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CUTTING EDGE



The College of Surgeons of Hong Kong Newsletter
香港外科醫學院簡報

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Simulation in Surgery

Newly added! Fellows Update

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Editorial

Simulation is becoming a trend in the field of surgery. From the teaching of medical students, training of surgical trainees, to post-fellowship continuous medical education, element of simulation is everywhere. In this issue, we try to explore the topic of simulation from different angles, from the prospective of the Hospital Authority, College and Surgeons. We hope that readers can gain an insight into this growing trend in surgical training.

The Editorial Board always tries to come up with a hot topic in the surgical field to report and discuss in each issue of Cutting Edge. At the beginning, we are afraid that we might be running out of interesting topics, and end up with nothing to say. However, very soon we found that topics worth discussing are everywhere. ***Have you ever turned on the TV and found that the news report saying there was nothing worth reporting on that day?*** Instead, our difficulty is the ability to be able to report the topics both in depth and in width. After all, the Editorial Board's manpower and resources is nothing comparable to the press or media. Actually, sometimes I feel sorry to push the members of the Editorial Board to submit their articles. All surgeons are busy in one way or the other, and my editorial is always the last article of the issue being submitted!

Recently, we are lucky enough to have some professional opinion for our Cutting Edge from a well-known figure in the media. One of the comments is, we need more writers, both regular and sporadic. I cannot agree with this more. Yes, more writers have to be recruited,.....but how? ***It also reminded me of my role in the Corporate Communication Subcommittee, which shamefully has almost slipped off my mind in the fully occupied schedule.*** I could still remember the mission is to enhance the communication between the College and the fellows, and to promote the sense of belonging and fraternity! Something has to be done..... to be done.



Fraternity!



Dr Chad Cheuck-wa TSE
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Special thanks to Dr Alfred CC WONG for providing the cover photo

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Message from the President



Time flies and my second year of service as College President was completed, which was marked by the Annual General Meeting of our College held in conjunction with Annual Scientific Meeting and Diploma Ceremony in September this year.

This year, we had a Conjoint Scientific Meeting and Diploma Ceremony with The Royal College of Surgeons of Edinburgh. The theme of the meeting was on Clinical Auditing and Surgical Outcome which is an important foundation for credentialing. Credentialing is a hot topic among all medical disciplines in particular those with procedures on patients and hence surgeons are the major focus group on this issue. According to our College's principles on education and training, all Fellows should be competent to handle 80-90 % of procedures under his/her specialty and hence automatic credential is expected. It is perhaps only the ultra-major operations or procedures that require post-fellowship training being an issue. Yet, another principle of our College is to encourage team work and collaboration among Fellows or doctors of other disciplines. Hence, for ultra-major operations or procedures, team credentialing might be the way forward. My personal view is that our College would just lay down some principles in credentialing such as those mentioned above rather than to identify the procedures or operations that individual Fellow is competent to perform as that would be impractical. I sincerely would like to register thanks to all our Fellows and Members for your participation in the Annual Scientific Meeting and for sharing your views and experience. As this is a conjoint meeting with Royal College of Surgeons of Edinburgh, we had distinguished speakers from the Edinburgh College to join in the discussion and the Meeting turned out to be very well-received and was a fruitful one.

Another important event was the Diploma Ceremony and Annual Dinner. All Fellows shared the joy with our new Fellows and also met old friends and colleagues, it was a precious opportunity for friendship renewing and showing your support to the College.

Your participation in Annual Scientific Meeting and Annual Dinner was of vital importance and I do look forward to your support again next year.

A handwritten signature in black ink, appearing to read 'H. LUK' with a stylized flourish at the end.

Dr Hung-to LUK
President

Princess Margaret Hospital

“Medical Simulation in Surgical Training”



Dear Fellows & Trainees

The teaching of medical students and residents has taken a major change over the past two decades. Because of the increasing amount of medical information and researches, the effectiveness of traditional methods of clinical medical education has been questioned. Patients are increasingly concerned that the students and residents are “practicing” on them. Moreover, modern day medicine focuses heavily on reduction of medical errors and improvement of patient safety. In the past, learning medical procedures would mean making mistakes on real patients. Therefore, medical education curriculum has evolved from small group discussion sessions and self-directed learning to the adoption of the use of medical simulation in order to bridge the educational gap between the classroom and the clinical environment.

Medical simulation is a branch of simulation technology related to education and training in medical field. Its main purpose is to train medical professionals to reduce accidents during surgery, prescription and in day-to-day clinical practices. It is a training and feedback method in which learners practice tasks and processes in lifelike circumstance using models or virtual reality, with feedback from observers, peers, actor-patients, and video cameras to assist improvement in skills. Simulation-Based Medical Education (SBME) involves the use of role play, standardized patients, computer-based medical simulation, videotape and mannequin simulators. Medical simulators allow resident to review and practice procedures as often as required to reach proficiency without harming the patients.

The College of Surgeons embraces a mission to uphold a high level of surgical standard for the best patient safety. To maximize learning opportunities for our young surgeons while minimizing the risks to patients, we have recognized the great potentials of incorporating simulation concepts and technologies in surgical training. Actually, in most of the mandatory courses which the basic and higher surgical trainees required to attend, simulation methods of teaching have been included. The clinical core competency course and the Basic Surgical Skills Course employed a number of basic simulation technologies for the purpose of familiarizing the basic trainees with the different surgical procedures and clinical practice scenarios.

With the imminent need for upkeeping the standards of the surgical training curriculum, the Department of Development has set up a Task Force on Simulation in Surgical Training in order to further develop and devise simulation-based training programme to our trainees.

The era of the old-styled Halstedian type of clinical medical education – “See one, do one, teach one” is definitely over. With technological advances, SBME is feasible and represents the way forward for enhancing good and safe clinical practices for the surgical residents.



Dr Andrew Wai-chun YIP
Censor-in-Chief
Private Practice

Message from the Honorary Secretary



“To be or not to be, that is the question.” Hamlet- William Shakespeare

The trilogy of College Fellowship, Academy Fellowship and Medical Council Specialist Registration is the usual hallmark of achievement of a recognized standard of practice after many years of hard work. The ultimate legal status to practice as a Specialist is conferred by the Specialist Registration with the Medical Council. Admission privileges in private hospitals for surgeons take reference to their registration as Specialists. Hospital Authority (HA) had also for years adopted Specialist Registration as condition for promotion to Associate Consultant (AC) or Consultant. Only Specialist will be awarded a permanent contract in HA.

It is therefore mind-boggling to hear from the news that a fellow of our College who had been promoted to AC in HA was found not to have registered as a Specialist. The media made a fuzz of this as that fellow was related to someone high up in the Hong Kong government. It was likely, however, that this fellow's failure to get registered as a Specialist had occurred as a slip rather than any special privilege. The omission did, however, take HA off guard and measures to tidy up requirements for Specialist Registration in senior posts were hastily promulgated.

The first batch of Specialists were grandfather fellows of the College recognized as Specialists according to their devotion of over 75% of their time working in the specialty they declared. Subsequent specialty fellows were only awarded after completion of prescribed training and passing of exit examination in that specialty. Obtaining a fellowship of our College is not the only way of becoming a Specialist in Hong Kong. From time to time, the College is asked by the Academy to vet whether the training of some overseas surgeons is comparable to that in Hong Kong. If so, the Medical Council can directly put these surgeons on the specialist list even though they remain neither a fellow of the Academy nor of our College. The catch here of course would be whether such surgeons are already registered to practice in Hong Kong by the Medical Council. Without basic registration to practice, they will not be admitted to the Specialist list. This is why surgeons from accredited Mainland centres would not become Specialists in Hong Kong even after they passed their exit examination.

Some senior consultants in HA remained not registered as Specialists. This is permissible as at the time of their appointment there was not yet the system of Specialist Registration in Hong Kong and a Fellowship of an UK College was the usual requirement for promotion. They can save some money by avoiding subscription to the academy and fees for specialist registration. Their insurance premium may be less as a higher premium is usually charged for some specialties with higher risks and responsibilities. However, they will need a specialist status if they seek to work in private or when they wish to work as part-time consultant after they retire. There had been a surgeon who needed to pay back all arrears before he got admitted again as a fellow of a specialty in our College. No money was saved and the trouble was immense.

Some surgeons worried that by declaring as specialist in a particular specialty may limit their practice in other fields. There is no such limitation imposed by our College. Indeed, there are specialists in plastic surgery, pediatric surgery or even urology who are doing general surgical work and vice versa. Besides their specialist qualification, surgeons can demonstrate their competency in operating through their experience and their operative outcomes. Insurance companies, however, would tend to adopt a simplistic view by artificially assigning certain operations exclusively to certain specialties and refuse reimbursement of operations at a specialist scale if they consider a certain operation as not belonging to the specialty of a particular Specialist. This simplistic view does not take into consideration the individual experience of a particular Specialist and limits patient's choice. However, that would be commercial decisions and choice between the insurer and the insured and there is little the College can do.



Dr Chi-wai MAN
Honorary Secretary
Tuen Mun Hospital

News from the Specialty Boards

CARDIOTHORACIC SURGERY BOARD

The Conjoint Examination in Cardiothoracic Surgery was held with examiners from the Royal College of Surgeons of Edinburgh and Academy of Medicine Singapore on November 21st in Singapore. There was a Specialty Update Course on November 22nd-24th immediately following the examinations following the last successful years Course. This year there were also 2 wet-lab 'hands-on' teaching courses concentrating on aortic root techniques, mitral repair and advanced trauma management. Other Educational activities in CTS in Hong Kong included a lunch symposium on 24th August at St Teresa's Hospital on 'Update in Aortic Dissection', and a VAT wetlab. Links are given below.

BST 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.

<http://acsuc2012.org/index.htm>

<http://www.surgery.cuhk.edu.hk/VATS2012/>



Prof. MJ UNDERWOOD
Prince of Wales Hospital

GENERAL SURGERY BOARD

The Royal College of Surgeons of Edinburgh / College of Surgeons of Hong Kong Joint Specialty Fellowship Examination in General Surgery was held on 10 – 11 August in Singapore. There were 18 candidates from Hong Kong, of whom 9 passed, with a passing rate of 50%. The next examination will be held in March 2013.

Inspection of training programmes for higher surgical trainees was carried out in September for the following hospital clusters: Prince of Wales / North District / Alice Ho Miu Ling Nethersole Hospital, Queen Mary Hospital / Hong Kong Sanatorium & Hospital / Tung Wah Hospital, Tuen Mun Hospital, Caritas Medical Centre, Kwong Wah Hospital / Our Lady Maryknoll Hospital, and Princess Margaret Hospital. The Edinburgh as well as Hong Kong inspectors found the training programmes of high standards, and most trainees expressed their satisfaction. The next round of inspection is scheduled for March 2013.



Prof. Simon Ying-kit LAW
Queen Mary Hospital

News from the Specialty Boards

PAEDIATRIC SURGERY BOARD

The 18th AGM of the Board of Paediatric Surgery was held on 26th October 2012. Sixteen board members attended. Currently we have 31 board members. The Programme Director for 2012-2013 is Professor Paul Tam.

The last inter-hospital clinical meeting was held on 26th October 2012 at Queen Mary Hospital and was well attended by board members and trainees.

The last conjoint exit examination was held on 10th March 2012 at Queen Mary Hospital. Two candidates sat for the examination and both passed. The board extends our congratulations to Dr. Ivy Chan and Dr. Paula Tang and welcomes them to our board. The Board extended our thanks to Queen Mary Hospital for the help in the successful hosting of the examination. The next conjoint exit examination will be held on 23rd March 2013 at Prince of Wales Hospital. There will be two local candidates sitting for the examination.

Paediatric Surgical Training for the coming Centre of Excellence in Paediatrics is progressing and specialists will be sent to various overseas centres for training.



Dr Kelvin Kam-wing LIU
United Christian Hospital

PLASTIC SURGERY BOARD

The MCQ & Viva workshop had been organized in July and the preparatory course for the exit exam for higher trainees had been conducted in Kwong Wah Hospital.

There were mock clinical and oral viva examination for the candidates.

The Exit Examination was held in Queen Mary Hospital in October this year.



Dr Wing-yung CHEUNG
Private Practice
Kwong Wah Hospital (Part-time)

News from the Specialty Boards

UROLOGY BOARD

Formal signing ceremonies for accreditation of urology training at Nanjing and Hangzhou were conducted on 2-3 March 2012. Board Committee members inspected the Urology Centre at Xian Jiaotong University on 14-15 April 2012. An off-site inspection of the Xian centre by our College together with the Edinburgh College was conducted on 5 May 2012 and the centre was accredited as the fifth centre for conjoint urology training in Mainland. Urology Board Committee subsequently deliberated on accreditation of further centres in Mainland and resolved that it would be preferable for centres first accredited for general surgery, i.e., Beijing, Shanghai and Guangzhou, to be the next batch of centres to be considered for urology training accreditation. The proposal was heeded by the Council and invitation letters had been dispatched to all Mainland centres accredited only in general surgery to invite application for urology accreditation.

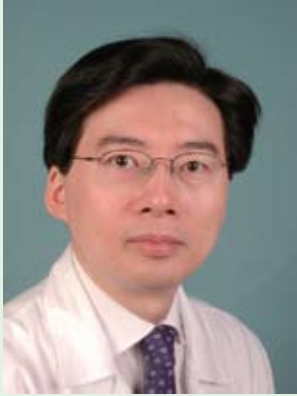
There was enthusiastic contribution from Board members in the 4th Urology question writing workshop conducted on 31 March 2012. The refined questions were submitted to Edinburgh College by the end of May. Examiners from both Colleges had been determined. The Examination will adopt a similar format as last year. Five centres due for inspection this year will have hospital inspections arranged on the first day of examination in September.

Board Committee members interviewed applicants for higher urology training on 19 April 2012. The Board Committee held a meeting with all higher urology trainees on 9 June 2012 to hear their comments on the training they received. Urology Curriculum for basic surgical training had been revised in June 2012. Basic and advance courses in endo-laparoscopic urology were scheduled in September and November 2012 respectively. The Board Committee considered that research requirement of a higher surgical trainee should focus on the generic research skills rather than specialty specific knowledge and therefore would accept the certificate of completion of research in all surgical specialties as adequate for research requirement for a higher urology trainee to sit in the Urology Exit Examination. A similar approach will be proposed for the other Specialty Boards.



Dr Chi-wai MAN
Tuen Mun Hospital

College Focus



Professor. K. M. Chu, as all we know is a very famous upper gastrointestinal surgeon in Queen Mary Hospital. Apart from the clinical duty, he also takes part in various academic activities, teaching courses and committees, which are closely related to the College of Surgeons of Hong Kong. These committees include the Research Committee of the College (2002-now), the Editorial Board of the College newsletter (2005-2008), the Task Force for Sub-specialization in General Surgery of the College (2006-now), the Examination Committee of the Hong Kong Intercollegiate Board of Surgical Colleges (2007-now) and the Board of Examiners of the College (2008-now). Apart from all these committees, he has now further his contribution to the College by becoming a Council Member of the College of Surgeons of Hong Kong.

The feeling of being elected as a Council Member is special and great to Professor Chu. However, to Professor Chu, being a Council Member means he had to bear more responsibility to the College and all the members in upkeeping the standards of surgical education and training. Besides, he also believes he can serve the College and brings the interests of Members and Fellows of the College into the Council. He believes that conjoint effort of members with different seniority, background and experience will bring along advancement. He will try to bring in ideas to improve surgical training, education and assessment of surgeons.

When talking about how to prepare his election campaign, Professor Chu thinks that participation in various sub-committees of the College is one of the most important preparations he had made. Thus, before the election, what he had done is the distribution of election material through mailing by the College and made a plea to colleagues to support all those Doctors within the Department, who were running for the election campaign.

To those young surgeons, who are interested to become Council member of the College, Professor Chu suggested that they could try to participate more in different committees of the College. By participation in the committees, they can have more understanding on how the College runs and at the same time, gather more experience on how they can make improvement in different aspects of the surgical field.

Lastly, Professor Chu would like to take this opportunity to thank all those who have supported him during the election campaign and wish they can continue to support him and the College.



Dr Ronald Pak-kin HO
Private Practice

A New Era for Medical Professional Training

The core value in healthcare profession is to provide up to standard service and do no harm to patients by continuously improving care through training and innovation development. With increasing public expectation and awareness in medical care, hospitals have to safeguard every patient with optimal treatment and avoid error through enhancing communication and skill-based training.

‘See one, do one, teach one’ was the traditional way of passing knowledge and skill from one generation to another generation in medical training. However, this model is insufficient to meet the current training requirements due to rapid advancement in technology and increasing complexity of diseases. The new evidence based on the successful experience of aviation industry showed that simulation training could reduce human errors and shorten learning curve. This is particularly important for trainees who may not have sufficient training with reducing duty hours.

“Simulation is a technique to replace or amplify real experiences with guided experiences that evoke or replicate substantial aspects of the real world in a fully interactive manner” Prof D M Gaba. Medical simulation, therefore, becomes a value added teaching tool to train healthcare professionals on rare events that will not occur often enough for experiential learning. It has a trend to replace certain clinical trainings, especially high-risk procedures that hands-on practices are limited.

A recent publication of American Hospital Association has stressed that interpersonal and communication skills are the second top ranked gap between physicians’ evident competency and their relative importance. Task force of physicians felt strongly that communication and teamwork competencies require focus as early as possible. In the era of multidisciplinary treatment for patients, mis-communication has contributed to large proportion of clinical errors. Back in the early 90’s, some hospitals under Hospital Authority (HA) has started to develop medical simulation training and the first simulation centre was established in 1994. With development over the years, we noticed that there is a need for a territory wide review in order to foster growth and delineate the corporate strategy in long term planning. Recently, HA has commissioned an external consultancy company to evaluate the development of medical simulation in HK.

The consultation study is almost completed and there more than 50 visits and focus group discussions between local key stakeholders and simulation experts from Australia, United States and Denmark, explored the history and significance of simulation in HK healthcare setting. The enhancement in governance and establishment of core elements of simulation training will be identified and put forth for development under training plan in HA. It is the time to construct an open system for all simulation centers and HA would have role in overall coordination and to facilitate local training for all HA staff especially in orientation, patient safety and specialty training.

Currently, there are 9 HA owned simulation centres, every centre has its strong historical background and has established individual funding sources, administrative and education programmes. These simulation trainings are well received and recognized by clinicians. However, it is found that there could be more collaboration with partner institutions like universities and professional bodies such as Hong Kong Academy of Medicine on training and standard development.

To conclude, there are examples of excellent simulation training within HA simulation centres, but there is yet a central co-ordination party to foster the future development of medical simulation. Key areas were identified to enhance team base training and communication skill for all clinicians, nurses and allied health professionals. Apart from scenario-based teaching, there is imperative need for further development in scenario-based simulation practice which is proven as effective medical training method. It is believed that healthcare professionals should take a lead in development of healthcare simulation training by establishing infrastructure and capacity in curriculum as well as standard development.

Dr F C Pang is a Fellow of Hong Kong College of Physicians and Fellow of The Royal Australasian College of Medical Administrators (RACMA). He is currently the Chief Manager of Medical Grade Hospital Authority Head Office. He is responsible for training and development of doctors in Hospital Authority.



Dr Fei-chau PANG
Hospital Authority



Dr Jessica Janice TANG
Hospital Authority

Dr J J Tang is a Chartered Applied Psychologist and a Fellow of The Royal College for Public Health with a PhD in education policy implementation. Before she works as a Manager in Medical Grade Hospital Authority Head Office, she was a research psychologist at Imperial College London with a research focus on medical-based simulation education.

Spotlight on ‘Simulation’

Simulation in Surgical Skill — local experience in laparoscopic course

Simulation, in dictionary, means “acting out or mimicking a real life situation”. Surgical training consists of developing cognitive, clinical and technical skills, the later being traditionally acquired through mentoring.⁽¹⁾ Simulation is particular attractive in surgery because it **avoids the use of real patients for skill practice and ensures that trainees have had some practice before treating humans.**⁽²⁾ In a recent systematic review in laparoscopic surgery, it found that in trainees without prior surgical experience, virtual reality training decreased the time taken to complete a task, increased accuracy, and decreased errors compared with no training; virtual reality group was more accurate than video trainer training group. In the participants with limited laparoscopic experience, virtual reality training reduces operating time and error better than standard in the laparoscopic training group; composite operative performance score was better in the virtual reality group than in the video trainer group.⁽³⁾

Surgical simulation is mainly used in training in Hong Kong, but it can also be used as an assessing tool in some other countries. We are lucky as we have our first simulation course - Basic Laparoscopic Surgery Course in 1995 (Figure 1), nearly two decades ago; while the first Advance Laparoscopic Surgery Course for HST (Figure 2) was held in 2005. Both courses are compulsory nowadays and are accredited by the Hospital Authority.



Fig.1 First Basic Laparoscopic Surgery Course in 1995 in PYNEH



Fig.2 Advance Laparoscopic Surgery Course for HST 2012



Fig.4 Computer Simulation Model on Laparoscopic Cholecystectomy used in Advance Laparoscopic Surgery Course

Surgical skills simulation can be achieved through different means, ranges from simple animal viscera, to those sophisticated computer program and model (Figure 3-7). It can be applied in different aspect of daily surgical practice, including endoscopies, laparoscopic procedures and even robotic surgeries. For the endoscopic procedures, we have now the OGD (Figure 8), colonoscopy (Figure 9) and even ERCP computer simulation models. These models have a build-in computer program with different case scenarios, together with a sensor inside a tubular structure to mimic the human GI tract. In case when looping occurred, the computer will alert the trainee that patient is in great discomfort, and they need to reduce the loop. Intervention such as polypectomy, injection therapy, hemostasis, papillotomy can all be practiced through the models. A personal file can be set up so that the trainee can compare his or her own results and monitor the progress. This training is now compulsory in some hospitals before the trainee touching the real patients.



Fig.3 Setting of Simulation Laboratory in PYNEH

Reference:

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2. Issenberg SB, McGaghie WC, Hart IR et al. Simulation technology for health care professional skills training and assessment. *JAMA* 1999;282:861-866
3. Gurusamy KS, Aggarwai R, Palanivelu L et al. Virtual reality training for surgical trainees in laparoscopic surgery. *Cochrane Database Syst Rev* 2009 Jan 21;(1):CD006575

Spotlight on 'Simulation'



Fig.5 Another Computer Simulation Model on Laparoscopic Surgery



Fig.6

Artificial Human Organs for Laparoscopic Surgery Simulation Training



Fig.7

In laparoscopic surgeries, one of the models used in the laparoscopic course was the POP model - Pulsating Organ Perfusion (Figure 10-12). It is a simple model without the requirement of a computer program. Before the procedure, pig's viscera was prepared by the technicians, with the major arteries cannulated and connected through a plastic tube to a mechanical pump. Red fluid was actively pumped into the organs in a periodical cycle. The prepared organ was then placed inside a sealed box mimicking the peritoneal cavity. Trainees can practice different laparoscopic surgeries on these models, such as laparoscopic cholecystectomy and colectomy. If vessels were injured during the procedure, bleeding will occur! All the usual energy source and laparoscopic instruments can be practiced during the procedure.



Fig.8 OGD Simulator



Fig.9 Colonoscopy Simulator



Fig.10 POP (Pulsating Organ Perfusion) Model

In conclusion, surgical simulation is one of the hot topics in the surgical training. It is believed that it can help the trainees to acquire the skills faster with lesser complications. However, cost is a potential problem and the cost-effectiveness is still not addressed in the current literature.

Acknowledgement:

1. Department of Surgery, PYNEH
2. Dr. Hester Cheung
3. Dr. Alex CF Tsang



Fig.11 The Common Hepatic Artery is cannulated and connected to pump



Fig.12 Demonstration on POP Model 2012



Dr Dennis CK NG
North District Hospital

Dr NG is an Active Trainer and Helper in a number of Basic and Advance Laparoscopic Surgery Course.

Spotlight on 'Simulation'



The College has set up a Task Force on Simulation in Surgical Training in order to develop a simulation-based programme for our trainees. As we all know, such programme has been used in Advanced Trauma Life Support (ATLS) course for many years. Its efficiency in conveying trauma knowledge and related management skills is well recognized. The editorial board is honored to invite **Dr Yuen Wai Key, currently ATLS Program Director, Course Instructor and Chief of Service of Department of Surgery, Tung Wah Hospital**, to share with us his personal views and experience in simulation-based training.

Can you brief us on the history of the ATLS in Hong Kong?

This dated back to December 1995, the year of the establishment of the Committee on Trauma of the Hong Kong Chapter, American College of Surgeons (HKC). Following this was the site visit of Dr Brent Krantz, the late chairman of ATLS Subcommittee in January 1996. A Memorandum of Understanding was then signed with Prof John Wong representing the HKC. A survey was also conducted to understand the demand of the Course in Hong Kong and the result was overwhelming. (Fig.1)



Fig.1

A group of twelve core members, including myself, were sent to Harbourview Medical Centre in Seattle, Washington to attend the ATLS Student Course and Instructor Course. In the list of delegates, there were a total of five surgeons, two A&E doctors, one anaesthesiologist and two nursing co-ordinator candidates. (Fig.2)



Fig.2

After one whole year of planning, the Inaugural Course was finally launched in January 1997. It was conducted in the Hong Kong Jockey Club Surgical Skill Centre in Queen Mary Hospital. At that time, our primary aim was to conduct a high standard trauma course that helped enhance the standard of trauma service in Hong Kong.

In the first few years, we also invited overseas experienced instructors to teach the Course. From 1997 till now, there were 110 courses being organized and close to 1700 doctors attended the Course. The majority of the participants are surgeons, emergency physicians, anaesthesiologists and orthopaedic surgeons.

How was the program structured?

This is a structured postgraduate trauma course that emphasizes on the multi-disciplinary trauma care in the first few hours after injury. It is a two and a half day program. The content consists of lectures, skill stations, case scenarios, group discussion and demonstration. There are only 16 participants in each course with a high instructor to participant ratio. To successfully complete the course, one has to take time to review the content in the Course Manual and pass the post-course written test and the initial assessment skill stations. Based on the latest scientific evidence, the course content is updated every four years by an international faculty.

How has the simulation enhanced the training of general surgeons?

There are two types of simulation used in the ATLS Course. The first is the extensive use of case scenarios assisted by imaging studies, so that the participants are exposed to a wide variety of trauma situations in a very short period of time. It also emphasizes on the importance of interactive teaching style and hands on experience. Second, by making use of animal model and moulaged patients, we can demonstrate the trauma scenarios in a more vivid manner. (Fig. 3 & 4)

Spotlight on ‘Simulation’



Fig.3



Fig.4

Do you think this model is effective in the training of surgeons?

Yes, I think so. In particular, there are not many major trauma cases in Hong Kong. The majority of doctors under training do not have a lot of experience in managing these patients and the practical knowledge gained in their undergraduate days is also minimal. On the other hand when on duty, they have to manage these sick patients by themselves, in particularly, in the middle of the night. Moreover, the hospital trauma team is composed of doctors from different disciplines with variant level of experience. A common language based on the ATLS Course helps to enhance their team spirit, and minimize unnecessary conflicts.

The surgeon is often assigned the leader’s role in a hospital trauma team. I am glad to say that the College Council adopted the ATLS Course for Doctors as one of the mandatory courses for all higher surgical trainees in 2011.

What are the key features and pitfalls of simulation training?

I think reality is the key in simulation training. If the simulation is not close to reality, the learning value will be much reduced. In some other simulation courses, costly and high tech Manikins and Simulators are used, but unfortunately, the simulation is far too unreal and artificial. In my personal view, the learning value of these courses may not be proportional to their cost.

Besides, a high quality and dedicated teaching faculty is the back bone of the Course. I am glad to say that we are lucky that ATLS can maintain a group of teaching faculty who are willing to spend time in sharing their knowledge and experience with the young trainees. I must thank the surgical instructor colleagues, both in private and public sectors in keeping this tradition.

One of the major pitfalls of simulation training is that if the participants, after completing the course, lack the chance of putting the stuff they learn from the course into clinical practice. The knowledge and skills will soon deteriorate with time. The other pitfall is the scope and depth of the content. The material taught in the course should neither be too broad nor too focused. It will not be useful if the core content is something that are so common that the participants encounter frequently in their everyday clinical practice.

If the College accepts this model for surgical training in the future, what support does the College need?

A good education format is vital. Take an example. The whole program of the ATLS Course for Doctors is endorsed by a group of international educators after evaluating the learning value of each component of the Course. As mentioned above, without a group of enthusiastic and knowledgeable instructors, the quality of the simulation course cannot be easily maintained. Sustainability is always a concern. The startup cost and investment, both in design and actual operation, can be rather high too. One has to carefully and thoroughly think it through before deciding on embarking a new simulation training course.



Dr Yee-man LEE
Private Practice

Simulation in urology – reason or season?

“Vita brevis, ars longa, occasio praeceps, experimentum periculosum, indicium difficile. (Life is short, the art long, opportunity fleeting, experiment treacherous, judgment difficult)” On the Physician -Hippocrates 460-357BC

“To have innate knowledge would be supreme. To know through learning comes next. To learn only when necessity arises is less desirable but the worst would be not learning even when the need is there.” Analects -Confucius 551-479BC

Urologists are very down to earth people. Urology training in Hong Kong has all along been based firmly on actual operating experience on patients. Higher trainees are required to have participation in over 100 major cases in each half year session throughout their four years of training. They are expected to be able to handle over 80% of cases that would come under the care of an urologist after they completed their training. As most major operations in urology are being performed as elective cases, even though shortened work hour is an issue for general surgical training due to reduce on call time, urology training is much less affected. Inadequate chance for hands-on experience has never been a real reason for urologists to explore simulation training. There is such ample chance to work for the trainees in Hong Kong that most of them won't bother with simulations for procedures like transurethral resection of the prostate (TURP) or ureterorenoscopy URS).

Neither had external pressure been the reason for urologists in Hong Kong to take up simulation. When Hong Kong urologists started simulation workshops for urological procedures in the mid 90's, they knew nothing about the success of simulation in aviation industries, and there was not any outcry from the public for surgeons to practice on models before operating on them. Prior practice on a simulation model would not have been admitted as a defense for untoward results of an operation, as neither judges nor juries would have heard anything of that. In litigations related to operations it was real operative experience that counted; and this is still true.

When Hong Kong urologists started from scratch to devise and deliver simulation workshops in mid 90's, the real driving force was rapid technological development, and the impetus of urologists to share among themselves things they thought great. What was in their mind was simple: to get most colleagues, public and private, familiar with the then relatively new endourological technologies in the shortest possible time. It would be no good to just talk about those new tools. Colleagues would need to touch them, hold them and try them on something. It would be nice to try them on something with even the slightest resemblance to the structures in a patient. Urologists had therefore gone to lengths to assemble instruments from institutions and industries, create models from inanimate objects, animal tissues or organs, or borrow or purchase commercial models and put everything together into prototype hands-on workshops. They had thus started simulation even before they know its name.

The track record of urologists in organizing such simulation training would serve a clear testimony of their ability to cope with changes and needs. In the early 90's, the new generation of less traumatic ureterorenoscopes had completely phased out open surgery for ureteric stones. A tantalizing array of energy sources for stone treatment had appeared: including electro-hydraulic, pneumatic, ultrasonic and laser lithotriptors. Workshops to allow urologists to get familiar with these new advances had been conducted with the support of industries first in Princess Margaret Hospital (PMH) and then in other hospitals including Pamela Youde Nethersole Eastern Hospital (PYNEH). When urologists in Hong Kong were mastering and refining the then new skill of percutaneous nephrolithotomy (PCNL), a table turning revolution in the operation for large renal stones, it was realized that ability to master the new tools and a new three dimensional conception of the pathology and approach would be required. A PCNL workshop with X-ray guidance was run against all odds in Queen Elizabeth Hospital (QEH) in late 90's, using expensive models purchased from UK. Subsequently, more economic workshops using ultrasound guidance and chunks of pork loin with attached kidneys had been repeated in PYNEH. Workshops to update the already popular technique of TURP had also been conducted. As these endoscopic procedures of TURP, URS and PCNL become routine practice in all urology centres by the turn of the millennium, training in these procedures was integrated into the curriculum for the new generation of urologists. Simulation in these endourological skills got incorporated into orientation courses for the new trainees.

With the introduction of new technologies for BPH (benign prostatic hyperplasia) treatment various workshops to get urologist acquainted with the new techniques had been organized, noticeably in North District Hospital (NDH) where urologists had practiced on a bovine prostate with green laser. There were simulation workshops for bipolar resection on prostate models made from potatoes in PYNEH and from pig kidneys in QEH. Bipolar enucleation using special electrodes with pushers had been practiced on chicken gizzards in small groups in various hospitals.

Spotlight on ‘Simulation’

When the Urology training programme was started in the mid 90’s, it was noted that renal transplant was concentrated to four centres. To ensure that trainees had exposure to the knowledge and skill of renal transplant operation, workshops to simulate renal transplant in living pigs had been conducted in the late 90’s in Queen Mary Hospital (QMH). With the development of a comprehensive rotation system for higher urology trainees by the turn of the millennium, each urology trainee is guaranteed rotation to at least one centre with renal transplant work. The animal simulation for renal transplant lost its importance and faded out.

The tide of minimal access surgery started in the early 90’s with the introduction of laparoscopic cholecystectomy. In early 90’s urologists already started attempts to apply the new technology to urological conditions but the conditions they could identify then, including varicocele, undescended testis, ureteric stones, pelvic lymph nodes, pelvic lymphocoeles and nephroptosis, did not form any part of the main bulk of urology practice, and for some conditions the laparoscopic approach were overlapping with other less invasive techniques or were at best controversial. Laparoscopic nephrectomies had been started by the Americans in early 90’s but they were made to appear so difficult that urologists in other parts of the world felt intimidated. Only when UK and Australian surgeons came to Hong Kong in the early 2000’s to demonstrate a revised and easily reproducible technique of laparoscopic nephrectomy did the operation started to gain popularity in Hong Kong. Hands-on workshops allowing urologists to try laparoscopic nephrectomies on pigs were conducted in Prince of Wales Hospital (PWH). Urologists at United Christian Hospital (UCH) also developed an ingenious model of human retroperitoneum made from plaster on which a kidney was attached. That provided a cheaper alternative for practicing the basic steps of laparoscopic nephrectomy. A few years later, when the UCH group, followed shortly by the Tuen Mun Hospital (TMH) group, demonstrated that even the complicated operation of radical prostatectomy can be performed laparoscopically in Hong Kong, laparoscopic surgery had taken foot hold on two major cancers in urology. While some still argued about its advantages, laparoscopic operations began to get perceived as an irrefutable trend by urologists and enthusiasm bloomed. Among such enthusiasm a cadaveric workshop for laparoscopic nephrectomy and radical prostatectomy had been conducted in QMH. This was the best possible simulation for the real operations except for the fact that cadavers would not bleed. The effort could not be repeated due to infection concerns from the carbon dioxide blown through the dead bodies and the reluctance of the industries to subject their instruments to similar infection hazards again. Despite such, enthusiasm of urologists remained unabated.

However, by this time urologists were already lagging much behind general surgeons in the application of laparoscopy. Even worse, they lack common basic urological operations to keep up their laparoscopic skills, while their general surgical counterparts were abundantly provided for with laparoscopic appendicectomies and cholecystectomies. In order to catch up, many urology centres started to develop their own ways of practicing laparoscopic skills. The reconstructions required in laparoscopic prostatectomy and laparoscopic pyeloplasty could not be circumvented by bringing out as in laparoscopic colectomies. Intracorporeal suturing became an essential skill for any urologist serious with laparoscopy. They developed trainers from plastic drawers or even paper carton boxes and practiced suturing under view- cam or handy-cam at home. The TMH group developed the chicken leg models to simulate vesico-urethral anastomosis in radical prostatectomy and pyelo-ureteric anastomosis in pyeloplasty. The number of cases of radical prostatectomy and pyeloplasty in each centre remained limited and such practice on simulations helped to keep the skills of the surgeons up.

Greater challenges in laparoscopy continued to occur to urologists. By mid 2000’s, the dilemma of choosing minimal access total nephrectomy or open partial nephrectomy for small renal tumours appeared to have been resolved by the introduction of laparoscopic partial nephrectomy. Hong Kong urologists were deeply impressed when the American pioneer of the technique transmitted life demonstration of laparoscopic partial nephrectomy to Hong Kong during the Asian Congress of Urology in 2004. The technique required resection of tumour and suturing of the resected surface within the short time constraint of warm ischemia to the kidney. Practice for this very demanding operation required a bleeding model. Pig workshop had been conducted in PWH but the effort was expensive and repeated only infrequently in QMH. PYNEH group had developed a pulsatile model for simulation training on partial nephrectomy, using a chunk of pig kidney with aorta and intact renal vein and artery, which was connected to a trainer with perfusion pump. Red dyed fluid was pumped through the pig kidney in pulses to simulate a living kidney. In 2010, another difficult technique was introduced: laparoscopic single site (LESS) surgery. In LESS, laparoscopic operation was performed by curve instruments crowded through a single port. Workshops on LESS nephrectomy in pigs had been conducted in PWH and QMH.

Spotlight on 'Simulation'

The difficult urological procedures of radical prostatectomy, pyeloplasty and partial nephrectomies had a real take off when robot was introduced to Hong Kong in 2006. With the increase degree of freedom of movement, suturing suddenly became efficient and easy. More urologists had confidence to perform these procedures routinely when they have access to robots. In Hospital Authority, after the number of centres with robots increased to four by 2010, robot assisted prostatectomy had overtaken open and conventional laparoscopic prostatectomy as the most common procedure for cure of prostate cancer. Robots are surgical facilities that had well defined conditions for access. Console surgeons need to have license training prescribed by the manufacturer, and this consists of two days of robotic operations on living pigs. This is the forerunner of mandatory simulation training. Initially, Hong Kong urologists needed to go to the States for such training. With the setting up of a second robot for training in PWH Hong Kong urologists could have license training locally.

In 2011, inter-hospital-clusters collaborations in robotic surgery were started with a view to diffuse robotic surgical technique to urologists in centres not yet equipped with a robot. The number of sessions available for such skill diffusion remains small and many centres only have chance to operate on the robot once every two months. The need to practice between the widely spaced sessions became real. The interest with virtual reality simulation was rekindled.

Virtual reality simulators had been developed in mid 2000's for endoscopic urological procedures including cystoscopy, TURP, URS and PCNL, and for laparoscopic skills training. Some machines are acquired by some centres including PYNEH and PWH. The machines are expensive. The graphics are far from real. There is lack of haptic sensation. They are useful to provide standardize, repeatable and documented introduction of trainees to new skills, and give objective measures of what they have achieved. Virtual reality simulation will be integrated into the curriculum of the European Association of Urology. They cannot, however, replace physical models that give tactile feedback, real tissue plasticity with cutting, clipping and suturing, and real action of different energy sources on tissues or stones. On the other hand, virtual reality can have important application in robotic surgery as the robotic system is too sophisticated to be duplicated with a physical model trainer. The lack of tactile sensation in virtual reality incidentally reflected the actual situation with robotic surgery. Virtual reality systems with consoles closely mimicking operating robot systems have been devised and marketed. They can be useful for urologists to get familiar with the robot system faster. Such system is still not available in Hong Kong.

This state of Laissez faire in which Hong Kong urologists adopt simulation to train themselves as they deem fit is eclipsed gradually in the recent years when simulation training becomes more in vogue. Increase litigation and increase public awareness of safety internationally had put pressure for training to be taken out of operating theatres. There is call for greater reliance on simulation in training, so as to provide hopefully a harm-free journey for training, with protection to patients and trainees alike. There is also a shift from time base and case base to competency base in surgical training and clearer documentation of skill acquisition by trainees are required. Against such a background, in 2010 the College of Surgeons of Hong Kong had started efforts to develop a simulation based training curriculum for basic trainees. The Urology Board introduced mandatory course in basic and advance endo-laparoscopic urological skills for urology trainees entering into higher training on or after Jul 2010. In 2011 the Hospital Authority (HA) had commissioned a consultancy to look into simulation training within the Authority.

It does not require a particularly astute observer to note that the activities in the existing 12 skills training centres in HA are fragmented and not coordinated. The consultancy is also quick to criticize that there is not coherent policy for simulation training in HA; most simulation are planned by clinicians locally, sometimes with informal relationship with outside academic organizations; there are no pooling of resources; and utilization of facilities remains poor. Urologists have indeed recognized the limitations of the workshops they have so far organized: the workshops were not regular, not comprehensive, not organized, not documented, and not validated. The simulation urologists have so far embarked on has been mainly skill based and lacking in nontechnical skills such as human interactions. The role of simulation in the career path of an urologist remains to be defined. So far simulation is used only for skill acquisition, but its potential in aptitude assessment, skill enhancement, certification, credentialing, conditions for higher qualification, practice or revalidation will all need careful scrutiny.

Spotlight on ‘Simulation’

With this in mind, urologists of the Specialty Group on Urology Service have made recommendation to the consultancy. As a strongly skill based profession, urologists are keen to have simulation formally established in their training. The Group reiterated the importance of mandatory courses already established in conjunction with the Urology Board of the College of Surgeons of Hong Kong. These basic and advance endolaparoscopic urological skill courses will serve to coach trainees on techniques of common endoscopies and basic laparoscopy in urology using combination of lectures and simulation skills stations. The Group also recommended the installation of virtual reality simulators for practice on percutaneous nephrostomy, PCNL and laparoscopic nephrectomy before operating on patients. The practice activities should be logged in a territory wide registry. Animal dissection for laparoscopic nephrectomy and suturing should be provided for advance trainees and young specialist yearly.

In its preliminary briefing in July 2012, the consultancy outlined the three areas in simulation training development: clinical orientation, technical skill and crew resources management. It went on to recommend streamlining of governance, clear role definition of centres, development of an integrated faculty of trainers, organization of an integrated curriculum with accreditation, and centralization of all expensive equipment. During the briefing session, the author opined that planning and assessment of simulation training as part of professional training curriculum (e.g., higher urology training) should be left to the organization administering the curriculum (e.g., College of Surgeons) rather than to a body under HA. The author pointed out that centralization of simulation facilities would not be conducive to effective use of facilities, in particular for facilities that allow surgeons to practice and warm up before operations. The author insisted that the trainer list for technical skills in a specialty should remain specialty specific and such lists are currently being administered by the professional bodies of the respective specialties. The author also pleaded that the much needed resources on technical skills training must not be sacrificed while developing training on generic skills and team work. Urologists will continue to keep an eye on the final draft of the consultancy report and give input before its submission to the government for funding.

Meanwhile, urologists will continue to formulate their own strategy and plan to better apply simulation in urology development. Simulation must be clearly defined as an integral part of training for trainees. As such, it must be prescribed as mandatory part of training, protected with allocated time for trainees to attend, pre-requisite to patient procedures and pledged support by HA. The support should come as allocated resources for training course development and administration, and as recognition of training as duty of trainers. The mandatory courses are now in place as condition for exit examination. They will soon be tied with procedural experience for issuance of competency certificates. The Urology Board of the College of Surgeons will continue to play a role to upkeep standard and coordinate the provision of simulation training to urology trainees and urologists with facilities and expertise from HA and professional organizations. With the attention put on simulation training currently, urologists are no longer working on their own as they had before. There can be no better chance to bring simulation training forward. The opportunity is here and now, carpe diem!

“How many things by season seasoned are
To their right praise and true perfection!”
Merchant of Venice -William Shakespeare. 1564-1616

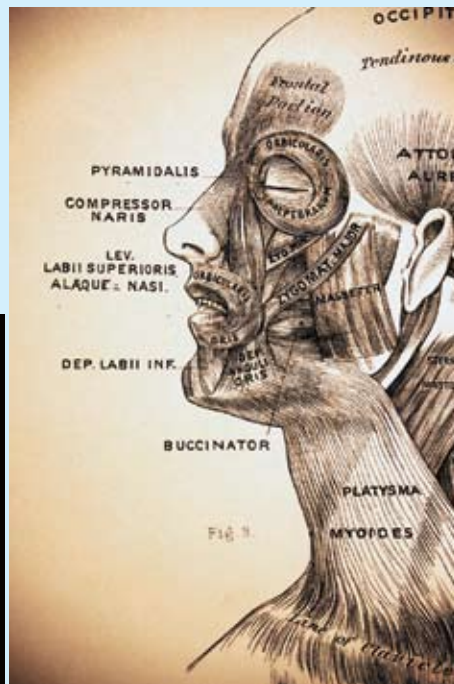


Dr Chi-wai MAN
Tuen Mun Hospital

Dr MAN is the Urology Board Chairman of the College of Surgeons of Hong Kong and the Chairman of the Specialty Group in Urology Services, HAHO

Development of Subspecialty Interest in General Surgery

In response to the call for more subspecialty exposures from Fellows who wish to develop subspecialty interest in general surgery, and to be in line with the global trend of subspecialization, the College will start off by looking for Training Centres to offer different subspecialties exposures to our Fellows who wish to pursue subspecialty interest. As a pilot exercise, the College will soon invite centres to be accredited for the provision of clinical exposure to Fellows who wish to develop their specialty interest in *Head & Neck Surgery*, *Breast Surgery* and *Vascular Surgery*. Should you have any views and comments towards the captioned exercise, please send your views via email at info@cshk.org or fax at 2518 3200.



College Express

The College organized the **CME lecture – Lunch Symposium at St. Teresa’s Hospital** regularly with different surgical topics for Fellows to advance surgical knowledge. This year, we organized the **Symposium on “Management of Difficult Wounds”** on 13 April 2012, **“Update in Aortic Dissection”** on 24 August 2012 and **“Perianal Sepsis and Fistula”** on 7 December 2012.

Lunch Symposium on Management of Difficult Wounds



Dr Hon-ping CHUNG delivered the presentation “Management of Necrotizing Fasciitis”



Dr Chiu-ming HO delivered the presentation “Surgical Management of Difficult Lower Limb Wounds”



Dr David Sau-yan WONG delivered the presentation “Plastic Surgery in Difficult Traumatic Wounds”



Dr Lai-kun LAM, the Chairman with the speakers

Lunch Symposium on Update in Aortic Dissection



Presentation of “Endovascular Treatment of Aortic Dissection” delivered by Prof. Stephen Wing-keung CHENG



Presentation of “Anaesthetic Consideration for Surgery of Type A Aortic Dissection” delivered by Dr Subid DAS



Dr Lik-cheung CHENG, the Chairman, delivered presentation of “Surgical Treatment of Type A Aortic Dissection”

Lunch Symposium on Perianal Sepsis and Fistula



Dr Cliff Chi-chiu CHUNG, delivered the presentation “Overcoming Difficult Anal Fistulae”



Dr Joe King-man FAN, delivered the presentation “Anal fistula: The Current Remedies”



Prof. Tony Wing-chung MAK, delivered the presentation “Current Management of Complex Fistula-in-ano”



Dr Samuel Po-yin KWOK, the Chairman with the speakers

Topic on film

Hong Kong Surgical Forum - Summer 2012

On July 14, 2012, the Department of Surgery held its biannual Hong Kong Surgical Forum, in association with the China-Hong Kong Chapter of American College of Surgeons. The Summer Forum covered a structured programme of four sessions dedicated to “Gastrointestinal Oncology”. The Forum featured informative and inspiring presentations by leading authorities including Professor Hiroaki Nagano (Osaka University Hospital), Professor Hideaki Shimada (Toho University School of Medicine), Professor Paris Tekkis (Imperial College London), Professor Naohisa Yahagi (Keio University) as well as some local experts. More than 250 local and overseas delegates attended.

One highlight was the GB Ong Lecture entitled ‘Management of Advanced Pelvic Cancer’, delivered by Professor Paris Tekkis, Professor of Colorectal Surgery, Department of Surgery and Cancer, Imperial College London, London, United Kingdom.



Department of Surgery
Queen Mary Hospital



Hong Kong Society of Hepatobiliary and Pancreatic Surgery

The Hong Kong Society of Hepatobiliary and Pancreatic Surgery is formed by a group of hepatobiliary and pancreatic (HBP) surgeons in Hong Kong. One important mission is to enhance fraternity and friendship among doctors interested in the field of HBP surgery. It also aims to promote and strive for the highest ethical and surgical standards while encourage sharing of experiences amongst members.



Council Members

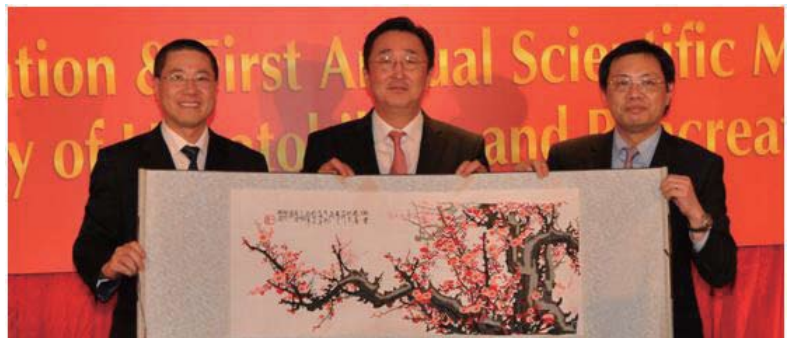
The Society was inaugurated with the first council meeting held on 13 January 2012, followed by its Annual Scientific Meeting. During the first council meeting, Professors Fan Sheung-Tat and Paul Lai Bo-San were elected President and vice-President respectively. In the first Annual Scientific Meeting, Professor Fan gave a talk on the current status of treatment of hepatocellular carcinoma. Professor Suh Kyung-Suk from Seoul National University was also invited to share his experiences in liver resection and liver transplantation. The inaugural event was very well attended and attracted many surgeons.



Professor Fan's lecture during First Scientific Meeting on 13th Jan 2012



Professor Suh Kyung-Suk from Seoul National University shared with us his experience in Liver resection and Transplantation



Presentation of gift to Professor Suh Kyung-Suk by Professor Paul Lai and Dr. S. C. Chan

Topic on film

In order to make a concerted effort in organizing future educational programs, the Committee for Training and Education has been set up and Dr Lam Siu-Ho was elected Chairman. A series of activities have been planned. Regular clinical meetings offering opportunities for the HBP community to meet new faces will be held in different hospitals. On 12 May 2012, the Multi-disciplinary Cancer Summit was held in collaboration with the Hong Kong Society of Clinical Oncology. The summit gave an excellent chance for HBP surgeons to communicate and discuss with oncologists in different perspectives of management of difficult HBP problems. An update course in liver resection was also held successfully in conjunction with the Department of Surgery of Prince of Wales Hospital on 16 June 2012. The response was overwhelming with more than 180 doctors and nurses attended. Given this successful experience, further update courses are planned.

Multidisciplinary Cancer Summit 2012



Professor Carsten Bokemeyer, Dr. T.P. Fung and Dr. Raymond T.T. Chan shared with audience their experience in multidisciplinary approach in management of colorectal liver metastasis



Faculties of the Update Course in Liver resection 2012



Update Course in Liver Resection held at Prince of Wales Hospital on 16/6/2012

Apart from educational meetings, a core group formed by Drs. Fung Ting-Pong, Philip Yeung, Lai Tak-Wing and Joseph Hui has recently been formed to develop a website that will provide updated information concerning the society. The website will contain our educational materials and presentations of past events for members' easy reference.

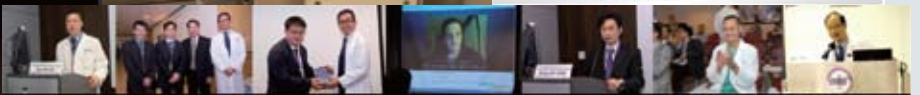
The Society is committed to provide a platform for sharing of knowledge, including surgical techniques and management of complex HBP diseases. Our next Annual Scientific Meeting will be held on 18 January 2013. Before that, please visit our website at <http://www.hkhbp.com> for information on other important events and activities.



Prof. Sheung-tat FAN
Queen Mary Hospital

Topic on film

This is a 2-day intensive course which was co-organized by The Minimal Invasive Surgical Skill Center, CUHK and the Department of Surgery of Kwong Wah Hospital. It focused on latest technology and development in **Laparo-Endoscopic Single-Site (LESS) Surgery**. This workshop consisted of various lectures by local & overseas speaker from France (Prof. Brice Gayet), Brazil (Dr Galvao Neto) and Korea (Dr. Sangchui Lee), live surgeries on LESS cholecystectomy, left hepatectomy and transanal Total Mesorectum Excision were demonstrated. There is also a half day Hand-on animal workshop on applying these new LESS technique in porcine model.



Dr Simon Kin-hung WONG
Prince of Wales Hospital

Topic on film

HKSUGIS & HKASO Joint Scientific Symposium –
Unmet Needs of Obese T2DM Patients
15th June 2012, Intercontinental Grand Stanford Hotel, TST, Hong Kong



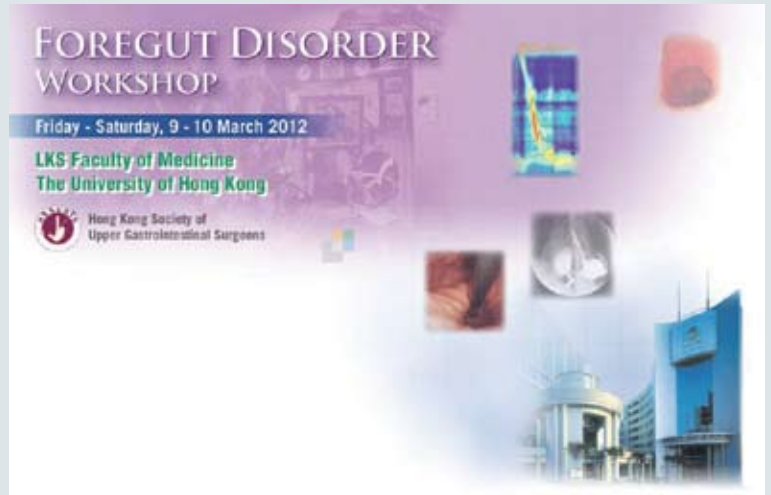
This Congress is jointly organized by Hong Kong Society of Upper Gastrointestinal Surgeons (HKSUGIS) and the Hong Kong Association for the Study of Obesity (HKASO). It is an evening dinner symposium dedicated for both surgeons and endocrinologists who are interested in the treatment of type 2 diabetes in Hong Kong and there will be about 60 to 70 local delegates to attend this event. There are two distinguish local faculties on medical & surgical treatment of diabetes, Prof Juliana Chan from the Chinese University of Hong Kong and Dr Simon Wong from Prince of Wales Hospital. They initially also invited Dr. Galavo Neto from Brazil to present his work on “EndoBarrier” – a new endoscopic treatment of T2DM. Although Dr Galavo eventually cannot come to Hong Kong, he had specially prepared a narrated video so all the audience can appreciate this innovative endoscopic treatment of T2DM.



Dr Simon Kin-hung WONG
Prince of Wales Hospital

Topic on film

The Hong Kong Society of Upper Gastrointestinal Surgeons (HKSUGIS) had organized a focused **workshop on Foregut Disorder** on 9 - 10 March 2012 at LKS Faculty of Medicine, HKU. Apart from local faculties of surgeons & gastroenterologists, they have also invited two distinguished overseas faculties from USA, John PANDOLFINO from Chicago, Jeffrey PETERS from Rochester and David WATSON from Adelaide, Australia. This meeting focused on both medical & surgical aspects on management of Functional Upper GI diseases and they have three hands-on workshops on: A Manometry Workshop focus on technique and interpretation on high resolution manometry (HRM); an advanced endoscopic workshop on live porcine model focus on endoscopic treatment of Barrett esophagus and placement of Barvo pH monitoring, and a laparoscopic surgery workshop on pigs focus on procedure such as Heller's myotomy, fundoplication and hiatal repair.



Dr Simon Kin-hung WONG
Prince of Wales Hospital

Topic on film

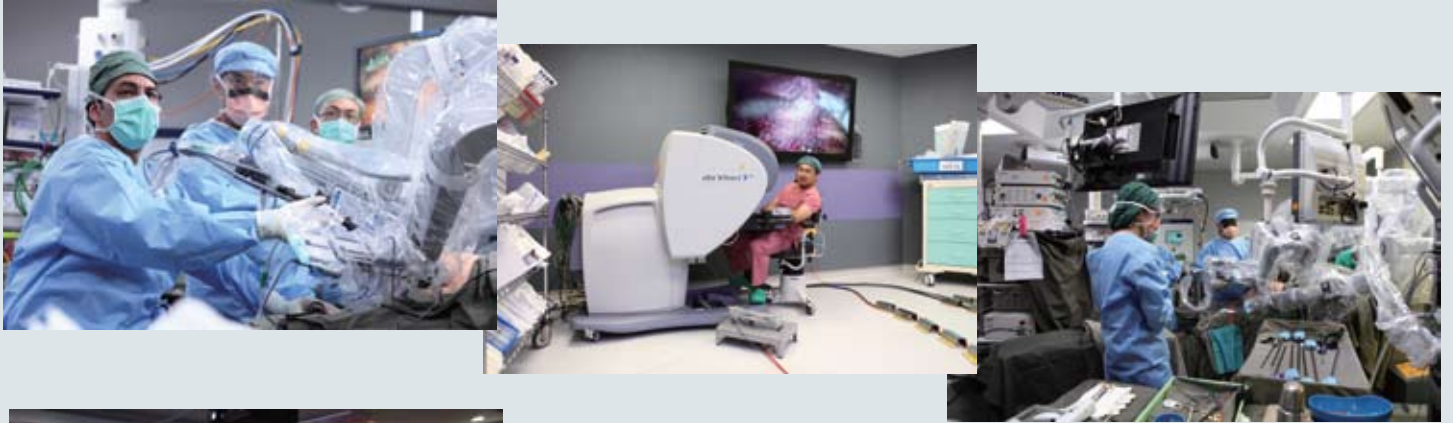
The 1st Asia CRSA for Hepato-Pancreato-Biliary and Colorectal Surgery



The first Asia CRSA for Hepato-Pancreato-Biliary and Colorectal Surgery was successfully held in Pamela Youde Nethersole Eastern Hospital (PYNEH) on 11-12 July 2012. CRSA is the Clinical Robotic Surgery Association, which is a worldwide robotic society founded in Chicago in 2009. Its aim is to provide clinical, educational and innovative services in a manner that will support the true mission of facilitating robotic techniques in general surgery and related specialties. This was the first robotic symposium in the Asia Pacific Region. The symposium included inspiring lectures, live demonstrations of robotic surgery from distinguished overseas and local experts. It provided us the latest updates on clinical technology and research findings on robotic surgical techniques, but also opportunities for exchange of experience among experts from different countries and regions. There was over 200 participants from Hong Kong, China, Macau and different parts of the world.



Topic on film



Dr Dennis CK NG
North District Hospital



Dr Hester CHEUNG
Pamela Youde Nethersole
Eastern Hospital

Women's Chapter

Being a working women is not an easy task, not to mention the life that of a women surgeon! Our daily chores ranges from doing over night calls, looking after our partners to feeding babies! Despite the long working hours, who says women surgeons cannot look fabulous? A group of us gathered together on 18th December at **ESTÉE LAUDER's** world- first Beauty Center in Causeway Bay, just before Christmas to get to know the great tips of skin care and DIY make up tips to look good for the holiday season!

The session started off with one of the beauty centres' instructors who went through details of cleansing, hydration and skin lifting. Getting rid of eye bags and dark circles was definite a favourite amongst the group. This was followed by a step by step DIY guide in doing a make over including foundation selection, choosing the colours which matches each individual the most. One of our surgeons even volunteered to be a model on the day. The day was so full of fun that it totally ran overtime! How can anyone want to leave such a memorable day of looking good and feeling good!

And everyone did look fabulous did they not?



Dr Ava KWONG
Queen Mary Hospital

Experience Sharing in the RACS 2012 Younger Fellows Forum

On 3rd - 5th May, 2012, I represented the College to attend the Royal Australasian College of Surgeons' 2012 Younger Fellows Forum in Selangor, Kuala Lumpur, Malaysia. The Forum impressed me very much not only because it was held at the Golden Palm Tree Resort at Selangor, one of the most famous resorts with natural luxury in the area, but also it has put together a meaningful two and a half day retreat including a mixture of discussions and interactions with young surgeon specialists, College leaders and external experts. I was astonished by the degree of emphasis the Australasian College had put on this Forum, that a set of Forum recommendations on various issues discussed will be submitted and considered during Council meetings. Two Councillors stayed the whole Forum and listened to young specialists giving their opinions on surgical training model, role of supervisors, preparation for practice, changing face of health care system, challenges in their practice, and so on.



Delegates attending the Younger Fellows Forum



Photo with Steve Leiman (Left), Chair of Younger Fellows Committee, and Paz Quiballo-Puyat (Middle), Younger Fellows Committee Secretariat

Although the Forum mainly focused on surgical practice in Australia and New Zealand, many issues are equally important and worth discussing in our locality: what is professionalism? Do young surgeons nowadays retain their rights to professional autonomy? How can the College assist and maintain all these?.... Things are discussed not only in the interests of the College but also to a personal career level, that every young specialist should think about his/her plan or vision, what we want to achieve with our career and make decisions accordingly, the balance between work and life, how we can maintain the durability and satisfaction with our surgical career, and to avoid burnout..... I am sure all these can stir up much hot discussions too if our local young specialists have the opportunity to sit down together

and share what we are facing currently. Although it may be disappointing if one wants to find the answers in the Forum, it provided stimulating insights and a wider perspective of seeing things. In one session, we were asked to play the role of a hospital administrator and to help solve a critical problem the hospital is facing. After listening to different opinions and ideas, I realized that being an administrator has so much things to balance that an easy way out is virtually impossible!

Apart from intense discussions and debates, the Forum was colored with an interesting cooking competition in that each group had to make a 3 course menu within one hour. This "surgeon master chef" competition brought everyone close and echoed what we go through

everyday on operating tables: decision making, being the chief or the assistant, tackling errors and mistakes, and facing the outcome together! On the first night, the traditional Malaysian fire dance at the beach party was another highlight - surgeons dance and sing hand in hand! What a wonderful picture!



Group photo of RACS 2012 Younger Fellows Forum

On my way back to the airport, I keep asking myself: can this Forum be replicated in Hong Kong? Will the Councillors be interested to spend a weekend with our young specialists, who are working so hard throughout the year and dedicating their careers in the operating theatres? I am looking forward to seeing this happening soon!



Photos with other delegates. Left to right: Dr James Lee (General and endocrine surgeon, Sydney), Dr Nicole Yap (Breast oncoplastic surgeon, Melbourne), Dr Allan Tsung (Hepatobiliary/ pancreatic surgeon, Pittsburgh, U.S.).



*Dr Wai-kit MA
Princess Margaret Hospital*

Membership Examination

The MHKICBSC Part 3 Exam was held on 12-13 Mar 2012 at Tung Wah Hospital. 53 candidates enrolled in the Exam in which 36 of them passed the Full Exam. The passing rate of this Exam was 67.9 %.

Another diet of MHKICBSC Part 3 Exam was held on 20 Sep 2012 at Prince of Wales Hospital. 23 candidates enrolled in the Exam in which 20 of them passed the Exam. The passing rate of this exam was 87 %.

Fellowship Examination

General Surgery

The Fellowship Examination in General Surgery was held on 14-16 Mar 2012 (14-15 Mar 2012 at HKAM JC Building; 16 Mar 2012 at Prince of Wales Hospital). There were 37 Candidates enrolled in the Exam in which 23 of them passed the Exam. The passing rate is 62.2 %.

Another diet of Fellowship Examination in General Surgery was held on 10-11 Aug 2012 at Singapore. There were 24 candidates sitting for the Exam (18 local candidates and 6 Singapore candidates) in which 13 candidates passed the Exam. The passing rate of local candidates was 54%.

Neurosurgery

The Fellowship Examination in Neurosurgery was held on 14-15 Sep 2012. (14 Sep 2012 at HKAM JC Building; 15 Sep 2012 at Prince of Wales Hospital) There were 5 candidates (2 local candidates and 3 Singapore candidates) sitting for the Exam in which 4 of them passed the Exam. The passing rate is 80%.

Paediatric Surgery

The Fellowship Examination in Paediatric Surgery was held on 10 Mar 2012 at Queen Mary Hospital. We had two candidates sitting for the Exam and both of them passed the Exam.

Urology

The Fellowship Examination in Urology was held on 24-25 September 2012 at HKAM JC Building. 6 candidates enrolled in the Exam and all of them passed the Exam.

Plastic Surgery

The Fellowship Examination in Plastic Surgery was held on 26 September 2012 at HKAM JC Building and 20 October 2012 at Queen Mary Hospital. There were 4 candidates sitting for the Exam in which 3 of them passed the Exam. The passing rate is 75%

Examination Corner

Congratulations to our Diplomates at the RCSEd/CSHK Conjoint Diploma Conferment Ceremony 2012



RESEd/CSHK CONJOINT DIPLOMA CONFIRMATION CEREMONY 2012

FELLOWSHIP CONFIRMATION

CARDIOTHORACIC SURGERY

YEUNG Chung Lai Eugene

GENERAL SURGERY

CHAN Ho Yan Yolanda
CHAN Hoi Yee
CHAN King On Canon
CHAN Kwong Shun
CHAN Pak Tat
CHOW Chi Yan Lorraine
CHOW Man Po
CHU Simon
CHU Wai Ho Colin
CHUNG Tat Ming
LAW Siu King
LAW Tsz Ting
LEE Ka Yan
LEUNG Lik Hang Alex
LO Wai Chung Eddy
LO Xina
LUK Wai Yin Sally
MA Kwok Kuen
NG Chung Kei Daniel
TSOI Yee Kei Violet
WONG Cho Lam Tiffany
WONG Kai Pun
WONG Wai Ho
WONG Yan Hon Daniel
YIP Jeremy

NEUROSURGERY

LAU Chi Yan Jane
NG Yuen Ting

PAEDIATRIC SURGERY

CHAN Hau Yee
CHUNG Ho Yu
TANG Man Yee Paula

PLASTIC SURGERY

LIU Hin Lun
NG Yim Hung Fiona

UROLOGY

CHAN Ning Hong
CHAN Tsz Yeung
CHUNG Yeung Vera
KAN Chi Fai
LAM Yiu Chung
LO Ka Lun
WONG Ming Ho Edmond

MEMBERSHIP CONFIRMATION

AU Kin Pan
CHAN Chung Yan Justin
CHAN Ka Man Fiona
CHAN Kar Vin
CHAN Man Hin
CHAN Ngo Lun Allan
CHAN Shun Yan
CHAN Sik Kwan
CHAN Wai Hong
CHENG Kwun Chung
CHEUNG Chung Yeung
CHEUNG Yau Fung
CHOW Kwan Ho
CHU Chi Ho Alberto
CHUM Hoi Leong
FUNG Tak Lit Derek
HO Lok Yan
HO Wai Yee
HUI Hon Cheung
KAN Wai Man
KONG Wai Chung Angela
LAI Chun Ting Terence
LAM Shi
LAM Tang Yu
LAU Cham Yat Vincent
LEE Suet Ying
LEE Yu Kit
LI Churk Fai Trevor
LI Hoi Man
LO Ting Kit
LOK Hon Ting
MAN Chi Mei Vivian
MAN Chun Hin Tommy
NG Ting Fung Karson
NG Yuen Shan
NGO Chang Chung
PANG Suet Ying
TAN Teresa
TEOH Yuen Chun Jeremy
TING Kong Ling Steven
TSANG Chiu Fung
WONG Hei Yi
WONG Ka Hon Stephen
WONG Ka Ming
WONG Kam Cheung
WONG Lai Yin Claudia
WONG Wui Bun

Off the Scalpel

好高興能夠在這裏同大家分享小弟工餘時的興趣！其實本人是一位百分百的Kidult, 好喜歡收藏玩具，其中最迷心的是Lego積木。

可能你會問Lego不是小朋友的玩兒嗎？但我可以肯定話比你知，它一定不只是小兒科，是三歲到八十都適合的玩具！

第一次接觸

從小已聽過一句廣告口號：「樂高(Lego)多創意，件件考心思！」當時年紀小，唔知其中意思，只知Lego可以砌出一間屋、一架車、一架飛機甚至一座太空基地。顏色吸引，又有小人仔，感覺好實在又好親切。可是當時Lego並不是一般家庭能負擔得起的玩具，所以在玩具店只能「拿得起，放得低」。當年是1987年，小四的我考到好成績，媽媽便買了第一盒Lego給我獎勵，這是Lego classic space系列，是一座火箭基地，現在已停產多年。如果現在要追買，相信你比置業更困難！因為是第一盒，所以格外十分頭入和珍惜，砌完拆完又再砌，甚至可以不看說明書單憑記憶再砌出來，連我現在都做不到。



離棄了Lego?

人大了，有朋友，知道他們玩甚麼，有的玩超合金，有的玩模型，有的玩電子遊戲機……感覺好似和人格格不入，最後終於把火箭機地打入冷宮。中學、大學時期更加沒有玩玩具，通常只是和朋友打波、流連機補或家中玩online game。直至工作了一段時間，當時2006年，本只是到斗斗城玩具店買禮物送給人家孩子，竟發現Lego太空系列已經進化到Starwar的界面，正好自己非常喜歡Starwar電影裏的各種細節，所以毫不遲疑以數百元買了電影中的名機 - Lego X-wing，並在家中當眼處展示出。想不到從此以後，已不知不覺走入了Dark Side of the Force！

一發不可收拾

原來Lego公司打算將所有Starwar裏的人物、飛船和情竟一一展現出來，結果出完一盒又出幾盒。自己經濟還可以，所以都一一買下，有的甚至買十盒以上，以量產一整隊軍隊，非常有氣勢！更嚴重的是，Lego出的其他系列都非常精美，不論城市、大屋、火車、城堡、海盜、其他電影例如奪寶奇兵、蝙蝠俠、復仇者都買了！每每有Lego系列首買日、Lego開倉和動漫節，我都會比返工更早的時間去排隊等買。問題是家中開始沒有空間擺放，有些只能放在牀



下底收藏，甚至向老家書房打主意。太太開始怨氣發放，為甚麼我們的display櫃現只放了你的Lego？我的小熊維尼呢？其實我偷偷地收起太太的收藏，螞蟻搬家式的「霸佔」了整個display櫃！結果太太開始禁制購入數量，有一段時期我好像做賊般要把貨物偷運到家中在暗格收藏，也有些太大盒，不能帶會家中，情景好比自己有外遇……好在最後太太知我是真心的，真心的愛Lego，所以已寬恕我，而我也節制了不少。

Off the Scalpel

收藏和購買心得

雖然Lego set 有大有小，從數十元到數千都有，所以可以豐儉由人地玩。最初以為只有大玩具公司才能買到，當然有的是獨家的，但價錢就是行貨價。原來買Lego最平的地方是美國，同樣的款式在香港買，價錢是美金價乘十至十四不等！所以建議到售賣Lego水貨的小店買，他們的價錢往往是行價的八折！有的甚至有Lego公司exclusive set售賣，但價錢浮動。你也可以到拍賣網站搜尋，這裡也是「淘金」的好地方，不過下標前記僅預先格價。除了先前提到、一般可在市面買得到的系列，Lego還有殿堂級的exclusive set，它們並不是一般小



孩子可應

付的大大一盒，有古典大宅、超大型Starwar裏的戰艦、世界文化遺產如巴黎鐵和印度泰姬陵……每盒都有數千件，結構複雜和組裝過程花時，但成品相當壯觀和華麗，是收藏家必然之選。它們俗稱「五個杯把系列」，因為貨品編號為10XXX，等如靚橙中的4012，紅酒中的La Fete……下過想擁有它是



有一定難度的，除非你價錢不是問題。原因一，它們只能在Lego official shop買到，香港是沒有的，亞洲最近只有南韓有official shop。原因二，售價往往是過千至數千港元不等，最平當然是在美國official shop入貨，所以如果有幸到美國一行，記得記得帶走至少一兩件，否則就是「入到寶山空手回」！市面買到的是水貨途徑運來的，貨少價錢好難平賣。小弟心得，出外靠朋友，多是從official網站購入再送去美國居住的朋友，再寄回香港。由於要運費，所以通常等待有promotion時入貨例如free internal shipping、有贈品送如限量人仔、減價……原因三，買樓買股有機會升值，買exclusive set不同，它一定會升值！因為產量有限，並且不會轉少少款式再出，加上市場有需求，停產後價值以倍數飆升，例如當年的自由神像，千多元的現已值過萬元！又例如10179 Starwar UCS Millennium Falcon，

2007年賣五千元，現在已近兩萬！所以王道是，如果可以便每款入兩盒，分分鐘你最後免費擁有一盒。總之「早買早享受，遲買平兩舊」並不適用，而是「遲買貴兩K」！

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Off the Scalpel

學習Lego哲學

砌Lego有多種玩法，你可以單純地照著說明書去砌，這是最基本的。有一個系列叫Creator，說明書會提供多種砌法，例如三種車、三種飛機、三種平房等，相對多點啟發性。也有走機械活動型路線，如Technic系列，滿足感來自它完成後會發光，發聲和有活動能力。但Lego的玩法是無窮的，你可以將幾盒去組成一種模式，例如房屋，交通工具、警察局、消防局加建築工程系列會組成一個小城，同樣用Starwar系列可以組成一個太空戰場！我也試過用Lego去寫故事在網上分享，玩法又另一層次。不過正如好多資深玩家一樣，都會覺得不想受制於設計者的局限，也會感覺到有時其設計並不完美，例如做醫護的，一定會覺得Lego醫院慘不忍睹，像是似服務富豪的診所。所以，玩到一定程度時便會開始



MOC(Make your Own Creation), 即是憑空想象，去砌一些獨一無二的作品，一些Lego公司沒有發表的系列。作品可大可小，題材廣泛，件數隨意，往往只是用手頭上的零件去創作，過程雖然困難，但成功感是筆墨不能形容的，畢竟無論好與差，這都是世上唯一的。我有朋友砌了個尖沙咀出來，讀者們有否到九龍公園參觀呢？而且你隨時可以還原它去製作其他的作品，非常乎合經濟效益同環保。不過要製作得好便要不斷嘗試和觀察，也要有立體的想象力，多參考別人的佳作和分享，是一生的學習，這就是所謂「樂高(Lego)多創意，件件考心思！」

Lego、我和將來

直到現在，收藏Lego都是我首選的，也走向MOC發展路線，時常要到外國網站訂特別零件去創作，更有幸的我有一間Lego工作坊。每每有新的MOC作品，都會在Facebook、本地網上Lego forum例如「人仔倉」甚至外國Lego forum分享，當中認識了很多志同道合的朋友，也參加了本地Lego公開比賽，雖然未能獲得任何獎項，但從中獲益良多，所以會繼續參與。工作繁忙，小女兒出世了，玩的時間少了，但會珍惜有得玩的機會！雖然知道小女兒喜



歡與否，我已為她買了一些Duplo兒童系列和對象是女孩的Friends系列，作為日後親子的活動，希望Lego能啟發她的想象力和觀察力。



他日退休後已有打算，就是開一間售賣Lego的店舖，一邊砌，一邊玩，一邊做生意。做醫護的，我一定打個八折給你！

鄒醫生除了是一位外科醫生外，亦是一個Lego收藏家，也是Lego自由創作者，曾參與香港動漫節Lego拼砌大賽，並於多個網站發表自家制作品包括玩具日報、人仔倉、Europe Brick Forum等



Dr Lysander Hin CHAU
United Christian Hospital

Off the Scalpel

I am very honoured when the College asked me to write an article here about running a marathon. As we have witnessed, the College of Surgeons for the past few years, produced a strong running team to participate in the Standard Chartered Hong Kong Marathon (SCHKM), an annual local running event which has earned its fame internationally in the world of marathon running. For me, I have participated in the event for more than ten years, seven of which are full marathon. Throughout the years of running, I have come to know a lot of strong runners in our surgical community, all of them like me, have enjoyed the sport immensely. I think for most of you who has been running hard for the past years will agree with me, long distance running is a bit like surgery, and a good runner shares the same trait as a good surgeon; it takes good physical fitness, as well as great determination of the mind, and good results only comes with long hours of training.

Running is an elegant sport. No fancy equipment is required, although a good pair of running shoes can save you from injuries. There is no need to book any venue for running; anywhere with a road that you can run is sufficient. It is probably the only sport you can do 12'o clock at night or 5'o clock in the morning. I started off like most people, just jogging for fitness. Soon, I wanted to run longer and faster, and once a 前輩 said to me, achieving that is relatively simple; you just run fast and not stopping. The general idea is correct, but achieving this will take a lot of training and determination. For those of your thinking of taking up running seriously, I suggest you to start with not stopping first. You can start off with a relatively slow pace, but persisting for a period of 30 to 45 minutes; the muscle will adapt from aerobic to anaerobic respiration at around 10 to 20 minutes (the point you want to give up most) after running so any period less than that will refute the purpose of training. Once you are over the pain threshold, and your body is familiar with the switching, you are then engaged in a long distance running mode, for which you can run a further distance with relative ease. You can then try to run faster and longer by setting goals, certain distance to cover. To run a longer distance, you must build up endurance; that is, in simple terms, muscle power and cardiovascular performance. For this, you need to accumulate your weekly mileage; that is the distance you run every week. Basically, I try to run every day, and for low season like in the summer, my weekly mileage is about 30 to 40km, gradually building it up to 60 to 80km during training season in the winter. That will average to 6 to 8km per day, with a weekend long run of 15 to 20km. I know this might sound a bit of hard work for most of you but if you have decided to do the sport seriously, it is important that you work on the endurance. For beginners, you might experience severe pain the next day after a long hard run; this is the result of adhesions building up between the muscle fibres as the result of running, and it is imperative to break this train and pain cycle but running the next day so that the adhesions will not form and hence no more pain.

In general, there are 3 kinds of race; 10km, half marathon (21km) and full marathon (42km). Most of you have participated in the 10km race in the SCHKM, but the Hong Kong Amateur Association (HKAAA) organises various races throughout the running season; you can obtain information on their web site. **I encourage you to enter races, for races are like examinations; it motivates you to train and work hard for better results.** 10km races are relatively straight forward, for most people can run for an hour, without much training.

Off the Scalpel

Every year, the HA organises a New Year Run (醫管局新春長跑), which is a nice 10km race where you get to race with your friends and colleagues from different departments and hospitals and I encourage you all to participate. Some of you would have challenged the half marathon; it is a fun and enjoyable race, and I assure most of you, with training, finishing the race is not a big problem. The full marathon is truly the holy grail of long distance running, and only a few of you would have endured the tough challenge. The body's normal physiological running (that is, when you are forced to run to the maximal distance) ends at around 30km. After that, your muscle runs out of ATPs and simply cannot contract further. It's like a car running out of fuel, what the runners described as "hitting the wall" and at that point, no matter how hard you try, you cannot lift a step further. This can only be overcome with training, and for those of you wishing to dare the challenge, at least 4 months of diligent training, dieting and muscle building is required just to finish the race.

I hope I did not put you off running by all this talk of hard work, especially running a full marathon. **I think, every runner should aim for a full marathon in their life time. For me and for those who had done it before, it is truly a life changing experience. By pushing your body to the limit, you get to know your body all over again; especially what it is capable of achieving.** I could not have picked the worst time for my first full marathon. I did mine in 2005, and for those close to me will remember, that year I nearly died from a serious drug reaction ending up in Steven-Johnson syndrome, staying in the ICU for a week, and in hospital for a month. Afterwards, I still decide to proceed with the full marathon and although the training was hard, I persisted and managed to finish the race. Throughout the race, only one thought went through my mind, which is not stopping and not giving up. After that, I view life differently, knowing that if one works hard at a goal, he will be rewarded by achieving it through determination.



Dr. Renny Yien (CONS, Surgery, PYNEH) and me at the finishing line, our first full marathon

I hope, by reading this article, I have inspired you to start taking up running. For those of you who are already regular runners, I hope to encourage you to participate in more races and to pursue the ultimate goal of full marathon. **May I wish you all achieving good result in your upcoming races and to see you all in the College Running Team for the SCHKM. Keep participating in sports and keep running a life-long passion.**



Dr Marcus Wai-leung YING
Kwong Wah Hospital

Besides being a surgeon, Dr YING has been an active runner since he first participated in Standard Chater Hong Kong Marathon since 1999, and had participated in every race since. His last 7 races he completed as full marathon. His best full marathon time is 3hrs 49min in SCHKM 2011.

This newly added column aims to provide updated information on our Fellow Colleagues' latest development, achievement and life events. The news include Retirement, Change of Practice, Marriage, Giving birth to new baby and the like. Please do not hesitate to share your joy and happiness in life by submitting the information to us via info@cshk.org. The followings are some examples.



Dr Andrew YIP changes to Private Practice

Dr Andrew Wai-chun YIP, our Censor-in-Chief has retired from Kwong Wah Hospital and begins the private practice.

Dr Hon Ka-lau LEUNG and Dr Ka-ki KWOK has been elected as LegCo Members

Congratulations to Dr Ka-ki KWOK for being elected as the member of the Legislative Council (2012-2016)(Geographical Constituencies). Hearty Congratulations to Dr KWOK for his accomplishment.



We would like to send our congratulations to Dr Hon Ka-lau LEUNG for being elected as the member of the Legislative Council (2012-2016) (Functional Constituency). May we once again extend our congratulations to Dr LEUNG for his accomplishment.

Sharing the Happiness of Dr Bonita MARK for her new-born baby boy

My son, Luca was born in May 2012. Luca is a name derived from Luke, which means bringer of light. Just like surgical innovations have been bringing light to people, Luca's coming has brightened up my life and I hope he can grow up into a useful person.

Dr Bonita MARK
Queen Elizabeth Hospital



Announcements

Results of the Council Election of the College

Results of the Council Election of the College have been released. The College congratulates Prof. Paul Bo-san LAI and Prof. Simon LAW for successful re-election and welcomes the new Council Member, Dr Edward Chuek-seen LAI to join the Council. In addition, the College would like to express our gratitude to our immediate past Council Member, Dr Wai-key YUEN, for his contribution and support to the College. Here are the list of Council Members in 2012-2013:



Second Row:

Council Members (From left to right): Dr Chad TSE; Prof. Philip CHIU; Dr Heng-tat LEONG; Prof. Kent-man CHU; Dr Chiu-ming HO; Dr Ava KWONG; Prof. Wai-sang POON; Prof. Wai-lun LAW; Prof. Stephen Wing-keung CHENG; Prof. Simon LAW; Dr Wing-tai SIU; Dr Edward LAI; Dr Wai-key YUEN (immediate Past Council Member)

Front Row:

(From left to right): Prof. Enders NG (Honorary Treasurer); Dr Chi-wai MAN (Honorary Secretary); Prof. Paul LAI (Vice President); Dr Hung-to LUK (President); Dr Po-chor TAM (Vice President); Dr Andrew YIP (Censor-in-Chief); Prof. Chung-kwong YEUNG (Immediate Past President)

Call for submission: Achievement from Fellows and Members

Our Fellows and Members not only have devoted their effort into medical services but they 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 in the Cutting Edge. The announcement of Non-College activity will also be posted on College website.

Obituary

Professor Academician WANG Zhong Cheng (王忠誠) will always be remembered – *“What we do for ourselves alone, dies with us; what we do for others and the world, remains and is immortal.”* (Albert PIKE, 1809-1891)

Academician Wang, elected Honorary Fellow of our College in 2008, presented in absentia in our annual diploma ceremony on 22nd September 2012, has passed away on 30th September. The neurosurgical community of the nation and the World Federation of Neurosurgical Societies are saddened by the loss of our founder of modern neurosurgery in Mainland China as an academic specialty. Dr. Wang started his professional life as a full time neurosurgeon in the 1950s, established essential technology such as cerebral angiography, management of traumatic brain injury and subsequently acquired the world’s largest experience in brainstem surgery. With this vast experience in the development of the profession, training of young neurosurgeons for both clinical and surgical skill, laboratory and clinical research in almost six decades since 1953, his national founder status of modern neurosurgery has elected him to the Chinese Academy of Engineering in 1994, won him the State Supreme Science and Technology Award in 2008 and honoured him the medal of honour of the World Federation of Neurosurgical Societies in 2001.

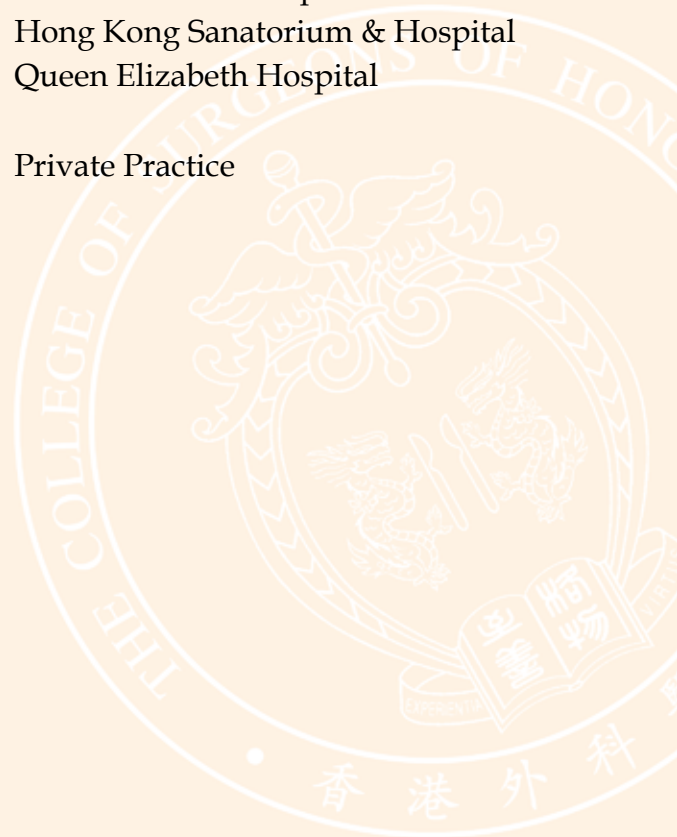
He has visited Hong Kong on at least three occasions in the 1990s, twice as a neurosurgical teacher and once as a recipient of a prestigious science and technology prize from the Ho Leung Ho Lee Foundation of Hong Kong. The neurosurgical community in Hong Kong is grateful forever for his teaching of technical neurosurgery and his passion for excellence has set an unforgettable example for all of us.



Prof. Wai-sang POON
Prince of Wales Hospital

Council of the College

President	Hung-to LUK	Princess Margaret Hospital
Vice President	Paul B S LAI Po-chor TAM	Prince of Wales Hospital Private Practice
Hon. Secretary	Chi-wai MAN	Tuen Mun Hospital
Hon. Treasurer	Enders K W NG	Prince of Wales Hospital
Censor-in-Chief	Andrew W C YIP	Private Practice
Council Members	Stephen W K CHENG Philip W Y CHIU Kent man CHU Chiu-ming HO Ava KWONG Edward CS LAI Wai-lun LAW Simon Y K LAW Heng-tat LEONG Wai-sang POON Wing-tai SIU Chad C W TSE	Queen Mary Hospital Prince of Wales Hospital Queen Mary Hospital Private Practice Queen Mary Hospital Private Practice Queen Mary Hospital Queen Mary Hospital North District Hospital Prince of Wales Hospital Hong Kong Sanatorium & Hospital Queen Elizabeth Hospital
Ex officio Councillor	Chung-kwong YEUNG	Private Practice



Structure of the College

COMMITTEE

External Affairs Committee

Internal Affairs Committee

- Corporate Communication Subcommittee & Editorial Board of Cutting Edge
- Women's Chapter
- Younger Fellows Chapter

Administration Committee

- Website Development

Finance Committee

- Business Development Subcommittee

CME & CPD Committee

Editorial Board of Surgical Practice

- Editor-in-chief

Research Committee

Education & Examination Committee

- Specialty Boards
 - Cardiothoracic Surgery Board
 - General Surgery Board
 - * Training Subcommittee
 - * Hong Kong Regional Subcommittee
 - Neurosurgery Board
 - Paediatric Surgery Board
 - Plastic Surgery Board
 - Urology Board
- Board of Examiners
- Appeal Board

CHAIRMAN

Paul B S LAI

Po-chor TAM

Chad C W TSE

Ava KWONG

Weida DAY

Chi-wai MAN

Wing-tai SIU & Wai-sang POON

Enders K W NG

Enders K W NG

Edward C S LAI

Samuel P Y KWOK

Paul B S LAI

Chung-mau LO

Andrew WC YIP

Malcolm John UNDERWOOD

Simon Y K LAW

Simon Y K LAW

Simon Y K LAW

Wai-sang POON

Kelvin K W LIU

Wing-yung CHEUNG

Chi-wai MAN

Andrew W C YIP

Andrew W C YIP

DEPARTMENT

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Joseph W Y LAU

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Che-hung LEONG

SECRETARIAT

General Manager

Stephanie HUNG



Souvenir Collection Catalogue

Souvenirs for Sale

1. College Tie available in various colors \$180@



Full set of ties (8 pieces A-G)

*Order of full collection (8 types of ties) can enjoy a 20% discount, i.e., **\$1,008**

3. T-shirt \$80@



Size of the displayed: M

4. Polo shirt \$100@



Size of the displayed: M



2. College Scarf \$150@



5. Mini Wireless Mouse \$100@

Souvenir Order Form

ITEMS	PAYMENT (HKD\$)
1. College Tie (A) _____ piece(s) (B) _____ piece(s) (C) _____ piece(s) (D) _____ piece(s) (E) _____ piece(s) (F) _____ piece(s) (G) _____ piece(s) (Full set) _____ set (s)	
2. College Scarf Unit : _____	
3. T-shirt Size (S): _____ piece(s) Size (M): _____ piece(s) Size (L): _____ piece(s)	
4. Polo Shirt Size (S): _____ piece(s) Size (M): _____ piece(s) Size (L): _____ piece(s)	
5. Mini Wireless Mouse Unit: _____	
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 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.: _____)

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