

什麼是「Harm to the patient」？因為，完成了這大堆工序後，也不是會幫到病人甚麼似的。例如病人的驗血報告「正常」，也不能確保他沒有急性心血管栓塞，或血管快將栓塞。急性心血管栓塞估計並不是靠單抽血檢驗的，而是更需要倚靠準確的臨牀問症，所以以為多做檢血，病人就更安全，其實是不全面的。

怎樣才能真正保障病人？就是醫生必需有一個良好臨牀醫學的能力。要提升臨牀醫學的能力，最好就是有個好的導師。這幾天，我也找著幾個好的SMO，對他們說：「交給你們了，我做了這麼多年醫生，也只能將好的臨牀醫學傳給你們幾屆的。」，也希望他們將我所傳的臨牀醫學的好東西，傳給接著的幾屆。

怎樣才能是好醫生？我想，除了把書讀好，醫生應有良好的操守，其實這與其他專業也是一樣。第一，要正直誠實；第二，要關心病人及體諒其家人；第三，要有效率。雖然，我本人將「效率」放在較低的位置，但不能否認，良好的效率，間接對醫生在治理病人和整體運作是很有幫助的。

論到「誠實」，我會與我的同事這樣分享，如果你沒有檢查過病人的胸肺，就不要在記錄上寫下「Chest NAD, no wheeze」。沒有檢查胸肺不是一個問題，但是，沒有檢查而寫了下來，就是問題了。將來你自己也會懷疑自己的記錄有多真實。如果連自己也不相信自己寫下來的記錄，就是大問題了，這也增加犯錯的機會。所以沒有做過的身體檢查，不要記

錄下來；沒有發問過的症狀，也不應寫在記錄上。

第二是要「關心病人的痛楚與痛苦」。痛楚與痛苦，醫生天天看慣了，可能會變得麻木，就不覺得是大問題了。但我們也要間中提醒自己，痛楚與痛苦對病人來說的確是一個問題。

那麼，急症室那麼多的病人，怎樣才可以時常做一個好醫生呢？這看似是不可能的要求。因為每個人在長期的忙碌下也會變得虛脫、變得冷淡，不可能天天都做到理想的地步。這樣，如果醫生真的出現冷淡的情況，對病人的痛苦無動於衷，那麼他真的要休息了。而且，上帝也叫我們休息、安靜呢！我想，沒有安息日，醫生也很容易變得無感情的。我自己也未必能時常對病人的痛苦很有感覺，這也是我需要反省的事。面對別人痛楚與苦楚，是整個醫療團隊和專業精神要面對的事情。

說到「效率」的問題，也頗復雜。「效率」很多時與質素有所衝突，所以我們需要在「效率」與「質素」中間找個平衡。只顧及「效率」，會容易導致病人得不到最好的治療，甚至出現錯漏。病人有機會再跑到急症室來，這無疑也影響到「效率」，甚至會引起發病、死亡的問題。相反，如果不顧及「效率」，診症會減慢，外面的病人會等候得太久，會感到不耐





煩，會與工作人員爭執，因而浪費工作人員的時間，又會引起情緒、投訴，因而更浪費時間和心力。增加病人痛苦的時間，也會帶來投訴。所以，要盡量找辦法減少痛苦、減少病情惡化的機會，我們也需要「效率」，「效率」是可管理的。

急症科已有二十多年歷史。從前，跑來急症室的病人是「先到先得」的，現在則按病人的病況分優先次序。急症室先要判斷哪些病人需要緊急或較早處理，哪些病人可遲些才處理，關乎到生死的緊急病人則要立刻處理、例如痛症的則次之，不關乎到生死的病人，則需要等候。在未來幾小時也不會有太大危險的病人，則要等較長的時間。

醫生一畢業，就要開始「學習」。考完專科試，就更需要學習。我們那個年代，以為畢業就認識了很多東西。考取了專科資格，就以為認識了所有。這是錯誤的觀念。考完試，才是「學習的開始」。其實，學習是很大的樂趣。我們的責任就是要讓醫生覺得學習是很開心的。愈學就愈有意義、有進步、愈快樂，並且愈想做得更好，學習不是一件苦事。要做個好醫生，一定要覺得學習是很開心的。對自己、對病人，只有益處。要做一個好醫生，一定樂於終生受訓練與學習。

那麼要學習什麼？好醫生是要向病人、同事、書本 (包括期刊) 學習，三缺一也不可。單從書本學習，一定沒有成效。單向病人學習，卻缺乏理論基礎，也不可能從病人身上學到些甚麼。有些問題，你的同事或上級會看得到，只是自己看不到，所以也得向其他人請教。資歷高的醫生要面對的困難，就是不敢向別人請教。職位越高，就更難向別人請教。單靠自己學習，事倍功半，方向錯了也不知道。學習如何請教別人是十分重要的。

分享一些「與同事關係」。你不可能單靠自己一個人做事，一個人做事很困難，也不能完成工作。什麼叫「關係」？即是「一起工作」互為團隊。大家思想上有分歧，是自然發生的事，不同意見是自然的，也不會停止不再出現。每個人看事物的角度也不同。爭執？遷就？妥協？這是一個要學習的技巧或是心態呢！我覺得，學習良好的心態才至為重要。單靠技巧，可能變成玩弄政策，這不是我所喜歡的。所以，做個好醫生，不是靠讀書就可以，要多學習，學習真實的包容，也要靈巧地擇善固執。

我是否適合做急症科醫生？

曾經有個學生想做急症室向我請教，我與他分享，先要「知道自己是誰」，才去選擇那一專科適合自己。不一定要做急症室的醫生，但是選擇急症科，你要懂得過一個「充滿壓力的工作天」而「不感到壓力」。因為，當壓力來到，你就不能把工作做得好。另外，當急症室醫生的函頭不像「心臟科醫生」、「腦內科醫生」等，因為很少人會深入認識「急症科醫生」在醫療系統的角色，這也影響了他們對你的信任。但是加入急症室，你能夠做到的實在很多。



這工作有多少滿足感，我也不知道怎樣評價。當中的滿足感，並不在於病人給予你的反應，因為當病人上到病房，就已忘記了哪個急症室醫生看過他。香港急症室的服務已算很好。相對於「卓越」，只有些少的距離。

至於入行所要求的個人素質，還是鼓勵當事人與上級傾談一下。每人的恩賜不同，有些人喜歡較靜，或不用太多對人的工作。相反，做急症室的醫生，則要面對很多人，對病人、對家人，兩邊也需要十足的關心，還要面對各相關專業、工作人員(如: 社工，精神科護士，警察、老人院職員)等。所以，「對人」是一個重要的因素。因此，對人的應對能力，則要掌握得好。相對外國，香港其實已有一個頗好的文化給予醫生學習空間，並得到上級指引。

你要看自己的性格去決定是否做急症室。千萬不要覺得做急症室就沒有做神經外科般辛苦，因而選擇急症科。現在的急症室與三十年前比較，是很不同的了。以前的急症室，不用學習或處理很多的專科危急病例。現在你不但要懂得運用所學，不斷進步。也要面對病人及其家人輪流的不斷詢問，因而影響了自己情緒。恐怕在太疲累的時候，到了一個地步，就是選擇什麼也不回應，這是要避免的。

怎樣可以避免變得麻木呢？我覺得真的是不容易避免。要倚靠神，而不是倚靠自己。想想這是神安排予你的病人。如果那是耶穌基督，你作在這小子身上，就好像作在耶穌身上。那麼，你的心態也立刻不同了。所以，若你已信了耶穌，神要你做什麼科目，你就選擇什麼科目。

做急症室醫生，先要有心理預備，要求的精力很大，下班或輪夜班後會很倦。有時，更要沒有假期。連續工作七、八天，總會感到吃力。那麼，怎樣知道自己是否適合？這真的要看看你的上級怎樣評價你。

急症科的專業培訓

關於那六年的訓練，你要考三個試，第一部分主要是筆試，準備只是較MBBS多點和好些basic science就可以了，但不能輕看basic science，basic science較深奧，長遠卻很有用。及後是Intermediate，即較多臨床考驗，如口試，short cases等。考第三部份Exit，實在有一定的難度，看漏了一些重點，答案就變了。

要臨床醫學表現好，你要到內科半年、外科半年，並急症室起碼兩年。即是，你要三年至三年半才可以考第二部份。第三部份與第二部份相似，但Viva部份較重。有一、兩個案例，會是較貼近日常遇到的，例如diabetic ketoacidosis、acute myocardial infarction、dizziness等，不能有失。其實，只要對書本很熟，並有同事經常與你溫習，相信不難合格的。所以，我不擔心同事考不過，只是擔心因太





大考試壓力失準，要考第二次才能合格。

考完試，到sub-specialty就要自己去掌握。所謂sub-specialty，美國、英國的制度建立得較好。最出名的sub-specialty 有major trauma、cardiac、stroke、toxicology、disaster management、ultrasonography等。Critical care transport 是新興的，即將危急的病人由一間醫院送到另一間醫院，或由現場把病人送到醫院。怎樣運送、整個過程要注意什麼等，這就是transport medicine。這正在香港開始發展了幾年，而且也開始得不錯。我不算太認識。

Sub-specialty是長期專心practice得來的，同行一談到某一科，自然就會想到那幾位醫生了。有些會頒發diploma。現時急症科的sub-specialty很難與其他專科相比。

至於工作時間，比起一些專科來說，不算太長。但星期六、日很多時沒有假期，對家庭、社交和返教會有一定的影響。當我看到那些初級醫生，工作之餘又要讀書、考試，我也覺得那六年頗為吃力。特別那些上教會的醫生，星期日上完教會，就要馬上上班。

結語

急症室是醫院的大門，需要與各樓層病房的配合和與外界聯絡。急症科醫生除了要把書讀好外，不斷進修，還要有良好的操守，正直誠實，關心病人及其家人，工作有效率。病人來到自己面前，就負起專業精神處理，醫生不能選擇病人。

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家庭醫學

FAMILY MEDICINE

一個健全的家庭醫療系統，對個人及家庭不可或缺，對社會大眾以及整個醫療系統也是莫大祝福。要做一個出色的家庭醫生，挑戰極大。我認為要真實地認識神，以神為大，與神同行，才能成就這美好的職份。

以下是有關基督徒家庭醫生的幾項主要理念：

1. 以真愛為本的服侍 -Caring with Agape Love

坐在診症室睇街症，什麼樣的人都有。我經常幫執紙皮婆婆看病，也有人定期從上海飛來看我。當中在病患中顯得「不友善」、「不正常」的病人何其多。病的種類也繁多，在瑣碎的徵狀背後，大多是undifferentiated的疾病和隱藏的健康問題。這過程中，動機和心志最重要。

若非為愛，病人必受苦受罪，醫生也是活受罪。但如何在自己的軟弱裡去愛一些「不太可愛」的人？只有持續仰望、認識基督十架的愛，才可以。

因此，家庭醫生的大前提是：單靠人本身是不可能做得到、做得好。治病必須靠主。

在病人進來前，先與主溝通。

「你們若單愛那愛你們的人，有什麼賞賜呢？就是稅吏不也是這樣行嗎？」

... 所以，你們要完全，像你們的天父完全一樣。(太 5:46-48) 」

家庭醫生四個字，於我有何等複雜的情感。只能說：

弟兄們，我不是以為自己已經得著了。我只有一件事，就是忘記背後努力面前的，向著標竿直跑，要得神在基督耶穌裡從上面召我來得的獎賞。(腓 3:13-14)

還有，我感謝神恩，因我每天都更喜歡做家庭醫生！



2. 診症學 - Diagnostician

家庭醫生必須具備對千分之一、萬分之一機會出現的罕症準確斷症的能力，治療才不致延誤。家庭醫學也是最重視臨床問診及「徒手診斷」功力的學科。前輩常說高手往往能將診斷收到很窄很精準，然後便能一招了。這比起很闊很全面的診療更難。是學問、心思、臨床經驗智慧的累積。

然而，很多時候更難的是讓病人認知自己有病，且對自身的病有正確的態度。例如曾有病人被確診癌症，卻諱疾忌醫躲在家中，後來醫生親自致電數次才肯面對。這情況對情緒病患者尤其常見。其實要做好家庭醫生，最重要是知道自己也是病人，這樣才會找最偉大的醫生 - 主耶穌，為自己診症。照出自己的盲點，才能看清病人的癥結所在。

... 康健的人用不著醫生，有病的人才用得著。(太 9:12)

3. 心靈關顧 - Psychosocial Care

幾乎所有病癥都可由情緒、壓力引發。很多人都不太了解心靈的實況，和其對身體、行為表現和關係的龐大影響力。很多人都不懂得如何真切地保守自己的心。貼近病人的心，是家庭醫生的關鍵角色。很多人的心事未必能向家人朋友傾訴。

但家庭醫生卻是一個可信任的角色，甚至是唯一能真正聽他/她的心聲而同時對其有深入認識了解的人。單是這一點，已能減輕身體痛苦、預防悲劇、甚至挽救生命。

... 因為一生的果效是由心發出。(箴 4:23)

4. 從關係而生的全人看顧 - Relational Holistic Care

身心社靈處於良好狀態，是世衛對全人健康的定義。然而同一句健康建議，相對地，出於一位對其家庭背景、性格、體質、生活習慣等有經年累月的認識了解的專業人士，那份獨特的親切感足以帶來較大的影響力。遇過一些隱蔽青年、獨居老人，他們拒絕任何協助，但有病了始終都要看醫生。久而久之關係建立了，便能為實際生活帶來改變和突破。也有一些長期病患者甚至末期癌症病人，因着相熟的家庭醫生到家中診斷和護理，在親切感中得到更適切更到位的治療。

... 來跟從我，我要叫你們得人如得魚一樣。(可 1:17)

5. 預防醫學 - Preventive Medicine

上醫醫未見之病。預防勝於治療，老生常談。今天體檢計劃林林總總，然而大多商業主導、遁例而盲目。真正的預防醫學，由對個人的生活習慣、家族病史、成長背景、性格心理、人生觀價值觀等，都需有一定了解，而這程度的認識，需要時間和經驗。只有家庭醫生才能發揮這種角色。全面而到位的健康評估，能凸顯身心社靈的潛在健康問題。

預防醫學的實踐，不單在於預防嚴重疾病，更著重建立積極主動的生命態度。

所以，你們要警醒；因為那日子，那時辰，你們不知道。(太 25:13)



6. 健康抉擇 - Health Decisions

今天各種醫學資訊都可隨手得到。然而當病患真的臨到自己身上，即使再雞毛蒜皮的問題，要作決定真是很困難。吃藥不吃藥？手術不手術？即使醫生自己患病也很多時是兩難。若發生在家人身上，作決定就更難。

... 那樣是可以的呢？(路 6:9)

家庭醫生的獨特角色在於對病人及其家庭的累積了解，相比起其他各科醫生更能從病人的心思和角度出發，引導他/她達致最適切的決定。

7. 持續看顧 - Continuity of Care

在病患中的人，很多時最難主動對病情保持跟進。很多時當他/她最需要的時候，卻正是其最不願意尋求協助的時候。

家庭醫生一個最重要的角色，就是在連病者自己都不理自己的情況下，依然在意他/她而主動聯絡和跟進。這對醫者來說是件頗費心力的事，卻極有價值！

曾有一些癌症和情緒病人，就是這樣被挽回的。

你們中間誰有一百隻羊失去一隻，不把這九十九隻撇在曠野、去找那失去的羊，直到找著呢？(路 15:4)

8. 醫療團隊的統領 - Coordinated Team Care

基於家庭醫生對個人和家庭的獨特認識，加上對各科知識的全面掌握，只有他能為人引進最適切的專才和資源，提供高度協調的診治。

除了統領各專科資源，家庭醫生也需要良好的管理能力，帶領自己的診所團隊（如護理人員和醫務社工）。同心同德的隊工，服侍病人往往能帶來超出所想的效果。

有人帶著一個癱子來見耶穌，是用四個人抬來的 ... (可 2:3)

以上，也可被看為家庭醫生診症過程的順序八個步驟。

最後，家庭醫生的第一個病人永遠是自己。

知易行難，因為自己也有盲點有待光照，自己的生命也需時間成長。

家庭醫生四個字，於我有何等複雜的情感。只能說：

弟兄們，我不是以為自己已經得著了。我只有一件事，就是忘記背後努力面前的，向著標竿直跑，要得神在基督耶穌裡從上面召我來得的獎賞。(腓 3:13-14)

還有，我感謝神恩，因我每天都更喜歡做家庭醫生！



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我要感謝神給我這福份可以見證祂，願主賜福給你們，願一切榮耀頌讚都歸給祂。

首先，我很願意讓你們知道，你們今天選上醫生作為職業，並不是出於偶然，也不是出於“幸運”，而是創造天地萬物的主已經揀選了你，在醫生的崗位上有需要做的事。

讓我作自我介紹，1985年我畢業於澳洲雪梨大學醫學院，翌年2月在昔日位於般咸道的那打素醫院開始婦產科的訓練，現任柴灣東區尤德夫人那打素醫院婦產科部門主管。在這25年的醫生生涯中，不單經歷了醫學科技上的發展，資訊發達，更重要是體會到社會的變遷，包括人類價值觀的轉變、溝通模式上的變更、人際間信任程度的減少、加上不合理投訴文化愈趨嚴重，今日當醫生實在不容易！

回想當初開始受訓時好積極，渴望學多點、做多點、接生更多嬰兒，務求增廣知識見聞，但久而久之，發覺OPD的工作令人疲累，on call的生活很艱苦，婦科病人也叫人煩厭，她們的申訴總是離不開月經的流量、經痛的嚴重性、子宮纖維瘤及卵巢瘤！至於產科，很多人會說：「你的工作一定很開心，因為可以見到很多BB出世」，但師弟師妹們，我想讓你們知道，日子漸久，人可以變得麻木，凡事會變得乏味，一切似乎都是理所當然的。

這是我的體會，也是對你們的一個提示，最可怕的並不是一個「不醒目」的醫生，而是一個「沒有心」的醫生。我要感謝我的主耶穌，祂讓我看到的，並不是病人的病，而是這病背後的人。病並不可愛，也沒有甚麼了不起，但背後的人就截然不同，因為每一個人都是神按著祂的形像造的，每一個人都有他/她背後獨特的故事。正因此，本來一個沉悶，時常見慣的病例就會變得

在我廿多年的工作日子中是否天色常藍，花開常漫？當然不是！有沒有在臨床工作中犯過錯或作出不適當的決定？當然有！有沒有因我這些過錯而引致病人或嬰孩受創？當然有！感受如何？乃是極其難過、自責、內疚、錯敗感圍繞著我，也有屢次想放棄的時候，但感謝我的神，祂的恩典足夠我用，在祂裏面有無窮盡的恩慈，使我可以再次站起來，繼續走這條恩典之路。

多姿多彩。分別就在於這個是「人」，不是「個案」。在過去20多年中，神給予我恩典可向病人、其家屬、同事傳福音，有數位“病人”已變成了朋友。雖然在實際環境下，沒有可能有時間及心力去接觸關懷每一位病人，但我已學會若有感動時，就不可消滅這感動，因為你可能會錯失了一個寶貴的機會，「施比受更有福」，這話是對的。

早前提及現今世代變得複雜，是非對錯變得模糊，資訊科技發展使人與人之間產生隔膜，年青一輩(包括醫生)已經越來越不懂得面對面與人溝通，清楚表達自己的心思意念，寫作的基本技巧也較前遜色，這點希望大家小心留意。千萬不要讓SMS代替親口說的問候，email取替親身的出現面談。因為每個關心的眼神和觸摸都帶有親切的關懷和安慰，是SMS和email所不能給予的!

作為產科醫生，可以親身見證生命的誕生，是神給予我的福份。一個小生命的出現叫人不能夠不發出讚嘆，感受到生命的奧祕。

羅馬書1章19-20節：「神的事情，人所能知道的，原顯明在人心裡，因為神已經給他們顯明。自從造天地以來，神的永能和神性是明明可知的，雖是眼不能見，但藉著所造之物，就可以曉得，叫人無可推諉。」

詩篇139章13-16節：「我的肺腑是你所造的，我在母腹中，你已覆庇我。我要稱謝你，因我受造奇妙可畏，你的作為奇妙，這是我心深知道的。我在暗中受造，在地的深處被聯絡，那時，我的形體並不向你隱藏。我未成形的體質，你的眼早已看見了，你所定的日子，我尚未度一日，你都寫在你的冊上了。」

創天造地的主讓我們體會到祂的能力和智慧是無法測度的，然而祂卻以無窮盡的愛去愛護，關顧我們；新生嬰孩的單純和純潔可以觸摸到父母的心深處，愛就是這樣自然地流露出來。

在我廿多年的工作日子中是否天色常藍，花開常漫？當然不是！有沒有在臨床工作中犯過錯或作出不適當的決定？當然有！有沒有因我這些過錯而引致病人或嬰孩受創？當然有！感受如何？乃是極其難過、自責、內疚、錯敗感圍繞著我，也有屢次想放棄的時候，但感謝我的神，祂的恩典足夠我用，在祂裏面有無窮盡的恩慈，使我可以再次站起來，繼續走這條恩典之路。





箴言3章5-6節：「你要專心仰賴耶和華，不可倚靠自己的聰明，在你一切所行的事上，都要認定他，他必指引你的路」，是神給我寶貴的提醒，祈盼這也能成為你們的指引。

“越忙就要越多禱告，越忙就更加不能不禱告”

公營的婦產科現在正經歷著嚴峻的時刻--- 隨著私人市場的開放，很多中層(擁有10年經驗以上)的婦產科醫生轉投私營機構，甚至連一些接近退休年齡的資深顧問醫生或主管也離職，令到醫生(及護士)的流失率已亮起紅燈。

病人的數目越來越多(內地孕婦已達到整體的50%)，病人的要求越來越高，投訴的文化越來越烈，醫管局不斷推行的新政策，令仍然留守的員工叫苦連天，士氣重挫，形成「走得就走」的現象，日子看來實在艱難。作為主管的我要面對的挑戰，就是在人力資源極其缺乏的情況下仍然要堅守崗位，給予受訓醫生們足夠的訓練，確保病人得到適當的治療，及維繫部門所有員工的士氣。若不是神的恩，我想我早已放棄了。我深信神有祂為我所預備的，祂的話語也成為我每日的幫助。

詩篇34篇9節：「耶和華的聖民哪，你們當敬畏他，因敬畏他的一無所缺。」

以賽亞書41章10節：「你不要害怕，因為我與你同在。不要驚惶，因為我是你的神。我必堅固你，我必幫助你，我必用我公義的右手扶持你。」

以賽亞書49章15-16節：「婦人焉能忘記他喫奶的嬰孩，不憐恤他所生的兒子。即或有忘記，我卻不忘記你。看哪，我將你銘刻在我掌上，你的牆垣常在我眼前。」

「然而我今日成了何等人，是蒙神的恩才成的」，所以每一天，第一要緊的就是禱告。靠著祂，作一個忠心的僕人。

願我的主耶穌基督，永活的神，賜福與你們。



O&G Training

1) Require total six years of postgraduate training.

Four years of basic training

Two years of higher training

2) Trainee can sit for MRCOG Part I during the year of internship.

3) After completion of the second year of training, trainees are eligible to sit for SOE (Structured Oral Examination) conducted by the HKCOG (Hong Kong College of Obstetricians and Gynaecologists, www.hkco.org.hk), as an intermediate examination before the membership examination, and is a prerequisite before they enter into higher training.

4) The membership examination is in conjunction with the RCOG(England) (Royal College of Obstetricians and Gynaecologists).

5) Trainees can sit for the RCOG membership examination (MRCOG Part II) after completion of four years of basic training. The MRCOG Part II examination consists of written and oral part. The passing rate for the written examination for Hong Kong candidate is around 50%.

Only those who pass the written examination are then eligible to sit for the oral part. The passing rate for the oral part is about 80%.

Hence overall pass rate for MRCOG Part II examination for Hong Kong candidate is ~ 40%.

6) If Part II membership is obtained, then two more years of higher training is required before they can sit for the EXIT examination.

7) When the requirements for EXIT examination have been met, the candidate is then eligible to be titled an O&G specialist, who can then register with the HKAM (Hong Kong Academy of Medicine, www.hkam.org.hk) as fellow of O&G and with the Hong Kong Medical Council as specialist.

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MEDICAL ONCOLOGY

感謝主讓我在內科腫瘤科工作。這裡的病人面對特別的困難尤其是生死的問題，往往比我們想像中更接受直截了當的福音討論，是一片待收割的禾場。這裡亦讓我體會自己的軟弱：驕傲、懶惰、急躁、冷漠等，但我願靠著主，逐漸成為他合用的器皿。願一切榮耀歸於主！

凌晨二時，六十歲男士胸口劇痛入院，心電圖診斷急性心臟病發。病況危急，內科當值的我連忙向心臟科同事報告。在短短半小時內，我作了初步檢查、驗血和超音波，給予患者藥物治療，並向他及家人解釋緊急心臟血管支架植入手術的風險。心臟科同事趕到，病人立即被送往手術室，途中護士還忙於整理病人身上的各種喉管，而血壓儀器正響著警報。

手術室大門關上，我留守病房打點，一切頓時安靜下來。手術順利，病人病徵舒緩，神色判若兩人，而心臟科同事亦面露滿足的笑容，對病者及家人宣佈：他已脫離危險期了。這刻，我發現一個有趣的對比：大部分醫學專科都以救人脫離死亡、維持生命為終極目標，令病人活下來就是醫生最大的成功；而在我而言，內科腫瘤科卻要帶領病人面對“絕症”甚至準備進入死亡，很多時候病人安然經過、去世，反而是我們釋懷之時。

內科腫瘤科與其他專科（包括臨床腫瘤科、外科和舒緩治療科等）緊密聯繫，治理癌症病人。相對這些專科，我們採取進取的治療方向並從事學術研究，特別運用多線化療、標靶藥物和研究新藥，助病人舒緩症狀、對抗癌症。因著我們專科要求包括各內科專科的基本訓練，在治療癌症同時，我們也會留意並調理病人全人的身體狀況。儘管醫療科技發展日新月異，癌症仍是人類的忌諱。患上癌症就被等同為絕症，下一個問題就該是：還有多少日子。癌症的併發症諸如疼痛、消瘦、長在體外的腫瘤對身體外觀的破壞、治療帶來的嘔吐、脫髮等等，有時候比死亡本身更令人畏懼。加上癌症通常逐漸侵蝕身體，過程中病人亦要作很多困難的決定，徘徊希望和絕望、堅持與放棄之間，身心靈承受的壓力非外人道。

在當內科腫瘤科醫生的學習中，主給我幾方面的提醒。初入行時，同時兼顧博大精深的內科和畢業前不多觸及的新領域腫瘤科，知識有限，會有靠常識行事。隨著當醫生的經驗和年資漸漸增加，加上在我們專科有較多機會運用嶄新科技和研究藥物為病人帶來新的希望，在治療病人時會倚靠自己的知識能力。但是聖經勸勉我們“要專心仰賴耶和華，不可倚靠自己的聰明”，無論自己有可恃或無可恃，都單靠主而非自己。其實在醫治病人的過程中，人力有限是醫生不可避免承認的事實。即使身體上的病患可以治癒，很多人心靈上的創傷亦非人力所能及。唯有引領病人認

識創造主，使人與神、與別人及與自己的關係復和，並有永恆生命的盼望，才能使人獲得真正的全人醫治；這點在人面對死亡時尤為明顯。我見證過沒有盼望的病人身心痛苦掙扎，離開時眼神空洞得令人毛骨悚然，家人亦傷心得呼天搶地；仰望主耶穌的人也會經歷痛苦，但永生的盼望和主的同在為病者及家人帶來實際的平安，就連醫生也感受得到。當然，主亦會使用我們的醫術治好病人，但不論治好與否，總要專心仰賴主，並認清終究幫助病人的不是各種藥物和醫術，而是永恆的主。

如前文所言，我們照顧的病者都是有特別身心靈需要的一群，比其他病人期待更多的關注。仔細巡房過後，剛已看過的病人也許會再三呼喚：“醫生，可否再解釋治療方案？”“醫生，為何我仍是有咳嗽？”“醫生，我想要喝水。”或“請把床頭放下讓我躺下來。”當我想到未完成的繁重工作而感到煩躁，主提醒我耶穌柔和謙卑的樣式，甚至為門徒洗腳，又讓我看見病床上躺著的都是耶穌，他說：“這些事你們既作在我這弟兄中一個最小的身上，就是作在我身上了。”主沒有呼召我在醫學院作轟轟烈烈的大事或成呼風喚雨的權勢，他要我放下自己的驕傲，謙卑服侍，隨時隨地敏銳於病人的需要及有所行動。

工作繁忙是一個實際的困難，但不能成為向病人見證主的攔阻。有一位蒙神使用的內科腫瘤科醫生曾告訴我一件小事，令我深受鼓勵：在繁忙的門診，看一位病人大概只有數分鐘，不然其他病人就要久等了。這位同事看到一位末期肝癌的男士，正打算盡快處理他的病況然後打發他走，卻轉念想到三個月後的復診期也許不能再見到這位病者，在匆忙之間說了短短一句著他信耶穌。哪知下次復診時同事剛好再遇這位病者，病者一眼認出同事，述說他因同事的那一句話和以後的經歷已經相信耶穌！我們只要向主盡忠，獻上我們的有限，主必作成他的工。把握時機在腫瘤科尤其重要，因為生命轉瞬即逝。

親眼看見病人接受救恩，固然是主給我們的恩典，讓我們從中得著鼓勵；縱然病人的拒絕令我們失望，我們亦只要交托主。一位三十多歲的女病者來到我們部門確診為晚期乳癌及接受治療時，我正剛成為內科腫瘤科的訓練生。以後三年來的多線治療包括臨床研究裡，我照顧著她的起起落落。後來她因細菌感染入院，情況急轉直下，不但因病十分痛苦，又因牽掛孩子和丈夫心靈受著煎熬。我多次與她禱告並分享耶穌，雖然每次她都感到主即時的舒緩，但卻因不明白受苦的所以然未有親口承認相信耶穌。一天她病況平穩，我下班後和同事為她禱告，誰知翌日我發現她已離世，我亦無法得知她結果有否接受主的救恩。雖然想起來仍覺忐忑，但主提醒我萬事都在他的手裡，而我只要完成僕人的份。

儘管肩負傳福音的大使命，我很多時候都有愧於主。在我成為醫生的首數年，幾乎沒有向任何病人見證主。到了現在，亦有為軟弱所勝。當我因此懊惱的時候，主說“凡事都有定期，天下萬務都有定時、、、人莫強如在他經營的事上喜樂，因為這是他的分。”主滿有憐憫，體諒我的軟弱，他只願我常在他裡面，從他支取力量，休息有時，做工有時，卻常常喜樂。故此我在傳福音的事上亦毋需給自己壓力，畢竟靠聖靈才能成事。

感謝主讓我在內科腫瘤科工作。這裡的病人面對特別的困難尤其是生死的問題，往往比我們想像中更接受直截了當的福音討論，是一片待收割的禾場。這裡亦讓我體會自己的軟弱：驕傲、懶惰、急躁、冷漠等，但我願靠著主，逐漸成為他合用的器皿。願一切榮耀歸於主！

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Training in Medical Oncology

"...I urge you to live a life worthy of the calling you have received. Be completely humble, and gentle; be patient, bearing with one another in love. Make every effort to keep the unity of the Spirit through the bond of peace..." (Ephesians 4:1-3)

Background

Medical Oncology is a medical subspecialty dedicated for the management of cancer patients with particular reference to medical treatment. The main area of expertise is in the systemic or drug treatment of cancer using chemotherapy, hormonal therapy and, increasingly, new molecular targeted therapy. These may be given in order to cure the disease, or to relieve symptoms and achieve better control of the disease for palliative care, as treatments have much improved

for advanced or metastatic cancer which has become a longer-term chronic illness for many patients. The role of the medical oncologist is to discuss the treatment options with patients, supervise the therapy and manage any complications of disease and/or treatment that may arise. Therefore, medical oncologists are physicians trained to work in multidisciplinary teams to care for cancer patients from the time of diagnosis through to cure or palliative care.

Medical oncology also has a strong research basis and a lot of medical oncologists around the world are involved in clinical trials. With the ever-increasing advances in the medical treatment of cancer patients, the training is indeed broad but most medical oncologists will specialize in one or two tumour types eventually especially for the academic medical oncologists.

As survival rates for cancer improve, some medical oncologists also have a particular interest in survivor issues and late effects of treatment. Medical oncologists work in multidisciplinary team with surgeons, clinical oncologists, pathologists, radiologists, specialist nurses and allied health professionals including medical social workers and clinical psychologists, all contributing to the care of patients at different stages.





Training Objectives

- 1) To provide a broad-based training and in-depth experience at a level sufficient for the trainee to acquire competency and professionalism as a specialist in Medical Oncology in order to be able to provide a consultative and advisory oncology service to physicians and surgeons in general hospitals and to provide specific systemic cancer therapy for solid tumours.
- 2) To equip the trainee to be able to provide professional input in the multi-disciplinary team in conjunction with other specialties towards the provision of multi-modality anti-cancer treatment.
- 3) To inculcate and enhance critical thinking, self-learning and commitment to continuing medical education in Medical Oncology
- 4) To raise the interests in both basic scientific research and clinical research such as running clinical trials for solid tumour patients.
- 5) To understand the health delivery issues concerning Medical Oncology in the community, and develop a sense of responsibility and leadership in knowledge exchange and public health education on cancer prevention and management.

Entry Requirement

Three years of accredited structured Basic Physician Training in Internal Medicine, plus a pass in the Intermediate Examination of the Hong Kong College of Physicians and the Membership of the Hong Kong College of Physicians. The potential higher physician trainees for Medical Oncology, like all other medi-

cal subspecialties, need to approach their respective programme director for their region to discuss their wish for Medical Oncology training and to discuss with the proposed trainer in their respective cluster for further definitive plan of the training.

Programme Structure

This is a 3-year supervised and accredited training, comprising:

- 1) A 2-year "core period" with
 - a) 18 months in a recognized Medical Oncology training unit with major clinical activities OR 18 months combined supervision in individual units (minimum of 6 months full-time or part-time equivalent periods in each unit) with major clinical activities in solid tumours / Haematology Oncology while these individual units need to be accredited by the Medical Oncology Specialty Board.
 - b) Radiotherapy planning and delivery (a minimum of 3 months full-time or part-time equivalent as a member of the radiotherapy team)
 - c) Palliative care and hospice (up to 3 months full-time or part time)
- 2) An elective period of 1 year which may comprise 3-6 month in 2 or more of the following areas such as surgical oncology, gynaecological oncology, paediatric oncology, clinical pharmacology of anti-cancer drugs, basic laboratory research, tumour pathology/molecular biology/tumour imaging or a further period in 1 or more of the core curriculum subjects.

Assessment of Trainees

Throughout the Medical Oncology training period, continuous assessment is undertaken by the respective trainers with continuous assessment of the log book to record all clinical and procedural experience as a review of assessment of competence. Trainees are encouraged to keep up with medical advances, to understand both teaching and research are important activities for advancement of knowledge. An annual interim assessment will be conducted throughout the training.

At the end of the third year training, a final appraisal of each trainee will be conducted by the respective Specialty Board, with review of log book, previous performance in the interim assessments, oral examination and assessment of a dissertation.

References

Hong Kong College of Physicians – Guidelines on postgraduate training in internal medicine. July 2011. Fifth Edition, Hong Kong SAR



“醫生”這身分在你 在我代表甚麼？

那些年 是白袍 尊敬和地位這些年 是怨氣？是失誤？是失德問責？

我們進醫學院或多或少都有願意付出的心...

我們經過考試 學習 到畢業 興致勃勃要發揮所學

經過實習 我們的熱心被燒了一半 剩下的是找份有“錢”途的舒適工作

經過幾年行醫 我們剩下的一半也燒光就算沒錢途也不舒適

踏踏實實沒犯錯繼續就好了

也許我們欠的只是戰地裡的正面故事

也許我們缺的只是繼續堅持下去的原因

可否單純 單純為了香港 做一個好醫生？

是的 沒有一個部門有充裕的人手資源 也沒有一位醫生除了工作以外不用兼顧生命其他角色 但 的確有不少依然願意犧牲 堅持和付出 在船上當一口螺絲釘

沒有難處嗎？不 有著數嗎？也不 但 為了甚麼？你好奇嗎？

林婷醫生



陳漢鏘醫生
瑪麗醫院
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內科 MEDICINE

「世人哪，耶和華已指示你何為善。他向你所要的是甚麼呢？只要你行公義，好憐憫，存謙卑的心，與你的上帝同行。」(彌迦書 6:8)

在醫院工作體驗中，我有「三不」和「三要」和大家分享。

三不：

- 1.不可斤斤計較
- 2.不可背後講人壞話
- 3.不可利慾薰心

三要：

- 1.要任勞任怨
- 2.要有誠信
- 3.要和團隊有福同享，有難同當

這「三不三要」見證無數前人的成功和失敗。所謂各有前因，做事斤斤計較的人，表面上保護了自己，實際上卻自絕了去路。在一個龐大的機構工作，講求團隊內外合作；自私自利，自己顧自己，很快會被別人看出來，別人不用孤立你，你自己也會變得非常突出。另外，不要做是是非非，遠離一些無知的辯論或是非圈，也不要背後抹黑別人，你描人越黑，自己終有一日自食其果。至於利慾薰心，很容易令人掉進名和利的陷阱中，迷失自己。

醫生的三不
和三要

如何才能保守自己，做個好醫生呢？或反過來問，甚麼是好醫生？你是否家人眼中的好兒女，好醫生？又是否你病人眼中的好醫生？是否你上司眼中的好醫生？要是你上司都不是好醫生，如何是好？

在我學習裡，唯一可倚靠的是耶和華我們的神，斷不能倚仗世人。如何行？倚靠聖靈，聖靈會指引你，你尋求，聖靈會告訴你，或左或右，這是正路，要行在其中。

如何具體尋求呢？我願和你分享一個我生命中難忘的經歷：

2003年三月，SARS 肆虐香港，威爾斯醫院疫情嚴重。有天我下班聽電台節目，聽到威院同事哭著和當時之醫管局高層對話，投訴N-95加護口罩不夠，高層說是足夠，她哭著叫他到疫症病房巡視一下。相方各執一詞之際，我忽然聽到耶穌對我說：「你願意進入病房，代我去照顧有需要的人嗎？」我猶疑，祂再重複向我說，我回應：「主啊，是你，我便去，請給我印證。」其後祂真的給了我印證，我便申請進入疫症病房

工作。事實上，當時各醫院的疫症病房中，有很多同事在默默無聲地工作。我和眾多同僚，也在學習摸著石頭過河，同舟共濟，獲益良多。此事帶給我的學習非常震撼，我洞悉到在危難時間，制度和官僚都很脆弱；我們屬神的人，不能倚靠制度和人，唯有倚靠神。是否會免死呢？不一定，但如果有這一日，你是為神而死，是值得的。

在職場工作中，求神讓我們不斷的鍛鍊淨化自己，除以上三不和三要外，讓我們攻克己身，叫身服我，培養生命中那份熱愛和能力：

1. 每天花時間來認識耶穌，親近神

「求你開我的眼睛，使我看出你律法中的奇妙。」（詩119：18）

「這律法書不可離開你的口。總要晝夜思想，好使你謹守遵行這書上所寫的一切話。如此你的道路就可以亨通，凡事順利。」（書1：7-9）

* 當我們歇力尋求時，就尋見，每天經常思想神的話語，禱告，祈求和感謝，你選擇與神同行的路，神會在祂的時間開啟我們。

「人躺在床上沉睡的時候神就用夢，和夜間的異象，開通他們的耳朵，將當受的教訓印在他們心上，好叫人不從自己的謀算，不行驕傲的事。」（伯33：16）

「於是耶穌開他們的心竅，使他們能明白聖經。」（路24：45）



2. 唯靠基督寶血

* 我們要經常警惕自己，我們成為新造的人，全靠基督捨身的寶血，要知道我們是基督重價救贖的。

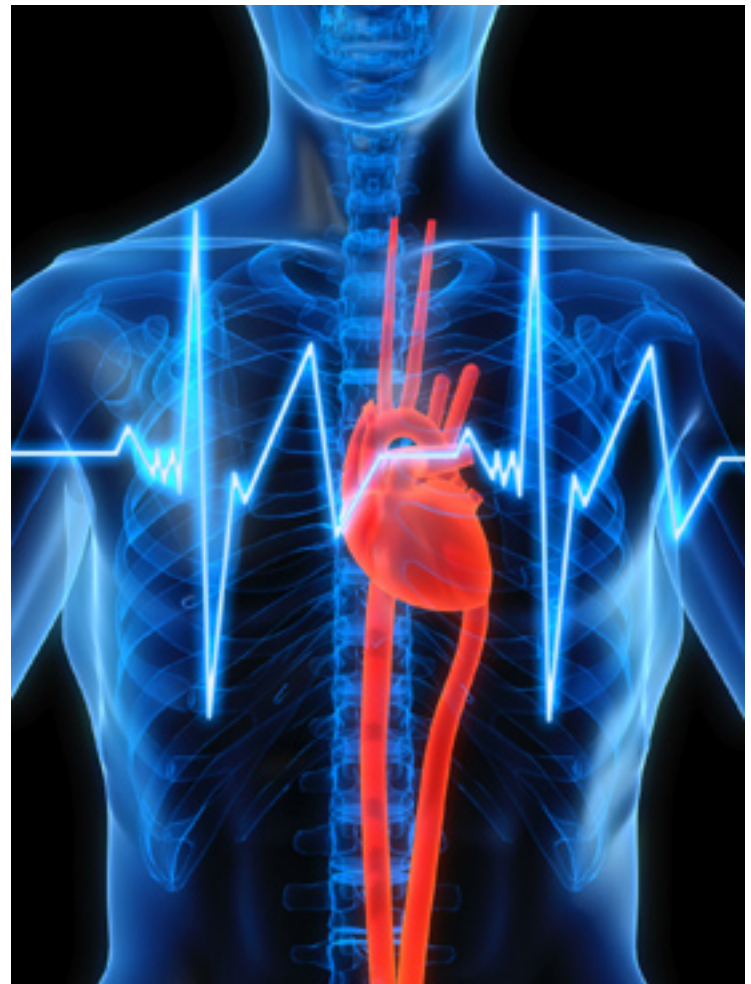
「他兒子耶穌的血也洗淨我們一切的罪。... 我們若認自己的罪，神是信實的、是公義的，必要赦免我們的罪，洗淨我們一切的不義。」(約一1:7-9)

3. 清楚我們能力的源頭，能力來自耶穌，給相信的人

「信的人必有神蹟隨著他們，就是奉我的名趕鬼；說新方言；手能拿蛇；若喝了甚麼毒物，也必不受害；手按病人，病人就必好了。」(馬可福音 16:17, 18)

「耶穌對他們說：『我曾看見撒但從天上墜落，像閃電一樣。我已經給你們權柄可以踐踏蛇和蠍子，又勝過仇敵一切的能力，斷沒有甚麼能害你們。』」(路加福音 10:18, 19)

「他就設立十二個人，要他們常和自己同在，也要差他們去傳道，並給他們權柄趕鬼。」(可3:15)



4. 行使能力的尷尬

* 小心我們的動機和出發點，歸榮耀給神。

「當那日必有許多人對我說、主阿、主阿、我們不是奉你的名傳道、奉你的名趕鬼、奉你的名行許多異能麼。我就明明的告訴他們說、我從來不認識你們、你們這些作惡的人、離開我去罷。」(馬太福音 7:22-3)



"We die young in my family - It's a cultural thing."

Training in Internal Medicine (total 7 years of training)

(By Dr Law Kwok-chi, Department of Medicine, Kwong Wah Hospital. Email: ruthkclo@gmail.com)

BASIC PHYSICIAN TRAINING (3 years)

- aims at a broad-based training in general internal medicine
- requires to take 2 written exams (Part I and IIa) and 1 clinical exam (PACES) to pass the MRCP(UK)

HIGHER SUBSPECIALTY TRAINING (4 years)

- requires a minimum of 4 years of supervised training for dual certification including 2 years of core training in Internal Medicine (Advanced Internal Medicine (AIM) or Geriatrics) and 2 years of core training in one other subspecialty*
- from July 2011 onwards, every Higher Physician Trainee (HPT) should pass one Interim Assessment (viva exam) and one Exit Assessment (viva exam and dissertation) for each subspecialty that they have enrolled in
- in addition, AIM trainees should complete all requirements from AIM Board regarding Self Learning Tool (SLT)

*Subspecialties

Advanced Internal Medicine

Clinical Pharmacology and Therapeutics

Infectious Disease

Palliative Medicine

Cardiology

Critical Care Medicine

Dermatology and Venereology

Endocrinology, Diabetes and Metabolism

Gastroenterology and Hepatology

Geriatric Medicine

Rehabilitation

Haematology and Haematological Oncology

Medical Oncology

Nephrology

Neurology

Respiratory Medicine

Rheumatology

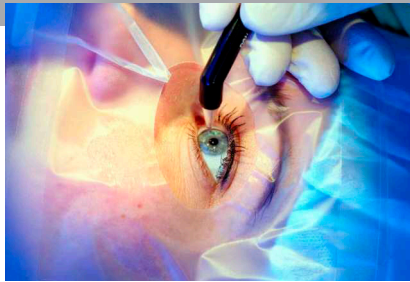
Immunology and Allergy

For details, can go to web

<http://www.hkcp.org/training.htm>
chapter of Guidelines on Postgraduate Training in Internal Medicine, Fifth edition, July 2011

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眼科 OPHTHALMOLOGY

Things beyond Our Vision

It is an exciting moment to plan for our future, to choose a specialty as our life career. However we know that many of us do not eventually get into the dream specialty. Most important is not whether we got what we wanted, something in our imagination. But primarily we are to develop ourselves into very good doctors serving patients in whatever specialties we are put into.

Knowledge and skills are important. But the most common reason for failing to be a good doctor is communication. I don't want to be lengthy here. It should not be too difficult. Put ourselves into the position of patients with their worries and questions. And one can see how badly we doctors often behave and talk. If we ask some of our own friends, it is quite common to hear how doctors could become the cause of sufferings and pain for patients!

I switched from Orthopedic and Traumatic Surgery to Ophthalmology for a number of reasons. A significant one was better working hours. Another was its challenging surgeries. I am a handy man and I just like fixing things. Not until after a few years did I realize that Ophthalmology is such an important specialty. I worked in Afghanistan as an ophthalmologist and medical director in the NOOR Eye Institute from 1993 to 1999. Before 1960's there was no eye care at all in the country. It started when a Christian ophthalmologist from New Zealand went to do an eye camp in Afghanistan. The King then invited him to stay and he started NOOR.

"We fix our eyes not on what is seen, but on what is unseen. For what is seen is temporary, but what is unseen is eternal." (2 Corinthians 4:18) Let us pray for true wisdom, the love for God and for human kind.

Ophthalmology is usually developed late in any country because it is not a life-saving medical service. Yet if you ask any person what kind of disability one would fear most, the answer is very likely to be blindness. Because of this fear and worry, we need to be extra caring when we explain to patients.

We have patients from all age groups. Parents worry about their kids' myopia getting worse; young people wanting to get rid of their glasses or contact lenses; middle age group experiencing sudden floaters and fearing retinal detachment, onset of presbyopia; and a lot more eye problems when people get older. Because of better general health knowledge and the access to internet, people tend to have more to worry about. But they often have misconceptions. So we need to listen to their stories, to explain with patience, and to relieve their psychological burden. Well explained and honest guided decisions are very comforting to patients.

When we think of ophthalmology we would immediately imagine the very fine surgeries and steady hands. This is only part of the whole picture. Ophthalmology is both surgical and medical. It demands multiple skills. In some countries it is even so divided that they cannot do both. Though this is a kind of highly specialized division of labor, personally I think it is a loss of the art of medical practice and often the holistic care of a person. When I was trained in Hong Kong during the early days, we were practicing more like comprehensive ophthalmology. When one was capable one could move on to do any kind of surgery. But now even trainees would be asked to choose their subspecialties quite early. I think it is too early, but there are always pros and cons.

It was fun to begin learning surgical techniques. Suturing was practiced on pig eyeballs. But the tissues were thicker than the human eye. The lens was too soft so we used the microwave to make it a little harder! I have observed many young ophthalmologists picking up their surgical skills. Steady hands are good to have, but that's not essential. Of course one with obvious tremor would not have chosen ophthalmology. There are surgeons with a little shaky hands but they do very nice operations. The most important factor is that they use their brains!

Those who repeatedly make mistakes are the ones who do not think enough. A good trainee always asks me or oneself what was being done well and not so well for each step after each operation, whether it was a nice job or a difficult one. They observed the minor details and always asked why. These would be the future great surgeons! They learn fast, and they learn from their own and others' mistakes and success. A common habit of many of us is to blame others when complications occur. We may blame the nurses, the patient, the assistant or surgical instruments. Worst is to say that it's bad luck of the patient. One should always first evaluate oneself. Of course we tend to be defensive. Other doctors would support that. But true humility is the way to learning and progress.

I always pray for my patients. We cut, God heals. That is already a gracious miracle. I don't want to blind any eyes out of my carelessness or mistakes. The eye is such an important organ that we cannot afford to make many mistakes.

What would be some personalities or characters that are good to have being an ophthalmologist? Well, there would of course be some general ones for being a good doctor. An ophthalmologist definitely needs to have a lot of patience. Do not imagine oneself as a great surgeon shouting around in the operation room, throwing surgical instruments, and blaming others for causing mistakes. These make lousy surgeons! I don't see any fine ophthalmic surgeon with a bad temper. But I have seen many who make surgical mistakes or even serious complications because of too fast or too slow reactions. One may panic, or may go blank if something goes wrong during an operation! This shows that one has not prepared or thought through. A calm and peaceful character would help. Quick logical thinking and solution would come next to tackle the problems.

It may be good to be a little obsessive. Precision is needed. But one needs to know when to stop. That's wisdom and experience. Excessive handling and prolonged operations would lead to complications. Every move must have a reason. Don't move if one does not know what to do. There is not much space to play around within the eyeball.

Well of course there are many other tricks and principles when we get

into the specialty. We all need to be creative to improve our techniques. All standard procedures can be modified just because we are different human beings. Trainers who are dogmatic with their techniques often do not realize their own blind spots. Thus courage and creativity help us to become better than average.

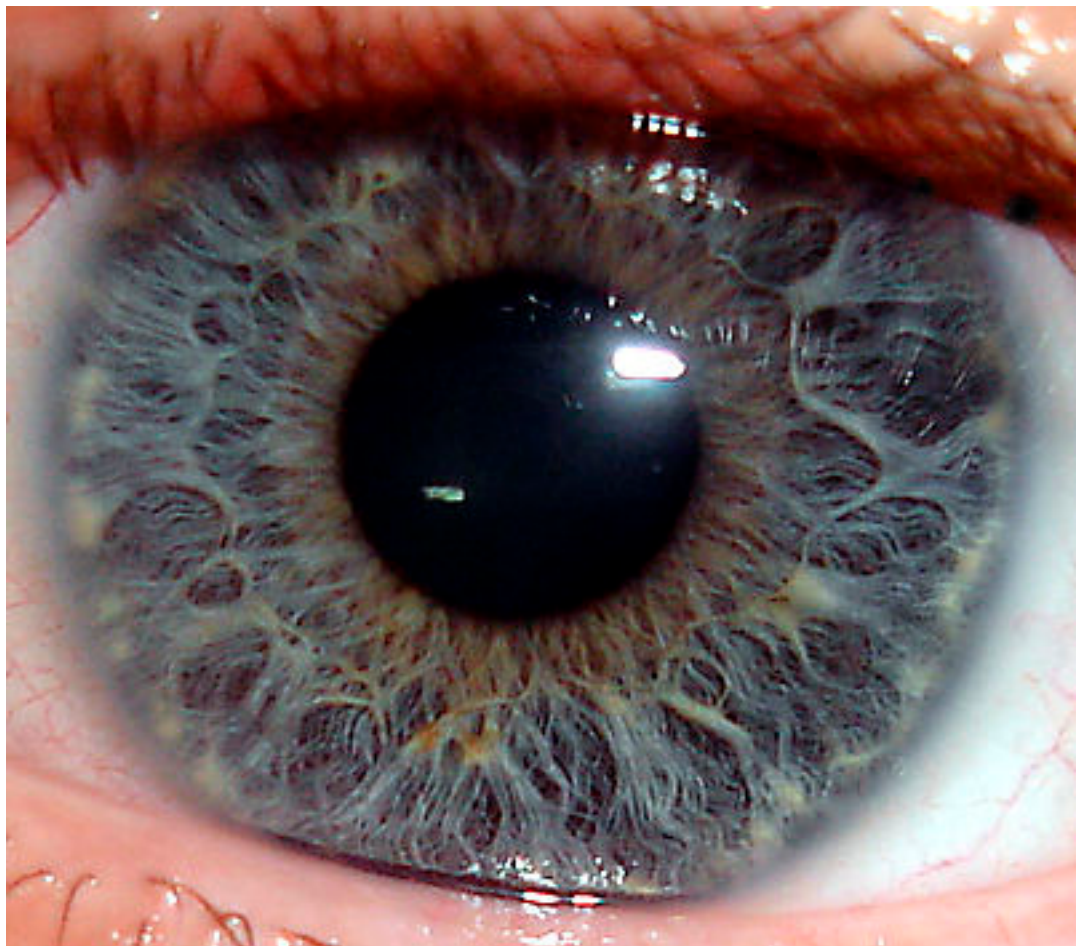
Trainings and opportunities have become very different now in Hong Kong compared with many years ago. Now it is very competitive even for entry into the specialty. After that, training opportunities vary markedly. In the past it really depended on the effort of oneself and there were always opportunities to climb up the ladder. Now it has become quite complicated. I have seen many frustrated trainees, but also trainers. One should ask around carefully about the situation in different training units. It doesn't mean there are no-go zones. We just need to know the problems of our medical system, the problems of personnel, and be ready to face the hardships.



Most of the eye clinics in the Hospital Authority are very busy. It is indeed a suboptimal environment to give good care. However, it is always possible to be a little more human to the patients and staff. It's the way we speak, the way we listen and appropriate eye contacts that make a big difference. A lot of the complaints or bad feelings can be avoided. Yet we still need to be diligent, decisive, and not to shirk one's responsibility. Uphold the values of integrity and honesty.

Once I did some reflections on insights from the Bible, following the common vocabulary of ophthalmology: focus, visual field, blind spot, blurring, enucleation, corneal foreign body, blindness... It was a lot of fun and learning. I just want to mention one verse here.

"We fix our eyes not on what is seen, but on what is unseen. For what is seen is temporary, but what is unseen is eternal." (2 Corinthians 4:18) Let us pray for true wisdom, the love for God and for human kind.



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眼科

OPHTHALMOLOGY

感謝主，給我機會在這裏分享在搵工的過程中，如何經歷神的恩典。

我在大學三年級時已經好想入眼科，但我知道，我既不是出自“豪門”、不是什麼“王親國戚”，又不是什麼天才、沒有 distinction，更加沒有什麼“姿色”（靚女待遇當然唔同），可以憑什麼去入眼科呢？當初我只是抱著一試的心態，在那年暑假的SSM，參加了養和醫院眼科的 Attachment program，認識了養和醫院的眼科醫生。其中一位醫生之後給了我一個topic去嘗試寫份review article。當時我好開心，因為或許這是神為我開的路。

當真去寫那份 article 時，才知道比想像中困難好多好多倍！那時，我只是一個student，何來有能力和經驗去做“專家”、去學人寫 review？有好幾次，寫到中途時，心好想放棄。但感謝神，在這些最艱難的日子，祂給我力量去面對，相信無論結果如何，神會給我最美好的一課。於是我便“嘔心瀝血”的把它完成了。半年後的一天，我收到了消息——那份 article 竟能在HKMJ 上刊登！這簡直是一個神蹟，我好開心，這不單是因為我的CV上多了一個 item，而最感動的是，神透過這個經歷給了我很大的鼓勵。

在往後的日子，神繼續為我開“入眼科的路”。有醫生邀請我去眼科醫學年會幫手招待，又參加了一些眼科學會的義工服務，以及到不同醫院的眼科去做attachment，我的 CV 漸漸地豐富起來，我入眼科的“籌碼”開始多起來。我當然希望自己的 CV 是最特別、最突出，讓人看見自己是最有熱誠的一個。但這個時候，我心裡有好大的掙扎，我應否將這些寶貴的機會與其他想入眼科的同學分享呢？我知道，作為基督徒，不應“收收埋埋”，我既然知道這全是神給我的機會，就應該將神的恩典與他人分享。經過多番的掙扎，我終於把自己放下，與其他同學一齊參加那些醫學年會、義工服務和眼科attachment等，但是我的CV 就不再突出了。

在搵工的過程，見到許到人性真實的一面。你的好朋友可能會成為你的競爭對手，有些事甚至你不想他們知道，但我體會到，你越願意跟別人分享，神便會有更多的恩典，所以基督徒們，我鼓勵你，有什麼“好嘢”，例如知道去哪裏attachment好，哪裏開位等等，不妨多同別人分享，因為你所得的，天父會為你持守。

到眼科實習的報名階段，又是另一個考驗。那時威爾斯醫院還有眼科實習醫生的職位，而且要報名面試，才可以“當選”為那裏的實習醫生。當時知道可以報名的人不多，我本來計劃自己靜悄悄地去報名，因為越少人報名，自己成功的機會就越大。那個掙扎係好真實的。不過神再一次責備我自私的心，祂讓我知道，做人要光明正大，這報名的消息，難道不都是祂的恩典麼？我十分慚愧，於是決定告訴身邊想入眼科的同學一齊去報名眼科實習。

面試結果在四月公佈，當時在眾“候選人”中被取錄了，但卻是在“第四水”（即四月至六月），其他同學則能在較早的時間實習。那時心情很複雜，也有失望，因為在第四水實習，一切已“塵埃落定”，什麼好位都已被填滿，所以作用根本不大。我再一次將自己的前路交托主，因為我知道祂顧念我，祂會為我安排最好的！六月時正式公佈各水實習去向，眼科實習的制度竟然自我那年開始改制?!由“四水制”改為“六水制”，每水做兩個月，而我就改為一月至二月到眼科實習!!!剛好在搵工之前!!!!神讓我看見，不可能發生的事竟然發生了。

這些經歷叫我體會到一個屬靈道理，就是，當你越願意與人分享神的恩典，神便會越加倍賜恩給你。神為我開的路是超乎我所想所求的。神給我機會在houseman期間另外寫了兩份review articles和兩份case reports，也有機會在某大型會議裏在各眼科主管面前present。

當我的“籌碼”越來越多時，我自信入眼科的機會一定比別人大得多，心裏有點“占占”自己的成就。神讓我在真正搵工面試時，經歷了挫敗。那時最早面試的，是明愛和屯門醫院。我一早已把求職信寄出，不但音訊全無，還眼見身邊一個又一個同學去面試，自己卻連面試的機會也沒有。當時的心情沉到了谷底，很徬徨，很難受；為何我比別人付出了那麼多，但卻連面試的資格也沒有？走了這麼久，只差最後一步，難道我所花的努力已付諸流水？感謝神，在禱告中讓我看見祂是我的主，是我生命的主，在我的前路上有主權，並且祂對我的帶領必定是最好的。

神讓我去學習等候，祂也帶領經過了這“死陰的幽谷”。過了兩個星期，東華東醫院開始面試。感謝神，我順利過了第一次和第二次的面試，最後終於被取錄了！我記得interview的時候，老細見到我的CV，就問我，“Why are you so obsessed in Ophthalmology?”他不知道這全是神的恩典。

有了東華東的offer後，我已心滿意足，不再去interview其他的科目。不料，過了一個月，另一個eye centre也給我offer呢！這讓我體會到，神給我的恩典，原來不但是足夠，而且是有餘的，多過我的所想所求。

這就是我houseman搵工的見證，在整個過程中，我體會到：

一、做houseman真係好辛苦，不但要on call，又要受醫生、護士的氣，受到一些不公平、不被尊重的對待。但我覺得這些精神和肉體上的辛苦，都不及搵工的壓力，想入自己理想的科目，這壓力真的很大。

二、在搵工的過程，見到許到人性真實的一面。你的好朋友可能會成為你的競爭對手，有些事甚至你不想他們知道，但我體會到，你越願意跟別人分享，神便會有更多的恩典，所以基督徒們，我鼓勵你，有什麼“好嘢”，例如知道去哪裏attachment好，哪裏開位等等，不妨多同別人分享，因為你所得的，天父會為你持守。

三、當你將來回顧 houseman 搵工，或許沒有什麼特別，或是微不足道。但我鼓勵你，可以透過這個機會，去真真實實的經歷神的帶領。將你的前路交托在主的手中，祂必定帶領你走最好的路。

四、在神手中沒有難成的事，祂能帶領我這個平平無奇的人入眼科，還有什麼神是不能作的？

願將一切榮耀頌讚歸給神!!

Training in Ophthalmology (Total six years of training)

Basic Training (Two years)

Aims at broad-based training in basic science related to ophthalmology and optics, basic clinical refraction, clinical examination skills, and ophthalmic investigations

Requires taking the Intermediate Exam (Part A and Part B):

Part A: Basic Sciences related to ophthalmology, optics, ophthalmic investigative techniques and generic issues of medical practice (MCQ)

To be taken after at least 12 months of basic ophthalmic training

Part B: Clinical refraction, clinical examination, oral examination, and written (MCQ)

To be taken after at least 20 months of basic ophthalmic training

Higher Training (4 years)

Requires rotation of different sub-specialties for training within own department, which includes: Anterior

segment; Posterior segment; Glaucoma; Pediatric; Oculoplastic; Neuro-ophthalmology

Requires taking the Exit Exam (Part C and Part D):

Part C: Written, oral and clinical

To be taken after at least three years of higher training

Part D: Log book inspection and assessment

To be taken after at least four years of higher training

(Details please refer to the web: <http://www.cohk.org.hk/exams2.php>)

Cataract Surgical Training

Cataract surgeries are bread and butter for ophthalmologists. All trainees will start with learning extracapsular cataract extraction (ECCE) surgery. After completed around 20 cases, they will start learning phaco-emulsification (phaco) surgery.





Overseas Training

Each trainee will be granted for six weeks overseas training during their training period or post-fellow period.

Daily life of Ophthalmology trainee:

You will spend most of your time in OPD, seeing lots of general ophthalmology clinics. There are up to 50 patients in the am session and 30 patients in the pm session for each OPD room.

You will learn some laser techniques, such as Yag-capsulotomy, peripheral iridotomy, laser barrier, pan-retinal photocoagulation, macula focal and grid laser.

You will have about 5 – 8 surgical training session for each month. The sessions are mainly focused on learning cataract surgery during the first three years. You will have exposure on other surgeries, such as pterygium, lids surgery (ectropion, entropion, ptosis, and dermatochalasis), dacryo-cysto-rhinostomy (DCR), squint surgery, trabeculectomy, assisting corneal graft, and assisting the vitreoretinal surgeries.

Ophthalmology training involves lots of presentations, such as the departmental academic meetings (weekly to bimonthly), inter-department commissioned-training programs (around three per year), and annual scientific meeting (December of each year). You should be prepared to make lots of presentation during your training period. Most departments support research activities.

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骨科

ORTHOPAEDICS

The Making of an Orthopaedic Surgeon

1. Orthopaedics in Hong Kong

The word "orthopaedics" comes from the Greek words "orthos" and "paidion" meaning "putting right" the "child", due to the fact that the correction of spinal & bony deformities in children was the mainstay of orthopaedics in the old days. Though Orthopaedic Surgery has been a part of surgical practice in Hong Kong for many years, it was established as a separate specialty only about 50 years ago. Towards the late eighties the official name of "Department of Orthopaedics & Traumatology" was used.

Nowadays the specialty covers the management of a wide range of disorders and injuries of the musculoskeletal system, including paediatric orthopae-

dics, orthopaedic trauma, sports injuries, spinal surgery, hand & microsurgery, joint replacement, foot & ankle surgery, musculoskeletal tumor surgery, and orthopaedic rehabilitation. Generally speaking, orthopaedics is concerned with the restoration of function and quality of life. It follows that rehabilitation is an inseparable part of orthopaedics. Since 2003 "Orthopaedic Rehabilitation" became the first subspecialty listed in the Hong Kong College of Orthopaedic Surgeons, recognized by the Hong Kong Academy of Medicine and eligible for specialist registration.

2. Some misunderstandings about orthopaedics in general:

i. "Orthopaedic surgeons lead an easy life, they don't have to deal with many emergencies and they don't work long hours" ...?

There are indeed emergency situations, and working in the odd hours is not uncommon. Moreover, certain orthopaedic operations are "ultra-major" operations requiring long hours of work (some personal records: twenty-five-hour complex bone tumor resection, thirty-hour replantation for multiple finger multi-level traumatic amputation, etc)

ii. "Orthopaedic Surgery is not suitable for female doctors" ...??

Traditionally orthopaedic surgery is dominated by male doctors, and yes many orthopaedic operations require a bit of physical stamina. But more and more female doctors in Hong Kong are taking up orthopaedics lately. Regardless of gender, there is a place for all who are interested, provided one knows his/her own strengths and weaknesses.

3. The orthopaedic surgeons – what do they do and what is required of them?

Technical skills: orthopaedic operations often involve a fascinating array of surgical appliances/implants (e.g. fixation implants, arthroscopy, microscope, joint replacements, computer navigation, etc). Knowledge in surgical anatomy and sound application of biomechanical principles is important to provide the appropriate treatment.

Mind-set of reconstruction & functional restoration: many orthopaedic operations require meticulous pre-operative planning & preparation. Comparing to mechanics, orthopaedics is almost like building / re-building bones and/or soft tissues for the restoration of function. Even in orthopaedic tumour ablation, one needs to think of reconstruction as an integral part of the surgical plan.

Mind-set of rehabilitation: orthopaedic surgeons must understand that surgical treatment is just the beginning. Rehabilitation is an essential and integrated process for the restoration of function.

Decisiveness in life-threatening conditions: one example is poly-trauma & major pelvic trauma. In particular, orthopaedic surgeons working in major trauma centers require a high level of commitment and timely action within the "golden hour" . Labour-intensive limb saving through microvascular surgery: one example being traumatic limb amputations requiring revascularization/replantation. Owing to a fall in incidence of such kind of severe injuries, it's increasingly difficult for young surgeons to develop and maintain the skill. Microvascular surgery is a field that requires special training, dedication and much hard work. (Reference: Repair, Reconstruct and Rehabilitate: Half a century of Orthopaedics in Hong Kong. Chapter on "Hand & Microsurgery" Hong Kong Academy of Medicine Press 2004)

Holistic care and technical expertise in musculoskeletal oncology: this is a highly subspecialised field with service provided in a few tumour centers only. It requires sound knowledge of pathology, anatomy, and a broad mastery of surgical skills such as fracture fixation, microsurgery and joint replacement etc. At the same time it is important to provide holistic care to these unfortunate patients who are struggling with survival choices and possibilities. Caring attitude in dealing with chronic disabilities: By virtue of the "surgical" orientation of most orthopaedic surgeons, they may not be patient enough to listen to patients' chronic complaints especially multiple and non-specific pains. Nevertheless in real life orthopaedic doctors need to take care of patients whose problems cannot be readily solved by the knife. To be a good listener is always beneficial not only as a therapy itself but also is a safeguard against missing serious underlying conditions. It will also make a happier doctor after all!

4. Training to be an orthopaedic surgeon

Basic Surgical Training: The first two years of training as a Basic surgical Trainee (BST) is coordinated under the auspice of the Hong Kong Intercollegiate

Board of Surgical Colleges (HKIBSC). <http://cshk.org/training-bst.php>. During the first year of residency, all BSTs are advised to declare their interest in intended higher specialty training as early as possible, if they so wish. The declaration of interest will be recorded in their Registration Form on entry to BST and in their Record of Curriculum before next rotation. So if one is interested in choosing orthopaedics as their career, they should make such declaration early. They are also advised to register with the Hong Kong College of Orthopaedic Surgeons (HKCOS), which will enable him/her to access education information and materials from the HKCOS, to have preferential participation in HKCOS educational programs, and to receive training points from the HKCOS.

Higher Orthopaedic Training: the Hong Kong College of Orthopaedic Surgeons (HKCOS) coordinates the higher training provided by 13 orthopaedic departments in the HKSAR.

The requirements of higher orthopaedic training are detailed in the HKCOS web site:

<http://www.hkcoss.org.hk/Training-Guidelines-2010.asp>

In a nutshell, higher training program in orthopaedics could be completed in a minimum of 4 years (48 months). It includes the following clinical rotations in approved centers:

a. Compulsory subspecialty clinical rotations made up of the following combinations (total 39 months):

i. 18 months in Trauma

ii. 12 months in General Orthopaedics, including adult joint reconstruction, sports medicine, foot and ankle surgery, spinal surgery, and musculoskeletal oncology

iii. 3 months in Hand Surgery

iv. 3 months in Paediatric Orthopaedics

v. 3 months in Musculoskeletal Rehabilitation

b. The remaining 9 months may be spent in one or more orthopaedic subspecialty clinical rotations of the trainee's choice, including those described above.

c. Up to 6 months may be spent in approved basic science or clinical research in orthopaedics and traumatology.

d. Of all the clinical rotations, 2 rotations of 3 months each should be carried out in another training center in Hong Kong. This is arranged by the College Secretary.

5. My personal story

It is not easy to comprehend how one moves along the various paths in life. There are so many things one cannot control. Looking back, while I was making many conscious decisions, I believe a higher hand was guiding my way ahead.

It all began in HKU medical school in the mid-seventies. At that time, student movement on university campuses was campaigning for the understanding of our mother country and the society (認中關社). During an extracurricular movie showed on

the medical campus, I was fascinated by the remarkable achievements in microsurgery by Mainland Chinese orthopaedic surgeons. (Note: China was one of the first countries in the early sixties that successfully replanted severed limbs & fingers). At the same time, I was inspired by honorable people like Josephine So Yan-pui, founder of Breakthrough, whose humble life and fervent spirit made a positive impact on many. I still remember how she shared on the biblical passage of Exodus 32:32 to challenge us to a life of sacrificial service for our fellow countrymen. Under these influences there emerged a notion that I might be able to serve the country in some special way via the field of hand and microsurgery.

This took a rather unexpected start during my orthopaedic internship. While I was on call one day I admitted a lady with severed tip of the finger, but the hospital paging system broke down completely (there was no DECT/mobile phone in those days) and I was not able to contact my seniors for help. Interns in those days did a lot of "minor" surgeries like revision amputations, tendon repair, finger fracture fixation and even local flaps like finger tip V-Y plasty etc. With this background I had no choice but to go ahead to replant the finger by myself in the treatment room. Believe me - the finger survived after the surgery! I had a grateful patient who afterwards sent me a fruit basket. On the next day during the ward round my senior lavished me with compliments and encouraged me to pursue hand and microsurgery as a career. I followed his advice and joined the department next year. It was indeed a miracle.

When I took up orthopaedics my initial focus was hand surgery, while

doing laboratory research on microsurgery at the same time. The laboratory practices helped a lot to refine my microsurgical skills. I also went through general orthopaedics as part of my training as well. In the early days I spent extra time with my patients, often visiting them in the after hours. This was feasible especially during my residence in Duchess of Kent Children Hospital. I can still remember some of my patients from the old days, especially the young ones with bone malignancies. I shared their anxieties, gave counseling and prayed with them. I believed I've found my calling & vocation.

As I moved along my path I have had lots of chances to reach into Mainland China, to interact and share with many people through my profession. I was also able to serve through Christian voluntary agencies for short terms in remote areas of the country. I believe God used these modest efforts to shape my life as well as help the people in need.

Life is not a straight path, and there is no end to surprises. My career and life journey made several unforeseen turns through the years. I have switched hospitals, took on challenging positions, and even changed subspecialty late in my career. I found myself often reaching out to the unknown and sometimes stretched to my limit. Indeed, no one is able to see beyond the bend, but there is Somebody bigger than you and me. Through my thirty-three years as a Christian doctor, I've learnt that it is worthwhile entrusting myself to the Lord of life, the ultimate healer of all.

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兒科

PAEDIATRICS

Specialty Overview

The specialty of Paediatrics, in most developed countries nowadays, serves patients from newborn up to about eighteen years of age. From the most tiny and naive, barely salvageable 500gm premature baby to the physically fully matured but psychologically most unsettled and complex adolescents, paediatric care covers a broad spectrum of distinctive and rapidly evolving patient groups of various ages.

The delicacy of tiny baby and the great variation in the body size, physical and psychological make-up of paediatric patients of different ages call for a high degree of carefulness, patience and meticulousity in patient care. For instance, the technically demanding attempt in setting up access into the tiny blood vessels and the exactness required in calculating the rate of intravenous fluid therapy and drug dosage are not usually encountered in the management of adult patients.

As another unique feature of Paediatrics, in no other specialties will you find your patients being so dependent on and treasured by their families. Not only the assessment (history taking, physical examination, investigation procedures) but also the treatment (drug taking, therapeutic procedures) of patients rely very much on the input and assistance from parents or other family members. On the other hand, the negative impact of a beloved, sick child is often so tremendous as to cause significant physical, psychological and social stress, if not torture, to the family. In essence, in paediatric care, you cannot manage the



patient in isolation but have to communicate and cooperate with and be concerned about the family as a whole.

Meticulous and intricate it may seem from the above account, on its bright side; paediatric service is uniquely attractive for being full of fun, life and hope. The cute look and joyous laughter of lovely kids are really heavenly gift that can lift up your weary heart and replenish your energy when you are so overwhelmed by heavy workload on a busy day. At an early age with enormous potential for growth and development, the power and hope of life is best demonstrated by paediatric patients.

It is really most gratifying to see the many tiny preterm babies grow out from the initial struggle at the edge of life to healthy young kids; and every 8 out of 10 children being cured of their acute lymphoblastic leukemia to live productive lives with normal expectancies.

From the perspective of the society, children are the master and hope of our future. It is of paramount importance to help our children to grow and develop with optimal physical, psychological and spiritual health. Nowadays, like many other places in the world, the Government and Health Authority of Hong Kong are increasing the investment of resources into paediatric health care.

In conclusion, committing into the specialty of Paediatrics is gratifying, worthy and privileged with ample opportunities for further development in the future.

Paediatric Service in Hong Kong – present and future

The health care system in Hong Kong provides a full range of paediatric services from primary to quaternary level. While private practitioners play an important role in providing primary paediatric services, a large proportion of secondary care and the almost exclusive majority of tertiary and quaternary care are provided by public health care sector under Hospital Authority in collaboration with the universities. Together, a comprehensive range of paediatric subspecialties including general Paediatrics, intensive care, neonatology, hematology, oncology, endocrinology, cardiology, respirology, neurology, nephrology, gastroenterology and hepatology, rheumatology, infectious disease and immunology are provided as high quality services of international standard. The favourable outcome of our neonatal services with low neonatal mortality rate comparable to advanced Western countries; the territory-wide comprehensive primary care provided by Maternity and Child Care Centres, Comprehensive Child Assessment Centres and Student Health Services; the reputation of our paediatric nephrology and oncology centres as quaternary centres for consultation and referral from neighbouring countries in South East Asia, are all good reflections of the commendable quality of care already achieved by our paediatric service in Hong Kong. With the establishment of the Centre of Excellence in Paediatrics (CEP) in 2016, further improvement in

the quality of service and advancement in clinical and scientific research are expected in the field of Paediatrics in Hong Kong.

Nevertheless, like most other clinical specialties nowadays, shortage of doctors in paediatric service is serious in Hong Kong. The ongoing upsurge of demand for neonatal and paediatric services from baby and children born locally to Mainland parents; the expanding private paediatric health care sector and the inevitable increase in manpower demand from the CEP in the near future all add to the tension in the supply of pediatricians and open up excellent opportunities for career and professional development for those are interested and committed to become a pediatrician.

Paediatric Training in Hong Kong

The Hong Kong College of Pediatricians (www.paediatrician.org.hk) is the professional authority governing the accreditation of professional qualification in Paediatrics in Hong Kong. Admission to Membership and Fellowship of the College has to be attained after going through structured basic training program followed by intermediate examination and higher training program followed by exit examination, respectively.

Basic training program

Eligibility for entry – MBBS degree plus completion of one year internship in medical and surgical departments under the Hospital Authority; paid up as an Associate of the College.

Training program – three years of working experience and training in accredited departments for paediatric training including at least six months of neonatology training.

Intermediate examination – consist of written (Part 1) and clinical (Part 2) examinations which may be attempted after at least 18 months of basic training.

Professional qualification – admission to Membership of the College to be granted upon completion of three years of basic training and passing of the intermediate examination.

Higher training program

Eligibility for entry – Member of the College,

Training program –three years of higher training in accredited departments for paediatric training including a period of rotational training in another local or overseas institution; writing up of clinical paper on Paediatrics.

Exit examination – conducted in Viva format

Professional qualification – admission to Fellowship of the College to be granted upon completion of three years of higher training program and passing of the exit examination.

Should I choose Paediatrics?

Having worked in the medical profession for quite many years, I came to realize that our aptitudes may evolve, interests may change, hidden potential and abilities may explode as we walk along in our career path. As



such, I don' t think there are any qualities in a person that will make him/her not suitable to become a pediatrician. On the other hand, I believe if you have personal interests and characters like the followings, they may help you appreciate the pleasure of, and facilitate your success in working as a pediatrician in Hong Kong:

1. You love kids and enjoy playing and interacting with them.
2. You enjoy listening with patience and dealing with interpersonal relationship and dynamics especially between parents and their kids.
3. You are a careful person and good at handling delicate matters with high degree of patience and meticulousity.
4. You are a person with aspiration and wish to contribute to the establishment of a healthy generation for our society in the future.
5. You are interested in clinical and scientific research and wish to find ample opportunities in your career to work for the advancement in your specialty of service.

Personal experiences and feelings as a pediatrician with Christian faith

Thanks God for placing me in the specialty of Paediatrics ever since my

completion of internship in 1989. Through the experience in my service as a pediatrician over the past 22 years, God has allowed me to have better understanding and appreciation of His unconditioned and unfailing love as our Heavenly Father; to developed conviction to His faithfulness and almightiness and to realize that He is a living God that is willing to walk with us and be our help any-time in our practical lives.

In Paediatrics, it is not difficult to encounter patients with congenital physical abnormalities and/or mental disabilities that will persist forever or even get worse with age. On the other hand, in the mist of economic and social problems in a society of growing complexity like Hong Kong, many children and adolescents come to us because of behavioral problems, conduct disorders, school refusal and, in increasing magnitude nowadays, substance abuse. Nevertheless, no matter how unappealing physically, mentally or behaviorally these patients may seem, in the majority of instances, they will still be treasured as beloved sons/daughters by their parents, who will try their best, often beyond the limits of their efforts and resources, to take care of them and forgive them for their rebellious and delinquent acts again and again. I can never forget the tender smile on the face of a lady when she was doing tedious body care on her two totally dependent teenage girls whom she had already devoted every aspect of her own to provide intensive care for their congenital muscular disease day by day for 10 to 15 years. God has made man in their image and after their likeness. This natural instinct of parents to love their children at all

cost is really living reflection of the unexplainable and immeasurable love of our Heavenly Father towards all mankind.

In a materialistic world where people admire fame, fortune and comfort; believe in competition, calculation and self-protection; to live and work with faith in Jesus and according to His will and teachings may appear obsolete and unrealistic, if not naive. Nevertheless, through repeated practical experience of His blessings and help at work, like enhanced competency in difficult procedures; added wisdom in the diagnosis and management of rare and difficult diseases; pushing forward of righteousness through defensive bureaucratic obstacles; rectification of inequalities and overwhelming work pressure, to quote but a few general examples, God has revealed to me the undeniable truth that He is faithful, almighty and will always be our help and protection if we trust in His promise and follow His teachings and will with humble hearts. Furthermore, our



faith in Jesus can also be blessings to our patients and our colleagues. In the past 5 to 10 years of service in Paediatric Oncology and Hematology, on top of managing patients with the best of our scientific knowledge and abilities, we prayed for them and preached the gospel to some of them and their parents. Quite a number of families were converted into Christians. Although not all of these patients got cured of their cancer but finally died, the peace and hope in Christ that they and their parents had demonstrated till the end of their physical lives served as living testimonies that had not only strengthened the faith and devotion of members of their churches but also opened up the



eyes and hearts of non-Christian doctors, nurses and ward assistances in our ward, drawing them closer to our Lord.

As concluding words to our medical students, green graduates and junior doctors from the bottom of my heart, if you are a Christian, I thank God for giving you the opportunity to serve in the medical profession where you are in a privileged position to lead you patients to God through your commitment and devotion to take good care of them and by the gospel that our Lord Jesus Christ has accomplished by scarifying Himself on the cross. In Paediatrics, you are even more privileged to have many chances to bring the whole family to God through the sick children. If you are not a Christian, I thank God for giving you the opportunity to work as a doctor. You will have many opportunities to encounter and experience God only if you are willing to open your eyes and your hearts. In Paediatrics, you will be in a privileged position to appreciate the heart of our Heavenly Father as reflected in the love of parents to their kids.

May all the glories and praises be directed to our Heavenly Father by all creations with love, Amen.

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紓緩治療科 PALLIATIVE MEDICINE

“A bruised reed shall he not
break, and smoking flax shall he
not quench.”
(Matthew 12:20)



Compassion is central to palliative care and it seeks to address the suffering and needs of a person threatened by severe illness. Palliative care is an approach that improves the quality of life of patients and their families who are facing problems associated with life-threatening illness; it prevents and relieves suffering through the early identification, correct assessment and treatment of pain and other problems, whether physical, psycho-social or spiritual (WHO 2018). Compared with the older hospice model mainly for cancer patients at the end of life, palliative care is now applicable early in the course of cancer and non-cancer diseases in conjunction with other therapies that are intended to prolong life and includes those investigations needed to better understand and manage distressing clinical complications (WHO 2021).

Principles in palliative care include:

1. Affirms life and regards dying as a normal process - Neither hastens nor postpones death
2. Provides relief from pain and other distressing symptoms and integrates the psychological and spiritual aspects of care
3. Offers a support system to help patients live as actively as possible until death and to help patients' families cope during the patient's illness and in their own bereavement



Becoming a Palliative Medicine Doctor

A. Specialty Training in Palliative Medicine

Under Hong Kong Academy of Medicine, there are two pathways of entering specialty training of palliative medicine:

one is through physician pathway

(<https://www.hkcp.org/hkcp/higher-physician-training.html>);

the other is through clinical oncology pathway

(<https://www.hkcr.org/education.php/tr>).

Both are subspecialty training, i.e., one requires finishing the basic training in medicine or clinical oncology respectively.

B. ASK (Attitude/ attribute, Skill and Knowledge) of a Palliative Medicine Doctor

Attitude/ attribute:

- Commitment to serve and to walk with people with advance illness and/or facing death
- Resilience and mature coping with people's suffering in illness and death

Skill:

- Empathetic active listening to patients and families
- Excellent communication to identify and align goals of care among patient, family and clinical teams

Knowledge:

- Holistic perspectives (physical, psycho-social and spiritual) in understanding suffering related to advance illness
- Medical and ethical knowledge to guide complex decision in the end-of-life context



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紓緩治療科 PALLIATIVE MEDICINE

進入醫學院

1982年我本著「希望幫助別人」的簡單心志加上不錯的高考成績，便進入了港大醫學院。那年迎新營的主題正是「做個好醫生」。

「紓緩」先聲

二年班的時候，聽了蔡元雲醫生在港大的一個講座中介紹Elizabeth Kubler Ross 所著 *On Death and Dying* 一書，我開始關注臨終病人被忽視了的各種需要，並以 *Meeting the Needs of Dying Patients* 為主題於「社區醫學科」作研究題目，認識了於歐美方興未艾的善終服務運動和在香港聖母醫院剛起步的善終服務發展情況。我的報告以一段聖經經文作結：“Listen to me, do but listen, and let that be the comfort you offer me.” Is this also a plea by dying patients in Hong Kong?

「大德曰生」

1987年畢業後我進入了婦產科接受訓練。當時選科主要考慮到在實習階段的四科(內外骨婦)中，在產科工作時比較愉快，而沒有認真考慮到自己的性向適合怎樣的工作性質與環境。工作了四年後，我對醫學生涯感到困惑，甚至放下了婦產科工作和醫生身份，到了加拿大追尋自己的路。

追尋

於彼邦的四年裡，透過與大自然的接觸、閱讀、思考、安靜、禱告，我重新抓住了人生之錨。於彼邦大學的一個認識自己的課程中，我了解多一點自己的性向特質：愛見別人成長、重視忠誠、愛與人建立深厚關係、敏感於別人的感受、愛思考事物背後的意義……等。有了這些基礎，我開始找尋工作方向。我參與了一所社區善終服務機構的義工訓練與家訪工作，走訪了多倫多一帶十多個紓緩治療部門了解它們的運作並訪問裡面的工作人員，知道紓緩治療是一個可投身的方向，便投石問路，回港投入了紓緩醫學的訓練。

終身學習

自1996年始，我逐步完成了內科醫學和紓緩醫學訓練，並於2006年註冊為紓緩醫學專科醫生，過程中有不少學習與反省。紓緩醫學需要甚麼特質的醫生呢？我認為以下幾項甚為重要：

- 在內科醫學有堅實基礎
- 注意細節、好尋根究底
- 委身於以病人為中心的全人照顧
- 樂意參與團隊工作，尊重每一成員
- 不斷從實踐與反思中探究生死病苦的意義



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ANATOMICAL PATHOLOGY

Anatomical pathology in career planning

Pathology is the most misunderstood and underestimated specialty by medical students and the lay population. Anatomical pathology, being the largest subspecialty within it and often run by low-keyed personnel, naturally bears the blunt. It is instinctively associated with autopsies, forensic medicine and criminology, therefore deemed to be an obnoxious occupation. Confinement within the laboratory with minimal patient contact puts medical graduates off when considering it as a life career. Only those in active clinical practice understand the importance and significance of anatomical pathology in everyday patient management. This happens after they have already made their choice in career planning, thus missing out the joy and satisfaction of a career in pathology.

The anatomical pathologist, being well-grounded in general and basic pathology, is intensively trained to study, diagnose and prognosticate diseases involving every system of the body. With the ever-expanding targeted therapy in cancer patients, the anatomical pathologist is also called upon to do molecular studies on tumour tissue for individualized therapy. Working mostly in a hospital setting, the anatomical pathologist is mostly involved in morphological study of specimens supplied by other doctors for tissue or cellular diagnosis. This includes naked eye examination of specimens with dissection and block taking, microscopic examination of glass slides, subsequent request and interpretation of ancillary studies. Rapid diagnosis or resection margin assessment is offered to the



surgeon by frozen section during operation. Nowadays, immunohistochemical profiling is widely utilized in the diagnostic algorithm, occasionally complemented by special molecular studies and electron microscopy. Visual acuity with pattern recognition, meticulous clinical-radiologic-pathological correlation, complex logical deductions and decisive judgment are required in the daily routine. Clinical and coroner autopsy rates have dropped drastically in the last decade. Post mortem studies thus occupy only a small proportion in the pathologist's work load.

An anatomical pathologist has to be well-versed in constantly revising pathology text books and be updated with current literatures. Self-driven life long education and continuous professional development cannot be overemphasized. In response to the clinician's biopsy or cytology request, the anatomical pathologist serves by crafting an accurate and succinct pathology report, pointing the direction for further management to the clinician. Mastering the written and verbal communication skills would greatly enhance the pathologist's professional armament. Participation in CPC and interdepartmental meetings plays an essential role in communicating with clinicians for patient management and mutual education. From these also evolve collaborative studies, clinical research and peer-reviewed publications in medical journals. The honest, objective pursuit of the anatomical pathologist with evidence-based conclusions places him/her in the more academic realm of clinical medicine.

In Hong Kong, qualification for anatomical pathology specialist status requires at least six years work experience in a recognized training centre including one year rotation to other units. The membership and fellowship college examinations can be taken after three and five years work experience respectively. Further information can be found on the Hong Kong College of Pathologists web site: <http://www.hkcpath.org>.

From a small scale survey conducted among anatomical pathologists, the answers to the following questions are summarized here.

1. What you like most about anatomical pathology? The top five preferences are: working with the mind, working with the eyes, regular working hours, decision-making and seeking after the truth.
2. What you dislike most about anatomical pathology? The answers include: lack of patient contact, being slighted by clinicians
3. What abilities and personality traits are important in anatomical pathology? The answers are highlighted by 'bold lettering' in the text.
4. What advise would you give a medical student considering future career in anatomical pathology? Take a short-term attachment or special study module in the anatomical pathology laboratory during medical student days to see and appreciate this specialty.



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CHEMICAL PATHOLOGY

How I look at Career / Prospect / Life in general?

Ecclesiastes 3:1 – 8 (life is about making the right decision and timing)

There are a time for everything, and a season for every activity under heaven: a time to be born and a time to die, plant / up-root, kill / heal, tear down / build, weep / laugh, mourn / dance, scatter stones / gather, embrace / refrain, search / give up, keep / throw away, silent / speak, love / hate, war / peace.

Ecclesiastes 9:11 (a matter of chance / circumstances and beyond us)

I have seen something else under the sun: The race is not to the swift or the battle to the strong, nor does food come to the wise, or wealth to the brilliant, or favor to the learned; but time and chance happen to them all.

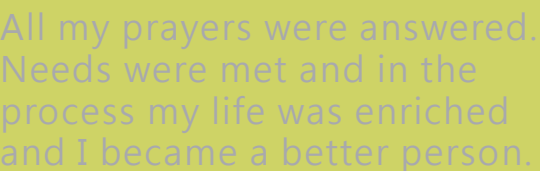
Comment:

Human planning and efforts etc very often are futile. How to secure success and happiness? The answers can be found in Ecclesiastes Chapters 9 and 12.

Answers to FAQs of Career / Pursuits

Which career?

What are my potential and talent, known and unknown?



All my prayers were answered.
Needs were met and in the
process my life was enriched
and I became a better person.



Which job, where to find the “get on the bus” 1st job?

What plan /goal / objectives, now and future, how to get there

What prospect now and later, any control?

Do I have a choice, or missed chances?

Should I take high risk path such as going academic?

How to get training?

Will I make it in this competitive world?

Will I be disappointed at the end?

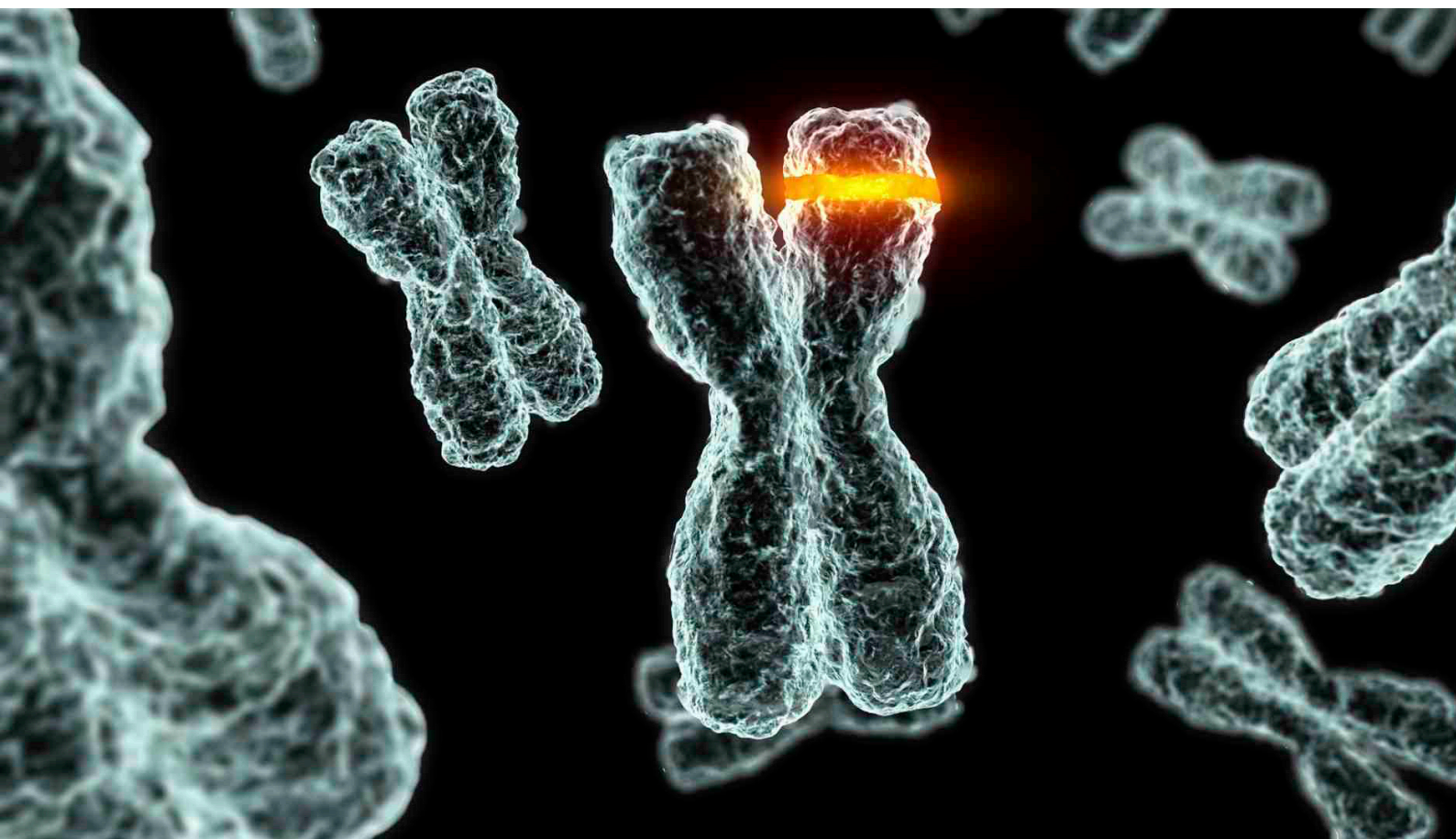
Technical issues – how to prepare CV and will it help?

- How to prepare for interview and will it help?

- Competitors / friends / politics / family and marriage dynamics etc

Comment:

Try to find answers to some of these questions from my own experience described below. Actually, I did not know how to ask many of these questions in the past.



Finally, I entered into Medicine.

Respiratory physician – I like respiratory medicine because somehow I had confidence and a good grasp of the subject. However, I put off after one bronchoscopy session. Also, one senior recommended me a better alternative and he said that there were a lot of chest people around, do things that bring in new tech to HK.

Metabolic physician (endocrinologist) – This is my next interest as I like numbers, painless, and there is most of the time no need to do procedures / putting needles into people. I also got good exposure at the UMU (University Medical Unit). But, I gave up after MRCP because there was slim chance to become a consultant physician (before HA days).

Practicing medicine in UK – I gave up because there was no chance to become consultant in those days.

Chemical pathology / ?pursuing PhD in UK – I gave up because of family needs and I came back to HK.

Chemical pathology in HK – I got some interest, and it was the only job that could be found at that moment:

I became the first MO in chempath in HK, eventually the first locally trained specialist and the first consultant chemical pathologist. I did “new tech” .

I was not happy soon after and I got stuck. I constantly prayed about where and when to leave.

Somehow I stayed on and came to like it a long time later.

I was eager to be an academic at one time, and became one but hoped to get out soon after

As a consultant chemical pathologist within HA, I gave up thyroid as there was no chance to develop further at PMH. However, I was made to realize the service needs in toxicology and I came to like it more and more. Another subject is inborn errors of metabolism (IEM), again there are service needs and I came to like it more and more. The third is genetics. Again, service needs drive me into this field as new adventure.

Comments:

Did I have a career plan?

Could I predict my career path?

What was my “favorite” ? Did I know?

Did I know myself?

A lot of changes, hurdles, and unknowns

Will I succeed?



Conclusion:

- Do not get too disappointed if one cannot get the first choice.
- Our interest can change rapidly and may not be that rational.
- We may dislike something soon after getting the chance to do it. Do not be too disappointed when there is no chance to do your first choice or even second choice.
- We may have a lot of hidden and unique talents, to be discovered years later.
- Be open-minded and learn to rely on the guiding hands of God.

What is Prayer?

Prayer = asking for things and expect everything granted?

Does it mean that christians will do well without working hard enough?

Would it be unfair to those who did not turn to God?

One example:

For a long time, I lost my interest in medicine in year 3 and year 4. I skipped a lot and a lot of classes. As a result, I did not know how to do abdominal examination properly even when I was in year 5. I got a lot of worry and regret. Final MB came rather rapidly and I got no chance to catch up. Therefore?

I wanted to pass the final MB. It was a "must pass" for me as overseas student in UK, so costly otherwise.



Prayer – "Heavenly Father, please help me because I can't fail!"

After some weeks – my prayer changed to "Please let me fail, because I could be a real risk to patients."

After a short period of time –my prayer changed to "Please let me pass, but please protect the patients. And help me to learn / relearn medicine after graduation."

Prayer is not about asking for things, but communication with God, establishing a relationship with Him, and in the process, we are guided away from selfish interest, and develop the faith and courage to trust in God.

Outcome

By chance, I did a student locum in Dr P's surgical unit and I managed to put up a respectable performance with my diligence and effort. Dr P was feared by all students. He seemed to fail everybody and that accounted for 50% of students who needed a pull up viva.

Some weeks later, I met him in final MB. He was more tolerant and more patient to me, and he seemed willing to wait for a few more seconds for answers. I was less anxious because he was not a stranger to me. Pass. I would have been a failure if somehow I did not have the previous encounter.

I also did the internship in medicine with Dr M for three months. I learned / relearned the approach to medicine. I learned the secret to continuously improve. I learned the secret of success – 90% perspiration and 10% inspiration, to search and re-search and repeat until one got it. Somehow I managed to gain an insight and a good grasp of the subject, and managed to survive in UK and HK. Patients were protected, no major blunders I could remember. I was respected by fellow MO and got exams passed in the first times.

All my prayers were answered. Needs were met and in the process my life was enriched and I became a better person.

How to face / cope?

I came to PMH in 1991. It was a very difficult job. I prayed for wisdom. The answers was in Daniel chapter 6. I learned this lesson in one of the quiet time.

It is The Lord will help me if"

v4 – to be blameless in work

v10 – to seek the Lord always and do not rely on own wisdom

v20 – to serve the Lord with diligence

I have observed this teaching. There is no lack of shortcomings in me but I strive. The principles guide me in the last 20 years. I was invited in 1998 to give an account of the secret of my success by senior HA officers. I told them that it was the result of prayers. The Lord is faithful and merciful. He remembers our needs.

Training in Chemical Pathology

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Chemical pathologist should have up-to-date understanding of the biochemical basis of health and diseases and the application of the chemical pathology principles and concepts in the diagnosis and treatment of human diseases. We should be capable of tackling the appropriate usage, interpretation, benefits, accuracy, pitfalls, interferences, and limitations of laboratory tests for a safe clinical practice.

Scopes are wide, such as carbohydrates metabolism, serum lipids and lipoproteins, proteins in plasma and other body fluids, nutrition, electrolytes & acid base disturbances, renal & liver function, other gastrointestinal functions, bone metabolism, enzymology, endocrinology, metabolic aspects of neoplasia, clinical biochemistry at the extremes of age, inherited metabolic diseases, genetics, purine and uric acid metabolism, iron and porphyrin metabolism, toxicology and therapeutic drug monitoring, and near-patient testing.

We need to provide an effective consultative service, to direct a pathology service in clinical biochemistry, and to involve in research and development.

We need to equip well in both clinical and scientific skills. Training spends a minimum of six years. There are two parts of examination (membership and fellowship). For details, you can refer to www.hkcpath.org/



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HAEMATOLOGY PATHOLOGY

沒有選擇的選擇

高級程度會考放榜時，我唸的是生物學，考的成績不錯，便報讀香港大學醫科。那時只有香港大學有醫學院，而且只看公開試成績，不需要介紹信，也不用面試便可入讀，所以想也不想便報名。這期間有一段小插曲，因為成績不錯，一家人外出晚膳慶祝，在食肆裏樂也融融，那時沒有流動電話，所以我去櫃檯打電話通知友好我的考試成績。突然間，有三、四個兇神惡煞的人闖進來，大叫「打劫」，要眾人把手錶錢財放在桌上。可能因為我正在打電話，在門口把關的歹徒以為我要報警，便把刀架在我頸上。那時的歹徒還只是為財，不太暴戾，所以搶了我的手錶(及其他人的財物)，便逃之夭夭。那一次令我深切領會「生命在神手中」的道理。

內外科擦身而過

畢業後，選擇了在「少林寺」- 瑪麗醫院大學內外科 - 實習。那時沒有固定工時，也沒有超時「補水」補假。大學內科部要六日四call，我負責的病房是A2和E2，是擁有最多新舊症的病房，曾經一晚有七十多位病人，而且還要照顧血液及內分泌科的病人。不過記得我沒有一個晚上要「捱通宵」，因為能和同一病房工作的同學互相替補。雖然大學內科部駐院醫生很多臥虎藏龍，我們仍以在他們巡房前clerk了所有病人，寫下當日要做的化驗、檢查，需要的護理、藥物等工作為己任；更以他們巡房時「一項病歷也不會少，一點工作也不用加」為榮，那時沒有抽血員，但很多時在顧問醫生或教授巡房前已把需要的表格預備好或把血抽妥。也沒有電腦，要自己填寫化驗表格及結果，更常要當跑腿，去病理學部「追」報告，去X光部約期。那時抱着一個信念，就是「我是醫生，病人是我負責的。」

「你不把自己管理好，別人便要來管理你」，所以現今的醫生，要有仁心仁術仁管理的認知，醫病醫人醫制度的承擔。

相對內科部而言，外科部工作比較輕省，因為我有內科部工作的經驗，很多時外科病人的內科病患都懂得處理，也曉得有需要時找內科部同事會診。雖然實習的同學當夜班時要輪流在手術室工作，不能互相替補，但記得只有一次實在太累，便倒在病床上，醒來時發覺護士們已為我拉上布簾，讓我安睡。還有一次在手術室通宵達旦，回到病房時，駐院醫生已在巡房，唯有告訴他要回宿舍稍事梳洗，他一口答應，並且在顧問醫生巡房時為我開脫。我們就是這樣工作和生活，那段日子很快樂，不覺得辛苦。

實習後要找工作，也不感覺徬徨。我的志願是在威爾斯親王醫院大學內科部受訓，不過那時醫院剛落成，所以我那一屆醫學院同學都是第二年才獲受聘去工作。當時大學外科部教授召我入他的辦公室，問我有沒有興趣留下來，這可能是因為我曾被護士們選為其中一位最佳實習醫生；其實我的刀法如何不得而知，因為我連一條「腸仔」也沒有正式切過(皆因遇上一些很「熱心」的駐院醫生)。但因我不喜歡困在綠帽和面罩下和藏於冰冷的手術室中，所以沒有即時答應。我記得外科部一位高級講師在歡送我們的晚宴上曾問我想去那兒工作，有沒有需要幫忙，那時也是年少「懵懂」，沒有作出反應。實習後循例要來一次面試，當時其中一位面試官是精神科主任，他問我為甚麼不選擇精神科，他舉了一個例子，說如果我做內科醫生，不懂精神科，誤診一位思覺失調的病人，便會害人害己。還是年少氣盛的我便反唇相稽，說如果我是一個精神科醫生，漏診一位患有潰瘍併發性胃壁穿孔的精神病人，也會身陷囹圄。不知是否這個原因，後來我被分派到病理學部，是我的第四志願，那時病理學並不是熱門的行業。

顯微鏡下的世界

入行後你會發覺很多專科在醫學院裏根本沒有正式接觸，工作的情形跟學生時領會的也有很大出入。實習前總以為內科便是一切，病人有急症，可以立即處理妥當，是何等威風快樂！但在內科部實習後卻知道醫生絕不是萬能的，很多時更是無助。在外科部見過不少大國手的風采，手起刀落，直達患處，覺得做醫生的理當如此。不過也遇上只懂得講，不懂得做，對其他醫藥學科一竅不通的外科醫生。我和內外科擦肩而過，不知不覺間進了伊利沙伯醫院病理學部工作，那時香港公營醫院病理學的工作主要是解剖病理學。我起初也以為解剖病理學主要就是做屍體解剖，但伊利沙伯醫院病理學部的前



輩卻令我大開眼界，知道醫學院教的只是皮毛，學會疾病分類的重要，明白到臨床與化驗的關係。隨着醫療水平的提升，病理學已成為醫院的基礎服務。值得一提的是，相信前人很多是老饗，因為喜歡用食物來形容病變，例如nutmeg liver和sago spleen；現今講求精準纖細，這種情趣已不復見。

那時我的老板(可她絕不老，到現在還是一位很有風采的女士)知道我本意是當內科，便安排我去瑪麗醫院大學內科部受訓，以考取MRCP，到現在我仍覺得這一年臨床經驗十分有用，令我更了解病房工作的難處及需要；其後七個月在瑪麗醫院病理學部及三個月在香港紅十字會輸血服務中心工作，更被派去英國牛津作為期一年的院士試前培訓，因為香港當時還沒有這方面系統化的訓練，培訓人材缺乏，就這樣我便跟血液學結下不解之緣。屈指一算，我離開伊利沙伯醫院去其他地方受訓，足有兩年十月之久，這在現在是不可能的。但我的老板很有遠見，在伊利沙伯醫院先後培育了微生物學及血液學專科醫生；在我受訓期間，同事們也毫無怨言地分擔了我的工作。

我入行時血液學還是在襁褓階段，那時流式細胞儀(flow cytometry)還未普及，更枉論染色體檢測(conventional cytogenetics)或分子遺傳學(molecular genetics)；很多時做診斷要在顯微鏡下數數目，看顏色、形狀，辨大小、粗幼和樣式。與病理學其他專科(例如微生物學及化學病理學)相比，解剖病理學及血液學較倚靠顯微鏡和eyeballing，注重pattern recognition。顯微鏡下的世界色彩繽紛，既悅人眼目卻又令人神傷。悅目是因為病變模式五花八門，檢測用上不同的著色劑(包括熒光)；傷感是因為要診斷病人患上不治之症。除了顯微鏡下的世界，血液學和化學病理學一樣最先自動化，和機器與電腦結下不解之緣。病理學也是最早講求素質，主動參與認證計劃的專科。後

者是因為我們明白化驗室的工作量大、工序繁覆、經手人多，以致容易出錯，所以需要系統化管理和客觀考核。

九十年代初，為了配合伊利沙伯醫院發展自體骨髓移植，病理學部要為血癌病人提供染色體檢測服務，便派了一位醫務化驗師去瑪麗醫院病理學部作為期三個月的訓練，回來後她做我的師傅，過了一段時間我便撰寫第一份染色體檢測報告。那時我們就是這樣發展服務，但這並不代表我們對服務素質沒有要求，這兩年我們的染色體檢測服務都被proficiency test provider評為「十分好」。現在環境不同，很難再這樣做，不過對醫生的要求還是一樣，就是要有承擔及不畏難。現在香港癌症染色體檢測主要是血液學專科負責，這工作也頗欺人，在顯微鏡一千倍放大下要一絲不苟，簡直是「細眉細眼」，對那二十四條染色體既要pattern recognition，更要珠璣計較，黑白分明，有時一個案例要花上一整天去研究，少一點耐性也不行。血癌遺傳學在過去十年演變得很快，染色體檢測只是基礎，有人更把它形容為夕陽工業；分子細胞遺傳學(molecular cytogenetics or fluorescence in situ hybridization 熒光原位雜交)是迅速發展以及現代醫療必需提供的服務。分子遺傳學更是血癌診斷、分類、預後及標靶治療不可或缺的一環。

愛學習和學習愛

做醫生的要知所進退、視病猶親。

醫生是有福的人，不單是因為一定有工做，有好的收入，又受人尊重；而是因為醫生的工作最貼近人的需要，也最觸摸到人的喜與悲。做專科醫生，若果能在比較大的醫院工作，雖然工作量大，但是每天見的病症也多，工作趣味及刺激性也較大，如何選擇視乎個人的取向及機遇。我在伊利沙伯醫院學習了兩年解剖病理學才轉去血液學，一直以來有幸能跟一位很

出色的解剖病理學專家學習，引導我進入血液學的世界，更奠定了日後我對學術研究的興趣。身旁還有一些在其他醫院做血液學工作(臨床或化驗)的同學一起成長，互相砥礪。能得名師指導是我的榮幸，有可以倚賴的同袍是我的福氣，這卻是可遇而不可求。隨着醫學科技的發展，沒有一個醫生能夠完全掌握最新的資訊，所以我們要謙卑，明白自己的不足，努力改善，例如聽取其他專科同事的意見，多與本科同業交流，多唸書、多看症，要緊是有一顆謙虛受教的心，不要傲慢「充大頭」。到現在，我還是因為遇上特殊病例而雀躍驚喜(雖然實在不該為病而喜)，並走告同行與他們分享，我盼望到老還能保持這份愛學習、愛分享的心。

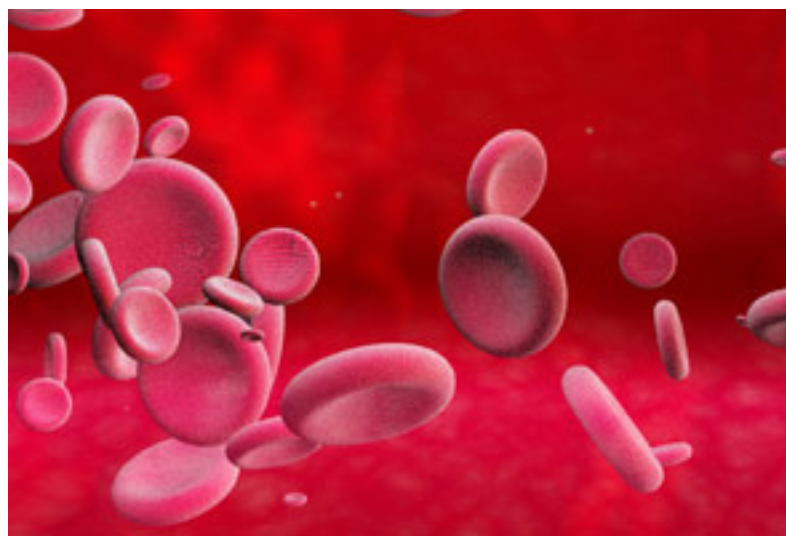
這是一個講權益、重制度的時代，我們要有最高工時，超時「補水」。但醫護工作是生命的服事，很難用「朝九晚五」去把它規範。雖然資源很多時和工作量不相符，但假若每個人能多走一步，我們的工作肯定會順暢一些，共事時也會快樂一點。化驗室認證強調文件控制，有一句名言就是：“Write what you do and do what you write.”，但有時這會被扭曲成不寫下的不做不想也不問，與「視病猶親」的理念相違背。試想一想，如果我們的父母或子女因病入院，我們一定希望醫生立刻趕來診治，也恨不得自己當抽血員及信差，即時把血液樣本送到化驗室。

我是半個管理人

醫生多不是理想的管理人才，尤其在這個講成本求效益的世代，因為醫生不懂管錢，特別是管別人的錢，而且生命是不能用金錢去衡量的。醫生也不懂管人，因為不是覺得自己是宇宙最強，就是怕處理人與人之間的矛盾；但醫院的資源總是有限，而人事這東西又不能拖。雖然這麼說，我卻是半個管理人。我認為管理，不在乎「管」，而在「理」——是傳理，是料理(「治大國若烹小鮮」)，因為「管」是

制度給你的權力，「理」卻是人與人之間合作的關係；所以能放手不管的就不管，該接手處理的要處理。這說來容易做時卻難，需要有洞察力、承擔感、不怕煩、不怕難、更要緊的是不怕「背黑鍋」。對人方面，小事要體諒、大事要分擔、凡事要包容；包容就是雖然不同心，但仍能協力。處事方面，大事要緩、小事要急；面對重大事故，要停一停、想一想、問一問，才能減少出錯。就像你要寫一封罵人的電郵，最好把它擱在一旁，反覆思量修改，甚至刪掉，不要動手指快過動腦筋。對於看似微小的事情，卻要快快處理，不單是怕積小成大，而是因為小事很多時是由下屬負責，你只要下一個決定或循例簽一個名；這些事不要拖，不要為他們添煩添亂。我常提醒自己及同事倘若下屬有事相求，必需即場回應「是」或「否」，若果一時沒有答案或作不出決定，要坦誠相告，並設下時限，把問題解決。

儘管有認為當管理的是failed clinician，但我覺得有一句話講得好，就是「你不把自己管理好，別人便要來管理你」，所以現今的醫生，要有仁心仁術仁管理的認知，醫病醫人醫制度的承擔。



血液學

曾聽說，每個人的心中有一個空間，所以歷代的人就不斷追求填補此空間的東西，而不論金錢、權力、地位、親情、愛情、友情……始終也未能填滿心中的空間。因為，唯有祂才是一生追求的。心靈的洞穴只有被耶穌基督才能充滿，成為基督精兵，負上大使命！人生變得充實，恩典滿溢。從此不因無夢想而做似鹹魚的人，也不再擔心當人生了無生趣時要玩魷魚遊戲 (squid game)。

傳道書3:11「神造萬物，各按其時成為美好，又將永生安置在世人心裏。」



與神相遇的時刻

相信活在現今世代的香港人也或多或少聽過基督教，甚至接觸過不少基督徒。至於我，回憶是小學時接觸耶穌，只因為就讀天主教學校！雖然聖經是必修科，可是當時自己沒有麻木地去信。其實在父神眼中沒有必要洗腦去迫人相信，祂是創造者，祂愛我們到底並給予我們自由選擇的意志。自由去選擇跟從俗世，還是跟從耶穌基督。每個人在祂眼中是獨特，有祂的計劃和時間表，而我隨著不斷的領受，到了大學時期正是對我最佳思考信仰，思考父神在你生命的創造我的目的，了解祂的旨意，感受基督在我身上的同在。

人生中面對不同的人 and 事，亦面對無數大小的抉擇，不過是巧合還是造物主的設計？那些人要好朋友，如何抉擇最好？在香港，夠分要選讀專業如醫科，否則擔心將來沒有份筍工？入了醫科要爭取好成績，否則增潤年或選修培訓 (enrichment year or elective training) 會無好選擇，甚至怕影響將來入不到理想的專科？每個抉擇有很多考量，也害怕錯誤的選擇帶來不理想的結果。

然而，此時此刻大家要相信神的恩典夠你用。詩篇139:13-16「我的肺腑是你所造的；我在母腹中，你已覆庇我。我要稱謝你，因我受造，奇妙可畏；你的作為奇妙，這是我心深知道的。我在暗中受造，在地的深處被聯絡；那時，我的形體並不向你隱藏。我未成形的體質，你的眼早已看見了；你所定的日子，我尚未度一日，你都寫在你的冊上了。」每次抉擇要向神祈禱交託，一位從你母腹已認識你，必然會引導你當行的路，未必一帆風順，但神同在並賜予恩典夠用。

與其在思考應該選擇什麼專科時，應該學習凡事以祈禱交託，盼望了解父神在你生命中的安排、感受聖靈的提醒，思考如何工作上榮耀神。在工作上見證信仰並不是易事，甚至其他人明知你的信仰會用各種手段去攻擊你，因為撒但不能攻擊神，所以會攻擊信神的人。曾經見證有些後輩工作上的弊病，當你只想循循誘導後輩勤力認真，竟然換來是被人誣蔑，那後輩甚至在即場上大吵大鬧。當刻我選擇沉默，那刻按捺自己的舌頭正因為的話語在腦中浮現 雅各書 3:8-10 「惟獨舌頭沒有人能制伏，是不止息的惡物，滿了害死人的毒氣。我們用舌頭頌讚那為主、為父的，又用舌頭咒詛那照着神形像被造的人。頌讚和咒詛從一個口裏出來！我的弟兄們，這是不應當的。」 因為即場對質，雖然道理在我但也很難在人前有好見證。聖經的話語就是良藥，之後有些同事看見抱不平，還甘願主動為我申冤作證。讓我深深體會神有祂的時間表，惡人如果不悔改是會自招惡果。

人絕對有軟弱的時候，所以職場上的基督徒互相結連，由神去堅立扶持各人，藉著彼此提醒激勵，令自己在日常工作好好榮耀父神。能做到嚴正公平、客觀評核、和撰寫每份報告也要倚靠不偏不倚的父神。每日把工作交上，用心用力做好本份，在職場上好好榮耀主，你的神。

追求智慧的醫生生涯

選擇醫生作終身職業就註定一生要不斷累積經驗和持續進修 (continuing education)。在我而言醫學院五六年的教導只是學習醫學的開端，啓導個人在行醫路上的進步。

從前我由急症科選擇到病理科，因為一心希望真正知道病人生病的原因，希望做到「快、靚、正」的診斷以協助病房醫生對病人有最合適的治療。沒有正確

的診斷，很難作出根本的治療，所以病理科被視為「醫生的醫生」 (Doctor's Doctor)，超過七成醫學上的決定也依賴化驗室的報告。如能夠了解真正的病因，自覺會是何等的滿足感。如能夠在醫療危急的情況以最快的速度去出檢測報告，例如：血癌、尤其急性前骨髓細胞性白血病 (acute promyelocytic leukaemia, AML-M3)、血栓性血小板減少性紫癜 (thrombotic thrombocytopenic purpura, TTP)，病人可以迅速有適切治療，可以大大增加成功治療率和生命率。血液是人重要的組織，血液科的診斷也是重要的一科吧！雖然從未看見病人的面貌，但深信因自己快速診斷以協助他/她活著，就是神的恩典，而自己也在當中以一己的知識去榮耀神。

不過漸漸會發現很多病未必可以解釋到，很多病亦未必有根本的治療，很多病人亦有很多原因未必能接受根本的治療。當你看到自己經驗和知識不足時，就從多方面去學習進步，向前輩請教、書本期刊尋找、各種座談會……可是世上仍然很多奇難雜症！人體的奧妙沒有人能自誇可以完全了解！之前自以為在某些緊急情況幫到手，可是在其他情況仍然感覺很無能為力。

看到醫學上的限制時人會想努力突破，在醫學倫理下為病人尋找更好的診斷。在公營醫療上的限制，會努力去思考有效運用現有的資源去發展，盡力幫助更多更多的病人。可是那種無力感就一直伴在左右，因為始終有很多限制是超乎你所想。

在此刻疲乏的心情時，會思考聖經：人的說明書。每當用新的產品也會看一看說明書，那麼突破人的限制也理應看一看創造者留給人的說明書吧！

箴言9:10「敬畏耶和華是智慧的開端，認識至聖者便是聰明。」

一個人有限制，而醫生只是一個受過醫學訓練的人，在某些情況下可以醫治病人，但不是所有情況下也做得到。生老病死是必然的。傳道書 3:1「凡事都有定期，天下萬務都有定時。」生死和醫治也有時，在過程中自己努力過，結果平常心面對。活在定時的時空，有很多沮喪的時候，然而把眼睛和心思此時應定睛在永恆之國度，會有不一樣的領悟。歌羅西書 3:23-24「無論做甚麼，都要從心裏做，像是給主做的，不是給人做的，因你們知道從主那裏必得着基業為賞賜；你們所事奉的乃是主基督。」再深思，其實我的煩惱並不獨有，每位醫者也應有經歷過的。感恩我在崗位上有一些基督徒醫生和同事互相彼此分享、彼此支持、彼此代禱。總不能一步登天，可能續步改善進步，並且明白不過肢體有不同的恩賜和作用，在整個團隊上互相幫助，務求病人得到最佳的治療。

羅馬書 12:4-6「正如我們一個身上有好些肢體，肢體也不都是一樣的用處。我們這許多人，在基督裏成為一身，互相聯絡作肢體，也是如此。按我們所得的恩賜，各有不同。或說預言，就當照着信心的程度說預言」所以用自己的知識和經驗去幫助眼前最需要你的病人，並以謙卑的心去與不同部門醫生和不同醫療人員合作討論去達到最佳的診斷，沒有一科是比其他的重要。盼主賜智慧予自己懂得爭取和運用以最少的資源去不斷發展科內重要的服務，使行業持續進步。

多年依然保留初心，無論何時也竭力為所遇到病人盡力服務。做到的原因只把眼睛定睛在祂上！人在最軟弱的時候就是神的恩典和工作架入並發揮之時候。傳道書 3:10及13「我見神叫世人勞苦，使他們在其中受經練。… 在他一切勞碌中享福，這也是神的恩賜。」我們要認識工作是神所賜的，而天天勞碌工作也是在事奉神的一種方式，亦是神的恩賜。

工作生活平衡

不論選擇什麼專科，醫生工作就是繁忙，尤其留在公營醫療體系的一群。日常工作除了處理臨牀和管理工作，在公營機構更堅負教育和訓練年青一代醫生和其他醫護人員，放工後仍要當值候命，空餘時間更要持續不斷進修，所以時間管理是十分重要，否則很難做到工作和生活平衡（work-life balance），更難以行醫為終身職業。

畢竟工作只是人生一部份，每個人背負著不同的身份（如女兒、姊妹、妻子、母親、朋友、教友…），當中有不同的責任和擔子、令人生活在各方面既付出又從中支取，這正正是生活，能活出平衡一切也是神的恩典，因為創造主是常與我們同在。每日每件事也是帶著感恩的心。

生活平平安安、工作順順利利時，不要驕傲以自己能力做到，因為沒有神的旨意，任憑個人的力量也不一定有好結果。就好像升職時，漸漸發覺有一些同伴即使同樣地努力，但是際遇不盡相同，最後升職的時間可能也會有分別。亦遇上一些同伴雖然起初升職比同期慢，但後來他的仕途卻有更好發展。更有一些同伴雖然在工作上沒有發展空間，但卻但神卻賜下美滿的家庭給他們。總言之每個人的道路也不盡相同但卻是父神的旨意，給予每一個人最好的，而大家一樣的就是仰望神、倚賴神、信靠神，把眼目定睛在神身上。



聖經很多經文好清楚教導我們要在不同生活崗位作好見證、互相為肢體。無論多忙碌，仍然是交託父神，不斷祈禱，因為必經歷奇異恩典的事。感恩我在不同的階段上，我在職場上和教會裡也有不同的基督徒鼓勵。當生活工作美滿時彼此為此感恩，相反生活工作患難時互相禱告交託。彼此學習靜默主前，學習順服，相信神必帶領與你一起渡過，因為我們是神最珍貴的創造物。

馬太福音 6:26「你們看那天上的飛鳥，也不種，也不收，也不積蓄在倉裏，你們的天父尚且養活牠。你們不比飛鳥貴重得多嗎？」

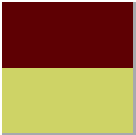
結語

當我被好朋友邀請這次的分享，心情很忐忑。一方面起感覺很榮幸，另一方面感覺有點壓力。最後我以謙卑的心向神禱告，總認為以聖經為本，用深刻的經文去面對問題正是當我遇到困難時的方法，希望在此與大家分享。因為自己實在有太多軟弱的地方，一切真善美也是父神眷顧，無條件的支援我去面對生活重擔。最後分享以下我喜歡的經文作結：

箴言 4:20-27「我兒，要留心聽我的言詞，側耳聽我的話語，都不可離你的眼目，要存記在你心中。因為得着它的，就得了生命，又得了醫全體的良藥。你要保守你心，勝過保守一切，因為一生的果效是由心發出。你要除掉邪僻的口，棄絕乖謬的嘴。你的眼目要向前正看；你的眼睛當向前直觀。要修平你腳下的路，堅定你一切的道。不可偏向左右；要使你的腳離開邪惡。」

我尤其喜歡 箴言4:23「你要保守你心，勝過保守一切，因為一生的果效是由心發出。」，以心待人，向神無限支取力量。不斷提醒自己不要偏離道路，求主除去自己眼中的樑木，為主作見證。基督徒本身也是罪人，但有耶穌的教導，與其他信徒在職場上彼此提醒和代禱去作一群基督的精兵，為主作見證。阿們。





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IMMUNOLOGY PATHOLOGY

在大多數市民的心目中，醫生的工作應該是巡房、做手術、為門診病人診症等。事實上，除此之外，還有這樣的一群醫生，他們不需要應診和做手術，卻是默默地躲在醫院的某一角落裏埋頭苦幹，他們究竟是所為何事呢？

相信大部份市民都不會察覺到我們的存在——病理科醫生。即使是作為醫生的我也是因為中途轉職才有機會深入認識目前這份工作。很多同事都會誤以為病理學專科醫生的工作比較清閒，沒有即時面對病人生與死的壓力或羨慕我們不用隨時候命。其實這完全是一個美麗的誤會。也許不同性格的人，用不同的方式，在不同的工作崗位，是可以產生不同效果的，這一切都視乎個人的工作熱誠和處事態度而已。經

過這些年的實踐，我相信一個出色的病理科醫生是應該具有外科醫生的效率、科學家的思維及藝術家的執着。舉例而言，以往撮寫病理報告相對地要花較長的時間，但現在我要求自己在此崗位上精益求精，運用外科醫生的處事方式，加快測試和縮減提交報告的時間；也運用科學研究精神來開發更準確的測試技術，再以藝術家追求完美的標準，改善質量，好讓臨床醫生能作出準確的診斷及為病人處方病人理想的治療。

香港大學醫學院院長李心平教授曾批評現今的醫生：缺乏仁心，對病人的關懷和耐性俱見不足；我很讚同也很憂慮。如果醫生和病人的關係，祇是純粹的服務提供者和服務購買者，那麼行醫彷彿再不是一個使命或榮耀，而只是淪為一場「金錢與勞力的交易」了。須知道，醫生很多決定都是性命攸關，稍有差池，足以遺害病人終身甚至賠掉病人寶貴的生命。確保病人能獲得安全妥善的診治，是每一個醫生必須有的責任。到底什麼是醫生呢？穿上白袍的權威？擁有可觀收入的？或只是一個專銜呢？

很喜歡張曉風的散文。其中有一篇寫給準醫科學生的《唸你們的名子》，當中提到「醫生」會成為他們畢業後的外號。我很認同她的看法：在成為一個醫者之前，第一個需要被醫治的，應該就是自己，這樣才能感同身受。正如耶穌來到世上，要跟世人一樣，必須遇見試探、飢餓、甚至死亡，才能醫治我們的罪和戰勝死亡。

請謹記病人好像我們的老師，他們給了我們信任、機會和時間去醫治他們的「病」，所以我們除了面對人的「病」外，更要照顧患病的「人」，他的「心」，以至他的家屬。試想想，病人常常真誠地道出自己背後的生命故事，對於作為陌生人的我們，這是何等的權利和信任！非以役人，乃役於人，讓我們一起用良心、愛心去看待病人吧！我們獲得的的祝福和喜悅，定必超越一切物質上的回報的。

TRAINING IN IMMUNOLOGY

An immunopathologist should have expertise in the clinical laboratory and function as a director in service of clinical immunology and tissue typing. We need to advise clinicians about the investigation and management of patients with immunological disorders.

During the six year of training, one year of post-registration experience in clinical medicine (preferably internal medicine or paediatrics) is a required part of the basic training. Trainees are also required to undertake at least one year of rotation in other pathology specialties, which include a minimum of 3 months in haematology. Research experience is also valued.

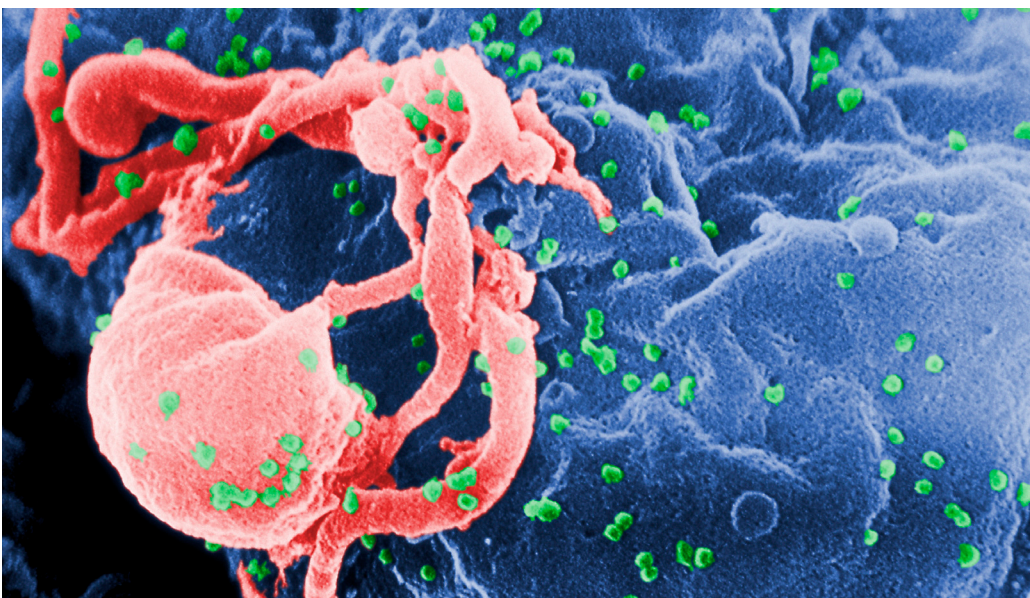
In basic training, areas in serology, cellular immunology, tissue typing, molecular pathology and immunohaematology will be involved. Trainees also need to learn and equip with the analytical parts with methodologies and instrumentation, immunofluorescence and immuno-precipitation and relevant result interpretation and reporting. As pathologist, we need to conduct test development in response to clinical demands and involve laboratory management. Overseas training is possible.

In higher training, trainees need to equip well in clinical skills, by providing consultation, regularly attending outpatient sessions in relevant subspecialties (e.g. rheumatology), and ward rounds (e.g. AIDS, paediatric infectious diseases) and clinico-pathological meetings.

EXAMINATIONS IN IMMUNOLOGY

There are Membership Examination and Fellowship assessment. The former includes two papers (MCQ and SAQ and essay questions), a practical examination testing the skill of laboratory procedures and a viva examination. The Fellowship assessment includes also a viva examination, a casebook collection of at least 10 cases and any one of dissertation / PhD/MD thesis/ minimum of 5 publications.

For details, you can refer to www.hkcpath.org/





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CLINICAL MICROBIOLOGY & INFECTION PATHOLOGY

Interview with Prof KY Yuen

Q1 : What types of candidate are you looking for in Microbiology?

- HK does not need microbiologists but clinical microbiologists are the most in need.
- Around 20 to 30 years ago many microbiologists only stayed in laboratories doing gram stains or cultures alone. But this should not be the case. Doctors hiding in the laboratories were a waste of resource. Now, we are looking for candidates who have a few years of experience in clinical medicine, and also have strong interest in laboratory testing. Someone can do both well in clinical and scientific areas.

- The candidate would not be suitable if he/she doesn't like to see patients or to perform laboratory testing.
- These people have multi-tasking skills and they are special.
- Actually, the above qualities do not only apply to microbiology but also in all pathology disciplines.

Q2: How can a fresh graduate know whether he/she has the skills described by you?

- You would not be a good surgeon if you have problems in tying shoe laces. You would know your clinical skills level when you were working in the wards during student time.

- Would you be worried to see a group of laboratory tests/ gram stains? How do you feel about dealing with numerical values? Are you interested in p values/ standard deviations/ statistical analysis? These questions can be used as a guide.

Q3: What's the actual life of being a clinical microbiologist?

- Some candidates apply for microbiology purely in search for a comfortable job. However, this mind set is not correct, because it is not a simple job. Candidates who left had found that the job was not as easy as they originally thought. Working hour is nearly 8am to 8pm daily. And quite usually you need to work at home. Without being needed on-call doesn't mean the work is light. In our unit you need to report cases every lunch hour and in the grand round weekly.
- Some of the microbiologists do not take the initiative to improve. The main reason is that they don't want to be exposed. I would ask my colleagues to go to the wards, see patients and also make



clinical entries. Why some microbiologists cannot be well-trained? The main reason is not being exposed. Some medical students learnt poorly in school but their real learning only started when they work as medical officers. Being medical students you would not be sued and therefore students do not take on the responsibility during training. We can only learn properly when there is the risk of being sued. And the risk of being sued starts when you make clinical entries. Some may think that being microbiologists is a low risk profession and seldom being sued. However, huge number of resignations occurred in the microbiology field in the past.

Q4: How do HK clinical microbiologists contribute internationally?

- Sometimes, WHO would invite HK clinical microbiologists to talk in seminars about management of outbreaks or infectious diseases. Also international meetings may invite HK clinical microbiologists to share experience in their specialized fields or to write publications.

Q5. What are the differences between microbiologists in different countries?

- In USA, the title is ID (Infectious Disease) physicians. They do not have laboratories and only deal with clinical work.
- The system in UK is similar to HK. They manage patients in collaboration with the physicians in charge.

Q6. What are the difference in having microbiology training in HA hospitals and private hospitals?

- The spectrum of coverage when training in private hospital may not be comprehensive. For example, you would seldom see drug overdose cases in private hospitals. It is important for young doctors to get a wide exposure in their first 2-3 years.
- There are advantages for private hospitals. Workup is complete when financial support is sufficient. There' s no stones unturned for a case.

- Private hospital is a good place to be trained but not enough. Acute hospital training is a must. And there are different strong areas in each teaching hospital. Nothing is absolute. I myself was trained in UCH and I think I am a reasonably well trained doctor.

Q7. What will be the new challenges young generations in microbiology field may face in future?

- I always encourage my junior staff to try to walk on new pathway and to track unknown paths. I believe in future the direction would point to being a clinical microbiological immunologist.

- In future dealing with infections, apart from giving one drug to kill the bugs, there would be another drug to modulate your immune system. There will be lots of immunomodulations and immunological manipulations. You have to have the vision and courage to walk on it – or else you cannot bring the specialty a step forward.

Q8. What is the training pathway for clinical microbiologists?

- It mainly follows the system in UK. It is best to do two years of medicine and obtain MRCP first.

- After five years, you can sit for the UK examination, which is tough and challenging. But also it's good as you would gain confidence once you have passed the exam.

Q9. Are there any subspecialties training in Microbiology?

- There are no formal subdivisions but there are microbiologists

doing more in areas which they are interested in. Basic virology/bacteriology should be familiar to all microbiologists. But parasitology or mycology is specialized field. There are no special exams for subspecialties. Mainly the subspecialty trend will be reflected by the topic of your publications.

Q10. Do you have any general advice to medical students or interns?

- You have to learn how to be a person at the first start.

- As you know that our curriculum is going to be changed and there's one more year in university years. I believe the following activities will be helpful to equip ourselves:

1. To have physical training e.g. outward bound training
2. To follow a young patient with expected short life expectancy – visit him/her on weekly basis till he/she died and then attended his/her funeral. And also visit his/her family once after the funeral.
3. To receive psychotherapy and counseling to understand and explore our own self.
4. To outreach to a remote area to be volunteers for at least 1-2 months
5. To have the best training in medicine: Go to a ward. Imagine that you can have chance to visit a private ward with a single room, you can follow up a patient from morning to night, record all things happened to the patient and discuss with a senior physician. The physician would discuss and explain why those changes

would occur to the patient. In this sense, I believe that you can learn medicine better.

Changes need to be made by you – as the young generation of the time, do bring in new changes and suggestion to the medical education, and give initiative to the teachers for change and improvement.

In my impression, young doctors tend to have low self-reflection ability. Why? The difficulties you are facing are totally different from our generation. We went through difficult moments when we were young. We only have a few pennies for a day, including transport and meals. Dr WM Kou and I were very thin around 95 pounds when we graduated. You can see the hardship we encountered. These make our spirit strong. Our generation faced a lot of hardship and sufferings in the society. Lots of baggers on the streets, policemen were getting bribes, lots of people died on streets. Most people died in 30-40s. We realize deeply that life is so short and time cannot be wasted. At that time, the pop song themes were mostly about separation. Nowadays pop songs are about love rela-

tionships. Our acumen is high. We live alertly in the “war” mode since our childhood to survive. Despite life expectancy is longer, if you don’ t find the things which make you realize life is short, you would waste your time. You have to find your own way and no one can give you the answer.

In our times no one would sue doctors. But this is not the case now. Now you are being served by your parents or domestic helpers. It is two different worlds. We cannot blame you. If you put me into your times, I would have been the same as you. This could not make you to be a good doctor. You have to find your own way and road. It is vital for you to learn individually and to communicate effectively with others.

There are lots of politics in any workplace – mainly due to immaturity of people. The conflicts originate from comparison. If there is no sportsmanship, conflicts and arguments occurred. One needs lots of self reflection so that one can know how to handle one’ s emotions and stress.

According to my experience, trainees having poor performance in their work mainly due to three reasons:

1. Not dealing their relationship problem well. One then becomes moody and has poor performance.
2. Too occupied by investments e.g. stock markets
3. Poor health: no taking good care of self

Interviewed by Dr Yung Ching-ching and Dr Mak Miu





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PRIVATE PRACTICE CARDIOLOGIST

A Christian Cardiologist

'In Him we were also chosen, having been predestined according to the plan of him who works out everything in conformity with the purpose of his will.'
(Ephesians 1:11)

"I urge you to live a life worthy of the calling you have received."
(Ephesians 4:1)

We are living in the world with a purpose, we need to find that purpose while we are choosing a specialty as our lifelong career. We are not just following the secular world view of struggling for money, power, fame, knowledge, academic achievement, stability, marriage, family, comfort etc.

In a book "The other six days" written by R. Paul Stevens which is about vocation, work and ministry in biblical perspective, he mentioned that occupations have meaning in something larger than personal fulfillment. Vocation does not equal to occupation, it is a calling from God with a purpose. We start with being called to Someone before we are called to do something. It is not something we choose, like a career. We are chosen. The Latin roots of the word 'vocation', vocatio and voco, mean simply to be called or to have a calling. If we substitute the word 'vocation' or 'work' with 'calling', it will immediately invite the question, 'Who called?' The loss of meaning of 'calling' in 'vocation' in the modern and postmodern world is further indicated by the fact that almost the only people who speak of being 'called by God' are 'full-time' missionaries and pastors. However, we must have the conviction that we are called by God to be a doctor and not by our own choice.

We live in a post-vocational age (loss of vocation: unemployment, consumption, creative leisure and worker alienation, secularism). We lapse into debilitating alternatives: fatalism (doing what is required by 'the forces' and 'the powers'); luck (which denies purposefulness in life and reduces our life to a bundle of accidents); karma (which ties performance to future rewards); nihilism (which denies that there is any good end to which the travail of history might lead); and, the most common alternative today, self-actualization (in which we invent the meaning and purpose of our lives, making us magicians). The biblical doctrine of vocation proposes that the whole of our lives finds meaning in relation to the summons of a good God.





‘Commit your way to the Lord; trust in him, and he will do this.’ (Psalm 37:5)

‘... Work with your hands, just as we told you, so that your daily life may win the respect of outsiders and so that you will not be dependent on anybody’

(1 Thessalonians 4:11b-12)

In choosing my vocation, I commit my life to God and being a witness of God to my patients and colleagues.

I was graduated in 1984 and had six months of internship in the University Surgical Unit in Queen Mary Hospital followed by another six months of internship in the Department of Medicine in the Queen Elizabeth Hospital. I joined the Department of Medicine in Queen Elizabeth Hospital in 1986 as a medical officer after working in Castle Peak Hospital as a psychiatrist for eight months as waiting for vacancy in the specialty of medicine.

The experience of working in surgery in Queen Mary Hospital and medicine in Queen Elizabeth Hospital bear a great reason for me to choose internal medicine as my permanent career. I think that a good first experience will guide one to that specialty. Especially for me to work in these two specialties for six months which gave me chance to know these two specialties more deeply. Moreover, I did not have the chance to work in other specialties which decreased my interest in other specialties. As I worked in general surgery and general medicine in my internship, I can appreciate that both specialty view a person in a holistic manner. Moreover both specialties also follow a person from early adulthood to end of life which gives me the opportunity to follow a person’s cohort or longitudinal life. The experience of my patients also enrich my life. These two fields also require more comprehensive knowledge and need a broad and open mind to view a person as a whole. This also suits my personality as I like to have a more holistic picture of a person. I choose general medicine rather than general surgery because I had a better self-fulfillment during my internship in medicine. I can find the excitement of high technology of operating a patient by the seniors and the satisfaction of curing a patient by surgical treatment. However, I prefer to accompany a patient with medical illness which is not curable but need long term support both in medical, psychological and also spiritual aspect. As a physician, I can give patients hope, not just for treatment or cure, but a promise for accompaniment along the road of suffering and weakness and even the road to death.

The hymn "God has not promised" has reminded my role of bringing hope, support and care to my patients.

1. God hath not promised skies always blue,

Flower-strewn pathways all our lives through;

God hath not promised sun without rain,
Joy without sorrow, peace without pain.

But God hath promised strength for the day,
rest for the labor, light for the way,

Grace for the trials, help from above,
Unfailing sympathy, undying love.

2. God hath not promised we shall not know,
Toil and temptation, trouble and woe;

He hath not told us we shall not bear,
Many a burden, many a care.

But God hath promised strength for the day,
rest for the labor, light for the way,

Grace for the trials, help from above,
Unfailing sympathy, undying love.

3. God hath not promised smooth roads and wide,

Swift, easy travel, needing no guide;

Never a mountain, rocky and steep, Never
a river, turbid and deep.

But God hath promised strength for the day,
rest for the labor, light for the way,

Grace for the trials, help from above,
Unfailing sympathy, undying love.

Personality will also determine the choice of lifelong career. As many medical diseases are chronic and incurable and sometimes deteriorating and debilitating, a physician needs to accept human limitation and insufficiency. Practicing in medicine needs to have a caring heart and compassion. A physician should not avoid to building up relationship with people.

Cardiology is one subspecialty in internal medicine. The technology in cardiology has developed very fast recently. Actually, cardiology can be divided into non-invasive and invasive stream. The non-invasive stream includes investigations such as echocardiogram, computerized tomography scan, magnetic resonance imaging, radioisotope scanning, preventive cardiology and rehabilitation cardiology. The invasive stream includes coronary artery and peripheral artery intervention, structural heart intervention, arrhythmia including pacing, internal defibrillator, electrophysiology study and radiofrequency ablation.

Cardiology is different from other specialties in medicine as cardiology has fast growing technology. Cardiology has interventions which need a surgical mind of quick and accurate decision. The eyes and hands need a high skill. Ability is a crucial factor in choosing cardiology.

Cardiology has a high potential of development in Hong Kong, nearly all hospitals in Hong Kong have catheterization laboratories and can do intervention independently. All hospitals have good echocardiogram machines. The training is adequate in Hong Kong. The patient load is very large and the people with cardiac diseases are in the rising trend. Cardiology field also has very good regular yearly international conferences in Europe and the USA which provide good continued medical education. Research in the field of cardiology is also very fast growing with a lot of advancement in management of patients.



I chose cardiology because there are a lot of new technologies to learn and the new technology for intervention is rapidly growing. More patients with cardiac diseases can be cured by intervention. As compare to other medical subspecialties, cardiac patients have fewer chronic complications and are less debilitating. However, as medicines and intervention techniques have advanced markedly, the life of cardiac patients are prolonged. More cardiac patients will have intractable debilitating conditions such as intractable heart failure. Cardiologists have the role of journeying with the patients and relatives through the chronic, long suffering road and bringing them support, encouragement, compassion and hope.

Cardiology has tremendous growth in the last ten years. I can highlight some of the advancement especially in the field of intervention in terms of minimally invasive surgery. Echocardiogram has added modality such as three dimensional real time reconstruction, strain and speckle tracking. For the diagnosis of unknown syncope or suspected arrhythmia, there is implantable loop recorder (insertable cardiac monitor). In the field of structural heart disease such as valve surgery, we can have percutaneous intervention such as transcatheter aortic valve implantation (TAVI) for aortic stenosis, Mitraclip (transcatheter mitral valve repair) for mitral regurgitation, TriClip

(transcatheter tricuspid valve repair) for tricuspid regurgitation. Furthermore, left atrial appendage occlusion device implantation provides an alternative treatment of stroke prophylaxis in patients with atrial fibrillation. Transesophageal echocardiography with real time three dimensional reconstruction offers great support of intervention of structural heart disease. In percutaneous coronary artery intervention, there are new stents and ancillary new device such as intravascular ultrasound, optical computerized tomography and flow wire for fractional flow reserve improves the success rate and decrease the recurrence rate of the procedure. There is Micra pacemakers (leadless and MRI safe) by percutaneous implantation for the treatment of bradyarrhythmia. There is also subcutaneous leadless implantable cardioverter-defibrillator (S-ICD) for treatment of arrhythmia. In the field of treatment of arrhythmia, catheter ablation such as radiofrequency or cryoablation is extended to the treatment of atrial flutter / fibrillation and ventricular arrhythmia in addition to supraventricular tachycardia. Finally, a lot of new medications such as heart failure treatment, anti-arrhythmics, anti-platelet agents and novel oral anti-coagulants provide longevity and better quality of life of patients.

As a preparation for the choosing cardiology as lifelong career, try to gain as much practical experience in cardiology as possible, no matter in medical student days or during internship training. Try your best to be involved and engaged in some interventional procedures so that you may know more about the actual performance of the interventional techniques. Try to think about your personality whether you can stand the stress of rapid changing nature of cardiac patients and the need to make quick and accurate decisions during interventional procedures. Also try to think about your ability of performing interventional procedures especially good visual acuity and stable hands.

Cardiology is a specialty suitable for long term private practice as the patient load is high and cardiologist can practice independently. I left Hospital Authority in 1996 and joined a private hospital. I am now working with some cardiology partners in a private clinic since 2008. After I worked in a private setting, it gives me more flexibility for preparation of my voluntary service inside and outside Hong Kong. Flexibility of working hours facilitate me to engage in further education in other areas so that I am better equipped and prepared for voluntary services.

Private practice can be achieved in three ways - leaving Hospital Authority hospitals and joining a private hospital, starting a solo practice or working with partners, either cardiologists or other specialists. Working in a private hospital is a good first stepping stone after leaving public hospital as the change is not so marked, the necessary adjustment is less and there are still colleagues working together so that sharing of experience and knowledge is still possible. The feeling of loneliness is less. Moreover, the income is steadier. However, the working hours are longer and night call is usually required by the private hospital, so that private, social and family life is affected significantly. Working as solo practice is another extreme, it needs to set up a clinic so that administrative work is necessary such as managing nursing staff, keeping stock of medicines, set up of the clinic, control of budget such as rent and financial management. However, it is the most flexible way of time management and more autonomous to arrange private business such as voluntary work and services, hobbies, further education in other areas other than medical field, family time. Another mode of private practice is to build up partnership with other colleagues. It has the advantage that all partners can share common commodities such as drugs, nurses, equipment and facilities so that it is more cost-effective. It also has the advantages that colleagues can cover both outpatients and inpatients care during vacation leave. The



potential disadvantage is that it needs to cooperate with other colleagues so that it needs wisdom to deal with different opinions in order to achieve common consensus. It also needs a more gentle personality in order to maintain harmony among the partners despite everyone has different perspectives and opinions.

No matter which type of private practice, one need to be mature in medical knowledge and techniques, communication skills, independent personality with full training in Hospital Authority hospital as no formal training can be arranged in a private setting except some tailored made individual training sessions can be arranged with Hospital Authority hospital by a friendly basis. Working in a private setting needs a more sociable personality, knowing how to communicate with patients as the patients and family members are expecting medical services more than a Hospital Authority hospital. Private practice also needs to build up good relationship with private hospitals and other colleagues in order to increase the network of referrals.

According to Paul Stevens, everyone has three levels of vocational calling – the human, Christian and personal vocation. As a metaphor, a wedding cake has a large base (the human vocation), a smaller layer built upon it (the Christian vocation) and still smaller layer at the top (the personal vocation). They are interrelated, each building on the other.

‘Nevertheless, each one should retain the place in life that the Lord assigned to him and to which God has called him’ (1Cor. 7:17).

Vocational guidance is not discerning our ‘call’ but, in the context of our call to discipleship, holiness and service, discerning the guidance of God in our lives and learning how to live in every dimension to please him.

The article is revised after two year period of the COVID-19 pandemics which has altered the tradition of in-hospital patient management especially the limitation of visits by family members. This pandemics has bombarded the medical profession not just in the scientific basis of management but also in the philosophical and theological reflection of life. Before ending of this review, I would like to discuss about the initial objective of the medical profession about the holistic care of patients. Health, according to the World Health Organization (WHO), is “a state of complete physical mental and social well-being and not merely the absence of disease and infirmity.” The WHO defines Palliative Care as an approach that improves the quality of life of patients and their families facing the problems associated with life threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual. In providing the holistic care in all aspects, doctors need to team up with other paramedical personnel such as hospital chaplains. During the pandemic, hospital chaplains had encountered difficulty in visiting patients due to the isolation policy of hospitals. The persons who can give psychological and spiritual supports are those frontline medical carers including doctors, nurses, allied health workers such as health care assistants, physiotherapists, occupational therapists and speech therapists. As doctors, we can spend one more minute, walk an extra mile to show our care and compassion in addition of providing medical care to our patients and their relatives as demonstrated by the following quotes from mother Teresa.

“Not all of us can do great things, but we can do small things with great love.”

“Faith in action is love and love in action is service.”

Lastly, I like to express my role as a cardiologist in accountability to my patients and my colleagues by the following song and let this song be a prayer as mutual encouragement and support in the Christian medical profession. I also pray that being Christian doctors, we do the right things and do the things right at the right time and in the right place, through our works, we give praise to God’s glorious grace with our testimony.

Bring your healing to the Nations

May we be a people, a people of integrity. Being who we say we are, and doing what we say.

May we be a people, a people of humility. Reconciled to God and man, in Jesus’ Name.

Bring your healing to the nation, through our lives and through our hands.

Bring your healing to the nation, Dear Lord, Change our lives and change our land.

May we be a people, a people mending broken lives. Giving hope to broken world, by the grace of God.

May we be a people, a people serving God and man. Bringing love and dignity, in Jesus’ Name.

Bring your healing to the nation, through our lives and through our hands.

Bring your healing to the nation, Dear Lord, Change our lives and change our land.

May we be a people, a people of sincerity. Unafraid and unashamed, speaking truth in love.

May we be a people, a people of fidelity. Trusting God for miracle, in Jesus’ Name.

Bring your healing to the nation, through our lives and through our hands.

Bring your healing to the nation, Dear Lord, Change our lives and change our land.

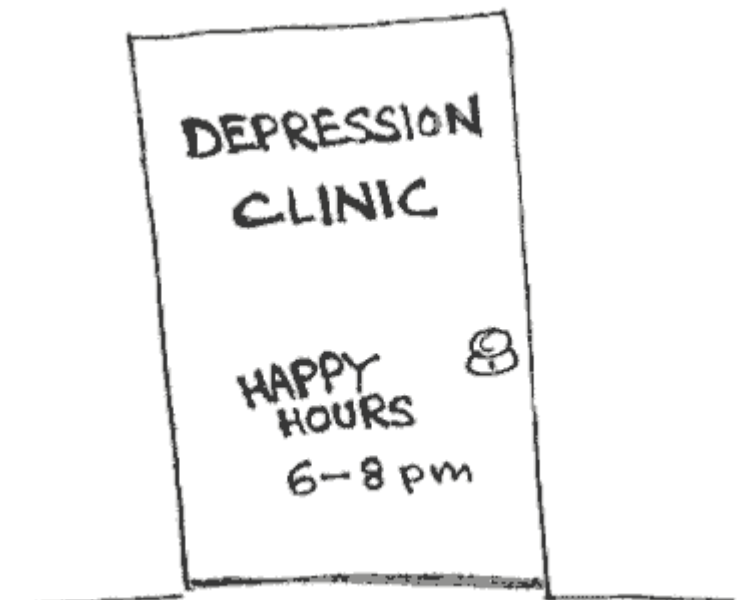
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精神科 PSYCHIATRY

Psychiatry is defined in Oxford Dictionaries as the study and treatment of mental illness. However, it is interesting to note that the term “mental illness” in fact embraces a very large range of disorders and is not limited to disorder of psychological causes. Disorders in the widely used ICD-10 classification of mental and behavioural disorders include delirium, dementia, harmful use of psychoactive substance, schizophrenia, mood disorders, somatoform disorders, eating disorders, sexual dysfunction, personality disorder and disorders of psychological development. As other branches of clinical medicine, treatment options in psychiatry are expanding, which include psychological interventions, use of psychotropic drugs, and brain stimulation methods such as electroconvulsive therapy. Most

psychiatrists are working as general adult psychiatrist in different settings, including both general and psychiatric hospitals. Other major subspecialties include child and adolescent psychiatry, old age psychiatry, rehabilitation and social psychiatry, substance abuse and addiction psychiatry, psychotherapy, intellectual disability psychiatry as well as forensic psychiatry.

If you decide to be a specialist in psychiatry in Hong Kong, you should apply for admission to the training scheme of the Hong Kong College of Psychiatrists and get an offer for a resident trainee post in the Hospital Authority. After fulfilling the requirements specified in the training scheme, the trainee can join the professional examinations (Part I, Part II and Part III) organized by the Hong Kong College of Psychiatrists. The resident trainee will begin with around 3 years of general psychiatric professional training. After passing the Part I and Part II examination, the trainee will be promoted to be a senior trainee, who will receive higher psychiatric professional training which should not be less than three years. During the training, the trainees will be required to work in different subspecialties and hospitals to gain more experience. For the final (Part III) professional examination, the trainee will be required to conduct a research project and submit a dissertation.



The application procedure for admission to the training scheme may vary each year, the reader of this article should be aware of the latest situation and official announcement from Hospital Authority. However, the real-life experience of a Christian doctor, Dr Wong, may give the reader some hints on the preparatory work. Dr Wong successfully got a resident trainee post in psychiatry in July 2011. In December 2010, when Dr Wong was a house officer, she decided to be a future psychiatrist. She prepared application letters and curriculum vitae, which were mailed to psychiatric units of all clusters. Dr Wong was then asked by some units to attend job interview or have one-day clinical attachment. Around February 2011, as other house officers, she was asked by the Hospital Authority to state her choice of specialty for resident training post. Dr Wong chose psychiatry as her first choice. She was subsequently invited to attend a central selection interview in March 2011, where the interviewers were representatives of psychiatric units of all clusters. During the interview, Dr Wong explained her reason for choosing psychiatry. After the central selection interview, Dr Wong was informed about the selection result and she selected a psychiatric unit where she preferred to start the training. The allocation of her trainee post was based on her preference and her rank in the central selection interview.

“Why choose psychiatry?” is an important question for new doctors, whether it is asked during the interview or not. The doctor should be honest to oneself on this issue, and have his or her own answer before choosing psychiatry as one’s first choice. A universally and politically correct answer may not exist. However, specialty training is a long term commitment, the doctor should understand more about the specialty before committing to it. You can read books about psychiatry. Another useful resources are the websites of the Hong Kong College of Psychiatrists and the Royal College of Psychiatrists.

“What makes a good psychiatrist?” is an interesting question. The wide range of disorders and treatment options in psychiatry suggest that there should be different types of good psychiatrists. In fact, there are many good psychiatrists in Hong Kong and they are different in personality or lifestyle. However, psychiatry is a medical specialty. Good doctor-patient relationship and communication skills are essential. Psychiatrists are often required to provide treatment or intervention together with other health professionals, including nursing staff, occupational therapist, medical social worker. The ability to work with others as a team is also important.

Mental illnesses stem from a complex and mysterious interaction between the brain, mind, gene and environment. It is a very challenging speciality because there are many things in our brain that we do not understand. But it is also a very interesting and rewarding speciality, especially for a Christian doctor. The functioning of our brain is so sophisticated that a Christian can appreciate the grace and miraculous work of God on us. Many psychiatric patients are socially excluded and disadvantaged. A devoted and compassionate psychiatrist could really make a difference to their life and help them to regain meaning and hope for their future.

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放射科 RADIOLOGY

Radiology – Unexpected Market of Harvest

It is all His blessing!

I am a class 94 graduate. After one year of internship, I joined the emergency department and worked there for almost two years. After equipped with basic skills of handling emergency patients, I prayed for the change in my career. I have had interest in radiology since my undergraduate clinical period. I enjoy photography and I love imaging. I admired the radiologists and the way they could use their “X-ray” eyes to diagnose disease. Thank God for granting me the opportunity to pursue radiology as my career.

Last but not least, I would like to share a Bible verse, “Take your sickle and reap, because the time to reap has come, for the harvest of the earth is ripe.” Revelation 14:15. Let’s work together and do the harvest in our “market” .

All radiology trainees are required to enroll in the training program under the Hong Kong College of Radiologists. At least one year of post-registration recognized clinical experience outside radiology is necessary before commencement of training. Basic training is usually about three years and the trainee must acquire the Fellowship of Royal College of Radiologists (FRCR) before going onto the two years of higher training. At least one of the followings, Cardiovascular Imaging, Gastrointestinal & Hepatobiliary Radiology, Head & Neck Radiology, Musculoskeletal Radiology, Neuroradiology, Obstetrics & Gynaecology Radiology, Paediatric Radiology, Thoracic Radiology and Vascular & Interventional Radiology should be selected as the major subspecialty in higher training. After that, trainees will be qualified to sit the Exit Assessment for the award of the Fellowship of

Hong Kong College of Radiologists (FHKCR) and the Fellowship of Hong Kong Academy of Medicine (FHKAM). For the training details, please go to <http://www.hkcr.org/>.

As a radiologist, we should always have a 3D mindset from 2D images. Nevertheless, there are varieties of sophisticated imaging techniques to help us in the diagnosis, like ultrasonography, fluoroscopic imaging, computer tomography, magnetic resonance imaging, radionuclide imaging and the fusion images of different modalities. In my hospital, there are ten sessions in a week. In general, there are two CT sessions, one MRI session, one reporting, one interventional radiology session, one fluoroscopic imaging session, two US sessions and one radionuclide imaging session. One to two free sessions are available for administrative work or research. Overtime work is expected occasionally for urgent reporting.

From anatomical imaging to functional imaging, and from macroscopic body imaging to molecular imaging, the development in radiology is like a speedy bumblebee! We should be eager to learn and keep up with the pace of the advanced technology. Furthermore, with the application of interventional radiology in the field of minimally invasive surgery, we are not only diagnostic radiologists but also interventional radiologists. Needless to mention, good hand-eye coordination is very desirable. We provide off-site on call services, for urgent diagnostic imaging consultation and emergency interventional radiology. We are anatomists as well as friends of other medical disciplines. We have to acquire knowledge of other specialties so that we can communicate with other clinicians. We are working as a team for the benefit of patients.

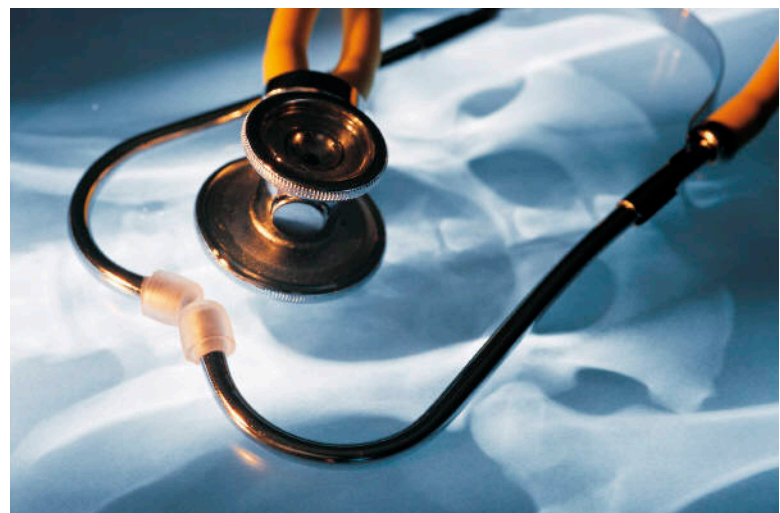


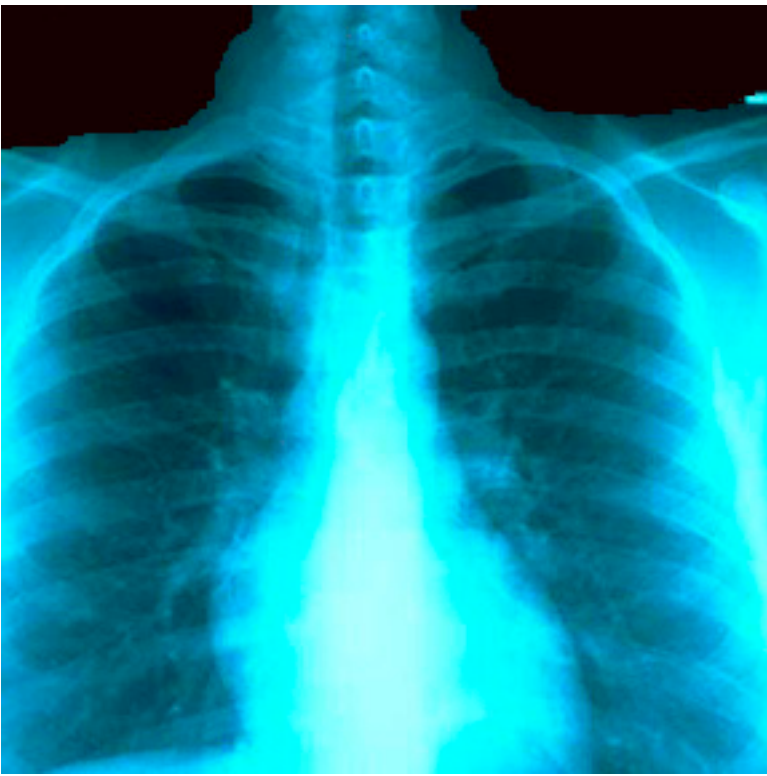
Though there are bumps and hurdles through my training after I became a doctor, I thank God for leading and guiding me through to become a specialist. I am now a radiologist with special interest in interventional radiology and radionuclide imaging. However, I lost my passion and vision after finishing all the professional examinations. Hospital life was only a routine to me.

Thank God for His guidance, and after reading the book of "Purpose Driven Life", I did change. I cherish the chance to talk with patients, particular those require trans-catheter chemotherapy. Before each intervention, I have to explain the procedure and its complications to the patients, and try to understand and relieve their anxiety. This is the rapport as well as building up of doctor patient relationship.

Every time, I pray for the procedure for a peaceful outcome. Mishaps do occur, as some interventions might end with failure or complication. I understand that I am not a "superman" but only a servant of Lord. What I can do is casting my burden to Him, and hope for the best result of the procedure for my patients. I usually do my best to follow the patients up. I would like to introduce Jesus to them, especially those with fear. To my astonishment, most of them do not reject and some of them even have interest to know more about Christianity. Maybe, God use me to give peace to those with sorrow, hopelessness, anxiety and poor in spirit.

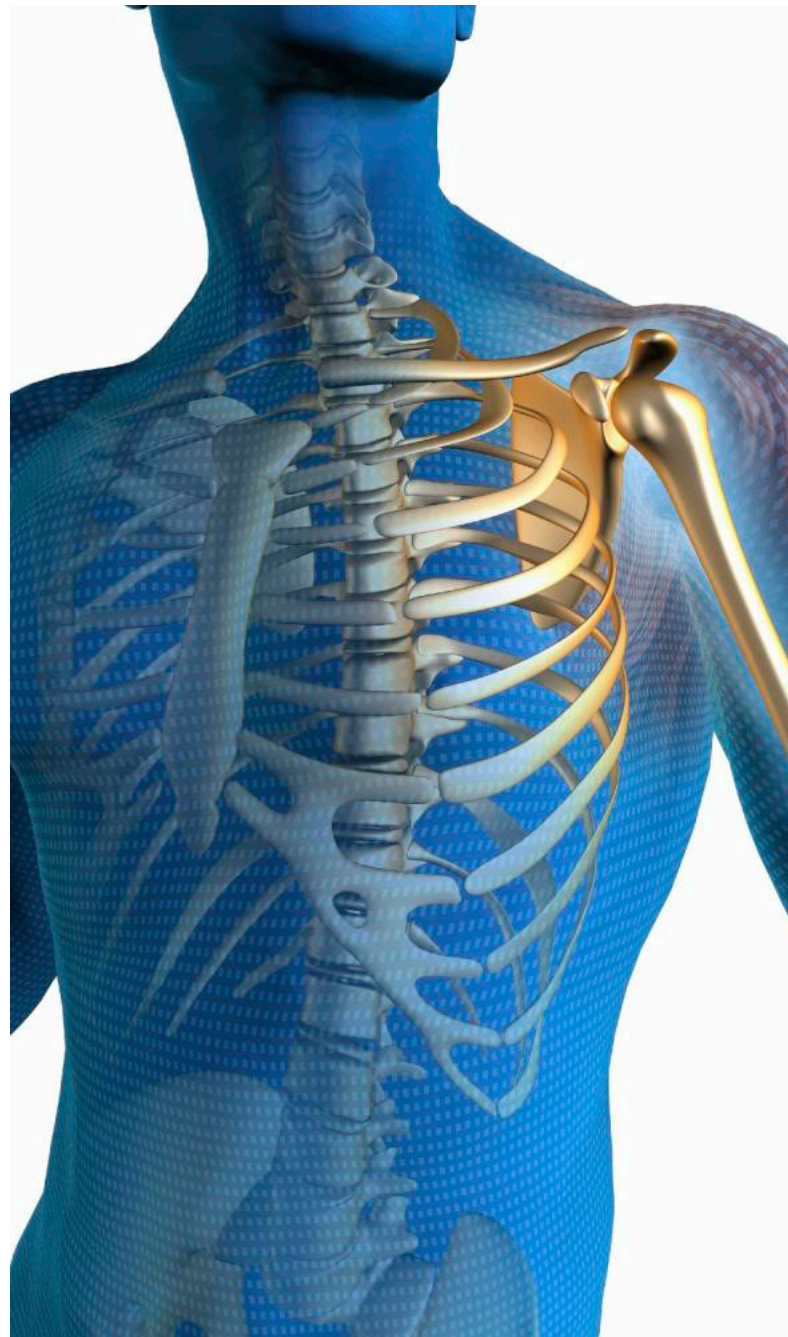
"Blessed are those who mourn, for they will be comforted". Matthew 5:4. God is love. Patients are usually alone in the ward and they welcome us to talk and share with them. If the patients are terminally ill, they are likely to be hungry spiritually. I pray for them and give them a small booklet of gospel. In fact, some are willing to convert to Christ at the bedside. It is the magnificent work of the Holy Spirit. I do make good friends with them and occasionally have their home visit. On the other hand, I also refer those who need special follow up to the hospital chaplain. Mr. Ho was an example. He had liver cancer and after the chemo treatment, he was introduced to the chaplain. He was then invited to a local church and served by a "cancer group" fellowship there. He was converted and enjoyed a new life.





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Needless to mention, the most unforgettable events are the patients' baptisms in the hospital chapel. With hymns and praise, and the witness of their family members and friends, the patients share the wonderful moment of His love. In the past ten years, I have witnessed many patients converting to Jesus, just before the end of their physical life. Though, we are now separated, we will meet again in heaven. I am very touched and blessed as God use me, as a tool in His project. Although the work load in the setting of Hospital Authority is heavy, I am working for the physical and spiritual health of the patients. Even though I am often frustrated in the present medical system, I have the beautiful blessing from God that I am working with Him. It is His plan that I am a doctor. It is our privilege to be able to understand the patients' needs and talk with them in the hospital environment. This is the market place theology and I am now further my Bible knowledge in a theology school.



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外科 SURGERY

我在瑪麗醫院任職外科醫生已經有十多個年頭，回想起我能夠成為醫生真是神的帶領和保守。我是在一個基層家庭中長大，自小已經對大自然的奧妙驚歎，相信萬物都是那創造主的設計。後來給我考上香港大學讀醫科，在畢業那年信了主，更加認定這是神給我的命定，用祂給我的才能去服侍有需要的人。在醫院中做任何事都全心全意去的，做好神給我這份「差事」。但發覺自己用己力去應付這工作是困難，因為除了病房繁忙的工作，還要小心翼翼去做手術，面對病人及其家人的追問，真是心身疲累。但聖經提醒我，「你的日子如何，你的力量也必如何。（申33：23）」我們關心病人和熱愛工作的力量從何以來？耶穌在天未亮的時候（其實同我們的工作時間差不多），都會到曠野禱告與主親近，如果不是神給我們愛心同理心，就算有多智慧能力耐力也徒然。





當我還是醫學生第一次走進手術室時，看見那主刀的醫生自信地往病人身體切下去的時候，那露出來的五臟六腑和湧出來的鮮血，都叫我看得亢奮。當他純熟地將腫瘤從身體切除，然後將各器官重新放置時，那細心認真的技能是身經百戰地斷練的，從那時起，我便決心要成為一個信心十足的外科醫生。後來當自己幫病人做手術時，看見所作的是直接令病人痊癒，也這是最令我滿足感最大的。在醫治過程中，我們作外科醫生應該是「整全醫治」，除了開刀那部分，手術後病情的跟進及病人在生活工作的影響，應作出適切的意見和關懷。

現時在香港外科醫學院中，在首兩年基本外科培訓中 (basic surgical training)，最少有半年時間要做骨科或急症室，其間要考 the Hong Kong Intercollegiate Board of Surgical College Membership (MHKICBSC) Examination Parts I, II, and III。完成後就有資格入高級外科培訓 (higher surgical training)，在此可以再選擇不同專科繼續受訓，有普通外科 (General Surgery)，胸肺外科 (Cardiothoracic Surgery)，神經外科 (Neurosurgery)，耳鼻喉外科 (Otolaryngology)，小兒外科 (Paediatric Surgery)，整形外科 (Plastic Surgery) 和泌尿外科 (Urology)。一般要多四至五年時間訓練後，才可考最終的Exit examination，然後就能獲取香港外科專科的資格。(The College of Surgeons of Hong Kong, www.cshk.org/)

所以要成為一個外科醫生是漫長的，要成為一個出色的「大國手」更可能要比其他專科花多額外時間鍛煉學習。常常要在醫院值班，在手術室做手術可能長達十多個小時，甚至好幾天都不能有充足的睡眠休息。面對工作上的壓力和繁重，與家人朋友聚少離多，要立志成為外科醫生的，不但要對工作有熱誠、有衝勁，還要謙卑地去不斷改進和學習，特別是新的手術技術，才可為我們病人尋求最好的福祉。