The HK Private Specialists -

APMSHK Members' Newsletter

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2026



From the Editorial Board

It is a pleasure to bring you the fifth issue of the APMSHK Newsletter, featuring clinical insights, member stories and professional updates from across our medical community.

All published issues are now available in the Newsletter section of the APMSHK website at https://www.pms.org.hk, making it easier to revisit past editions at any time.

At its heart, the Newsletter is about staying connected with you. We hope you enjoy this issue, find something useful or inspiring, and continue to share in the conversations and activities that bring our Association together. Thank you for reading and for being part of APMSHK.

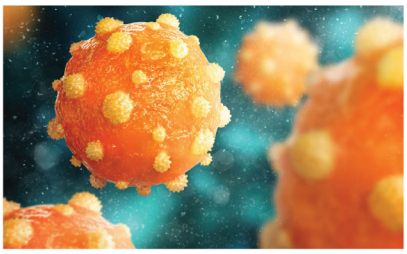
Regards,
Dr WONG Tin Yau Andrew
Dr LAM Kui Chun
Dr WAI Yuk Chun Veronica

Highlights



Spotlight on APMSHK

An interview with Dr Ricky Chan on cross-border care, GBA opportunities and Hong Kong specialists' evolving role in regional healthcare development.



Towards HBV Elimination

Hong Kong's hepatitis B control efforts highlight the impact of vaccination, prevention strategies and community-based screening in reducing long-term disease burden.



Dying in Place

A timely reflection on end-of-life care, advance medical directives and practical pathways for supporting patients' final wishes in Hong Kong.



Members' Hub

Featuring HDRC's medical dispute resolution platform and ways for members to stay connected with APMSHK through updated contact information.

The views and opinions expressed in the articles of this publication are solely those of the respective authors and do not necessarily reflect those of the Association of Private Medical Specialists of Hong Kong (APMSHK). Every care has been taken to ensure the accuracy of the content at the time of publication. However, APMSHK accepts no responsibility or liability for any consequences arising from actions taken based on information contained herein.

Pioneering Cross-Border Care: An Interview with Dr. Ricky Chan Wai Keung



We are honoured to feature a conversation with our Vice-President, Dr. Ricky Chan Wai Keung. Dr Chan obtained his medical degree from the University of Hong Kong in 1996 and his general surgical specialist fellowships in 2007 and is in private practice.

Beyond the operating theatre, Dr. Chan is a leading voice as the Founding Chairman of the Greater Bay Area Medical Alliance. He has been a pivotal advocate for expanding "Hong Kong-style" patient-centric medical management—emphasizing evidence-based care, risk management, and international standards—into the mainland. He actively helps the profession leverage milestone policies like the Hong Kong and Macao Medicine and Equipment CONNECT (港澳藥械通) and the Elderly Health Care Voucher GBA Pilot Scheme. Dedicated to the future of our profession, he has also shaped ambulatory care standards with the HKAM and continually mentors the next generation of medical professionals. In this exclusive interview, Dr. Chan shares his strategic insights on GBA integration for the medical profession in Hong Kong.

Q: GBA "Hong Kong-Style" Care: As Founding Chairman of the Greater Bay Area Medical Alliance, you strongly advocate for exporting "Hong Kong-style medical management" (such as patient-centric care, evidence-based practices, and standardized services). How do you envision this model fundamentally changing the healthcare landscape across the border?

A: Hong Kong-style medical management could reshape healthcare in the GBA by introducing a more predictable, patient-centred approach aligned with international standards. Its main contribution is to move care away from a hospital-centred, volume-driven model toward one focused on standards, outcomes and regional coordination.

At its core, this model promotes patient-centred care, evidence-based practice and consistent service standards. In daily practice, it can support clearer clinical pathways, more transparent communication, shared decision-making, need-based triage and stronger protection of patient rights.

Hong Kong's clinical culture is also shaped by international guidelines, audit and peer review. Applying this approach across the GBA would encourage greater use of clinical protocols, outcome-based quality indicators, regular audit cycles, morbidity and mortality reviews, and transparent data for benchmarking across cities.

Hong Kong's operational standards, especially in medication safety, infection control and hospital governance—could also help build more unified service standards, Hong Kong-style accreditation, cross-border credentialing for healthcare professionals and stronger referral networks between Hong Kong and mainland hospitals.



Dr Chan with Prof Clifford Pang (彭磷基教授), CEO and Hospital Director of Clifford Hospital, Guangdong (廣州番禺祈福醫院).

Q: Cross-Border Policies: With the expansion of the "Hong Kong and Macao Medicine and Equipment Connect" (港澳藥械通) and the Elderly Health Care Voucher Greater Bay Area Pilot Scheme (Voucher Scheme) to more mainland hospitals, what immediate opportunities and challenges do you see for the private specialists reading this newsletter who are looking to practice in the GBA?

A: As these schemes extend across the GBA, demand for services from Hong Kong doctors is likely to rise. The Elderly Health Care Voucher Greater Bay Area Pilot Scheme now serves more than 1.78 million eligible Hong Kong seniors through 21 designated mainland service points, giving private practitioners a steadier outpatient base when they practise or consult within GBA hospital networks.

At the same time, the 港澳藥械通 scheme allows more than 140 urgently needed Hong Kong-approved drugs and medical devices to be used before broader national approval. This enables Hong Kong specialists to offer timely treatment options in suitable GBA settings.

Qualified specialists may also work with designated mainland healthcare institutions in high-demand areas such as ophthalmology, dentistry, chronic disease management and other services where Hong Kong expertise can add value.



Dr Chan with fellow guests at the 2023 Guangdong-Hong Kong-Macao Greater Bay Area High-Quality Medical Integration and Development Forum (2023年粵港澳大灣區醫療高質量融合與發展論壇).

Several practical constraints remain. The Voucher Scheme applies only to outpatient care and cannot be used for inpatient services, day surgery or standalone purchases of medical products, limiting its value in specialties where procedures or admissions are central to treatment.

Credentialing and scope of practice are also not fully aligned between Hong Kong and GBA systems. A Hong Kong specialist may be experienced in a procedure but not automatically authorised to perform it in the GBA if local rules assign it to another specialty. Clear credentialing, defined roles and close communication with local institutions are therefore essential.

Patient trust will also need to be built over time. Mainland patients may be less familiar with Hong Kong specialists' training, qualifications and expertise, so doctors practising across the border should clearly explain their credentials, service scope and clinical standards.

Complaint handling and medicolegal processes differ because the two regions have distinct jurisdictions, regulations and patient expectations. For Hong Kong-registered doctors practising in the GBA while remaining accountable to the Medical Council of Hong Kong, strong documentation, risk management and institutional support will be essential for sustainable cross-border practice.

Q: Tech & Innovation in GBA: You have highlighted the potential of a "Hong Kong R&D – Bay Area Transformation" model, as well as the use of AI in diagnostics and telemedicine. How should private specialists in Hong Kong prepare to integrate these digital health technologies into cross-border practices?

A: Hong Kong private specialists should view GBA digital-health integration as more than a technology upgrade. It calls for a broader professional shift that combines clinical excellence, digital capability, cross-border regulatory awareness and new ways of engaging patients.

They will need to become digitally capable cross-border clinicians, using AI-supported diagnostics, telemedicine workflows, interoperable records and GBA regulatory systems while upholding Hong Kong's standards of clinical governance.

To prepare, specialists should develop practical skills in digital tools likely to become routine in GBA practice, including AI-assisted diagnostics, structured telemedicine and remote triage, guideline-based decision support, and remote monitoring for chronic disease, elderly care and rehabilitation.

Hybrid cross-border practice is also likely to grow, combining Hong Kong clinics, GBA satellite centres, virtual consultations, scheduled in-person follow-ups and joint specialist centres in cities such as Shenzhen, Guangzhou and Foshan.

To work effectively in these models, specialists should understand GBA telemedicine rules, cross-border licensing pathways, data-sharing and privacy requirements, and insurance reimbursement arrangements.

Cross-border digital practice will also require new approaches to patient management. These may include virtual pre-consultation questionnaires, AI-assisted appointment triage, remote follow-up protocols, and digital tools for consent and patient education. Hong Kong specialists will need to manage continuous digital patient relationships, rather than relying only on episodic clinic visits.

Q: Differentiating HK Services: You have mentioned that Hong Kong doctors shouldn't just compete on scale with mainland public hospitals, but should focus on high-quality, differentiated services like advanced specialty care. What specific clinical areas do you think hold the most "blue ocean" potential for our members?

A: For Hong Kong specialists in the GBA, the most promising blue-ocean opportunities are not in high-volume care, but in complex, high-trust services where Hong Kong's clinical governance, safety culture and international standards create a clear advantage.

These opportunities are strongest in advanced specialty areas that are difficult for mainland public hospitals to scale, especially services that require precision, multidisciplinary teamwork, long-term follow-up and international-level safety standards.

Cardiology is a good example. Hong Kong cardiologists already work to international standards and have strengths in TAVI, TMVR and other structural heart programmes, complex PCI and chronic total occlusion interventions, inherited cardiac disease clinics, and advanced cardiac imaging such as CT and MRI. These services have strong blue-ocean potential because they depend on patient trust, careful risk management and robust clinical governance—areas where Hong Kong expertise can stand out.



Hong Kong's private sector is also well positioned in advanced minimally invasive and orthopaedic care. Areas with particular promise include robotic joint replacement, complex spine surgery, sports performance medicine for elite athletes, and cross-border rehabilitation supported by tele-physiotherapy.

Paediatrics is another area with strong potential, as many GBA families have confidence in Hong Kong's child healthcare standards. High-value services include paediatric cardiology and cardiac surgery, paediatric neurology and developmental clinics, neonatal intensive care, and rare disease and genetic paediatrics.

These are blue-ocean fields because Hong Kong can offer a strong trust advantage, while many mainland cities still lack sufficient high-level paediatric subspecialists.



Eliminating hepatitis B in Hong Kong: 30 years of public health efforts and the path forward





WONG Chun-kwan Bonnie | WU Hin-yam Zenith | POON Chin-man

Viral Hepatitis Control Office, Special Preventive Programme, Centre for Health Protection, Department of Health



Introduction

Chronic hepatitis B virus (HBV) infection can lead to serious liver complications, including cirrhosis and hepatocellular carcinoma (HCC). Over the past 30 years, global health efforts have made remarkable strides in controlling HBV infection, largely through vaccination programmes. Recognised as the world's first anti-cancer vaccine, the use of hepatitis B vaccines has transformed the epidemiological landscape, significantly reducing new infections and liver cancer incidence in many regions, including Hong Kong.[1, 2] Despite these achievements, hepatitis B remains a global health challenge, with millions living with chronic HBV infection, and many unaware of their status and unlinked to appropriate care and treatment. As the world approaches the 2030 elimination target as set by the World Health Organization (WHO), it is crucial to review the progress made, understand ongoing challenges, and strategise future efforts to eliminate hepatitis B as a public health threat.

The Global and Local Burden of Hepatitis B

Globally, HBV infection poses a significant morbidity and mortality burden. As reported in Global Hepatitis Report 2026, an estimated 240 million people are living with chronic HBV infection in 2024, with approximately 0.9 million new infections annually. Most (75%) HBV-related deaths, mainly in form of cirrhosis and HCC, and the highest mortality rates in 2024 took place in the WHO African and Western Pacific regions.[3]

Locally, as derived from the results of Population Health Survey (PHS) 2020-22 conducted by the Department of Health (DH), the prevalence of chronic HBV infection is estimated at 5.6%[4], implying an intermediate-high hepatitis B endemicity.[5] Liver cancer ranks as the fifth most common cancer, with 1 700 incident cases in 2023, and the third leading cause of cancer deaths, accounting for over 1 370 deaths in 2024. A previous review study found that up to 80% of HCC cases are related to chronic HBV infection.[6] Data from Hong Kong Cancer Registry also indicates that in 2023, about 74.6% of patients with HCC had a positive test result or prior documentation for HBV infection, underscoring the importance of ongoing hepatitis B prevention and control measures.[7]

The Impact of Vaccination: Progress and Achievements

The introduction of hepatitis B vaccination in Hong Kong in 1983 marked a pivotal moment in public health. It was initially used in high-risk groups in the early 1980s before incorporated as part of the universal childhood immunisation programme in 1988 (Figure 1). The high acceptance of the immunisation programme, coupled with high coverage, has led to a dramatic decline in hepatitis B prevalence. The latest immunisation coverage survey conducted by the DH demonstrates that the coverage of the third dose of hepatitis B vaccine remains consistently high at above 99%[8], while statistical return for the birth dose hepatitis B vaccination also shows more than 99% coverage.

The impact of the immunisation programme can be reflected in the epidemiological trends. The prevalence of HBV infection among the general population has been gradually declining from more than 10% in the 1970s to about 5.6% in 2022.[4,9] The effectiveness of the vaccination could be best demonstrated by the much lowered prevalence of HBV infection in the younger generation, below 1% for those born after 1988. Local observational study also found a numerically lower, albeit not statistically significant, HCC incidence among people born during the vaccination era (1988 – 2002), suggesting the possible contribution of universal immunisation in reducing HCC incidence.[2]

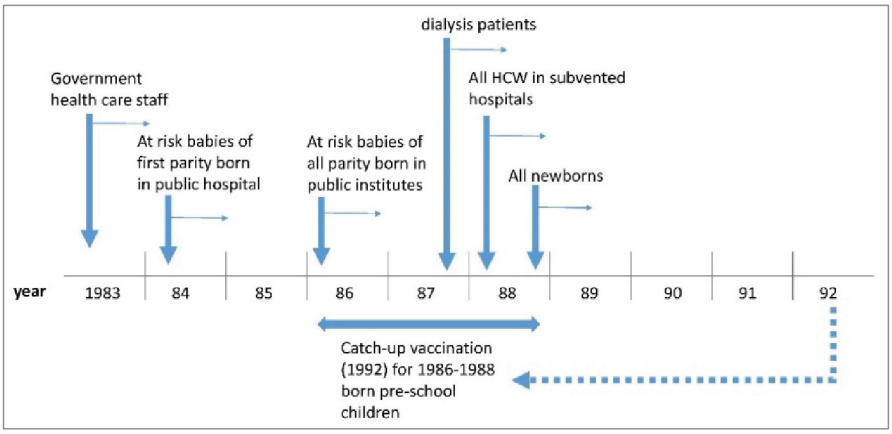


Figure 1. Timeline of the evolvement of the universal hepatitis B immunisation programme in Hong Kong

Although the vaccination has dramatically reduced new chronic HBV infection among younger cohorts, the PHS 2020-22 found that the prevalence of HBV infection remains high among those participants born before 1988, mainly reflecting infections acquired before the implementation of the universal immunisation programme.

Evolving Strategies for Prevention and Control

Preventing mother-to-child transmission (MTCT) of HBV remains the cornerstone in the prevention and control of hepatitis B. As set out in the Hong Kong Viral Hepatitis Action Plan 2020-2024, MTCT prevention measures have been further strengthened through a multifaceted approach.[10] In addition to the long-standing measures on universal antenatal screening and hepatitis B vaccination for the newborn, as well as the administration of hepatitis B immunoglobulin for babies born to mothers with chronic HBV infection, the use of antiviral prophylaxis for pregnant women with high viral load has been introduced since 2020 in all birthing hospitals under the Hospital Authority. Moreover, the initiative of post-vaccination serologic testing (PVST), implemented since 2022, plays a crucial role in evaluating the immune response in infants, ensuring that those who do not develop adequate levels of antibodies are identified early and provided with revaccination. With these enhancements, Hong Kong is now moving towards a hepatitis B-free generation.

Nevertheless, the substantial size of the population with chronic HBV infection remained undiagnosed or unlinked to care poses a significant public health challenge. The PHS 2020-22 gauged approximately 40% of people with chronic HBV infection were unaware of their status, and about 70% did not receive any medical follow-up for their liver diseases, contributing to ongoing disease progression. This highlights the need for targeted interventions and specific screening programmes to address the gaps in diagnosis and treatment coverage.

The Hong Kong Viral Hepatitis Action Plan 2025-2030 (the Action Plan 2025-2030) sets out a series of strategies and initiatives, including the introduction of a risk-based



hepatitis B screening and management programme in the community, with a view to reducing the morbidity and mortality related to HBV infection, especially those caused by liver cancer. In February 2026, Primary Healthcare Commission launched the Hepatitis B Co-care Scheme (the Scheme) to identify people with chronic HBV infection in the community and provide long-term follow-up services, with an aim to reducing the risk of developing serious complications, including cirrhosis and liver cancer. The Scheme targets populations at increased risk of HBV infection, where Hong Kong residents, who (i) were born in or before 1988, (ii) have family members (including parents, siblings or offspring) or sexual partners having chronic HBV infection, (iii) have no known medical history of chronic HBV infection or related symptoms, and (iv) have not received a complete course of hepatitis B vaccination, may receive free HBsAg rapid diagnostic test at District Health Centres or District Health Centre Expresses as initial screening. To support the implementation of the Scheme and facilitate management of chronic HBV infection by primary care physician, “Management of Adults with Chronic Hepatitis B in Primary Care” has been published under the Hong Kong Primary Healthcare Reference Framework in January 2026.[12]

Conclusion: Future Directions and the Path to Elimination



Hong Kong has demonstrated its sustained political commitment to combat the public health burden of hepatitis B since the 1980s. Our experience exemplifies how high vaccination coverage and targeted prevention strategies can dramatically reduce disease prevalence and related mortality. The progress made offers hope and a blueprint for the future, where hepatitis B can be effectively controlled, and ultimately eliminated, to ensure healthier lives for generations to come.

The strategic plans and policies in place provide a solid foundation for future success, guiding continued dedication, resource allocation, and collaboration across sectors. Looking ahead, the Hong Kong Viral Hepatitis Action Plan 2025-2030 emphasises optimising screening strategies based on local context, strengthening primary care management, and maintaining high coverage of MTCT prevention measures. A key component is the expansion of community-based screening programmes to identify undiagnosed cases early and establish linkage to care for diagnosed cases. Meanwhile, the ongoing professional training and public awareness campaigns provide essential support for smooth and successful implementation of these initiatives to close the existing gaps on the path to hepatitis B elimination.

Achieving the WHO goal of hepatitis B elimination by 2030 requires sustained commitment from policymakers, healthcare providers, researchers, and communities. Along the hepatitis B care continuum, healthcare providers in different specialties could play their respective roles from offering prevention measures, performing screening or diagnostic workup, facilitating linkage to care, to case management in primary, secondary and tertiary care levels. The concerted efforts would facilitate Hong Kong's advancement in realising a future without threat from hepatitis B (Figure 2).

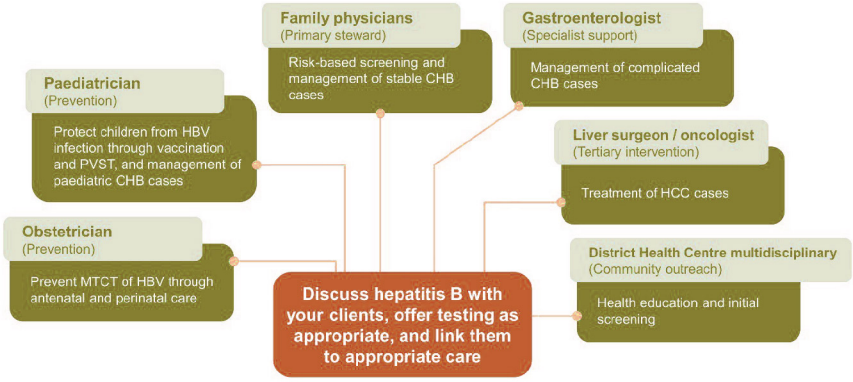


Figure 2. Role of healthcare workers by specialty in hepatitis B care

While universal immunisation, together with other measures to prevent MTCT, is effective in protecting the next generation, eliminating hepatitis B as a public health threat depends primarily on identifying people living with chronic HBV infection and linking them to appropriate care and timely treatment.

For more information

Viral Hepatitis Control Office, Department of Health

Hepatitis B Co-care Scheme

Hong Kong Viral Hepatitis Action Plan 2025 - 2030

Management of Adults with Chronic Hepatitis B in Primary Care

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Dying in Place: Feasibility and Practice in Hong Kong

Key takeaways from five lectures presented at MMMC 2026

One of the final sessions of the Multi-Specialty Medical Mega Conference (MMMC) 2026 addressed a question every specialty meets but few meetings tackle directly: not whether we can prolong life, but where our patients spend the end of it. “Dying in Place: Feasibility and Practice in Hong Kong” was co-ordinated by the Hong Kong Geriatrics Society, the Hong Kong Society of Palliative Medicine and the College of Nursing Hong Kong, chaired by Dr Cheng Hon Wai Benjamin, Ms Ku Wai Yin Ellen, Dr Lam Ching Yu Janie and Dr Yuk Ka Lok.

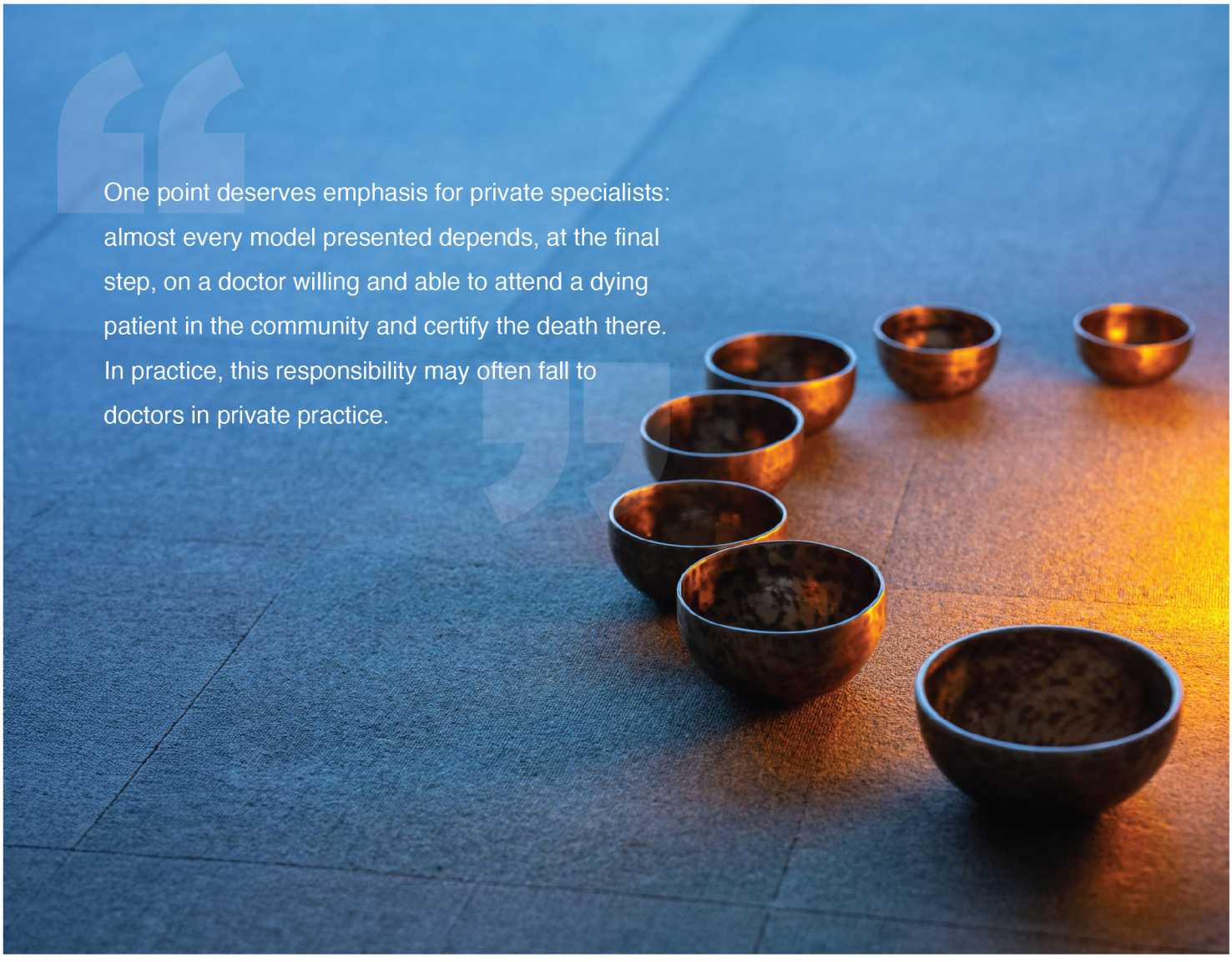
The timing proved fortunate. Seven weeks later, on 31 July 2026, the Advance Decision on Life-sustaining Treatment Ordinance (Cap. 651) came into operation, giving Hong Kong its first statutory framework for advance medical directives (AMDs) and for do-not-attempt cardiopulmonary resuscitation (DNACPR) orders carrying continuing effect outside hospital.[1] Much of what the speakers described as local workaround now has a legal spine; much of what they identified as unresolved — the 999 default, out-of-hours certification, caregiver exhaustion, the funding cliff — remains unresolved.





Presentation of appreciation certificates to the chairs and speakers of the “Dying in Place” session at MMMC2026.
From left: Dr LAM Ching Yu Janie, Dr CHENG Hon Wai Benjamin, Dr LEUNG Man Fuk Edward, Dr WONG Chit Wai, Dr CHAN Lut Ming, Dr CHEN Wai Tsan, Ms YUEN Lai Wah, Ms KU Wai Yin Ellen and Dr YUK Ka Lok.

> One point deserves emphasis for private specialists: almost every model presented depends, at the final step, on a doctor willing and able to attend a dying patient in the community and certify the death there. In practice, this responsibility may often fall to doctors in private practice.



Lecture 1
Supporting older people with advanced medical conditions in the community



Dr LEUNG Man Fuk Edward
Specialist in Geriatric Medicine
Director, Geriatric Medicine (Healthy Ageing), Hong Kong Sanatorium & Hospital
President, Hong Kong Association of Gerontology

Dr Leung highlighted cancer (11,212), heart disease (5,437), cerebrovascular disease (2,441), dementia (1,358) and septicaemia (1,016) among the leading causes of death in Hong Kong people aged 65 and above[2] — conditions whose trajectory is largely foreseeable, which is why place of death can be planned rather than merely suffered. Hong Kong recorded some 46,000 deaths in 2014, around 90% of whom presented to HA facilities. A 2016 HA projection estimated that annual deaths could reach 92,000 by 2046.

Among elderly people who died in HA facilities, roughly 40% were residents of residential care homes for the elderly (RCHEs).[3] A 2017 study of 457 deceased residents across 34 subvented homes found an average age of 89 years and an average stay of 5.8 years, with heart failure, dementia and cancer commonest. These are people who have already left home once; sending them to an acute ward to die is, for many, a second and unnecessary displacement.

Most of the talk described the Jockey Club End-of-Life Community Care (JCECC) project across its first decade (2016–2025). Working with 27 NGOs, it reached 113 of Hong Kong's 183 subvented, contract and nursing homes. Its innovations are unglamorous and effective: an individually renovated end-of-life room allowing a resident to die in privacy with family present; a trained bank nurse pool for that room; and structured training for visiting medical officers, 221 of whom have attended the certificate course.
The outcome data are worth quoting to sceptical colleagues: among residents enrolled for more than 90 days, emergency attendances fell 33.2%, admissions 33.2% and bed-days 31.1%, all statistically significant, giving an estimated saving of about HK$142,800 per resident according to Dr Leung. Dying in place is not a soft option purchased at the system's expense; it relieves the system.

He closed with private-sector cases, including an 88-year-old woman with inoperable pancreatic carcinoma who was kept comfortable at home and died peacefully surrounded by family. His enabling checklist is entirely practicable in private practice: an advance directive or documented advance care planning (ACP); adequate family communication; ability to see the patient within the preceding 14 days; adequate symptom relief; certification paperwork (Forms 18 and 2) prepared; and settled body-handling and funeral arrangements.



Take-home messages

- Dying in place is not merely a preference to honour — it reduces emergency attendances, admissions and bed-days, at an estimated saving of about HK$142,800 per resident according to Dr Leung.
- Among elderly people who died in HA facilities, roughly two in five were RCHE residents.The care home, not the hospital, is where the largest single gain is available.
- The private practitioner's checklist is short: AMD or documented ACP, family communication, review within 14 days, symptom control, certification paperwork ready, body handling arranged.
- Since 31 July 2026 that ACP conversation can culminate in a statutory AMD, and a DNACPR order under the Ordinance carries continuing effect in the care home — removing the ambiguity that attended earlier non-hospitalised DNACPR forms.

Lecture 2
A collaborative care model for end of life: dying in residential care homes



Dr WONG Chit Wai
Specialist in Geriatric Medicine
Consultant, Department of Medicine and Geriatrics, Ruttonjee Hospital

Dr Wong began with the legal change that made the project possible. The amendment of the Coroners Ordinance in June 2024 means deaths of RCHE residents no longer have to be reported to the Coroner where the usual conditions of recent attendance and established cause are met.[4] That single change removed operators' strongest reason for sending every deteriorating resident to hospital.

Since August 2024 the Hong Kong East Cluster Community Geriatric Assessment Team (CGAT) has run a tripartite collaboration with participating RCHEs and the JCECC district end-of-life team, now covering three homes. Residents with advanced irreversible chronic illness are recruited after a family conference covering goals of care, advance care planning, a DNACPR order with continuing effect, and an advance directive where the resident remains cognitively intact. Ongoing care follows colour coding adapted from the UK Gold Standards Framework — green for the stable resident, yellow for the deteriorating resident seen at least fortnightly, red for the final days. In the red phase the family chooses a geriatric ward or the home's end-of-life room; in the latter case CGAT hands over to the community doctor and nurse, who certify the death.

By 31 May 2026, 30 residents had died — 12 in the care home, 18 in hospital. Nine had no hospital admission at all after joining and 18 had only one or two, against a usual pattern of three to four admissions in the six months preceding death. Forty-two residents are currently under end-of-life care, 18 of whom have opted to die in the home.



Dr Wong's account of the difficulties was refreshingly concrete. The first is divergence over goals of care: a resident who has stopped eating and drinking may still be receiving insulin on the home's usual diabetic protocol, because that is what staff have always been trained to do, at the moment the clinical team would relax or stop it. The second is knowing how far to go — transfer for intravenous antibiotics or transfusion may reverse the acute episode, but at a quality of life the resident would not have chosen. Neither has a protocol solution; both yield to sustained communication until home, family and clinical team reach a shared position.[5]

Dr Wong was candid about sustainability: the JCECC project is scheduled to end in June 2027, and within Hong Kong East only about 630 of some 6,200 residents are currently covered.

Take-home messages

- The June 2024 Coroners Ordinance amendment removed the reporting requirement for qualifying RCHE deaths and is a practical foundation of dying in place in care homes.
- A simple green/yellow/red coding system is enough to structure escalation and de-escalation.
- Nine of 30 residents needed no hospital admission at all before death, against a usual three to four in the last six months.
- The recurring conflicts — routine disease-specific treatment continued in a dying resident, and how far to escalate — are solved by conversation, not protocol.

Lecture 3
Supporting patients to die at home in the public sector



Dr CHAN Lut Ming
Specialist in Palliative Medicine
Associate Consultant, Department of Medicine, Haven of Hope Hospital



Dr Chan's lecture provided a practical and compassionate account of supporting patients who wish to remain and die at home within Hong Kong's public healthcare system. Through the story of Mr. M, a 75-year-old man with metastatic colorectal cancer and an enterocutaneous fistula, the lecture illustrated that home-based end-of-life care requires more than symptom control. It depends on early communication, advance care planning (ACP), caregiver preparation, multi-disciplinary collaboration, and a clear plan for deterioration and death.

Mr. M had progressive disease despite surgery, chemotherapy and targeted therapy. After he declined further anti-cancer treatment, he was referred to palliative care. Although he initially required acute management of sepsis associated with tumour fistulation, he was clear about his priorities: he felt prepared for death, wished for a peaceful environment, and hoped to stay at home for as long as possible. This illustrates the importance of recognising when the therapeutic focus should shift from disease-directed treatment to comfort, dignity and goal-concordant care.

The palliative care team undertook a holistic assessment addressing physical, psychological, social and spiritual domains. His mild wound-related pain, lower limbs oedema and impaired mobility were managed alongside his concerns about becoming a burden. His wife and son were involved in discussions and were given opportunities to express their worries and caregiving needs. Input from physiotherapy, occupational therapy, dietitian, medical social worker, chaplaincy and wound care nurse was essential in preparing both the patient and family for discharge.

A particularly important aspect was the role of the Kowloon East Cluster (KEC) palliative care team. After discharge, Mr M received home-based monitoring and medical review. Discussions addressed possible blood testing, artificial hydration, analgesia, circumstances requiring admission, and caregiver stress. These conversations demonstrated that ACP is not merely documentation; it is an ongoing process that prepares patients and families for foreseeable clinical decisions while preserving flexibility when circumstances change.

The lecture also introduced the Palliative Care Last Journey (PCLJ) programme, which coordinates palliative care teams, community nurse, emergency departments and acute medical wards. The programme aims to facilitate patients' preference for dying at home while ensuring appropriate procedures after death, including death certification, body transfer and avoidance of unnecessary police investigation or coroner referral when appropriate. Retrospective local data from the programme showed that all enrolled patients underwent ACP and shared decision-making, all caregivers received education and bereavement support.[6] Dr Chan noted that many patients required subcutaneous hydration, opioids or infusion pumps.

Mr. M ultimately deteriorated with coffee-ground vomiting and declined admission initially. When his condition worsened, he was transferred to the emergency department, where death was certified. Although he did not die physically at home, the family valued the opportunity for him to remain at home until the final stage and avoid repeated burdensome hospital admissions. This case reminds us that success should be judged not only by the eventual place of death, but by whether care remains aligned with the patient's values, comfort and family's capacity.

Take-home messages

- Explore preferences for place of care and death early, and revisit them as illness progresses.
- ACP can include patient's values, place of care, symptom management preference, artificial hydration and caregiver capacity.
- A home-death plan requires proactive caregiver education and accessible professional support, not simply discharge from hospital. Multidisciplinary and cross-sector coordination is indispensable for safe, individualised end-of-life care.
- "Dying at home" is possible in the public sector with appropriate clinical support, while responding compassionately and realistically to changing clinical needs.

Lecture 4
Dying in place: lessons from interdisciplinary palliative care



Dr CHEN Wai Tsan
Specialist in Palliative Medicine
Consultant Physician, Haven of Hope Sister Annie Skau Holistic Care Centre

Dr Chen described her centre's palliative home care model as concentric rings around patient and family: the nurse at the centre as case manager, coordinating services, training caregivers and leading advance care planning; the doctor guiding complex decisions and symptom prescribing; the social worker providing psychosocial and spiritual care and bereavement support; and an outer shield of volunteers, therapists and chaplains assembled case by case.



When a patient wishes to die at home she works through eight questions in two columns — clinically, whether the illness is terminal and irreversible, whether goals are strictly palliative, and whether symptoms can be controlled at home; practically, whether the family's wishes are aligned, whether there are dedicated available caregivers, and whether the home and supporting services are adequate.

Preparation proceeds on four fronts — administrative (ACP, AMD or DNACPR, goals of care), logistical (equipment), medical anticipation (equipping the caregiver for the symptoms to expect) and, distinctively, a post-mortem strategy. This last is most often neglected: body handling and transfer must be planned in advance, including alerts for a pacemaker or implantable defibrillator, notification of infectious disease, and — obvious only in retrospect — a mapped exit route from the flat.

Among the cohort of patients receiving palliative home care before the implementation of the new ADLST Ordinance, only around 10% died at home. Most patients instead chose inpatient palliative care, primarily to achieve better symptom control. Among those who died at home, 23% had their death certified at home by a registered medical practitioner, 17% were admitted to hospital and died within 24 hours, and 60% were preceded by a 999 emergency call. These findings suggest that, despite patients remaining at home, the default emergency care pathway continued to prevail during the final moments of life in the majority of home deaths.

She set the two routes side by side. The registered medical practitioner path runs: terminal diagnosis, attendance by an RMP within 14 days, certification using Forms 18 and 2, registration at Deaths Registry, and direct removal by the funeral service. The 999 path runs into what she called a systemic mismatch — an emergency response that defaults to life-saving intervention, applied to a patient for whom that is precisely the wrong thing. The new Ordinance, she noted, closes part of that gap.

Dr Chen closed her presentation with a comparison against Singapore's strategic policy, hospital–NGO partnerships, 24-hour respite beds and digital death certification.

Take-home messages

- Plan the post-mortem logistics in advance, including pacemaker or ICD management, infectious disease notification, and the physical exit route from the home.
- Even in an experienced service, only about 10% of home care patients died at home before the implementation of the new ADLST Ordinance.
- With the new ADLST Ordinance, the legal and procedural gaps that previously limited home deaths can be addressed, facilitating greater alignment with patients' end-of-life preferences and potentially increasing the number of home deaths in Hong Kong.

Lecture 5
Transcending boundaries in care: challenges and strategies for nurses implementing dying in place



Ms YUEN Lai Wah Eva
Secretary, College of Nursing Hong Kong
Head, Residential Services for Elderly, Haven of Hope Christian Service

Ms Yuen began with the official definition: dying in place means spending the final days at the place of the patient's choice — home, RCHE or nursing home — and not necessarily a hospital.[7] She paired it with survey evidence from the same consultation. Asked where they would wish to receive end-of-life care if expected to die within a year, 58.4% of elderly respondents chose home and 17.0% a hospital. But when the question narrowed to having only days left, the picture inverted: 33.8% chose home and 49.5% a hospital. The preference for home is real but fragile, and it fails at exactly the moment it is tested.

Her service data covered two Haven of Hope residential settings, where dying-in-place cases accounted for 5.3% and about 10% of deaths respectively. More striking was the timing: of 176 clients, 60.2% died outside office hours — 27.8% between midnight and 8 am and 32.4% between 6 pm and midnight. Dying in place is, statistically, a night and weekend service, and this is the fact that most sharply exposes the resource gap.

She grouped the challenges under five headings: education and competence (inadequate end-of-life training, weakness in symptom control, difficulty recognising the dying phase); emotional support (moral distress, compassion fatigue, the cumulative weight of multiple deaths on a small team); system and resource constraints (staffing in number and skill mix, limited 24/7 support, referral pathways); family communication (ACP meetings, caregiver constraints, family dynamics, persistent myths); and social support (recognition, human resources, funding).



Her strategies followed directly — interdisciplinary teamwork, expanded professional roles, systematic information sharing, clear levels of communication, a defined ACP model, public education about advance medical directives, and policy change. On public education she was emphatic, and the roundtable bore her out: the Ordinance will only work if patients and families understand it before the crisis, not after. She ended with Dame Cicely Saunders — "you matter because you are you, and you matter to the last moment of your life".

Take-home messages

- Stated preference for home is high in the abstract (58.4%) but collapses when death is imminent (33.8%); support must be strongest precisely as death becomes imminent.
- Six in ten deaths in place occur outside office hours — without 24/7 nursing and out-of-hours certification the service is only notionally available.
- Moral distress and compassion fatigue among care home staff are a resource issue, not a personality issue.
- Public education about AMDs is the rate-limiting step for the new legislation, and care home nurses are well placed to lead it.

The roundtable: one barrier, one vision

The chairs asked each speaker to name a single barrier and describe what dying in place might look like in five years. Public education came first and most often: the concept remains poorly understood outside the professions, and without public understanding no policy is easily implemented. Medical–social collaboration came second, with concern about what replaces JCECC after 2027. From the nursing and care home side the barriers were operational — the absence of 24/7 resources; the difficulty of certifying death at night or over a weekend, precisely when most deaths occur; how long a body may remain in a care home before transfer; and the stigma attaching to a room in which residents die

The panel was nonetheless cautiously optimistic. That MMMC 2026 hosted a dying-in-place session at all was taken as a marker that the subject has moved beyond palliative medicine and geriatrics into the wider medical community. With the Ordinance in force and the Health Bureau committing resources to public education, they expected awareness to be substantially higher within five years.



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A New Path for Medical Disputes

The Healthcare Dispute Resolution Centre (HDRC) has launched a dedicated online platform https://ehdrc.org for medical and healthcare dispute resolution, providing access to mediation and arbitration through both virtual and face-to-face arrangements.





The HDRC medical dispute resolution platform marked its official launch on 28 August 2026, with Dr Ko Wing Man joining as Guest of Honour.

Medical disputes can be stressful for both doctors and patients. When disagreements escalate into litigation, the process can be lengthy and costly and may further strain the doctor–patient relationship. Mediation offers an alternative approach, bringing parties together in a confidential setting to explore a mutually acceptable resolution with appropriate professional support.

Seeking mediation at an appropriate stage may help address differences constructively before they become more difficult to resolve.

APMSHK members facing a complaint or dispute are encouraged to consult their indemnity provider at an early stage and consider whether mediation may be appropriate for their individual circumstances.

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