I hope you will like the new design of this issue of Cutting Edge. Starting from the front page to the layout of the content, we have given them a new look. The previous design had been used for a couple of years already. The editorial board feels that it is time to give our newsletter a new dress. Our secretariat staff has worked very hard in accomplishing this mission.

Thank Dr. Alfred Wong for his support by sending us photos of professional standard for the front page. We will keep searching for high quality photos to decorate our booklet, and make it more attractive.

Did you notice that this booklet is thicker than before? It’s because we have a much richer content and therefore more pages now. Thanks to the editorial board members and the fellow colleagues for generously contributing different articles for publication. The success of this newsletter greatly depends on your support. After all, it is something “by our Fellows, for our Fellows!”

The spotlight of this issue is on Subspecialization. It’s a very controversial topic that has profound effect on our profession’s future. We think that it’s time to bring up the discussion and alert every fellow. Following the Cutting Edge, you will keep yourself abreast of the latest development of our profession. Don’t miss it!

Finally, it has all along been our mission to introduce different aspects of life of a surgeon other than work. It gives us a fresher mind and a richer life. May it be your family, your hobbies, your favourite sports, or anything you love doing. You are welcome to share with us!

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The advancement in knowledge, technology, equipment and skills makes it difficult if not impossible to handle patients with various problems and this forms the basis of Surgical Specialization. It is beyond doubt now a General Surgeon should not perform Neurosurgical procedures which I personally did 20 plus years ago. This is possible in cities like Hong Kong but is that also practical in rural areas? This is a question often asked!

Taking a step further to subspecialization, it is of course easier in large communities like Hong Kong where we have the caseload as well as the workforce for elective service. But for emergency work, it would require a much bigger workforce than present if we are going to provide subspecialty services. Also, there are grey areas where it is not easy to delineate which subspecialty should provide the care and might result in conflicts. Another worry is that subspecialization would result in narrowing the scope of practice and might even limit service provision which is not welcomed by private surgeons. Taking General Surgery as an example, a General Surgeon is trained to cover 80 to 90 percent of common procedures such as laparoscopic cholecystectomy, thyroid surgery, hernia repair and GI endoscopy. It would be quite unreasonable to limit cholecystectomy to hepatobiliary surgeons and thyroid surgery to endocrine surgeons.

Although with such criticism, subspecialization should have its place. It is beyond doubt that it would improve the surgical outcome. However, it might be impractical to have over subspecialization as our society really doesn’t need a lot of superspecialists and our economy can neither support.

It is noted recently that our younger generation of Surgeons on completion of their training strives to improve themselves in particular to handle complex clinical conditions and perform ultra-major procedures such as esophagectomy, hepatectomy and robotic low anterior resection. Besides complex surgical procedures, much emphasis is on multidisciplinary approach in patient management. We do not expect a General Surgeon can handle such a wide variety of complex clinical conditions with today’s standard of surgical practice and hence subspecialty training comes into place. There is demand for subspecialty training from our young Fellows and our College has the obligation to assist them.

The role of the College is to maintain a high Surgical Standard through education and training. We would project the workforce requirement of our society and monitor that through the accreditation of training post. However, something beyond us is the distribution of workforce between the public and private sector resulting in the inaccurate projection of workforce that our society needs. Another challenge is of course the possibility of limitation in the scope of practice if subspecialization is taken to the extreme.

My personal view is that at this juncture, it is realistic to have subspecialty interest development to improve the standard of surgical practice. No individual Surgeon is able to master all the skills and knowledge in his/her specialty and it is of utmost importance to have a good team work, irrespective of public or private sector so that we can provide the best care to our patients both in elective and emergency situations.

The College Council has endorsed the direction for subspecialty development in General Surgery. General Surgery Board started consultation to our Fellows and is putting 3 subspecialties, namely Breast Surgery, Head & Neck Surgery and Vascular Surgery as pilot in the development and hope that our Fellows can give us valuable advice.

Dr Hung-to LUK
President
Princess Margaret Hospital
Message from the Honorary Secretary

“The sea takes in a hundred rivers, and through accepting, greatness is achieved.” Lin Zexu 1785-1850

I n line with an understanding between the Hong Kong Academy of Medicine and the Minister of Health of China, our College entered a new phase of development in 2009 when we accredited jointly with the Royal College of Surgeons of Edinburgh and two leading surgical centres in Beijing for surgical training culminating in award of Fellowship of Edinburgh and two leading surgical centres in Beijing. By 2012, a total of 13 and 5 elite Mainland centres had already been accredited for training in general surgery and urology respectively. This accreditation of surgical centres in Mainland was a bold step because by promoting to these centres a high standard surgical training that we trust, practice and develop, we are allowing those Mainland colleagues who share our belief in training and who put in the same efforts to eventually be able to join in our College as our Fellows. It is an important step because even though these Mainland Fellows will not be coming to Hong Kong to practice without basic registration, however, being carefully chosen from elite centres (approved by Minister of Health) and controlled in number, they will serve the College not in Hong Kong but in Mainland, where they will help to spread our idea of surgical training and enhance the image of our College.

In order to prepare for taking in our Mainland colleagues as Members and Fellows of our College, there is a need to revise certain Articles in our Constitution.

The requirement that a Member must be a registered practitioner in Hong Kong will be extended to include also a trainee from an accredited centre outside Hong Kong who has completed the required training and passed the required examinations. The existing article on Fellows would be clarified so that instead of ‘Any person’, only registered medical practitioner in Hong Kong or registered trainee from a training centre accredited by the College outside Hong Kong who has completed training and passed examinations prescribed by the Council can become a Fellow of the College.

There is also a perceived need to award Fellowship without Examination to some senior Mainland colleagues in recognition of their contribution in conjoint training. Accordingly, the existing article on Fellowship without Examination will also need to be revised to include in addition to registered practitioner in Hong Kong also trainer in a training centre accredited by the College outside Hong Kong.

Fellows awarded through examinations, whether Mainland or Hong Kong, will enjoy the same right to vote. However, the requirement for a Council Member to be a registered practitioner in Hong Kong remains unchanged.

In the new phase of our College, our College members will help to spread our idea of surgical training and enhance the image of our College.

Dr Chi-wai MAN
Honorary Secretary
Tuen Mun Hospital

Message from the Specialty Boards

General Surgery

Spring comes and it is examination time. The RCSEd/CSHK Joint Specialty Fellowship Examination in General Surgery was held from 24-26th March 2013. A total of 31 candidates participated in the examination, of whom 27 were from Hong Kong. Twenty-one candidates (17 from Hong Kong) passed the examination, making an overall passing rate of 68%. Congratulations to all those who passed. For those who did not make it this time, please do not be discouraged. Hopefully they will be successful next time. We are also thankful to our examiners, especially those who sacrificed their Sunday doing the examination. We would like to express our gratitude to our College staff, as well as Drs. CN Tang, Eric Lai and their team at PYNEH, without their meticulous organization and efforts, the examination would not have been possible.

Prof. Simon Ying-ki LAW
Queen Mary Hospital

Paediatric Surgery

The Conjoint Exit Examination was held on 23rd March 2013 at the Prince of Wales Hospital. There were two local candidates sitting for the examination. Tutorials for HSTs are on-going and progressing well.

The next inter-hospital clinical meeting will be held in Queen Elizabeth Hospital. The exact date will be announced in due course.

For the coming HST selection exercise, there will be training posts in paediatric surgery. Those interested to apply can watch out for the circulars from the Hospital Authority or obtain more information from Prof. Paul Tam, the current Programme Director.

Paediatric Surgical Training for the coming Centre of Excellence in Paediatrics is progressing. Several specialists have been sent to overseas centres for training in various sub-specialties. The training programme is continuing and more specialists will be sent in the following years.

Dr Kelvin Kam-wing LIU
United Christian Hospital

Plastic Surgery

The preparatory course for Exit Exam in Plastic Surgery 2013 was organized by QMH on 13 April 2013. Dr Leung Shue Cheong Mark, Dr Lau Ying Kit Edgar, & Dr Chow Ling Yu Velda had passed the Exit Examination in Plastic Surgery in 2012.

The coming Exit Exam in Plastic Surgery MCQ will be held on 11 Sept 2013 at the Academy and the Viva/clinical Exam will be organized by Kwong Wah Hospital on 19 October 2013.

There will be two HST posts for open recruitment in the coming selection exercise, one in NT cluster and one in Kowloon cluster.

Dr Wing-yung CHEUNG
Kwong Wah Hospital

Cardiothoracic Surgery

The Conjoint Examination in Cardiothoracic Surgery will be held with examiners from the Royal College of Surgeons of Edinburgh and Academy of Medicine Singapore on November 29th and 30th in Singapore (Final Dates to be confirmed.) There will be a Specialty Update Course on immediately following the examinations following the last successful years Course on December 2nd to 5th. This year there will also be 2 wet-lab ‘hands-on’ teaching courses concentrating on aortic root techniques, mitral repair and advanced trauma management. BST’s who are interested in a career in Cardiothoracic Surgery should contact Board Chairman (Professor MJ Underwood) or local Head of Service to discuss career opportunities.

Prof. MJ UNDERWOOD
Prince of Wales Hospital

Cutting Edge April 2013
Message from the Specialty Boards

Urology

Re-accreditation inspection was carried out for five training centres in Hong Kong on 24 September 2012. A requirement for centres to be inspected at least six months prior to expiry of their accreditation had been promulgated by the Academy. All inspected centres were accredited for a period of three and a half years, so that a re-inspection at three years would still comply with this new requirement.

The Urology Board organized the 12th Joint Specialty Fellowship (Urology) Examination on 24 and 25 September 2012. This is the third year of successful implementation of the new oral examination. Six candidates sat in the Examination and all passed. The top candidate, Dr Ada NG, had achieved the level required for the Dr Leong Che Hung Medal, which will be awarded to her in the Diploma Ceremony 2013. The number of attempts in Exit Surgical Examination will be awarded to her in the Diploma Ceremony 2013. This is the third year of success in Exit Surgical Examination.

Six urology centers in China previously accredited are due for re-inspection; however, since no candidate from these centers has been recruited as trainee, there is no apparent need to re-inspect these centers at the meantime.

The Urology Board resolved in September 2012 on regulating the intake of higher urology trainee. From 2014 onwards intake of Urology HST will be limited to at most 4 per year for the whole of Hong Kong. Each training center can only admit one trainee in every 2 years cycle. Training centres agreed that final decision/approval to taking in any trainee should rest with the Urology Board. Consensus was reached that manpower shortage should be addressed by recruitment of senior staff, rather than by taking in trainees.

Basic Urological Endoscopy and Laparoscopy skills workshops had been held on 29/9/2012 and 6/10/2012. Advanced workshops were held on 3/11/2012 and 8/12/2012.

Members of the Specialty Committee are determined to introduce new initiatives for the congress as we believe that new ideas will diversify the congress, broaden its audience and attract participation from both Fellows and Trainees. One of these is the Surgical Nightmare session, which was conducted in a format resembling surgical grand round. Surgery is peculiar in that it is a beautiful combination of science and art, and surgical management is both evidence and experience based approach. Sharing through case discussion is most of the time-honored arena to share experience in surgery. This new session received tremendous responses and we resolved to extend the session into one for general surgery and one for specialty.

Introduction to Scientific Committee

I am privileged to serve as chairman of the Scientific Committee of the College of Surgeons of Hong Kong since 2 years ago. The Scientific Committee is empowered to organize one of the main events for the College – Conjoint Scientific Congress. Building on the success of previous conjoint scientific congresses, our team immediately faced new challenges in organizing this event in 2012.

As decided, the congress will be a conjoint meeting between the College of Surgeons of Hong Kong and the Royal College of Surgeons of Edinburgh. And the 2012 congress is the first ever one where the Colleges invited participation from Accredited surgical training centers in China. These new initiatives had led to an unexpectedly large number of abstract submissions. We were excited to receive almost 200 abstract submissions, while half of those were from our Chinese fellows and trainees. It is also the first time that the Royal College of Surgeons of Edinburgh established the China award for the best scientific abstract presented for trainees from China and Hong Kong.

Another new initiative is the lunch symposium jointly organized by the Younger Fellows Chapter and the Women’s Chapter. The objective of this symposium is to invite representatives from various parties to express their views and discuss on issues relevant to the surgical community, while at the same time participants can relax with the lunch and participate in the discussion. We are especially gratified to see active participation from our younger Fellows and our brilliant Trainees from Hong Kong.

The organization of this big event will not be successful without enthusiastic participation from our Committee members, College Council members and the support from our College Secretariat. I wish to thank everyone who had contributed to the success of 2012 congress, especially those who had participated in any part of this event! The next conjoint scientific congress will be held in 20th to 21st September 2013, and I wish to express our sincere invitation to all of you in joining the congress to make it another successful event.

Members of Scientific Committee
Prof. Philip Wai-Yan CHIU
Dr Danny Tat-ming CHAN
Dr Chiu-ming HO
Dr Ava KWONG
Dr Edward Cheuk-sun LAI
Prof. Simon Ying-kit LAW
Dr Michael Wai-yip LEUNG
Dr Siu-kee LEUNG
Dr Chi-wai MAN
Prof. Chi-fai NG
Prof. Wai-sang POON
Dr Edward Cheuk-seen LAI
Dr PO-chor TAM
Prof. Philip Wai-Yan CHIU
Dr Siu-kee LEUNG
Dr Michael Wai-yip LEUNG
Dr Chi-wai MAN
Prof. Chi-fai NG
Prof. Wai-sang POON
Dr PO-chor TAM
Prof. Philip Wai-Yan CHIU

College Express
SUBSPECIALIZATION

The Spotlight of this issue is Subspecialization. We have invited fellows to express their views in different perspectives.

“In general surgery, there are few world recognized subspecialties such as HPB, colorectal, breast, vascular, upper GI and others. There is no need to subspecialise all fields in one go. The more ready subspecialties in terms of adequate trainers, training material and feasibility for a self sustaining training programme should go first and act as pilot schemes.”

Dr Samuel KWOK

“The number of cases for general surgery HST is only marginally enough and I seriously question about whether the volume of cases will be enough for both HST and post-fellowship trainee in some subspecialty?”

Dr Weida DAY

“Although our College is relatively young in comparison to other Colleges, our achievements and our standard of governance have been well recognized by the international medical community. There is no pressing need to implement this programme for the sake of keeping us in sync with overseas standards when our situation does not favour this exercise at present.”

Dr Jason WAT

BACKGROUND

The concept of subspecialty training in GS is nothing new. Data from overseas suggests that there is a relation of workload for ultra-major operations such as oesophagectomy or Whipple’s operation. During hospital inspection for accreditation of general surgery training centres, the College had noticed that most of the training centres have surgical teams of different subspecialty interest. Dr. Samuel KWOK, Past President of the College, has the vision of formalising subspecialty training in general surgery. He initiated the project of subspecialty training in general surgery during his term of presidency. This difficult project was assigned to Prof. CM LO. A group of general surgeons with subspecialty interest were gathered to help Prof. LO in this project. With many meetings and exchange of opinions, the ground work was firmly laid down by Prof. LO. However, the progress was hampered by the unstable secretarial support from the College due to major change in personnel. The project came to a halt. It was around 2008 that the project was restarted. However, as Prof. LO taking more administrative and clinical duties in HKU, he did not seek for re-election as Council member. I was given the duty to take up his role as the convener of the task force for subspecialty training.

AIM OF SUBSPECIALITY TRAINING IN GENERAL SURGERY

The primary aim of this whole project is to provide opportunities for Fellows to undergo training in subspecialties in general surgery. With the accreditation of different training centres and trainers, the College envisaged that there will be much interaction and more regular meetings among the trainers and centres, which will ultimately improve the standard of care for patients. This project will not limit the practising right of existing or future surgeons.

IS SUBSPECIALITY TRAINING FEASIBLE IN HONG KONG?

I would say yes and this is also the view of all the members of the task force. The workload in Hong Kong would be sufficient to support training centres in different subspecialties in major hospitals. Hong Kong also has excellent surgeons, in terms of surgical skill, knowledge and research capability. Hardware is also not a major problem for most hospitals. Even for smaller hospitals, the formation of cluster training program would also work to provide sufficient workload, expertise and hardware to have successful training. I could see the major obstacle would be the willingness to provide training, which would mean most of the operation to be performed by the surgeon under training, more resources to improve hardware, organisation into subspecialty teams, more effort in research etc. The existing resources may not be adequate to meet the change required and extra resources will be required from the HAHO. Whether the administrators in the HAHO would be willing to do so would be the major obstacle as far as I can see. However, I think the HAHO should have the vision to inject money so as to keep our surgical standard high and ultimately benefiting our patients.

HOW FAR HAVE WE GONE?

 Actually Prof. LO had laid a solid foundation for the project. We had identified 7 subspecialties and criteria for accreditation of training centres, requirements for trainees were established and agreed amongst the members. We think that it will keep our training in par with overseas standards while at the same time taken into account the current situations of Hong Kong. The different criteria could be found in the College website.

We had proposed to start the subspecialty training in 2012. However, different opinions were raised towards the aims, feasibility and criteria. The College Council decided to withhold the process and seek for more feedback from our Fellows. The College did receive feedback from our Fellows and the Council decided that we should move on to subspecialty training in General Surgery.

We are now proposing to start subspecialty training in phases. 3 subspecialties, namely Breast, Head and Neck and Vascular surgery, will be the first batch for accreditation of training, as the Chinese saying ‘journey of a thousand miles starts with the first step’.

FUTURE DIRECTION

We plan to start subspecialty training in other subspecialties after successful implementation of training program in the initial phase and we welcome feedback from other Fellows and training centres. Successful trainees will be issued a certificate of completion of training.

IS THIS A MOVE TOWARDS FUTURE SUBSPECIALIZATION?

For future formal subspecialization, the process probably will take 10+ years even if there is consensus to go ahead for subspecialisation. I cannot see in the near future (3-5 years) there will be a consensus.

WHAT IS THE COLLEGE/COUNCIL/WORKGROUP’S VIEW ON THE FUTURE DEVELOPMENT OF SUBSPECIALIZATION IN GS?

The workgroup just focuses on the implementation of the training in subspecialties. View no. 1 is the agreement within the workgroup members. It will be the next generation surgeons to decide.

ARE THERE ANY AGENDA ON THE IMPLEMENTATION OF SUBSPECIALIZATION IN GS?

We aim at implementing the 3 subspecialties training which probably will not generate much controversy since the specialists involved are very well defined. We will collect feedbacks from other Fellows after the initial implementation before deciding on future development. We would like to have the implementation of training in all 7 subspecialties within 2-3 years time.

WHAT HAPPENS TO THOSE HOSPITALS WHICH ARE NOT ACCREDITED AS SUBSPECIALTY TRAINING CENTRE?

Their surgeons cannot claim themselves subspecialty surgeons even though they are running subspecialty teams. And no matter how many years they work there they cannot call themselves subspecialty surgeons. In the end there might even be less subspecialty practice than before.

“For future formal subspecialization, the process probably will take 10+ years even if there is consensus to go ahead for subspecialization. I cannot see in the near future (3-5 years) there will be a consensus.”

Dr HT LEONG, Chairman of task force of subspecialization in General Surgery

“As much proportion of operative cases is done in the private sector, and with many colleagues now worked as private surgeons, the application of this principle of subspecialization appears doubtful if not impossible.”

Dr Michael CHEUNG

“‘What happens to those hospitals which are not accredited as subspecialty training centres? Their surgeons cannot claim themselves subspecialty surgeons even though they are running subspecialty teams. And no matter how many years they work there they cannot call themselves subspecialty surgeons. In the end there might even be less subspecialty practice than before.’

Dr LS HO

“Although our College is relatively young in comparison to other Colleges, our achievements and our standard of governance have been well recognized by the international medical community. There is no pressing need to implement this programme for the sake of keeping us in sync with overseas standards when our situation does not favour this exercise at present.”

Dr Jason WAT

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Dr Jason WAT
Subspecialization in general surgery implies the practice within a special subject by those who have completed in-depth subspecialty training. As pointed out above, while a surgeon is good at his subspecialty, he should be qualified to practice in general surgery as well because he has gone through general surgery training. The difficulty here is that the differentiation between general surgery and its subspecialties is often fuzzy. In the continuing process of subspecialization, most subjects within a specialty have become subspecialties with only very little left for the mother specialty. But it is also a common view that within a subspecialty, there are some areas that could be adequately dealt with by surgeons with general surgery training. Only some of the more complicated and highly specialized areas should be under the realm of the subspecialty only. There is a need for subspecialization in those areas because a better outcome in surgery can be assured by subspecialty training and supported by high volume in the number of cases in subspecialty practice.

The feasibility of subspecialization in general surgery depends on whether there is sufficient volume of highly specialized work to support the development of the said subspecialty and the readiness to formulate a structured subspecialty training programme.

The process of subspecialization should be beneficial to both the system of healthcare and the surgeons who provide subspecialty care. And all this should accrue to the benefit of the patients who receive surgical care. The surgical outcome in the community should become better as the surgical stream is subspecialized because of concentration of subspecialty cases to their respective subspecialty centers or appropriate surgeons. And the surgeons providing subspecialty care should be more comfortable and have lower level of complication rates as the surgeons are practising within their realm of competence.

On the other hand, the process of subspecialization is a process of change. There will be both problems and issue in the early stage of development and this process can take long time. In the old system of surgical training, all general surgeons were trained in general surgery which encompass all subspecialties. Therefore in principle they should be able to practice general surgery in the old sense and basically all subspecialties. But due to the rapid advancement of each subspecialty, it is difficult if not impossible for surgeons to become subspecialists all the time and be competent in all. It is then quite natural for surgeons to develop interest in one or a few subspecialty areas only and have large experiences in those areas but not others. It is also difficult to keep all surgeons highly competent in all fields simply because the distribution of cases is not even and some surgeons are short in certain areas. However it is difficult to be prescriptive on what can do what general surgeons are trained all round. Therefore, in the beginning of the subspecialization process, it should not be seen as a system to restrict area of practice for general surgeons, but it should be looked upon as a change in training programme to be more in line with international standard and to enhance competency of trainees in their respective fields of training.

The other difficulty in subspecialization is the establishment of subspecialist training centers and accreditation of trainers for the subspecialty. Subspecialties are dispersed among the surgical training centers and there is no subspecialty centers accredited as such. I suppose when drawing up subspecialty training programmes, one may need to be open on which centers can be accredited and training programmes requiring trainees to rotate through a few centers instead of just one for completion of training may be useful.

What is your main concern when implementing subspecialization?

The cornerstone of subspecialization lies in the establishment of good training programme for each recognized subspecialty. To build up a structured subspecialty training programme from scratch is not an easy task. Reference could be made from international recognized programmes and tailored to our local Hong Kong situation and the need of the community in receiving subspecialty surgical services. Relevant services and training opportunities from the number of established surgical training centers should be taken out and put together into one comprehensive programme. The trainers and centers should go through the proper College accreditation process. One major concern may be whether the subspecialty center can only deal with subspecialty cases but not other general surgical cases or vice versa.

The other major obstacle to the successful implementation of subspecialisation is that subspecialty surgeons would have legitimate worry about the limitation of their practice to his subspecialty only. Since all general surgeons up to the present moment are trained all round in general surgery, although some might choose to obtain subspecialty qualification due to the desire of certification of their practice subspecialty cases but not other general surgical cases. I am of the opinion that one should concentrate more on the adequacy of the amount of relevant training rather than restricting trainees’ participation in work other than in the subspecialty. I suppose one barrier to successfully formulate subspecialty training programmes lies in the lack of trainee’s participation in general surgery calls if some trainees are totally removed from general surgery into subspecialty.

The surgical outcome in the community should become better as the surgical stream is subspecialised because of concentration of subspecialty cases to their respective subspecialty centers or appropriate surgeons.
Dr LS HO, 
Princess Margaret Hospital

I think that probably every surgeon will agree in principle that subspecialization is a desirable thing to have. But whether or not it is suitable for HK is the right time to implement it in HK is an entirely different story. Probably we have all been primed by our Council that we need to go for subspecialization to catch up with the world trend. But in reality we have asked ourselves who may benefit from this subspecialty training and who may suffer?

Are hospitals already running subspecialty teams? What difference does it make when the College adds on its accreditation?

Then some hospitals will become accredited subspecialty training centres and some will not.

Which hospitals are more likely to become subspecialty training centres?

The big 2 or 3.

Can surgeons from other hospitals go to training centres to have training and go back to parent hospital and practice?

In reality the chance for training is primarily occupied by the highly experienced ones, and space for surgeons from other hospitals is slim. And sending surgeons from one hospital to another will require a swapping and many units are reluctant to do that. To what extent the subspecialty surgeon out of its parent hospital is difficult because they may be uncomfortable to work in settings other than its own hospital with a big share of subspecialty practice.

What happens to those hospitals which are not accredited as subspecialty training centre?

Their surgeons cannot claim themselves subspecialty surgeons even though they are running subspecialty teams. And no matter how many years they work there they cannot call themselves subspecialty surgeons. In the end there might even be less subspecialty practice than before.

The benefits of such training may flow to those hospitals with subspecialty training centres. They will have less chance of treating these subspecialty patients. As time goes on and when more subspecialty surgeons are trained for subspecialty training then the medium sized hospitals will shrink in terms of patient number and patient variety. They will finally be downsized to small sized hospital capable of doing acute appendicitis and perhaps hernia. Under the existing administrative models in Hospital Authority the medium sized hospitals have no chance of increasing their patient number and variety. All the surgical work for subspecialists will happen in the specialty training centre. They are already under great tension being scrutinized by the SOMIP. This will make it difficult for smaller hospitals, and create burden in all related field (X-ray, Oncology etc.).

Subspecialization in General Surgery in HK is difficult. The logic behind subspecialization lies in the fact that common major caseload will allow surgeons to have more frequent exposure to the same group of procedures, thus allow easier maturation and standardization of techniques. This trend is mostly valid for subspecialties with low case volume are those areas that can easily benefit from subspecialties training. But it is not applicable to subspecialties with high case volume, which need much longer term changes in case allocations across the whole territories, involving patient transfer across many clusters, which could both be politically sensitive and practically difficult.

In addition, as much proportion of operative cases is done in the private sector, and with many colleagues now worked as private surgeons, the application of this principle of sub-specialization appears doubtful if not impossible. The other difficulty for subspecialized surgeons is that the need for operating exclusively in a designated field. In other words, one single hospital needs to have many different groups of “subspecialists” in order to be able to provide a comprehensive service to patients. This would be exceptionally difficult for 90% of public hospitals. In fact, as most experienced hospital administrative staff across the whole world had agreed, “mega size” hospitals like QMH and PWH is a history. If the number of cases for general surgery HST is only marginally enough and I seriously question about whether the volume of cases will be enough for both HST and post-fellowship trainee in some subspecialty? Perhaps, the number of cases on paper is enough but not the real training experience. At the end, the duration of pre-fellowship training will be prolonged in future because of the insufficient training materials of HST.

From your opinion, what are the pros and cons for subspecialization training in General Surgery in HK?

As I pointed out earlier, the potential benefit is better patient outcome. However, when we looked at the statistics from SOMIP report over the last few years, even for subspecialties with high caseload, i.e. colorectal surgery, it does not appear that hospitals with surgical teams having sub-specialized teams are that different from those without. The need for additional manpower, the transfer of patients across all clusters, the need for operating exclusively in a selected field to maintain a trainer status (especially as private practicing surgeons) are obvious drawbacks.

What is your main concern when implementing subspecialization?

The public will take a different view on hospitals not able to provide a comprehensive service by “subspecialist”. This would be especially detrimental in situation of surgical mishap and complications, as both the hospital and staff would be viewed as providing “sub-standard” service to the patient. It would also be extremely difficult for hospitals and departments without obtaining subspecialization training status to attract the number of patients to join the service. With the allowance of cross-referral clusters for patients, this would only create a problem where hospitals with known subspecialties attract even more patients, while the rest of the hospitals lose patient volume, i.e. smaller hospitals, and create burden in all related field (X-ray, Oncology, allied health, etc) that needs to support the extra patient load to that hospital.

In your opinion, how far we should go in subspecialization?

We should only limit subspecialties with low case volume, yet with known extremely high operative risks and demanding operative skills, preferably with high demand on accessory support (e.g. vascular surgery) to go for sub-specialization.

Mr LC Kwok, 
Younger Fellows Chapter

Recently the College has agreed, “mega size” hospitals like QMH and PWH is a history. If the number of cases for General Surgery HST is only marginally enough and I seriously question about whether the number of cases will be enough for both HST and post-fellowship trainee in some subspecialty? Perhaps, the number of cases on paper is enough but not the real training experience. At the end, the duration of pre-fellowship training will be prolonged in future because of the insufficient training materials of HST.

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As I pointed out earlier, the potential benefit is better patient outcome. However, when we looked at the statistics from SOMIP report over the last few years, even for subspecialties with high caseload, i.e. colorectal surgery, it does not appear that hospitals with surgical teams having sub-specialized teams are that different from those without. The need for additional manpower, the transfer of patients across all clusters, the need for operating exclusively in a selected field to maintain a trainer status (especially as private practicing surgeons) are obvious drawbacks.

What is your main concern when implementing subspecialization?

The public will take a different view on hospitals not able to provide a comprehensive service by “subspecialist”. This would be especially detrimental in situation of surgical mishap and complications, as both the hospital and staff would be viewed as providing “sub-standard” service to the patient. It would also be extremely difficult for hospitals and departments without obtaining subspecialization training status to attract the number of patients to join the service. With the allowance of cross-referral clusters for patients, this would only create a problem where hospitals with known subspecialties attract even more patients, while the rest of the hospitals lose patient volume, i.e. smaller hospitals, and create burden in all related field (X-ray, Oncology, allied health, etc) that needs to support the extra patient load to that hospital.

In your opinion, how far we should go in subspecialization?

We should only limit subspecialties with low case volume, yet with known extremely high operative risks and demanding operative skills, preferably with high demand on accessory support (e.g. vascular surgery) to go for sub-specialization.

Dr Michael Cheng, 
North District Hospital

Subspecialization in General Surgery in HK is difficult. The logic behind sub-specialization lies in the fact that common major caseload will allow surgeons to have more frequent exposure to the same group of procedures, thus allow easier maturation and standardization of techniques. This trend is mostly valid for subspecialties with low case volume are those areas that can easily benefit from subspecialties training. But it is not applicable to subspecialties with high case volume, which need much longer term changes in case allocations across the whole territories, involving patient transfer across many clusters, which could both be politically sensitive and practically difficult.

In addition, as much proportion of operative cases is done in the private sector, and with many colleagues now worked as private surgeons, the application of this principle of sub-specialization appears doubtful if not impossible. The other difficulty for subspecialized surgeons is that the need for operating exclusively in a designated field. In other words, one single hospital needs to have many different groups of “subspecialists” in order to be able to provide a comprehensive service to patients. This would be exceptionally difficult for 90% of public hospitals. In fact, as most experienced hospital administrative staff across the whole world had agreed, “mega size” hospitals like QMH and PWH is a history.

If the number of cases for general surgery HST is only marginally enough and I seriously question about whether the number of cases will be enough for both HST and post-fellowship trainee in some subspecialty? Perhaps, the number of cases on paper is enough but not the real training experience. At the end, the duration of pre-fellowship training will be prolonged in future because of the insufficient training materials of HST.

From your opinion, what are the pros and cons for subspecialization training in General Surgery in HK?

As I pointed out earlier, the potential benefit is better patient outcome. However, when we looked at the statistics from SOMIP report over the last few years, even for subspecialties with high caseload, i.e. colorectal surgery, it does not appear that hospitals with surgical teams having sub-specialized teams are that different from those without. The need for additional manpower, the transfer of patients across all clusters, the need for operating exclusively in a selected field to maintain a trainer status (especially as private practicing surgeons) are obvious drawbacks.

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Dr Weida DAY, 
Younger Fellows Chapter

Subspecialization training in General Surgery is indeed a common phenomenon among general surgeons and it is a natural path leading to the advancement of our surgical discipline. Nevertheless, one needs to take into account the feasibility and feasibility of this exercise in Hong Kong because of Hong Kong’s unique distribution of patients and its unequal distribution of hospital resources among public hospitals. Although the College has conducted a number of inquiries among its members regarding this topic, there is neither a general polling nor a formal discussion between the Council and the majority of ordinary Fellows which focusing on the implementation of this important project. Results of the previous electronic survey was never released rendering Fellows with more questions regarding the views of other Fellows. Different criteria and requirements for individual subspeciality training are not readily available on any website. There is no clear definition on the qualifications of the “trainer” concept within this new training process. Established surgeons in surgery have suddenly become trainees again. Uncertainties of Fellows in the majority of hospitals in Hong Kong seem to overwhelm the seemingly beneficial intent of this new concept. This shroud of ambiguity is slowly creating unrest among Fellows of our College.

Over the past few decades Hong Kong’s surgical community has flourished and has attained an international standard comparable to most overseas centers. Although our College is relatively young in comparison to other colleges, our achievements and our standard of governance have been well recognized by the international medical community. There is no pressing need to implement this programme for the sake of keeping us in sync with overseas standard when our situation does not favour this exercise at present. After all, creating widespread anxiety and paranoia to fellows does more harm to our patients than good.
NEITHER SPECIALIZATION NOR SUBSPECIALIZATION HAS BEEN AN END IN ITSELF. SPECIALIZATION OF UROLOGY HAS ARISEN OUT OF Necessity. UROLOGISTS JUStIFIED THE EXISTENCE OF UROLOGY SPECIAlITY BY BETTER PATIENT OUTCOME, WHICH HAS BEEN ACHIEVED THROUGH FOCUSING ON UROLOGICAL CONDITIONS, PROCEDURES, AND OPERATIONS. THIS CONCENTRATION ON UROLOGICAL CARE HAS ALLOWED UROLOGISTS TO ACQUIRE DEEPER KNOWLEDGE AND SKILLS IN THEIR RESPECTIVE AREAS OF INTEREST. SUBSPECIALIZATION IN UROLOGY HAS BEEN A DRIVER FOR IMPROVEMENT IN THE FIELD, ALLowing FOR MORE ADVANCED TECHNIQUES AND BETTER OUTCOMES FOR PATIENTS.

SPOTLIGHT ON SUBSPECIALIZATION

"Change' is indubitable, whereas 'progress' is a matter of controversy" Bertrand Russell 1872-1970

"We are all in the gutter, but some of us are looking at the stars" Oscar Wilde 1854-1900

"We are all in the gutter, but some of us are looking at the stars" Oscar Wilde 1854-1900

SPECIALIZATION IN UROLOGY, SINE QUO NON FOR PROGRESS OR STARGAZING?

SUBSPECIALIZATION IN UROLOGY, SINE QUO NON FOR PROGRESS OR STARGAZING?

“Change’ is indubitable, whereas ‘progress’ is a matter of controversy” Bertrand Russell 1872-1970

“We are all in the gutter, but some of us are looking at the stars” Oscar Wilde 1854-1900

neither specialization nor subspecialization has been an end in itself. Specialization of urology has arisen out of necessity. Urologists justified the existence of urology specialty by better patient outcome, which has been achieved through focusing on urological conditions, procedures and operations. This concentration on urological care has allowed urologists to acquire deeper knowledge and skills in their respective areas of interest. Subspecialization in urology has been a driver for improvement in the field, allowing for more advanced techniques and better outcomes for patients.

Subspecialization in urology is critical for progress. Without specialization, urologists would not have the depth of knowledge and skills necessary to provide the best care for our patients. Subspecialization allows urologists to focus on specific areas of interest, such as oncology, endourology, or pediatric urology, which enables them to become experts in their field.

However, specialization also poses risks. It can create barriers to collaboration and sharing of knowledge. To overcome these challenges, urologists must work together across different specialties, sharing knowledge and best practices.

In conclusion, subspecialization in urology is essential for progress. It allows urologists to become experts in their field, providing better care for patients. However, it is important to foster collaboration and sharing of knowledge across specialties to ensure the best outcomes for patients.

Subspecialization in urology is a critical driver for progress, allowing for the development of new techniques and technologies. It is essential for ensuring the best care for patients, but it is also important to foster collaboration and sharing of knowledge across specialties.
Spotlight on subspecialization

The basic premises that an urologist should be a general urologist with subspeciality competence just added on is also being upheld in America. All diplomats of the American Board of Urology with a general certificate in urology are certified to have been trained in all areas of urology including those for which subspecialty certificates are available. The issue of subspecialty certificates had been debated and opposed since the late 1980’s. Even though most American urologists believed that subspecialization would provide better care for some patients, advance research and improve training in special areas, they worried that the cost to patient would increase and experience and competence of general urologists might become restricted. Groups pressing for subspecialty certificates argued that this would help to ring-fence patients against competing specialists, and allowed training of a new breed of subspecialist who would remain leaders in rapidly evolving fields and serve as trainers of a future generation of urologists in subspecialty areas. They finally have their way and subspeciality certification is available now in the States for pediatric urology and female urology. However, the subspecialists need to maintain their general urology certificates at all times, and no operative procedure has been designated to be done exclusively by these subspecialists. Collaboration between subspecialties is maintained through the affiliation of the subspecialty organizations to the American Urological Association.

In Europe, subspecialization in urology is taken a step further. The European Board of Urology is poised to certify subspecialized urology centres that fulfilled criteria stated. The certified centre must be disorder oriented, high volume, multidisciplinary and provides most relevant methods of treatment with a structured pathway, producing high level of results with quality management, and pursuing clinical studies and research on the subspecialty to keep abreast with the latest developments. The centre should offer postgraduate training or fellowship programmes. After completion of a fellowship programme, the doctor is awarded a certificate of completion of subspecialty training. To achieve such a centre in Hong Kong would be an unrealistic dream. Subspeciality development is a gradual evolution of the profession geared to the need of the society. As the society is dynamic, we must expect and prepare for changes. Increase demand from our patients, increase in complexity of treatments and increase number of urologists all call for increasing degree of subspecialization, even though this might not seem clear and imminent. The logical first step would be the gathering and identification of urologists with subspecialty interests. Locally, the Hong Kong Urological Association has chapters on Oncology, Female Urology and Andrology. There is also a Hong Kong Society of Endourology. The Urological Association of Asia also has subspecialty organizations including the Asian Pacific Society of Uro-oncology, Asian Society of Female Urology and Asian Society of Endourology. These interest groups will provide impetus for formal recognition of subspecialty training and recognition. I do not have a crystal ball to gaze into but it appear reasonable to follow the UK steps, as we are adopting similar curricula. The final year of higher training can be designated subspecialty training. The subspeciality programmes and the centres providing them can then be more clearly defined, with objective data and criteria. This definition of subspecialty training programme would be prelude to formation of subspecialty teams and even subspecialty centres, depending on whether services could be concentrated through re-engineering. The recognition of training can be geared to the actual need. We can issue certificate of competence after the higher trainee completed his final year of subspecialty training. If subspecialty teams or centres can be formed, post fellowship subspecialty training could be provided culminating in a subspecialist certificate. In addition to service and training, subspecialty teams or centres must also be charged with duty to research. All these would have to be worked out by urologists locally, taking reference to international trends, and under the auspices of the College of Surgeons and the Hospital Authority of Hong Kong. Considering that we still do not have an independent department of urology here, this would be no mean feat!

“To polish a piece of jade, it takes a stone from a different hill.” Ode, Confucius 551-479BC

Dr Chi-wai MAN
Chairman, Urology Board
Chairman, Specialty Group on Urology Services

BRAIN is a series of annual conferences organized by the Neuroscience group of the Prince of Wales Hospital, the Chinese University of Hong Kong (Divisions of Neurosurgery, Neurology and the Department of Anatomical & Cellular Pathology). The conferences were organized with a strong belief in the multidisciplinary approach to the diagnosis and treatment of neurologic diseases. The conference is usually held in January of each year.

This year meeting came to the tenth event since 2003. There is a growing participation by neurosurgeons, neurologists, pathologists, oncologists and related scientists in Hong Kong, Mainland China, Taiwan, Asia Pacific region, Europe and America.

BRAIN 2013 was held in Postgraduate Education Centre of Prince of Wales Hospital on 18-19 Jan 2013. The meeting started with a pre-congress workshop on “Essence of clinical Trial for cell therapy”, and followed by a 2-days program on management of various neurological diseases and research. There were more than 30 speakers from Hong Kong, China, Taiwan, Europe and Canada and there were about 250 candidates joining the meeting this year. It was a great success this year.

For the nervous system diseases
The Hong Kong Society of Breast Surgeons was established in Feb 2012, by a group of interested surgeons in Hong Kong. One of our missions is to cultivate and develop our skills through sharing and interaction among specialists with special interest in breast surgery, and in the end, benefit the patients under our care. It also aims to promote the advancement and to strive for the highest ethical and surgical standards of breast surgical care in Hong Kong.

During the first Council meeting, Dr. Polly Suk-Yee Cheung was elected as the President and Dr. Miranda Chi-Mui Chan was elected as the Vice-President. One of our main activities is seasonal clinical meeting. In year 2012, we held three clinical meetings featuring breast cancer in young women, sentinel lymph node biopsy and preoperative breast imaging. We also worked with other societies in holding scientific symposium. We received positive feedbacks that the meetings were useful in keeping them abreast of the newest knowledge and the technology in breast surgery.

The Society was inaugurated on 3 March 2013, preceded with the oncoplastic breast surgery course. We were honoured to have the pioneer and world leader of oncoplastic breast surgery, Professor Werner Audretsch, to share his experiences and to deliver the inaugural lecture on “Technique and Art of Breast Cancer Local Treatment”. The response was overwhelming with more than 120 doctors and nurses attended. Dr. Ko Wing Man delivered speech during our inaugural dinner and witnessed a new chapter of breast surgery in Hong Kong.

In 2013, we are planning series of clinical meetings, workshops and courses, please do join our Society and enjoy our upcoming activities.
Joint Annual Scientific Meeting 2013 of the Hong Kong Society for Coloproctology and the Hong Kong Society of Minimal Access Surgery was successfully held in HKEC Training Centre on 26 January 2013. This year we had two world-leading experts, Professor Seon Hahn Kim and Professor Michael Li, to deliver two keynote lectures on management of colorectal cancer. Dr. Michael Poon and Dr. Shirley Liu shared their experiences on overseas training in Japan and Korea respectively. The free paper session this year again provided a platform for our Trainees from different hospitals to present their research projects. Dr. Shannon M Chan from Prince of Wales Hospital won the best paper prize of the Hong Kong Society of Minimal Access Surgery; and Dr. Philip Kam from Queen Elizabeth Hospital won the best paper prize of the Hong Kong Society for Coloproctology.
The Robotic Pancreatectomy Symposium was successfully organized by the Hong Kong Society of Hepatobiliary and Pancreatic Surgery and the Clinical Robotic Surgery Association on 17-18 January 2013 in Pamela Youde Nethersole Eastern Hospital. Three famous robotic surgeons from the United States were invited to share their experiences. They were Prof. Pier Cristoforo Giulianiotti and Prof. Francesco Bianco from the University of Illinois in Chicago; and Dr. Anusak Yiengpruksawan from the Valley Robotic & Minimally Invasive Surgery Center in New Jersey. Live Robotic Whipple’s Operation and Distal Pancreatectomy were the highlight of the symposium, and many hepatobiliary surgeons from Hong Kong and China were attracted to this symposium.

The sixth International Colorectal Disease Symposium (ICDS) was successfully held in Pamela Youde Nethersole Eastern Hospital (PYNEH) on 24-25 January 2013. ICDS is a major event among the colorectal surgeons in Hong Kong every 2 years since 2002. The theme this year was “Advance in Technique & Technology”. Experts from Hong Kong and all over the world including United States, Italy, Japan, Korea and Thailand delivered their keynote lectures and shared their experiences in managing the colorectal diseases. Fantastic live demonstrations and video sessions were the two most exciting sessions during the conference. Thousands of delegates mainly from Hong Kong and Asia-Pacific regions enjoyed the conference.
14: Prof. Chucheep Sahakitrungruang, famous colorectal surgeon, from King Chulalongkorn Memorial Hospital, Thailand
15: Prof. Yasunobu Tsujinaka, famous colorectal surgeon, from Tsujinaka Hospital Kashiwanoha, Japan
16: Prof. Yoshiharu Sakai, famous colorectal surgeon, from Kyoto University Hospital, Japan
17: Prof. Wai Lun Law, famous colorectal surgeon, from Queen Mary Hospital, Hong Kong
18: Prof. Simon Ng, famous colorectal surgeon, from Prince of Wales Hospital, Hong Kong
19: Prof. Siew Chien Ng, famous gastroenterologist, from Prince of Wales Hospital, Hong Kong
20: Dr. Tsz Kok Yau, Oncologist, from private practice, Hong Kong
21: The audience
22: The Live Surgery
23: Viewing the Live Surgery in 3D
24: Panel Discussion

25-26: Prof. Seon Hahn Kim, performing live robotic surgery
27: Prof. Michael Li and his team
28: Prof. Arun Rojanasakul, performing LIFT operation
29: Prof. Mariana Berho, demonstrating the quality of TME specimen and the technique in preparing of specimen
30: Prof. Seon Hahn Kim and Dr. Hester Cheung, at the Robotic Endolap OR
31-32: Lunch of the symposium
33-37: Faculty Dinner
38-40: Welcome Dinner

Dr Dennis NG
North District Hospital
MEMOKATH STENTS WORKSHOP -- ALTERNATIVE SOLUTIONS TO BLADDER OUTLET AND URETERIC OBSTRUCTION

The Memokath Stents Workshop on Alternative Solutions to Bladder Outlet and Ureteric Obstruction was organized by the Hong Kong Society of Endourology successfully in HKEC Training Centre for Healthcare Management and Clinical Technology on 2 February 2013. Dr. Noor Buchholz, a leading European expert in endourology and stone treatment, from United Kingdom; and Dr. Noboru Sakamoto from Japan were invited to share their experience on this topic. A hands-on workshop on ureteric stent insertion was also included. Urology trainees from different hospitals had a chance to practice the technique.

HONG KONG SURGICAL FORUM & SHENZHEN SURGICAL FORUM

The biannual Hong Kong Surgical Forum held its winter gathering on Saturday, 5 January 2013 with the theme of “Surgery without Borders”. Over 200 delegates attended the informative and inspiring presentations by leading authorities from London, Barcelona, Daegu, Seattle and Tokyo as well as some local experts.

The overseas speakers included:
• Professor Ara Darzi, Imperial College, London
• Professor Antonio Maria de Lacy, Hospital clinic de Barcelona, Bacrelona
• Professor Hoyong Park, Kyungpook National University Hospital, Daegu
• Professor Carlos A Pellegrini, University of Washington, Seattle
• Professor Takeshi Sano, Cancer Institute Hospital, Tokyo

7 prominent Mainland speakers had been invited to present areas of their expertise, 3 were the Academicians of Chinese Academy of Engineering, namely:
• Professor Lan-Juan Li, First Affiliated Hospital, Zhejiang University
• Professor Hong-Yang Wang, Eastern Hepatobilary Surgery Hospital, The Second Military University
• Professor Shu-Sen Zheng, First Affiliated Hospital, Zhejiang University

Topics on Hepatocellular carcinoma, Transplantation, Minimally Invasive Surgery, Digestive Diseases were covered. Responses and discussions from the floor were stimulating and enthusiastic.

The meeting was followed by the Inaugural Shenzhen Surgical Forum at the HKU-Shenzhen Hospital on Sunday, 6 January 2013. Over 400 participants attended, many were from outside Shenzhen area.
It was the third time that the College runners participated in the Standard Chartered HK Marathon! In the chilly morning on 24 February 2013, our fellow colleagues were wearing the orange tees which signifying vitality, enthusiasm and endurance, and gathering at the Causeway Bay Sports Ground at 5am to get ready for the Marathon. Some were unpacking their baggage; some were wearing their bib; and some were stretching and warming up. It was encouraging to see everybody concentrated on the Marathon and we demonstrated the mentality of ATHLETE!

Running in the dark, our energetic fellow colleagues were excited. Echoing the theme of the Marathon—RUN FOR A REASON, they insisted and reached the destination with sweat and joyfulness.

Getting interested? To experience the marathon journey, don’t hesitate to join our team next year. We need your support to make the College marathon possible. Let’s buddy up and form our team!
After the forum, we had a brief interview with our YFC member Dr Akin Chan:

**When did you join the MSF?**
I joined the MSF in year 2011, right after my specialist exam.

**Why did you join the MSF?**
MSF is a unique NGO that provides its assistance to populations basing on strict neutrality & impartiality. It has been my dream since young, to work with the MSF, helping the people in the third world & war zone. It is my great honor to become a member of this organisation.

**Could you tell us the most memorable moment in your MSF mission?**
The whole experience is full of memorable moments. Starting from the interviews, the preparation before the departure, the cultural shock, the way of collaboration with expats from all around the world, the kind & passionate local staff & patients etc. And the most memorable part is the satisfaction when you managed to save your patients & seeing them recovered from your care. Unlike in Hong Kong, we are lack of resources & manpower. Thus I had multiple identities apart from being a surgeon; I am ER doctor, physician, obstetrician, paediatrician, orthopedics surgeon, nurse, physiotherapist, psychologist, social worker, logistician, porter or even a cleaner... And what is more satisfying than seeing your patients leaving the hospital in good health under such condition?

**Will you encourage your colleagues to join? And the reasons?**
Definitely YES! As you can never understand the satisfaction unless you experience it yourself!
Being a female surgical trainee then a surgical specialist, I have always believed I got no different from my fellow male colleagues. I believe that we are no inferior to them in terms of academic achievement, professional knowledge & attainment. Actually I think that we are better in some aspects, say being more attentive to patient especially lady patients.

When approached for establishment of the Women’s Chapter, my first thought was that: “Why self –discrimination?”

Over the years working with fellow lady surgeons & serving our small community of lady surgeons & trainees, I start to convince myself how meaningful the Chapter had been & will be.

I myself went through the basic / advanced training then examination which coincided in timing with my major life events, mainly marriage & pregnancy. I can recall in my days, the College even did not have guidelines in counting the training fulfillment of a trainee’s maternity leave. Babies should not be jeopardized in training opportunities because of these beautiful life events.

With a strong community as our Chapter, our rights & benefits could be safeguarded. Nevertheless, what impressed me most is the “soft” aspect of the Chapter. The cosmetic make up course, jewelry course, are definitely ladies’ delight, to quote a few.

We will be recruiting new members to join the Committee soon, those who are interested in serving the committee please email us!

Dr Ava KWONG: avakwong@hkucc.hku.hk
Dr Mimi Poon: mimiwinona@hotmail.com
Dr Bonita Law: lawbonita@gmail.com
Dr Yeung Ying Fune: yeungyf@surgery.cuhk.edu.hk
Dr Ada Ng: adang713@graduate.hku.hk
The MHKICBSC Part 3 Exam was successfully held on 21-22 March 2013 at Queen Mary Hospital. 66 candidates enrolled in the Exam in which 50 of them passed the exam. The passing rate is 75.8%.

Membership Examination

The Fellowship Examination in General Surgery was successfully held on 24-26 March 2013 (24-25 March 2013 at HKAM JC Building; 26 Mar 2013 at Pamela Youde Nethersole Eastern Hospital). There were 31 candidates enrolled in the Exam in which 21 of them passed the Exam. The passing rate is 67.7%.

Paediatric Surgery

The Fellowship Examination in Paediatric Surgery was successfully held on 23 March 2013 at Prince of Wales Hospital. We had two candidates sitting for the Exam and both of them passed the Examination.

The College of Surgeons of Hong Kong

Dear Fellows and Members,

You are cordially invited to join

RCSEd/CSHK Diploma Conferment Ceremony & Annual Dinner 2013
20 September 2013, Friday at 6.30pm
at the Run Run Shaw Hall
Hong Kong Academy of Medicine Jockey Club Building
99 Wong Chuk Hang Road, Aberdeen, Hong Kong

RCSEd/CSHK Conjoint Scientific Congress 2013
20-21 September 2013
at the Hong Kong Academy of Medicine Jockey Club Building
99 Wong Chuk Hang Road, Aberdeen, Hong Kong
Today, he is a different man. He is a very optimistic person. He participated very actively in different kinds of volunteer work, especially in the patient support group for liver disease and he strongly believed that having received the love from someone unknown to him, he had to pass the love on to the one in need. I still remembered that once we came across a car accident on our way to hiking, and without hesitation, he stood out to help the victims and to direct the traffic at the scene, just as what he had been doing before his retirement.

We surgeons are always very busy seeing our patients and operating. But this provided us an opportunity to stay closer with our patients and to see the other side of their lives. I would say this is something more than a doctor-patient relationship. It is the friendship that linked up four of us.

And it finally came to the days of Trailwalker in November 2012. Dr Sharr and me actually had to work overnight the day before the event. It was a rainy and windy day and Dr Sharr unfortunately suffered a fall that resulted in facial laceration.

But it never stopped us from the journey. There were cheers and tears along the MacLehose Trail. We almost forgot that Sam was our patient until he told us that he forgot to take the immunosuppressant. Having the support from each other and from families and friends, finally we arrived the finishing point after 29 hours 40 minutes. It was slightly beyond our target but we were more than happy to finish it as a team. And, what was more important, it showed that having a liver transplant or liver donation did not restrict one’s life and he/she can even do something as strenuous as the Trailwalker without any problems.

Dr Jeff Wing-chiu DAI
Queen Mary Hospital
Hong Kong for Ireland to study medicine. Although I couldn’t have lessons from these masters after leaving Hong Kong, I continued to practice during my leisure hours to keep up my hobby and interest. (Figures 1 & 2) When I returned to Hong Kong, I picked up my practice again though I seldom participated in combats since then. A few years back, I joined the Tai Chi class in United Christian Hospital and have practiced Wu Style Tai Chi under Master Dr. Tsui Woon Kwong. (Figure 3)

Many people might be misled to think that violence is a key element of martial art. This in fact is a misconception. A real martial artist is a peaceful person who tries to avoid violence at all costs. There is always someone who is a better martial artist than you. The endurance and training would make you a better martial artist each day. There is no real competition with other people. The person you are competing with is yourself. Martial art is a recreational activity that can be enjoyed throughout one’s life. So much of it is mental. It involves a combination of combative maneuvers of kicks, punches, blocks and take downs done with high energy. Some forms of martial arts also include the use of weapons. Its philosophy is based on peace and personal defense although it also includes offensive maneuvers. The concentration, focus and dedication in martial art indeed could translate to any other endeavor one pursues in life. Martial art demonstrates that there are limitless possibilities one is given in life, and one can do with whatever one chooses to do.

Similarities exist between a surgeon and a martial artist. Both demands physical fitness, great determination, decisive thinking particularly at critical moments, and long hours of hard training before a good result could be achieved. A good martial artist would need to be exposed to various schools of martial art and select out what is good and suitable for you and discard those that are not. Bruce Lee, a great and well respected martial artist, said in his martial art philosophy: “You cannot express and be alive through a static put-together form, through stylized movement. The man who is really serious, with the urge to find out what truth is, has no style at all. He lives only in what is.” A good surgeon should not just follow the stylized steps of his teacher but needs to see how other surgeons are doing and achieves his goal finally with no particular style other than his own. All types of knowledge ultimately mean self-knowledge. We shouldn’t just stay with one school otherwise there would be no improvement.

Martial art is an activity that helps with maintaining balance and flexibility and also a great cardiovascular exercise in keeping the body healthy. Martial arts have always played a prominent role in my life and I recommend that to everyone. Of all the martial art disciplines will contribute to the development of personal physical conditioning, strength, flexibility, agility, speed, mental concentration, aerobic exercise, proprioception and balance. Martial arts today have evolved from a number of ancient combat disciplines. There are several basic forms of modern martial arts: striking (e.g. Boxing, Karate, Kung Fu and Tae Kwon Do), grappling (e.g. Wrestling), throwing (e.g. Aikido, Judo and Hapkido), weapons (e.g. Iaido and Kendo), and mixed martial arts (MMA - a relatively new version of martial art which has borrowed from several disciplines and has few rules). Archery, Boxing, Fencing, Judo, Tae Kwan Do, and Wrestling have become part of Olympic Games.

Because of the special characteristics of different disciplines, it is important to understand the fundamental nature of these disciplines and how they may be a good match for yourself or your family members due to personality, maturity, physical development and basic body build. One should also consider whether some martial art disciplines are more likely to have more serious personal injuries and whether they might be less suitable for women and children. One must be aware that martial arts can be dangerous, and therefore one should not use their techniques on other people outside the martial art class. For toddlers, the primary purpose for martial art classes is to have fun while getting exercise. For someone under the age of 12 years, a program that will concentrate on proper technique, form and non-aggressive contact is more appropriate. This is because the bones are still growing and there is chance of damaging the growth plates resulting in serious developmental problems. Their bodies are not yet developed enough to allow the kind of physical muscular control required of the various martial arts, and their cognitive thought processes are not mature enough to focus on a number of the mental aspects of martial art training. Teenagers and adults should be honest about their reasons for considering martial art training. One should start with disciplines with less physical contact. Reaching a competitive level will take months to years, depending upon your fitness and flexibility levels. Adults should always check whether they are in good health to start such a high level activity. Appropriate safety measures are essential to help prevent injury. They include training with appropriate martial art instructors. One should always follow the rules for wearing protective equipments for that martial art sports, including head guard, a body protector, forearm protectors, shin guards, and a groin guard for the more combative disciplines.

A lot of people burn out in sports because the drive to participate is from external or precipitate. Only if one shows interest and fun or else he won’t keep up with it. I hope I have inspired you and your family members to take up martial art as a hobby like what I have done. It not only trains your body but also your mind and would be of use to you throughout life.

Dr. Liu is a paediatric surgeon. Apart from works relating to paediatric surgery, he has been actively practicing martial art ever since school days. Having stopped participating in competitions after entering medical school, he continues to train for two to three times a week. The concentration and dedication in the sport have certainly benefited him not just physically but professionally too. Apart from the actual physical execution of the various patterns of moves (forms), Dr. Liu has a great interest in the history and philosophy of various styles of martial arts. He has a collection of books on martial arts in both English and Chinese.
Lower rate for joining the Membership of The Royal College of Surgeons of Edinburgh

The College collaborates with the Edinburgh College for offering a lower admission and annual subscription to candidates who successfully pass the Membership Exam and join the Membership of the RCSed.

The discount only applies to candidates who are newly admitted to the Membership of the College and apply the dual membership of the College and Edinburgh College simultaneously.

Details will be announced in due course.

Call for submission: Achievement from Fellows and Members

Our Fellows and Members not only have devoted their effort into medical services but have also excelled and were awarded in other domains including public services and voluntary work. The College congratulates the personal success of all Fellows and Members and appreciates their contribution to society.

The College is pleased to share the honor and happiness with fellow Colleagues by announcing their success at the Achievement column of Cutting Edge.

The Editorial Board of Cutting Edge cordially invites all Fellows and Members to notify the Board on their recent achievements by sending the announcements to info@cshk.org for further arrangement.

Charge for posting Non-College Activity at Cutting Edge

Effective from April issue 2012, HKD$4,000 will be charged for parties posting announcement of Non-College activity on the Cutting Edge. The announcement of Non-College activity will also be posted on College website.

Dear Fellows,

“Fellows Update” is an excellent platform updating our Fellows the latest development, achievement and life events of our Fellow Colleagues and creating personal touches with Colleagues since its appearance in the Dec 2012 issue. The content covers a wide range of topics such as Retirement, Change of Practice, Marriage, Giving birth to new baby and the like, where the news can be shared.

We are now calling for your submissions to “Fellows Update”. Please do not hesitate to share with us your happiness in life by submitting your unique life changing experiences with pictures to us via info@cshk.org.

If you have any enquiries, please do not hesitate to contact me at chadtse@hkam.org.hk.

I do look forward to hearing from you, thank you.

Dr Chad TSE
Chief Editor, Cutting Edge

Sharing the Happiness of Dr Peter Pang for his newborn baby boy

“Katherine and I would like to announce our baby boy Perren Pang has come to the world on 18 April 2013. Up till now he is still behaving well and doing his job (eating and pooping) diligently.”

Dr Peter Pang
Private Practice

Dr Hung-To LUK, our President has retired from Hospital Authority and begun his private practice. He keeps serving PMH as a part-time practitioner and trainer.

Sharing the Happiness of Dr Peter Pang for his newborn baby boy

“Katherine and I would like to announce our baby boy Perren Pang has come to the world on 18 April 2013. Up till now he is still behaving well and doing his job (eating and pooping) diligently.”

Dr Peter Pang
Private Practice
Structure of the College

<table>
<thead>
<tr>
<th>COMMITTEE</th>
<th>CHAIRMAN</th>
</tr>
</thead>
<tbody>
<tr>
<td>External Affairs Committee</td>
<td>Paul B S LAI</td>
</tr>
<tr>
<td>Internal Affairs Committee</td>
<td>Po-chor TAM</td>
</tr>
<tr>
<td>• Corporate Communication Subcommittee</td>
<td>Chad C W TSE</td>
</tr>
<tr>
<td>&amp; Editorial Board of Cutting Edge</td>
<td></td>
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<tr>
<td>• Women’s Chapter</td>
<td>Ava KWONG</td>
</tr>
<tr>
<td>• Younger Fellows Chapter</td>
<td>Weida DAY</td>
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<tr>
<td>Administration Committee</td>
<td>Chi-wai MAN</td>
</tr>
<tr>
<td>• Website Development</td>
<td>Wing-tai SIU &amp; Wai-sang POON</td>
</tr>
<tr>
<td>Finance Committee</td>
<td>Enders K W NG</td>
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<tr>
<td>• Business Development Subcommittee</td>
<td>Enders K W NG</td>
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<tr>
<td>CME &amp; CPD Committee</td>
<td>Edward C S LAI</td>
</tr>
<tr>
<td>Editorial Board of Surgical Practice</td>
<td>Samuel P Y KWOK</td>
</tr>
<tr>
<td>• Editor-in-chief</td>
<td>Paul B S LAI</td>
</tr>
<tr>
<td>Research Committee</td>
<td>Chung-mau LO</td>
</tr>
<tr>
<td>Education &amp; Examination Committee</td>
<td>Andrew WC YIP</td>
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<tr>
<td>• Specialty Boards</td>
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</tr>
<tr>
<td>- Cardiothoracic Surgery Board</td>
<td>Malcolm John UNDERWOOD</td>
</tr>
<tr>
<td>- General Surgery Board</td>
<td>Simon Y K LAW</td>
</tr>
<tr>
<td>* Training Subcommittee</td>
<td>Simon Y K LAW</td>
</tr>
<tr>
<td>* Hong Kong Regional Subcommittee</td>
<td>Simon Y K LAW</td>
</tr>
<tr>
<td>- Neurosurgery Board</td>
<td>Wai-sang POON</td>
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<td>- Paediatric Surgery Board</td>
<td>Kelvin K W LIU</td>
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<tr>
<td>- Plastic Surgery Board</td>
<td>Wing-yung CHEUNG</td>
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<tr>
<td>- Urology Board</td>
<td>Chi-wai MAN</td>
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<tr>
<td>• Board of Examiners</td>
<td>Andrew W C YIP</td>
</tr>
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<td>• Appeal Board</td>
<td>Andrew W C YIP</td>
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<tr>
<td>DEPARTMENT</td>
<td>DIRECTOR</td>
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<tr>
<td>Department of China Affairs</td>
<td>Joseph W Y LAU</td>
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<tr>
<td>Department of Development</td>
<td>Chung-kwong YEUNG</td>
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<td>Nivritti Gajanan PATIL</td>
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<tr>
<td>Department of Standard</td>
<td>Che-hung LEONG</td>
</tr>
<tr>
<td>SECRETARIAT</td>
<td>General Manager Stephanie HUNG</td>
</tr>
</tbody>
</table>

Souvenir Collection Catalogue

Souvenirs for Sale

1. College Tie available in various colors $180@

   A. Black with light blue stripes
   B. Blue with light blue stripes
   C. Blue with white stripes
   D. Light Blue with yellow stripes
   E. Champagne yellow in dotted pattern
   F. Golden yellow in dotted pattern
   G. Brownish red in check pattern

   Full set of ties (7 pieces A-G)
   *Order of full collection (7 types of ties) can enjoy a 20% discount, i.e., $1,008

2. College Scarf $150@

3. T-shirt $80@

Size of the displayed: M

4. Polo shirt $100@

Size of the displayed: M

5. Mini Wireless Mouse $100@
# Souvenir Order Form

<table>
<thead>
<tr>
<th>ITEMS</th>
<th>PAYMENT (HKD$)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. College Tie</strong></td>
<td></td>
</tr>
<tr>
<td>(A) _____ piece(s)</td>
<td>(B) _____piece(s)</td>
</tr>
<tr>
<td>(D) _____ piece(s)</td>
<td>(E) _____piece(s)</td>
</tr>
<tr>
<td>(G) _____ piece(s)</td>
<td>(Full set) ____ piece(s)</td>
</tr>
<tr>
<td><strong>2. College Scarf</strong></td>
<td></td>
</tr>
<tr>
<td>Unit: ______</td>
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<tr>
<td><strong>3. T-shirt</strong></td>
<td></td>
</tr>
<tr>
<td>Size (S): ______ piece(s)</td>
<td>Size (M): _____ piece(s)</td>
</tr>
<tr>
<td>Size (L): ______ piece(s)</td>
<td></td>
</tr>
<tr>
<td><strong>4. Polo Shirt</strong></td>
<td></td>
</tr>
<tr>
<td>Size (S): ______ piece(s)</td>
<td>Size (M): _____ piece(s)</td>
</tr>
<tr>
<td>Size (L): ______ piece(s)</td>
<td></td>
</tr>
<tr>
<td><strong>5. Mini Wireless Mouse</strong></td>
<td></td>
</tr>
<tr>
<td>Unit: ______</td>
<td></td>
</tr>
</tbody>
</table>

## TOTAL PAYMENT

**Collection Method** (Tick as appropriate)
- [ ] In person (College Secretariat Office)
- [ ] Courier (to mailing address)

*A courier charge of HKD$ 30 would be applied to the order of the above souvenirs. Free courier for any purchase over HKD$ 500.*

## Contact Information

Title __________ Surname __________ Given Name __________

Mailing Address ____________________________

_________________________________________

Contact no. __________ Email Address __________

Payee signature ___________________________ Date __________

*Purchase is on a first-come-first-serve basis.
A courier charge of HKD$ 30 would be applied to the order any of the above souvenirs. Free courier for any purchase over HKD$ 500.

## Payment

Delivery of your purchase would be valid upon the recipient of order form and payment. Payment can be made in person or by cheque made payable to "The College of Surgeons of Hong Kong Limited" to the following address:

Room 601, Hong Kong Academy of Medicine Jockey Club Building, 99 Wong Chuk Hang Road, Aberdeen, Hong Kong

**Opening hours & Enquiry**

Monday - Friday (9:00am - 5:40pm), Saturday & Sunday (Closed)

Enquiry Hotline: 2871 8799 Fax: 2518 3200 Email: corpcomm@cshk.org

**For Office Use**

Date of order __________ Payment by

- [ ] Cash
- [ ] Cheque (no.: __________)

*For Office Use*
The Innovative 3-in-1 mix with a unique 4-oil combination

Fish oil 15%
Soybean oil 30%
Olive oil 25%
Medium-chain triglycerides 30%

SMOFlipid® - Benefits of the unique 4-oil combination

- Positive impact on liver cell function and integrity\(^1,2\)
- Favourable immune and inflammatory response\(^3,4\)
- Study results indicate a reduced length of hospital stay\(^5\)

References: