Change is inevitable in life, so as in our practice. In the last issue, we discussed the topic of subspecialization, which is a transforming trend in our profession.

In this issue, we come up with a very interesting topic: “Part-time Practice in the Public Hospital”, which is a new alternative in the way we serve our patients. Colleagues who have worked in developed countries like the UK, Australia, or USA may notice that such practice is very common for their surgeons, and is almost a norm. As the manpower of our healthcare system is under stress, such practice has silently budding in the workplace. Data from the Hospital Authority shows that approximately 5% of surgeons are working in this way, not including those colleagues practicing in the universities.

Our Editorial Board members came up with a lot of innovative ideas when reporting this topic. We collected views from different stakeholders, including, HA officials, COS, Legislative Councilor, surgeons in HA, private, and those having part-time practice, in order to keep a balance in the viewpoint. However, we noticed that many colleagues who are already having part-time practice are quite reluctant to openly talk about it. This may indicate that people are still very conservative and skeptical about this practice. The role of the Editorial Board is to identify this changing trend and bring it up for discussion.

Another new change is our College’s new presidency & office bearer. We will interview them one by one in this and the coming issues of Cutting Edge, and see how would they lead us to go through the challenges ahead.

Finally, we are constantly trying to upgrade the format and enrich the content of this newsletter. Please kindly support by keep reading it and give us feedback. This is our College; I believe one way to make it better is by participating.
Being surgeons we always pay attention to details in every aspect of our patients. For me as an amateur photographer, I am sensitive to light too. Operating theatre is indeed a complex available lighting environment and photographing there is fun as well as a challenge. I took this photo after our new president, Prof SWK Cheng un-gared his magnifying loupe after a technical demanding vascular anastomosis, using two theatre ceiling lights as backlight and the bed sheet itself being a diffusion reflector which lights up both loupes and enriches the whole scene. The treatment of in-camera tungsten white balance cools down the environment and gives the photo a blue background.
Message from the President

It is a great privilege for me to serve as the President of the College of Surgeons of Hong Kong. I am very thankful for your entrusting me with the leadership and well aware of the immense responsibility of steering the College to new heights and excellence.

All great organizations are built on the hard work, dedication and tireless efforts of many. I am honored to be able to follow the footsteps of our predecessors who have laid down a solid foundation for our College, and I can count on their legacies and move our missions forward.

I would like to take this opportunity to thank our Immediate Past President, Dr. Hung-to LUK for his leadership, contribution and years of committed service to the Council and the College. I would also like to congratulate and welcome our newly elected Councillor, Prof. Simon Siu-man NG as well as the other re-elected Councillors, Prof. Philip Wai-yen CHIU, Dr. Chiu-ming HO, Dr. Heng-tat LEONG, Prof. Enders Kwok-wai NG, Dr. Wing-tai SIU and Dr. Andrew Wai-chun YIP. With such a strong cast of devoted colleagues, the Council will continue to serve the College wholeheartedly.

The College’s core and paramount responsibility is to uphold the highest surgical standards and in promoting advances in both the science and the art of surgery. We provide quality training for surgeons in Hong Kong and ensure that the required international standards have been attained via assessment. The College will strive to reinforce the foundation in our current surgical training and education system so as to breed new generations of competent surgeons at the highest level.

Modern health care has become more complex and involve skills across specialties. Our current Surgical Curriculum has evolved towards a modular and competency based approach with identified core competencies. Adequate clinical exposure to trainees is instrumental to the development of full-fledged surgeons. The College will further explore the development of simulation training so as to maximize surgical skills learning while minimizing the risks to patients. The recent opening of the Hong Kong Jockey Club Innovative Learning Centre for Medicine at the Academy provides a new opportunity for the College to develop new training platforms in future.

Another key initiative of the College will be on Subspecialty development for the improvement of surgical outcomes. Pilot Subspecialty training programs for Breast, Head and Neck, and Vascular Surgery within General Surgery are in place. The College will also take initiative in exploring more opportunities for our members and fellows to enrich their experience and broaden their horizons through clinical attachments or travelling scholarships, both in China and abroad. To face the challenges of rapid advancement in technology and knowledge, we will continue to deliver up-to-date and diversified scientific meetings and workshops to broaden our knowledge in the field.

As the College grows and prospers, it is paramount to maintain a leadership position in the international arena, and to foster closer collaborations between mainland, regional as well as overseas bodies. I will cherish our current international relationships, explore new directions, and am committed to bring closer links with our strategic partners overseas.

The College’s vision can only be achieved effectively through concerted efforts of every one of our members and fellows. Your unwavering support and participation is crucial to our endeavors.

Prof. Stephen Wing-keung CHENG
President
The Council for the year 2013 - 2016

President: Prof. CHENG Wing-keung, Stephen
Vice-President (External Affairs): Prof. LAI Cheuck-seen, Edward
Vice-President (Internal Affairs): Prof. NG Kwok-wai, Enders
Censor-in-Chief: Prof. LAI Bo-san, Paul
Honorary Secretary: Dr. MAN Chi-wai
Honorary Treasurer: Prof. CHIU Wai-yan, Philip
Council Members: Prof. CHU Kent-man
Dr. HO Chiu-ming
Dr. KWONG Ava
Prof. LAW Wai-lun
Prof. LAW Ying-kit, Simon
Dr. LEONG Heng-tat
Prof. NG Siu-man, Simon
Prof. POON Wai-sang
Dr. SIU Wing-tai
Dr. TAM Po-chor
Dr. TSE Cheuk-wa, Chad
Dr. YIP Wai-chun, Andrew
Immediate Past President: Dr. LUK Hung-to
Plastic Surgery

The Plastic Surgery Board 2013-16 was newly formed with Dr. David SY Wong as Chairman, Dr. WY Cheung as Vice Chairman, Dr. HP Chung as Program Director and Dr. Eric Choi as Secretary.

One of the most immediate aims of the new Board is to formalise certain aspects of training to meet the requirements of the public.

Congratulations to 2 passing candidates in the recent Exit Examination 2013 in October. The Exit Examination in Plastic Surgery has been transformed in the recent few years and has received very high acclaim by our External Examiner from the Edinburgh College.

Our monthly CME meetings will be overhauled with each 2-hour meeting organised into a Topic Review by an experienced colleague, a Journal Review and a Case Review by members. There will also be regular symposia on various aspects of aesthetic surgery to cater for the training needs of the younger members of the specialty. This is with a view to enrich educational opportunity for all concerned.

Upcoming educational activities include a symposium on aesthetic rhinoplasty with 2 expects from Korea, a co-sponsored meeting with the Hong Kong College of Dermatologists and a CME lecture on medical ethics at the Christmas Dinner of the Hong Kong Society of Plastic, Reconstructive & Aesthetic Surgeons. Two international experts are coming to Hong Kong in early 2014 and will be participating as the expert in a HA Commissioned Training and as a Visiting Professor of CUHK.

Paediatric Surgery

A conjoint exit examination was held on 23rd March 2013 at the Prince of Wales Hospital. There were two local candidates. Both passed the examination. Our Board extends our congratulations to Dr. Kristine Pang and Dr. Kenneth Chung, and welcomes them to be our new board members. As there is no local candidate next year, the next diet of examination will be in 2015 with five local candidates.

Inter-hospital clinical meetings were held in April 2013 in Queen Elizabeth Hospital and in October 2013 in Prince of Wales Hospital respectively. They were well attended by board members and trainees. The next inter-hospital clinical meeting will be held in Queen Mary Hospital. The exact date will be announced in due course.

For the last Higher Surgical Trainee Selection Exercise, there were two training posts in paediatric surgery. Dr. Judy Hung and Dr. Vicky Wong were selected and they are working in Queen Elizabeth Hospital and Prince of Wales Hospital respectively.

Paediatric Surgical Training for the coming Centre of Excellence in Paediatrics is progressing. Several specialists have been sent to overseas centres for training.

The 19th Annual General Meeting of the Board of Paediatric Surgery was held on 25th October 2013. The following Board Committee was elected:

Chairman: Dr. Michael Leung
Vice-Chairman: Dr. Tam Yuk Him
Honorary Secretary: Dr. Nicholas Chao
Board Committee: Dr. Edwin Chan, Dr. Patrick Chung, Dr. Lee Kim Hung, Dr. David Man, Dr. Kenneth Wong
Ex-officio: Dr. Kelvin Liu

Cardiothoracic Surgery

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 29th and 30th in Singapore. There was a Specialty Update Course on immediately following the examinations. Following the last successful years Course, this year was run from December 2nd to 6th. There would be a series of ‘hands-on’ teaching course concentrating on aortic root techniques, mitral repair advanced trauma management and minimally invasive surgery.

Trainees 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.
Message from the Specialty Boards

Urology

Re-accreditation inspection was carried out for two training centres in Hong Kong, namely Queen Elizabeth Hospital and the United Christian Hospital-Tseung Kwan O (UCH-TKO) Cluster. Owing to a typhoon, the re-inspection had been rescheduled from 23 to 25 September 2013. Both centres were re-accredited for urology training for another three and a half year, and the number of training posts in UCH-TKO was increased to three.

A certificate of competency in endoscopic and laparoscopic skills in urology for higher urology trainees upon their completion of mandatory skill courses will be jointly issued by the Urology Board and the Specialty Group on Urology Services of Coordinating Committee, Surgery HA. The first issue will be in July 2014. Trainees need to obtain required experience before the certificates can be issued to them. Animal dissection workshop was co-organized with the Department of Surgery, University of Hong Kong and scheduled on 28 September 2013 and March 2014. The total number of participants will be 40 for the 2 workshops.

A Urology Training Curriculum with 13 topics covering areas of knowledge, clinical skills and procedures had been drafted basing on the Intercollegiate Surgical Curriculum Programme of United Kingdom. The Urology Curriculum was endorsed by the College Council and had been put up on the College website.

The 13th Joint Specialty Fellowship (Urology) Examination on 23 and 24 September 2013. This is the fourth year of successful implementation of the new oral examination. All five candidates sat in the Examination passed, though none had achieved the level required for the Dr Leong Che Hung Medal.

The Chairman participated in the working group on defining high risk medical procedures performed in an ambulatory setting under the Food & Health Bureau. A procedure thereby defined as high risk would in future, if to be performed outside a hospital, be performed only in a regulated ambulatory facility that would be subject to a set of regulatory standards and measures yet to be promulgated. Only non-high risk procedure would continue to be performed in a doctor’s clinic that has not attained regulated ambulatory facility status. Two mail surveys had been conducted with urology fellows. Their opinions were collated into a submission to the sub-group conveners of the working group on 7 August 2013. The general direction of the submission was to maintain status quo of current office practice of private urologists without requiring any significant shift of work to regulated ambulatory facilities.

The Urology Board had been asked to give support to a symposium promoting a pamphlet “Screening for Prostate Cancer, Information for men and their families” prepared by a Cancer Expert Working Group under Department of Health. Urologists, however, had not been involved in the process of actual drafting of such pamphlet. Even though the Urology Board did not object to the block support given by the College on the symposium, the Urology Board was of the opinion that input from urologists should have been solicited in the preparation of such public education material on prostate cancer screening. Urologists in Hong Kong are actively involved in early detection of prostate cancer and play a key role in the management of this disease. The public would certainly be better informed if input from urologists could be enlisted. A response to Professor TH Lam, Chairman of the Working Group, was sent on 20 August 2013 to give further comments on the pamphlet, in particular relating to certain aspects that were inaccurate and misleading. The Chairman attended and voiced out such opinion again during the symposium on 19 September 2013. The Chairman was invited to join in a meeting of the Cancer Expert Working Group on 17 October 2013. During the meeting, a position statement jointly issued by the Urology Board and the Hong Kong Urological Association on early detection of prostate cancer was presented to the Working Group. The Urology Board will seek active participation in the revision of the pamphlet on prostate cancer screening.
At different stages of one’s career, one would have different priorities of their works. In recent years, I have set my focus in accreditation and setting standard for training because of my works in Macau. Joining the Council would give me a chance not only to serve our surgical fraternity, but also to learn what it takes for the College to operate to meet its targets.

Over the past seven years, I had served as the representative for the Macau Surgical Association, and had many opportunities to participate in social and academic activities in Mainland China. The sheer size of the hospitals, the vast volume of clinical works, the sophisticated technical skills of Mainland colleagues are absolutely amazing. Young surgeons in Hong Kong should be fully aware of the challenges already confronting them, and prepare themselves better for the tough competition ahead. The College, on the other hand, should provide a formal channel for our surgeons to appreciate surgery in China better, and build the necessary infrastructure to strengthen our forte. Professor Joseph Lau, and our past College leaders had already done a significant amount of work to develop our China relationship, and I hope that I could continue, or even strengthen it.

Recent incidences had put our Specialist Registration on the spotlight as a surgeon could be removed from the list by the Medical Council while keeping their license to practice. The College had been approached both by our Fellow to help evaluating their standard on one hand, and the Medical Council to assess a particular mishap for the competency of a surgeon on the other. As far as I recall, the College has no structured program to certify the professional standard of our Fellow after completion of their training. While individual surgical department in the public sector might be assuming such role for their own staff, Fellows in private practice are left to the mercy of individual private hospital. The College should deliberate on the sovereignty of the Specialist Registration, and if successful, the necessary details, for the best interest of both our Fellow and citizens of Hong Kong.

If one decides to do something, one can always squeeze the time out of his “busy” schedule. Our colleagues in both public sector and academia are also very busy but perhaps, they could have more control of their own timetable.

I started Kendo since I finished my internship and continued to practice even when I was doing my training in Los Angeles. I try my best to practice twice a week, Tuesday evening and Sunday morning if at all possible. In addition, I do TaiChi as a martial art, instead of a past-time by “Seniors in the Victoria Park”, for the past ten years. The traditional martial art is very helpful to my Kendo as if you are looking at a problem from different perspectives. I enjoy a wide variety of music, from Cantonese to Japanese, and from Classical to Rock to keep up with my kids.
The Extraordinary General Meeting (EGM) of the College was successfully held on 6 November 2013. The purpose of the EGM is to rectify a conflict of articles in the College MOA, which would have put the validity of the recent election and the subsequent election council meeting into dispute.

After AGM and announcement of election result of new Council members, the terms of members of the previous Council should have expired. New Council members should then convene an election council meeting to elect the new President and new Office Bearers. Terms of office of a Council member has therefore been given as “ending on the conclusion of the third Annual General Meeting” (Article 6A)

However, since there may be some time lapse between the AGM and the election council meeting, and that the College should at no time be void of leadership, it was amended in 1999 that the terms of the President and Office Bearers should be extended to “ending on the conclusion of the Election Council Meeting held in the third year” (Article 7c)

Such amendment leads to overlapping of terms of outgoing President and Office Bearers and the newly elected Councillors. Since the President will not be re-elected into the Council, he/she will become an extra member in the Election Council meeting.

There is, however, a limit to the number of members in the Council to “not more than eighteen” (Article 3). Probably owing to some oversight, there is no corresponding amendment on this to accommodate for the transient extra number of Council members during the election council meeting created by the amendment of Article 7c.

Without such corresponding amendment to accommodate for the extra number of Council members during election council meeting, a valid election council meeting could not be conducted. The election that leads to such a situation would also be considered invalid. The process of handing over is therefore stuck.

After consulting our Legal Advisor, the solution was to make a corresponding amendment to accommodate the extra number of Council members during the election council meeting, such that: “for the purpose of calculating the number of Councillors … excluded the office of Councillor assumed by the President in the period between (i) the conclusion of the Annual General Meeting immediately prior to the Outgoing Election Council Meeting and (ii) conclusion of that Outgoing Election Council Meeting.” A valid election council meeting could then be conducted for handing over.

THAT the Articles of Association of the College be and are hereby amended as follows:

1. that Article 3 be amended by adding the following words in the place immediately after the words “eighteen Councillors”: “(subject to Article 7(d) and not including any ex officio Councillors)”

2. that Article 7 be amended by inserting the following as paragraph (d) in the place immediately after paragraph (c):

“(d) For the purpose of calculating the number of Councillors that the College may have for the time being and from time to time, there shall be and shall always be deemed to have been excluded the office of Councillor (the “Said Office as Councillor”) assumed by the President in the period between:

(i) the conclusion of the Annual General Meeting immediately prior to the Outgoing Election Council Meeting and

(ii) the conclusion of that Outgoing Election Council Meeting.

For such purpose “Outgoing Election Council Meeting” means the Election Council Meeting on the conclusion of which the term of office of that President ends in accordance with Article 7(c)(bb).”

For the avoidance of doubt, the provision of this Article applies only to the calculation of the number of Councillor as aforesaid and shall not derogate from and affect the powers, rights and duties of the Said Office as Councillor.

3. That Article 22 be amended by deleting the words “A clear seven day’s (exclusive of the day of posting or receipt)” (called “Such Words”) and substituting the word “notice” in the place immediately following Such Words by the word “Notice”.

After the EGM, the Annual General Meeting (AGM) convened for the 20 September 2013 adjourning to the 6 November 2013 had been concluded. The Election Council Meeting was held after the AGM and a new Council (2013-2016) was established.

The College would like to thank our Fellows for their support to the EGM and look forward to your continuous support to the future activities of the College.
Interview with Dr Fei-chau PANG, Chief Manager of Medical Grade of the Hospital Authority Head Office

“Employment of part-time doctors is one of the manpower strategies to alleviate the medical manpower shortage in HA. We will continue to explore on measures to increase employment flexibility.”

Non Full-Time Practice in Hospital Authority

L: How many part-time doctors are working in HA? How many are surgeons? What is the trend for applying part-time practice? What is the trend for applying part-time practice?

P: As at June 2013, there are 299 part-time doctors in HA. Among them 33 are surgeons. With respect to 602 surgeons working in HA, the percentage of part-time practice in surgery is 5.5%. We can see an increase of part-time practice in the past 2 years.

L: What is the seniority of surgeons working as part-time in HA?

P: Among 299 part-time doctors working in HA, nearly 220 are at consultant or AC level. In the field of surgery, it may be more common to have senior colleagues working as part-time as 32 out of 33 part-time surgeons are at specialist level.

L: For the part-time surgeons, what is the average number of working hours per week?

P: As at June 2013, the average working hour is 13.6 per week. This is roughly equivalent to 1.5 days per week. The part-time surgeons usually do not take up on-call duty.

L: Is there any central policy in HA regarding part-time practice?

P: There is a central policy for employment of part-time doctors in HA. However, the mode of clinical practice of part-time surgeons is determined at department level by individual Chief of Service (COS).

Dr Michael Wai-yip LEUNG
Queen Elizabeth Hospital
Whenever public hospitals are criticized for long waiting queue, the Hospital Authority will use “doctor shortage” as an excuse. Upon the HA’s request, Government increased the medical undergraduate places to 420 for the 2012 – 15 triennium. These extra doctors will only be available in 2019, by that time they may not get a job in the HA if the Government does not further increase its subsidy, or if the wastage rate of doctors reduces as what had happened between 1997 and 2003.

A much better, immediate and logical solution to the HA “doctor shortage” is to recruit part-time doctors from private sector. At present, less than half of the specialists in Hong Kong work in the HA to provide ~90% of hospital services, while the other half works in private to provide the remaining 10% of services. I myself, and I learn from many colleagues that the private sector have plenty of spare time to provide more services.  *It is common for big institutions to employ certain percentage of part-time staff or outsource some services because of the fluctuations in funding, service demand and manpower provision.*

After hearing the proposal from the public and LegCo in 2011, the HA invited those doctors who recently left public hospitals to provide part-time services. I received an invitation from the HA in July 2011 and replied shortly after. But I waited for 6 months to get an offer for a part time post. It seems that there are some obstacles in the employment of “part-time” policy making us to think about the concepts on how should the public doctors’ work be quantified and rewarded.

At the moment, the HA does not need to pay its full-time doctors for overtime work, and HA would not be rewarded for shortening the long waiting times; hence it lacks genuine incentive to employ part-time doctors. It may just be a gesture in response to the public and LegCo’s request. The terms of employment are not ideal and the scale of recruitment is symbolic.

With reference to a litigation in overtime work, the Court confirmed that the contractual “normal working hour” of the HA doctors was 44 hours per week, however it also ruled that the doctors may be required to work overtime without any compensation. When the HA designed its remuneration package for the part-time doctors, it had assumed that full-time doctors work 65 hour a week. As a result the hourly wages of part time doctors is only ~66% of those full-time doctors who actually worked 44 hours a week. It is unfair and inevitable to deter private doctors from joining the scheme.

“At the moment, the HA does not need to pay its full-time doctors for overtime work, and HA would not be rewarded for shortening the long waiting times; hence it lacks genuine incentive to employ part-time doctors. It may just be a gesture in response to the public and LegCo’s request. The terms of employment are not ideal and the scale of recruitment is symbolic.”

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**Non Full-Time Practice in Public Hospitals**

Dr Hon Ka-lau LEUNG, Member of the Legislative Council of the HKSAR and a Fellow of the CSHK

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**When...**

**At the moment...**
The HA management claimed that if “full rate” was offered to part-time doctors, then it was “unfair” to full-time doctors who worked more than 44 hours a week, and would result in a new wave of brain drain. What is truly unfair was the Court’s decision that doctors’ overtime work would not be compensated. If full-time doctors can be properly compensated for overtime work, wastage will decrease, existing full-time doctors will be more willing to work overtime for meeting service demand (such that part-time may even be unnecessary), and private doctors will be more readily to provide part-time services.

There are some concerns on whether part-time doctors can provide continuity of care. The HA claimed that doctors are required to work long hours because of the necessity to provide continuity of care to patients. In fact, individual public doctor does not provide continued care to patients: Patients may not be seen by the same doctor when they have follow-ups at out-patient clinics, they may not be operated by the same doctor who makes decision to operate, public doctors will invariably be off duty after long working hours. The so-called continuity of care is on a “team” basis; patients are just taken care by the same team of doctors, rather than the same doctor. On the other hand, private surgeons provide true continuing care to patients and still have plenty of spare time because of a lower patient load. So “continuity of care” is nothing to do with long work hours and part-time is not a “contra-indication”.

Few weeks ago, a group of QEH’s colleagues were criticized by the local media for taking French leave. Indeed they were paid Special Honorarium to work overtime, and they arranged patients to attend earlier such that they might finish work and leave early. I am also worried about falling victim to such criticism as I can finish my cases ahead of schedule and leave early.

Work may be rewarded on a “piecework” basis or a “work hour” basis. Usually the cost per unit time is much higher for “piecework” than for “work hour”. Therefore if caseload is not high and the employee has plenty of idle time, it may be advantageous for the employer to pay on a “piecework” basis. However if caseload is high, and the time of employee is usually fully occupied, it is advantageous for the employer to pay on a “work hour” basis.

In principle, doctors should not be paid on a “work hour” but on a “piecework” basis, i.e. we will not leave our patient because time is up, but only when we finish what we need to do for a patient. However in public hospitals, as caseload is usually high, doctors being paid on “work hour” basis is just for the HA’s benefit. The average time for each case may be taken as a reference, and then together with an agreed caseload, a “normal working hours” can be calculated. The “normal work hours” should only be regarded as fulfilled when the agreed numbers of cases are finished, regardless of the actual hours of work which may be longer or shorter than the “normal working hours”.

Of course, it is up to the HA to adopt different package to deal with different situations. For example, if the caseload is low, such as senior on-call duty where doctors may only be called once a week, the work may be purely rewarded on a “piecework” basis; if the caseload is high and the demand on continuity of care is low, the work may be rewarded on a pure “work hours” basis. The professional nature of doctors’ work itself is not an obstacle to “normal working hours” or “part-time”, it is the bureaucracy that withholds a proper rewarding system has restrained the full utilization of available medical power.
Interview with Dr Jennifer SIHOE

Dr Jennifer Sihoe graduated from the University of Nottingham Medical School in 1995, she received surgical training at the Queen Mary Hospital and Prince of Wales Hospital. Jennifer obtained her fellowship in Paediatric Surgery in year 2005 and started her private practice in year 2011. Meanwhile she has not given up her work in public hospitals, here she shares with us the struggle on balancing different roles in her life.

S: Resigning from a full time permanent post in HA was probably one of the most difficult decisions in my life! As a female surgeon, it is of utmost importance to me to be able to strike a good balance between my work and my 3 children! This was definitely not easy! One side always seemed to lose out and it felt like a lose-lose situation. Eventually, I made the decision to move into the private sector hoping that my control of my time would be more flexible and that I can pursue another area of job satisfaction through a more direct doctor-patient relationship of a higher quality which I felt was difficult and restricted in a public setting. However, I had to prepare myself to lose out on the academic and teaching side of my career which I very much enjoyed too. The unexpected offer of a part-time post made it possible for me to continue to pursue this area of my interest. In addition, it allows me a much larger volume of major and ultramajor subspeciality cases in paediatric urology which is my passion and is relatively sparse in the private sector.

L: Why is it attractive to you?

S: Actually, I did not know at the time that I resigned. Part-time posts are not commonly available or advertised. I was very fortunate to have been offered a Part-time post on my resignation from PWH and am indebted to Prof Paul Lai who made the offer at the time. In fact, I was doubly fortunate, that I had been offered another Part-time post in UCH on completion of my one year contract at PWH.

S: No, not for me, at least. I think this will depend on what you are expecting. The job nature should have been discussed and ironed out before committing to the post so that you have realistic expectations.

S: Of course I would encourage HA to keep and make available more part-time posts and do you have any suggestions for further improvement?

S: No, not for me, at least. I think this will depend on what you are expecting. The job nature should have been discussed and ironed out before committing to the post so that you have realistic expectations.

S: Yes, I think it is important that both parties talk openly on what is expected of the role so that both parties are happy and do not have unrealistic expectations to make this working relationship work out successfully. When I took on the part-time post in PWH, this was at a time when 2 specialists resigned. At that time, my role was mainly to provide an extra pair of hands at such a critical time to ease the stress on the Team and to allow the Team more time to pick up on the extra workload. I was working on a fixed number of sessions a week but the actual session would occasionally vary dependent on where and when I was needed, be it out-patients or in OT. Obviously, it would not be worthwhile to go to work if the OT list is cancelled, for example. During this time I was working part-time, the Team was able to recruit another specialist from overseas. With my current part-time post, my commitment is quite different. In addition to providing an extra pair of hands, I have also taken on a role of training and developing the paediatric urology service at the Institution. On taking up this part-time post, expectations from me is probably more significant that what my expectations are as it would not be responsible on my part to take up a post half-heartedly. My job nature would obviously include work in all areas of clinical service as well as training and research. However, as I also have a commitment in my private work, and also not forgetting my initial objective to have more time for my children, I also have to gain the support of my colleagues so that in reverse, they can also be more understanding in my limitations.

L: Are you satisfied with the pay?

S: This is a very important factor to consider. I remember many years ago when my first child was born, I was just day-dreaming that one day it would be good if I can “retire” early and work part-time. But during those days, the idea was frowned upon by surgeons in general saying that it would not be possible for part-time posts to exist in surgery as surgeons would not be able to take care of their patients well if they are only working part-time and just operate and leave their patients, problems and complications to others. However, I feel very happy with my work at present and this is all made possible by the help and support of colleagues. We are quite lucky in paediatric surgery as we are a very small and close community where we know each other well and all trainees now rotate through all the 3 training centres during their higher training. This means we know how each other work and we have seen how we manage our patients. Communication is the most crucial factor to make it work. This is even more enhanced with the aid of advanced technology...eg. we can send captured images to each other. I am happy to discuss anything with colleagues at any time and we will discuss any post-operative management problems / complications so we always have a good consensus on the management before proceeding. It is also important to set up some management protocols which will help juniors and nurses who also play a crucial role. Most colleagues and nursing staff are always very accommodating and helpful as they also know that we are also here for the benefit of our patients and everyone is helping to make things work.

S: No. Or should I say, that the difficult part in getting the post approved was dealt with at a higher level. I just had to apply and get through the interview.

S: Of course I would encourage HA to keep and make available more part-time posts. I understand it may not work or be a feasible option in all situations and I definitely do not think it would be healthy to maintain too many part-time posts within one specialty / team. However, I do see a benefit in having part-time posts to retain expertise and to relieve man-power problems. At least, in the short term, I believe this to be beneficial to both parties.

L: How do you know of the availability of part time jobs at HA?

S: This was dealt with at a higher level. I just had to apply and get through the interview.

S: In general, do you think it is worth for HA to keep these posts and do you have any suggestions for further improvement?
SPOTLIGHT on Non Full-Time Practice in Public Hospital

Views from our Fellows ...

We have randomly interviewed a no. of Fellows of various sectors & seniorities

Questions:

i) Do you aware that there’s non-fulltime practice in the public hospital now?
ii) Why do you think there’s such a practice now?
iii) What are the advantages & disadvantages of this practice from your viewpoint?
iv) If given the chance, would you consider this practice?

Male, Senior, Public Sector

i) Yes
ii) Not enough full time doctor
iii) Advantages:
   - To meet the demand of doctor
   - To suit some doctors who cannot work
   - full time
   Disadvantages:
   - Incoherent patient care
   - Lack of team building
iv) Yes

Female, Resident Specialist, Public Sector

i) Yes
ii) Shortage of manpower in public sector
   - Elder doctors wish to work part time for family
   - Elder doctors wish to join public again for exposure to variety of cases
   Advantages:
   - Help the problem of shortage of manpower
   - Better family-work balance
   Disadvantages:
   - If too many part time may jeopardize continuation of care to patients
   - iv) Maybe, but working part time may still end up working full time as it’s difficult for me to refuse request from work

Year of attaining Fellowship (2005), QMH

i) I am not aware of the existence of a non-full time practice in the public hospital. Probably because I have never worked in a public hospital and I am too senior/old to know.

ii) I suppose it has been created to fill up vacancies left open as a result of retirement or movement of staff to other jobs. The department concerned will have the benefit of a readily available work force that is reliable and well known to them.

iii) Advantage is the one can continue to be in touch with clinical practice and plan a work load most suited to his/her state of health and mind. This can be agreed upon between the department head and the doctor concerned.

Disadvantage is that one will probably be used as a pair of working hands like managing an OPD session or performing minor OT in OPD. One probably will not be given an opportunity to participate in the management of interesting/complicated cases. Life can be rather monotonous.

iv) I probably will not consider this practice.

Female, AC, Public Sector

i) Yes
ii) Lack of manpower in public sector
   - Continue medical education especially in view of new technology and research

iii) Advantage:
   - More experienced manpower in public sector
   - More learning opportunities for trainee in HA
   - Disadvantage:
   - Potential post for promotion for new fellowship may

iv) Yes
**SPOTLIGHT on Non Full-Time Practice in Public Hospital**

1. **Female, Resident Specialist, Public Sector Years after Fellowship Qualification (1)**
   - I am not aware of the existence of a non-full time practice in the public hospital. Probably because I have never worked in a public hospital and I am too senior/old to know.
   - I suppose it has been created to fill up vacancies left open as a result of retirement or movement of staff to other jobs. The department concerned will have the benefit of a readily available workforce that is reliable and well known to them.
   - Advantage is the one can continue to be in touch with clinical practice and plan a workload most suited to his/her state of health and mind. This can be agreed upon between the department head and the doctor concerned.
   - Disadvantage is that one will probably be used as a pair of working hands like managing an OPD session or performing minor OT in OPD. One probably will not be given an opportunity to participate in the management of interesting/complicated cases. Life can be rather monotonous.

2. **Female, 8-years Fellow**
   - Yes, if I retire.

3. **Male, 15-years Fellow**
   - I probably will not consider this practice.

4. **Female, 1-year Fellow**
   - Yes.
   - Increasing number of female doctors.
   - Not enough manpower in public system.
   - Advantage:
     - Allow female doctors to have more opportunities in taking care of family.
   - Disadvantage:
     - Difficult for manpower planning.
     - Cannot deal with on call and night duties.

5. **Male, Professor, Public Sector Years after Fellowship Qualification (12)**
   - Yes.
   - Manpower shortage.
   - Increased female doctors.
   - Advantage:
     - When there is manpower issue, it provides an option.
   - Disadvantage:
     - Cannot solve the manpower issue.
     - There is no manpower issue.

6. **Female, AC, Public Sector Years after Fellowship Qualification (5)**
   - Yes.
   - Think it's a win-win situation. I cannot think of any disadvantage.
   - Yes, but I think this practice only works for certain sub-specialties.

7. **Female, 4-years Fellow**
   - Yes.
   - It's good for retired surgeon or female women who want to take care of family, but they still want to keep cutting experience which may not be possible in private practice.

8. **Female, 5-years Fellow**
   - Yes.
   - It's a win-win situation. It's for the continuity of care.
   - No, if retire.
SPOTLIGHT on Non Full-Time Practice in Public Hospital

i) Yes
ii) Too much workload in pubic hospital
iii) Advantage:
   For participating private doctors, it can provide a constant income. Also it provides a channel of direct communication with the pubic sector and be kept up-to-date with the current practice.
Disadvantage:
May induce conflict between pubic and private doctors

iv) Yes

Female, Consultant grade
Director of private clinic, Private Sector
Years after Fellowship Qualification (12)

i) No
ii) Politics
iii) Create conflicts between full time and part-time staff
iv) No

Male, Consultant grade private surgeon
Private Sector, Years after Fellowship Qualification (more than 10)

i) Yes
ii) Inadequate Manpower
iii) Advantages:
   To compensate for inadequate manpower
   Allow passage of skills & techniques
Disadvantage:
   Part-time staff would not be on time for doctor, time management will be difficult
iv) Yes

Male, COS, Public Sector

Years after Fellowship Qualification (25)
**SPOTLIGHT on Non Full-Time Practice in Public Hospital**

i) Yes

ii) Manpower problem
    Staff prefer to come flexible working hours & no on call duty

iii) Advantages:
    Experienced staff can continue the contribution after retirement & help to keep the workforce in short term. Keep experienced staff who can’t afford full time work.

Disadvantages:
    may have conflict of interest. Those with part time as well as private work may affect the function of the team if filled with too many part time staff. May affect the development of the unit.

iv) Yes, after retired

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**Male, Consultant, Public Sector**

**Years after Fellowship Qualification (23)**

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i) Yes

ii) Multi-factorial. First of all, there are politics. Secondly, there are existing HA staff want to adopt a job with less working hours so that they can have a more balanced life. Thirdly, There are private doctors who have time and willing to work in HA as part-time staff. He or she may do so because of economical concern, work satisfaction, etc.

iii) It provides flexibility for staff’s choice. But may invite conflicts between full time and part-time staff

iv) No

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**Male, Consultant in private hospital before starting his own practice, Private Sector**

**Years after Fellowship Qualification (10)**

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i) Yes

ii) Due to shortage of power in HA & HA wants to attract private doctors to work in public service

iii) More free time for family/ Private Practice, at the same time, one can continue serving public/poor patient and get some guaranteed income

iv) Yes

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**Female, AC, Public Sector**

**Years after Fellowship Qualification (5)**

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i) Yes
First of all, I will like to take this opportunity to extend my heartfelt gratitude to all colleagues who have rendered great help to the Department of Surgery in New Territories West Cluster as part-time staff.

Full-time employment is all along regarded as the mainstay in medical workforce by Medical & Health Department as well as Hospital Authority. Part-time jobs are created when there is difficulty or reluctance to recruit full-time staff to do certain work. These include evening general outpatient clinics or operating sessions on weekends. Even so, most of such part-time (or rather, over-time) jobs are taken up by full-time employees. Doctors ‘outside the system’ had been viewed with skepticism. There was worry that retired staff would, with their continued presence, hamper the development of their former subordinates. For those that had already left for private practice, their return to do part-time work was suspected to be attempts in canvassing new clients for their private practice. The notion that public and private practices should remain distinct was deep-rooted. Retired staff or staff who had left for private might be asked to give help as Honorary staff, i.e., without pay.

In the wake of SARS outbreak in 2003, economy, and consequently private practice in Hong Kong was in doldrums. With fewer doctors leaving public service, there was difficulty for the Hospital Authority to employ all graduates. Contracts with harsher terms were dozed out to new recruits. Intake into medical schools was hastily slashed. When Hong Kong economic returned vibrant after 2006, Hospital Authority woke up to find itself hit on both flanks of doctors to private and a dwindling source of new doctors it can draw from. The demand for public health care was in the meantime relentlessly growing both in quantity and quality. Plans that would involve more doctors were put on hold. Overtime honorarium and promotion prospects were beefed up to put a brake on staff wastage. However, the source for more medical manpower remained to be addressed.

Shortage of doctors translated into a competition between public hospitals for doctors. Under the laissez-faire attitude of Hospital Authority, hospitals that started off less well-to-do inevitably lost out in such game. The Department of Surgery in Tuen Mun Hospital is remotely located and features constantly over 100% bed occupancy and highest emergency admission as well as highest emergency operation per staff. There came little surprise when the Department failed to recruit enough trainees to fill its vacancies during each selection exercise. Poor working conditions begot poor recruitment, and Tuen Mun Hospital was set in the course of a downward spiral. The unfavorable SOMIP report in 2010 sounded the alarm. Providing limited registration to doctors from outside Hong Kong had been proposed by Hospital Authority as a solution but that was a bit far-fetched for our Department. It was far more realistic to tap into the workforce in private and from those recently retired. With green light from our Cluster Chief we began to go around our friend for help. According to Hospital Authority regulations, part-time staff on emergency call for one night will be remunerated only as work for one hour. We realize that it would be impossible for part-time staff to help in calls on such terms. We just hope that part-time staff employed could help in elective activities so that staff could be given post-call off they much needed.

It turned out that the part-time consultants we employed had provided the Department much more than mere relief. All skepticisms related to part-time staff had been forcefully dispelled by their exemplary contributions. Dr KW Lau and Dr MC Lo, who had retired from our Department and from Queen Elizabeth respectively, helped to provide support to our general surgical specialist clinics in Tuen Mun Hospital. Dr Mimi Poon and Dr Henry Tang had taken time out of their busy private practice to help in general surgical operations and clinics in Pok Oi Hospital. All these part-time consultants are also generously sharing their experience with younger doctors in our department.

"I can see no future for part-time employment in Hospital Authority if cost neutrality is insisted. It is fair to neither these part-time surgeons nor their patients to regard part-time employment as merely a stop-gap measure. The vast experience of these part-time surgeons is a great asset to our patients and our young doctors. A mechanism should be established for such expertise to be constantly tapped into."

Non-full time employment: Experience at Department of Surgery, New Territories West Cluster

Dr Chi-wai MAN, Chief-of-Service, New Territories West Cluster

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Non-full time employment: Experience at Department of Surgery, New Territories West Cluster

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“"I can see no future for part-time employment in Hospital Authority if cost neutrality is insisted. It is fair to neither these part-time surgeons nor their patients to regard part-time employment as merely a stop-gap measure. The vast experience of these part-time surgeons is a great asset to our patients and our young doctors. A mechanism should be established for such expertise to be constantly tapped into."
When the late Dr LC Leung, first plastic consultant surgeon of our Department, unfortunately passed away in 2008, there had been difficulty in recruiting a replacement and our job offer had been turned down. It was fortunate that Dr CM Ho, a good friend, came along to support and nurtured the shattered plastic team. He generously transferred his mastery skills in head and neck surgery to our plastic surgeons. Thanks to him, our plastic team has now its own Consultant and engages in active training together with Prince of Wales Hospital.

The much needed thoracic surgical service in our Department was initially only provided by one senior staff. Recruitment had been impossible without training status. We are grateful that Dr KM Ko had kindly come in to help after his retirement as head of Cardiothoracic Surgery in Queen Elizabeth Hospital. Dr Ko shouldered a large share of clinical work and also benefited our thoracic surgeons with his vast experience. Thanks to him, our thoracic team has now its own Consultant and has trainee receiving training in Queen Elizabeth Hospital.

Our urology team has been a cradle of urologists for other public hospitals and private sector. The pace of training was outstripped and recruitment of specialist from outside was difficult. Promotion offers had been turned down. It was difficult to provide senior cover and training in the myriad of urological activities simultaneously going on in Tuen Mun and Pok Oi Hospitals. We felt greatly indebted to Dr S Szeto when he agreed without second thought to help upon our plead. He is now supervising younger urologists in doing operations. Other than friendship, I can think of no sensible reason why Dr Szeto would take time off his lucrative practice to help.

The enthusiasm of part time doctors is not reciprocated by Hospital Authority. Senior doctors who had just retired are required to submit their CV. Contracts are short, plans for renewal obscure, and terms continually changing. Contracts with over 18 hours work per week are discouraged as they attract full benefits. There had also been disputes over the use of titles of Consultants or Associate Consultants. Support from Hospital Authority to such part-time employment had been brief. Initially, Head Office provided funding for half of the salary for part-time employees. That was soon withdrawn by Head Office with the announcement that part-time employment should be cost neutral. The pendulum had swung and by 2015 a historical high number of medical graduates will be churned out by the two medical schools. There will be immense pressure to employ all these graduates. I can see no future for part-time employment in Hospital Authority if cost neutrality is insisted. It is fair to neither these part-time surgeons nor their patients to regard part-time employment as merely a stop-gap measure. The vast experience of these part-time surgeons is a great asset to our patients and our young doctors. A mechanism should be established for such expertise to be constantly tapped into.

A constant and better defined part time employment system would also help to address different need of work-life balance and different family roles among staff, in particular relating to the increasing ratio of women in the workforce. It will remain that many taking part-time employment will prefer no on call work. Eventually, on call or off-hour work will need to be separately addressed. It is senseless to have same pay for jobs that require call and those that did not. Systems should be devised to allow on-call and off-hour work to be handled by part-time staff as well.
Interview with Dr Wing-yung CHEUNG

Dr Cheung Wing-yung is the part-time consultant in plastic surgery in Kwong Wah Hospital (KWH). He has been working in KWH since 1989 and started his private practice 2 years ago.

L: What are the reasons for you to commence the private practice?
C: I have been working for 20 years in Hospital Authority and it is time to develop the second chapter of my career. Furthermore, I can have more autonomy to seek for the resources for my patients in private practice.

L: What are the reasons for you to consider part-time service in KWH?
C: There is shortage of manpower in experienced surgeons in our hospital. Also, I want to provide the expertise for our team and training for our frontline surgeons.

L: How do you allocate the time between private and public services?
C: I am working 4 sessions per week in KWH, mainly operating on patients and providing specialist consultations on complex cases in plastic surgery.

L: Do you think that Hospital Authority should promote the culture for part-time service?
C: The systems in UK and Australia are more mature and fair. They can provide flexibility for the surgeons on part-time practice. The consultants in public hospitals can spare their time for their private patients. Their autonomy of practice is well respected. We need such system in Hospital Authority. A good system can retain more experienced surgeons in the public services and release their incentives. Even HA can consider to transform some hospitals for private patient services in order to provide more choices for the patients.

L: If possible, will you consider continuing the part-time service in HA in future?
C: Yes, I can provide the service to our public patients and training to our young surgeons, with autonomy for doing my private practice. It is quite similar to the UK or Australian systems. However, we have to overcome the hurdle from the College. Currently I am not the trainer in plastic surgery as I am working less than 50% of time in HA hospital. In other countries, experienced private surgeons can also be the trainers. It is important for the surgical training, especially in small specialties like plastic surgery.

L: People may think that there is conflict of interest for a private surgeon to provide part-time service in public hospital. What is your view?
C: Definitely, there is such potential for conflict of interest. However, in KWH most of our patients come from lower social class and are much dependent on the public services. Also, as the surgeons we have to be very cautious to avoid the conflict to happen.

Interview with Dr Kai-ming KO

Dr Ko Kai-ming retired from the Hospital Authority in 2010 where he had been Consultant and Chief of Service of the Department of Cardio-thoracic surgery of Queen Elizabeth Hospital. As he felt that he was still capable physically at the age of 60 to practise his art he went into private practice.

However, since he was unable to make the transition from public service to private practice, he jumped at the opportunity to join Tuen Mun Hospital as a part-time Consultant in 2011. His main contribution there is to ease the staff shortage in Thoracic surgery. Thus he is able to continue to make himself useful to society.

He now spends one day at the OPD and two days in the operating theatre every week at Tuen Mun Hospital. He does not involve himself in ward rounds and emergency duties. During operations, Dr Ko mainly acts as an assistant and assumes a supervisory role if required. Having part-time doctors is an expeditious way to tackle the problem of staff shortage and to retain their vast clinical experience.

Employment of pre-retirement doctors on a part-time basis has the advantage of flexibility and may suit those who cannot commit to full-time work. Otherwise a lot of talent will be excluded from contributing to the provision of public healthcare. Dr Ko reiterates that part-time employment is a good temporary measure to ease staff shortage and to retain valuable clinical expertise.
The Eastern Hepatobiliary Surgery Hospital (EHSH) was founded in 1956 by a group of three led by Professor Meng-Chao Wu, a member of Chinese Academy of Sciences. It is now the most prestigious university hospital and research institute specializing in hepatic and biliary diseases. The EHSH has 660 beds, 56 senior physicians and 16 PhD instructors serving over 70,000 out-patients and 12,000 in-patients annually and they have built the biggest case bank of liver cancer in the world. Since 1978, the hospital has become a teaching and researching center in hepatobiliary surgery for PhDs, residents and fellows from all around the world, and the host site of many national and international conferences on tumours. The hospital has graduated 78 PhDs, and many fellows from overseas. In addition to clinical departments, the hospital also composes Tumour Immunology and Gene Research Institute, Biological Signal Transmission Research Center, Molecular Tumor Research Lab, Virus-Gene Therapeutic Lab. There are billions of dollars for their research fund received from the Chinese government and overseas.

During my two-week stay, I had attached to the Hepatic Surgery Department III and Biliary Tract Surgery Department II. Every morning, we would gather at the doctors’ office in the ward and make a brief report on the patients and ward condition overnight and then we would start the ward round together. We would see the films and discuss the management plan and sharing of experience between Hong Kong and Mainland China, and explained to the patients and relatives.

After that would be the operation time. Very simple instruments were used. One of the professors in biliary tract surgery shared with me their slogan for liver surgery: Five-ones. That is one patient’s position throughout the operation, one kind of incision, one type of suture (silk), one clamp and one scissor. That is how they perform liver surgery.

There are six departments of hepatic surgery, two departments of biliary tract surgery and division of special medical care, liver transplantation as well as laparoscopy.
Clinical Attachment of Younger Fellow

I had participated in a few hepatectomies during the clinical attachment and one of them was with Professor Wu. After mobilization of the liver, they would routinely perform Pringle maneuver. Stay sutures would be applied around the transection line to help retraction and haemostasis. Afterwards, parenchymal transection would be performed with a clamp to the patient side and cut with scissors. Upon the preference of the particular surgeon, tissue glue might be sprayed over the transection surface and a self-designed suction drain will be placed over the transection surface.

Wound was closed in layers with interrupted silk sutures. Free lunch would be provided to those who have participated in operation. The average post-operative stay was 7-10 days and ~30% might experience mild bile leak. In addition to the clinical activities, I have also visited their liver tissue bank, which is the biggest liver tissue bank in China.

Here are a few tips for those who may consider visiting the Eastern Hepatobiliary Surgery Hospital. The hospital is located at the Yangpu (楊浦) district, right opposite to the Changhai Hospital. It is within walking distance from Line 8 Shanghai Metro Station Xiangyan Road (翔殷路).

There is a downtown called Wujiaochang (五角場), located around 20 minutes walk from the hospital, where you can buy the grocery.

It is a special and valuable experience. I am glad that I can meet the living legend of liver surgery in China, Professor Meng-Chao Wu and had an opportunity to operation with him.

Dr Charing CHONG
Prince of Wales Hospital
My Two-Week Experience At The Cancer Institute and Hospital, Chinese Academy of Medical Sciences, Beijing (中國醫學科學院腫瘤醫院)

I arrived late in the evening at around 9 pm at the Beijing Capital Airport. This was my second visit to Beijing, my last being over 25 years ago when I was still in primary school. As a teenager back then I had never imagine becoming a surgeon and coming back to the capital to learn from one of the best surgical practice in the country. Although it was late, hot and humid, I was excited as I anticipated the prospect of the coming two weeks.

Beijing was sunny with clear skies on my first day at work, although a rare weather condition as described by some locals, it gave me a great impression of the city and started me off with a feeling of exhilaration. My hotel was conveniently located one block from the hospital and a pleasant 10-minute stroll would take me to the surgical building of the Cancer Institute and Hospital (CIH). The surgical building has eleven floors housing surgical oncology units in the neurosurgery, head and neck, gut, thorax, gynaecology, urology as well as a whole floor occupied by the ICU. I was collected by Professor Zhao Dong Bing (趙東兵主任医师/硕士研究生导师) on my first day at work. Prof. Zhao leads one of the nine teams in the abdominal surgical unit at CIH. His team consists of one post-fellowship surgeon, one visiting fellow from another hospital in Beijing, and a resident in his second year of training, and there are 12 to 15 beds under their care.

The difference between CIH and most hospitals in Hong Kong were evident on the subdivision of foregut surgery. While the abdominal surgical teams (such as that led by Prof. Zhao) take care of all gastric cancers, cancers of the esophagus including cancers of the Cardia were the responsibility of thoracic surgeons. My two weeks in the Cancer Institute was therefore split in halves with the first week under abdominal surgical team and the second week under thoracic surgical team to make up a comprehensive foregut surgical experience.

The entire first and second floor of the surgical building house the operation theatres of CIH. There are a total of 25 operating rooms to serve on average 70 to 90 operations a day at the CIH. Prof. Zhao’s operation list included one Whipple’s operation and a distal radical gastrectomy. I was kindly given the opportunity to assist Prof. Zhao in his operations and this has allowed me to learn so much more than being an observer. The speedy and precise sharp dissections and intellectual use of stapling techniques by Prof. Zhao amazed me of how swiftly a Whipple’s operation could be completed. By noon, Prof. Zhao and I were enjoying free lunch provided by the hospital, which was served at the dining area inside the operation theatre floor. The subsequent gastrectomy was performed by Dr. Guo (郭春光医师), who was the fellow apprentice under Prof. Zhao. Dr. Guo impressed me by both his knowledge and skill and while I was his first assistant, I observed that his composure resembled closely to that of Prof. Zhao. This apprenticeship in surgical teaching was particularly admirable and inspiring. There were minor differences in the way gastrectomy was carried out at CIH as compared to my hospital, but the overall oncological principle were the same and meticulous attention was paid to achieving radical dissection of lymph nodes as well as R0 resection.
The second operation day for Prof. Zhao’s team composed of one open sigmoidectomy and two laparoscopic TME for rectal cancers. I was excited to take part in these operations. The sigmoidectomy was completed uneventfully within an hour and the efficient turnover by theatre staffs had allowed ample time for the two laparoscopic TMEs to follow. Prof. Zhao applied the usual approach to laparoscopic mobilization of the rectum and descending colon and shared his views on ligation of the IMA and dissection of the mesorectal envelop. Despite us practicing surgery miles apart, we spoke of the same surgical language similar to musicians and their musical notes. I assisted Dr. Guo to carry out majority of the operation, while Prof. Zhao assisted in the dissection of the mesorectum. The operation was completed near noon so we were in time for a light lunch. The afternoon was filled by the second laparoscopic TME. I noticed Prof. Zhao would take the resected specimen somewhere outside the operation room, so I decided to follow him with the rectal tumor specimen in his hands. I was fascinated to see Prof. Zhao in an interview room where relatives of the patient were partitioned by a glass window. Prof. Zhao would describe the resected specimen over the speakerphones to the patient’s relatives and he would explain the specimen in details down to margin status. This was the first time I have seen this practice and I was told it would avoid unnecessary litigation and misunderstanding on surgical treatment by the relatives.

On the “non-operating” day for Prof. Zhao’s team, Prof. Zhao had a busy day of outpatient clinic ahead of him. I shadowed Prof. Zhao to his clinic, which was located at the outpatient building. It was early in the morning but already the whole waiting area was packed with patients and their relatives eager to be seen. Prof. Zhao also brought his resident Dr. Li (李鹏医师) with him to the clinic to assist him in preparing the case history and ordering investigation while Prof. Zhao would concentrate on reviewing the private films and large piles of case notes brought by patients from outside hospitals. We saw cases of gastric cancer, pancreatic cancer and colorectal cancers. One thing I learned from Prof. Zhao was the difference in doctor-patient-relative relationship in Mainland China. As most patients were referred from suburban areas miles away from Beijing, much was gained by observing Prof. Zhao’s communication skills in breaking down complex cancer treatments into concise information that would be understandable by the under-educated patients and relatives from rural farming areas. The busy clinic has exhausted the morning and I decided to excuse myself from the afternoon clinic and head back in the operation theatre to observe surgeries performed by the other abdominal surgical teams. Prof. Zhao introduced me to one of his previous apprentice Dr. Pei (白晓枫副主任医师), who is now an attending surgeon at CIH. Dr. Pei was performing a laparoscopic total gastrectomy. Dr. Pei shared that only about 10 to 20 percent of the gastric cancers are now approached laparoscopically as a significant portion of early tumors that were indicated have received endoscopic submucosal dissection (ESD). The surgery went smoothly and although I was not able to assist, the advantage of laparoscopic approach was that I could appreciate every step of the surgery as well as Dr. Pei’s skills comfortably by viewing the high-definition monitors!

The next day I found Dr. Ko (高树庚主任医师) who was performing resection of adenocarcinoma of the cardia. The operation was truly inspiring as CIH (and mostly other hospitals in Mainland China) would approach these cases through a single left posterolateral thoracotomy incision. This approach requires gastric mobilization and pull-up through split of the diaphragm and Prof. Ko has quite clearly demonstrated the excellent exposure with this approach without jeopardizing oncological clearence of the abdominal lymph nodes. I stayed to observe the subsequent cases of left thoracotomies for cancers of the cardia during that afternoon. It was impressive to see how the thoracic teams can finish two cases of cancers of the cardia and one case of lobectomy of the lung by early afternoon. In the evening I was invited to dinner by
Clinical Attachment of Younger Fellow

Prof. Zhao at The Quanjude Restaurant (全聚德烤鸭店) together with his team members, Dr. Pei, and the ward manager. It was a fun night with great food and wine. After several shots of Chinese white wine, the table was full of humor and joyful conversations and what a remarkable evening to end a busy day at work!

I was invited to give a 30-minute talk on surgical training in Hong Kong during the Friday departmental conference. I shared my surgical training and experience of being raised in a large multidisciplinary public hospital in Hong Kong. I was most grateful for the surgeons at CIH to have given me the patience and enthusiasm while my talk was delivered in Mandarin. Since CIH is sub-specialized in cancer treatments, the surgeons there were impressed by the amount of emergency workload we face in Hong Kong and some even approached me after my talk seeking exchange opportunities! My talk was followed by the weekly Multidisciplinary Clinical Meeting. This meeting was participated by radiotherapists, radiologists, medical oncologists and pathologists. The progress of some ongoing randomized trials at CIH was also updated during this meeting.

The second and third operation days for Prof. Mou involved a mix of esophageal cancers and lung cancers. A typical week shadowing a single thoracic team at CIH would allow the visitor to observe up to eight esophagectomies! Although none of them were hands-on experiences, I gain much by observing closely the skills in dissection, tissue handling, staple techniques, as well as the peri-operative management of these cases. The sub-specialization in managing foregut cancers at CIH has proven to me the advantages of treating some of these otherwise difficult cases at a centre with high volume and proficient skills, such that they were able to provide surgical care that is effective and industrious.

During the afternoons when Prof. Mou has no listed operations, I would join Professor Wang (王贵齐主任医师/硕士研究生导师), the renowned expert endoscopist in CIH. That day Prof. Wang was performing ESD for a patch of locally recurrent squamous cell cancer of the esophagus (in a patient with prior esophagectomy and gastric pull up). Prof. Wang would perform esophageal ESDs under general anesthesia; however, all other ESDs for gastric, colonic and simple esophageal lesions would be performed in the endoscopy unit. On average around 1200 ESD procedures for all gastrointestinal tract lesions would be carried out at CIH every year. Prof. Wang typically performs four esophageal ESDs in one afternoon and all the cases I had observed were complicated esophageal lesions such as circumferential dysplastic lesions, locally recurrent squamous cell cancer etc. I was honored to have Prof. Wang elaborating to me on some of his tricks and tools of the trade for foregut ESDs.
Clinical Attachment of Younger Fellow

This two-week clinical attachment at the Cancer Institute and Hospital in Beijing has opened my eyes to the surgical practice in Mainland China. Not only has it taken away the mysterious and skeptical feelings I had before my visit, I have respected and learned much more from their knowledge, ethos and operative skills than I ever could have anywhere else. This could never have been possible without the generous time and care provide to me by my great teachers: Prof. Zhao, Prof. Mou, Prof. Wang and their fellows, whom I owe profound gratitude. I would also like to thank the College of Surgeons of Hong Kong and the Hong Kong Academy of Medicine for providing me two weeks of invaluable experience in foregut surgery.

Examination Corner

**Membership Examination**

Hong Kong Intercollegiate Board of Surgical College Membership Part 3 Examination - (OSCE) was successfully held on 17 September 2013 at Prince of Wales Hospital. 30 Candidates enrolled in the Exam in which 23 passed the Exam. The passing rate is 76.7%.

**Fellowship Examination**

**Urology**

The Joint Specialty Fellowship Examination in Urology was successfully held on 22-23 September 2013 at the Hong Kong Academy of Medicine Jockey Club Building. There were 5 candidates enrolled in the Exam in which all of them passed the Exam. The passing rate is 100%.

**Plastic Surgery**

The Specialty Fellowship Examination in Plastic Surgery was successfully held on 19 October 2013 at the Kwong Wah Hospital. There were 3 candidates enrolled in the Exam in which 2 of them passed. The passing rate is 66.6%.
UPDATE COURSE ON PANCREATODUODENECTOMY

The update course on Pancreatoduodenectomy was successfully organized by United Christian Hospital and Hong Kong Society of Hepatobiliary and Pancreatic Surgery on 22 June 2013 in United Christian Hospital. It aimed to provide a comprehensive review and update on surgical technique of pancreatoduodenectomy. The program started with review lectures, and followed by video demonstrations and case discussions. There were 12 speakers from both public and private hospitals. It was well attended by more than 60 hepatobiliary surgeons and medical health professions; and it was a great success.

01: Attendants from both public and private hospitals
02: Prof ST Fan, President of HK Society of Hepatobiliary and Pancreatic Surgery, delivering welcoming speech for the course
03: Prof. Edward Lai is teaching on surgical anatomy for Whipple resection
04: Preoperative jaundice: to drain or not? Dr Eric Lai is giving an answer
05: Dr SH Lam is showing a step by step video on Whipple’s operation (conventional approach)
06: Dr Francis Mok thanks Prof. Paul’s Lai’s video demonstration on Whipple’s operation (Artery-first approach)
07: Dr KF Lee is showing different types of pancreatico-enterostomy
08: Dr TT Cheung is illustrating vascular resection in Whipple operation

Dr Derek TL TAM
United Christian Hospital
Thyroid Symposium 2013 was successfully held in PYNEH on 9 July 2013. This year, they concentrated on the practical management of thyroid cancer and the role of MAS on the thyroid disease. Local and international experts shared their experience through lectures, videos, and live demonstration. Hundreds of delegates from Asia Pacific regions participated in the symposium.
POST-EVENT REPORT ON THE FIRST CHEST WALL DEFORMITIES SYMPOSIUM

The First Chest Wall Deformities Symposium was held successfully on the 7th to 8th June 2013 by the Society of Hong Kong Cardiovascular and Thoracic Surgery in Queen Elizabeth Hospital (QEH), Hong Kong in collaboration with Department of Cardiothoracic Surgery, Queen Elizabeth Hospital, Hospital Authority.

The symposium provided an opportunity for participants to acquire wide range of knowledge pertaining to chest wall deformities. We were honoured to have six invited speakers from overseas including Prof. Donald NUSS (Norfolk, U.S.A.), Prof. ZENG Qi (Beijing, China), Prof. CHEN Gang (Guangzhou, China), Prof. JIA Bing (Shanghai, China), Prof. LIU Wen Ying (Sichuan, China), and Dr. CHENG TieHua (Beijing, China). Apart from 38 local participants (excluding faculty members), there were 16 participants from Mainland China, 5 from Taiwan, 1 from India, and 1 from Indonesia.

The symposium started in the morning on the 7th June 2013. Dr. HUNG, Chi Tim (Hospital Chief Executive of Queen Elizabeth Hospital) and Prof. David CHEUNG (Chairman of the Society) gave opening speeches. The first session was chaired by Prof. David CHEUNG and Dr. Kwok Keung HO and had two 30 minutes lectures by Prof. NUSS and Prof. ZENG. Prof. NUSS shared his thirty years experience in how minimal invasive procedure for pectus excavatum developed in his hospital. Prof. ZENG talked about how technical evolution in his hospital in the last fifteen years was.

After coffee break, we had the second session which was chaired by Dr. Innes WAN, and Dr. MA Chan Chung. In this session, Prof. CHEN gave us a speech how he managed adult patients with pectus excavatum, and Dr. ZHENG talked on perioperative management of patients undergo Nuss procedure from anaesthetist’s prospective. In addition there was a live surgery demonstration and surgery was transmitted to meeting venue simultaneously. A 23 year-old male patients with Park’s type 2A1 pectus excavatum was operated by Prof. NUSS. Two pectus bars were inserted. Operation was smooth and finished in 127 min. (Patient was discharged on day four)
Following lunch break, the third session started with a lecture by Prof. LIU followed by another live surgery demonstration. Dr. Kenneth WONG and Dr. THUNG chaired this session. Prof. LIU gave a speech how he performed Nuss procedure under transesophageal echocardiogram guidance. Prof. ZENG operated on a 14 year-old patient with Park’s type 2A1 pectus excavatum. Two pectus bars were inserted through very small incisions. Operation finished in 142min. Postoperative chest X-ray in the recovery room showed small pneumothorax which did not require intervention. (Patient was discharged on day six)

On the second day, the fifth session started with Prof. NUSS’s talk on technical pitfalls and complications of Nuss procedure. After his talk, Prof. Zeng Qi gave a speech on pectus carinatum. This session was chaired by Prof. Paul TAM and Dr. Alan SIHOE.

The last session of symposium consisted of a live surgery demonstration and two lectures and was chaired by Dr. Calvin NG and Dr. MA Chan Chung. Prof. Zeng Qi operated on a 14 year-old girl with type II chondrogladiolar pectus carinatum. The deformity was corrected by insertion of a pectus bar under minimal invasive approach. Operation time was 102min. (Patient was discharged on day 4) Soon after live surgery, Dr Zheng Tiejia gave a talk on postoperative pain management and Dr Howard CHAN shared with participants about experience in QEH. Finally the symposium was ended with closing speech by Dr. MA Chan Chung.

Our symposium was sourced by six sponsors including Biomet USA, Swedish Trading Company, Johnson & Johnson, Karl Storz, St. Jude Medical and UNI Rainbow. We sincerely thank to volunteer workers from QEH who had contribution to any part of the symposium from preparation to meeting days. All speakers and moderators were presented with souvenirs which printed with logo of our society. Participants received a conference bag with logo of our society.

The First Chest Wall Deformities Symposium achieved a resounding success. The enthusiasm of the delegates was overwhelming and number of participants was more than expected. The conference enabled participants to share knowledge and helped them to have better understanding of chest wall deformities. Although there was no evaluation forms, feedback by emails, and discussion were positive with some constructive criticisms. Finally success of the symposium provides a stepping stone for second meeting in 2015.

Dr Colin Shun-him CHU & Dr Colin Cheuk-kin LO
Queen Elizabeth Hospital
HONG KONG AND SHENZHEN SURGICAL FORUM

The Hong Kong and Shenzhen Surgical Forum was successfully held on 6-7 July 2013. This was the main summer academic program co-organised by the Department of Surgery, The University of Hong Kong and the China-Hong Kong Chapter of the American College of Surgeons. The theme of this forum was “Urology in the 21st Century”.

The first day programme was held at the Cheung Kung Hai Conference Centre, Li Ka Shing Faculty of Medicine, The University of Hong Kong on Sassoon Road, Pokfulam. For the second day, we moved to The University of Hong Kong-Shenzhen Hospital in Shenzhen to continue our programme there. We had a number of renowned overseas and mainland speakers, as well as many local urologists to share their expertise and experiences with us. Professor Paul Abram from UK updated us on Lower Urinary Tract Symptoms and Professor Ran Wang from USA on advances in Andrology. We were also delighted to have Professor Imran Mushtaq from UK and Professor Atsuyuki Yamataka from Japan to discuss their latest development in common paediatric urology diseases, namely hypospadias surgery and vesico-ureteric reflux management.

In addition, many distinguished experts from Mainland China were invited to speak at the Shenzhen Forum. We had Professors Bi Yun-Lin, Gao Xin, Huang Jian, Ma Lu-Lin, Sun Ning and Xiao Chuan-Gua delivering lectures in Adult and Paediatric Urology topics.

The GB Ong Lecture entitled “Resuscitation 2013: The Past and Present” was delivered by Professor David Hoyt, the Executive Director of the American College of Surgeons, before the lunch break of Hong Kong Surgical Forum on 6 July 2013.

The Forum was well attended by over 200 delegates both in Hong Kong and Shenzhen, China. We look forward to our next Surgical Forum, which will be held in January 2014.
On 20-21 September 2013, the College was proud to present another Conjoint Scientific Congress co-organized with the Royal College of Surgeons of Edinburgh to our fellow colleagues on the theme of “Emergency Surgery and Acute Surgical Care”.

More than 300 hundreds Fellows and Members had attended the Annual function and the feedback was excellent.
To enable our Fellows and Members to keep abreast of the latest development in surgical treatments and challenges in Emergency Surgery and Acute Surgical Care, worldwide distinguished faculty had been invited to share their expertise.
Mr Ian RITCHIE, President of the Royal College of Surgeons of Edinburgh had been bestowed the Honorary Fellowship - the highest honor of the College

Prof. Shan WANG, President of the Peking University People’s Hospital was another recipient of the Honorary Fellowship

Prof. Jie HE, President of the Cancer Hospital of the Chinese Academy of Medical Sciences had been awarded the Fellowship ad hominem of the Edinburgh College

Another landmark event - RCSEd/CSHK Conjoint Diploma Conferment Ceremony was held in the evening on 20 September 2013. Nearly 300 Fellows and Members gathered together to renew friendship and celebrate with our awardees on their surgical achievement and admission of Fellowship or Membership of both Colleges.

We look forward to seeing you again next year!

Dr Alex L.H. Leung, (Co-authors: Dr George P.C. YANG, Dr Oliver C.Y.CHAN, Dr Eric C.H. LAI, Dr C.N. TANG and Prof. Michael K.W. LI had been awarded the Best Original Paper Award of the Surgical Practice in the year 2012.
A CONFERMENT CEREMONY 2013
O C T E M B E R 2013

Another landmark event – RCSEd/CSHK Conjoint Diploma Conferment Ceremony was held in the evening on 20 September 2013. Nearly 300 Fellows and Members gathered together to renew friendship and celebrate with our awardees on their surgical achievement and admission of Fellowship or Membership of both Colleges.

Prof. Joseph Wan-yee LAU delivered the Arthur LI Oration on “The Good, The Bad and My Three Mentors”. This inspirational lecture was extremely well received.

Congratulations to Prof. Nivritti Gajanan PATIL being awarded the College Medal for his devoted service and contribution to the College.

The GB ONG Medal and the LI SHIELDS’ Medal had been awarded to Dr Tiffany Cho-lam WONG

The CH LEONG Medal & Scholarship had been awarded to Dr Ada Tsui-lin NG

Dr Richie Chiu-lung CHAN had been awarded the Best Research Paper Award (2nd prize)

Dr Melissa Shannon CHAN had been awarded the Royal College of Surgeons of Edinburgh China Medal

Dr Philip Ming-ho KAM had been awarded the Best Scientific Paper Award

We look forward to seeing you again next year!
RACS Younger Fellows Forum 2013

I was the delegate representing the College of Surgeons of Hong Kong and attending the RACS Younger Fellows Forum 2013 from 3rd May 2013 to 5th May 2013. The Forum was organized by Royal Australasian College of Surgeons and was held in Formosa Country Club, Auckland, New Zealand which is located at one hour’s drive from the Auckland International Airport.

The Forum was attended by 24 delegates from different parts of the world, namely, Australia, New Zealand, Malaysia, Thailand and Hong Kong. There was a good mix of surgeons of various specialties, including general surgeons, orthopaedic surgeons, ENT surgeons, paediatric surgeons, urologists, vascular surgeons and surgical oncologists. Among the 24 delegates there were two RACS College Councillors, namely Professor Spencer Beasley, Deputy Censor-in-chief and Dr Cathy Ferguson. Both were actively involved in all the activities and offered guidance and advice to us during the whole course.

The Forum officially started on 3rd May 2013 when Dr Andrew MacCormick, the Forum Convenor and Dr Jon Morrow, the Forum Co-convenor delivered welcome speeches to the delegates, giving an introduction of the RACS Younger Fellows Forum and its history, importance and uniqueness. Associate Professor Michael Hollands, President of Royal Australasian College of Surgeons, gave an account of the College and shared with us it’s vision and mission.

The highlights of the first day were a series of outdoors activities which were organized by program specialists and these included orienteering, rock climbing, canoeing, gun-shooting. We were divided into three teams and we competed for while the RACS President and the two councilors also took part. During the activities we needed to cooperate and work together in order to face the challenges and to solve the problems. Through these activities we began to have better understand among delegates, serving to enhance friendships.

The 2nd and 3rd days’ programs were conducted in the forms of lecture, interactive tutorial, brain-storming session and small group discussion while all delegates, including the RACS officials, were eagerly engaged in discussion. The topics of this year’s Forum included Indigenous health, work life balance and IT in surgical practice whereas Indigenous health being studied the most. Indigenous health is not much a major problem to the public in Hong Kong as medical service, general speaking, can be delivered effectively to most of the citizens locally. But it is a major medical challenge in Australia where the indigenous people live in remote rural areas that may be hundreds of miles from the cities. More importantly, lack of resources, low educational level and social statues, poor health awareness and ignorance make them susceptible to a number of diseases, violence and poor health conditions.

Each year the Younger Fellows Forum Recommendations will be formulated after the Forum. The recommendations are regarded as important opinions and will be directed to the College Council for consideration and future actions. This year is no exception. On the last day, with guidance from the College Councilors and Younger Fellows Chapter, all delegates worked together to formulate the 2013 recommendations. There were a total of 12 recommendations and most of them were based on the discussions and conclusions from the delegates. Of the twelve recommendations, six are related to indigenous health and they include mandatory learning module of indigenous health, training exposures to indigenous diseases, increased working experiences in indigenous areas, and granting awards and scholarships for researches related to indigenous health issues.

Dr Ricky Wai-keung CHAN
Private Practice
The Women’s Chapter was established in 2008. Over the past few years, we have grown. Today, we have more than 180 members with the increasing number of female surgical trainees.

The election of the new committee took place in September 2013. The Committee members for the year 2013 – 2016 are as follows:

Chairlady: Dr NG Tsui-lin Ada QMH
Vice-Chairlady: Dr TSANG Yee-yam Yvonne Private
Secretary: Dr MARK Hor-kee Bonita QEH
Treasurer Dr CHAN Hau-yee QMH
Committee Members: Dr CHAN Chun-ki PMH
Dr LAU Hiu-yan Stephanie QEH
Dr MAN Chi-mei Vivian QMH

Our mission is to promote surgery as a career for women and enhance professional advancement amongst female surgeons. We also aim to facilitate social, clinical and academic interactions amongst women surgeons and to encourage a balanced lifestyle so that women will be able to excel in a surgical career and yet can still enjoy a good family life. We plan to reach our mission through organizing a series of activities.

The inaugural mentorship programme of the Women’s Chapter took place in 2010, with more than 20 participants. The feedback was very positive, with a significant number of medical student mentees joining the surgical field. We will continue this meaningful programme, and the target mentee group will be Year 3 – 4 medical students, with priority to female medical students. The aim of our programme is to reinforce the connection between medical students and surgeons; to introduce surgery and provide assistance to students, and to let them explore the daily routine and lifestyles of surgeons in hope to entice and attract more young blood. We would also like to take this opportunity to invite all female surgeons (BSTs who have completed membership exam, HSTs & specialists) to join our programme as mentors.

We will provide 4-5 career sharing sessions targeting HKU & CUHK students, and senior secondary school students. For medical students, we aim to introduce the work a surgeon does, the qualities a surgeon possesses and introduce the different subspecialties. For secondary students, we would introduce the medical profession as a whole, and different specialties with a focus on the surgical field. To increase the target audience, we would hold the sessions at the university campus and also the chosen girls’ secondary schools.

Apart from nurturing the next generation, we would like surgeons to reach out and to serve the community. Women’s Chapter will organize health talks on female surgical issues to the general public such as breast cancer, urinary incontinence, varicose vein, plastic surgery by different subspecialty specialists. We will discuss the prevention, clinical symptoms, workup and different treatment options for different conditions.

Surgery on the whole is notorious for long working hours and poor work-life balance. Women’s Chapter will organize a series of social activities, including photography workshop, cake baking, and music jamming. Moreover, in conjunction with the Younger Fellows chapter, wine & cheese tasting event and coffee brewing & appreciation sessions will be organized.

Further information on the above events can be found on the Women’s Chapter of the CSHK webpage, and will be distributed in due course. We look forward to serving you and for your active participation. The Women’s Chapter can be contacted via wsc@cshk.org.
Interview with Dr Anthony TEOH

W: When & how you start you musical life?

T: When I was young, I really didn’t understand much about music. My musical “training” at that time was when my parents forced me to learn piano. I wasn’t really interested and I kept failing my piano exams until grade 5. Afterwards, my “real” relationship with music started when I turned 15. At that time, I saw some older high school boys performing on stage as a band. I was really impressed and amazed at that time and I thought the guitarist was really cool. I wanted to be like him. Then, I started learning guitar and a year later, I went on to the same stage with my own band in the school concert. Afterwards, I continued playing guitar for many years until I went to Sydney for further studies. In Sydney, I had many opportunities to meet music lovers and I also learned about more technical side of things. I did a diploma course on sound engineering, which involved recording bands and mixing music. I also got into the computer side of things including programming, sound editing and mastering.

I returned to Hong Kong in 1997 to finish my medical degree. At that time, I also had an electronic music group with another female singer. We were signed to Warner Brothers and were supposed to release a few albums. At the same year, one of our songs “O-Koneko” (Japanese for Hi kitten) ended up as a finalist in the CASH songwriter’s competition 2003. I was also working as a part-time audio engineer and I’ve recorded and engineered many artists including Sammi Cheng and Eason Chan. In addition, I also worked closely with a Radio DJ called 卓韻芝 (GCGoobi) doing music for her radio show.

W: When did you start your public performance and music album?

T: My first public performance was when I was 16, playing as a guitarist of a band in the end of term concert of my high school. Thereafter, I’ve done many performances with the largest one being in the Hong Kong coliseum for a charity show with over 20000 people. My first album was actually a sound track for an independent movie called...
**Off the Scalpel**

"Cross Harbour Tunnel" released in 1999, which eventually ended up being shown in the Berlin Film Festival. My first real solo album was released independently in 2004. It was an electronic techno album recorded in my home studio. I was very lucky at that time, because one of my good friends (who actually studied law but ended up doing music) was working in NHK Tokyo and he offered to master my album in Tokyo. So I had the privilege to use the NHK studios during after hours to have my album mastered there. And every morning, after we finished all the mixing, the engineer would take me to a Grand Turismo type car ride to Okohama listening to the night’s mix. It was truly an unreal experience for me and certainly made the album sounded much better. After the album, I’ve also ventured into many different kinds of music related works including art projects, advertising, and also music for a Coca Cola in the Beijing Olympics.

My list of discography as is follow:

- Cross Harbour Tunnel Sound Track (1999)
- Split - Elecktronik/denkki muzik groove vol.1” (2000)
- 我的世界末日 (Teoh remix) – Eason Chan mixed up (2001)
- Zonic – Coors light remix party (July 2004)
- Mut-a-Tech (debut album – August 2004)
- Tribal Punk – Xiang Gang Electric volume one (Nov 2005)
- Dolby – the sound of high definition Blue Ray (2010)
- Retox’D – Year of the dragon (2013)

**W**: I know retox’d have the album release few months ago – how is its response and will you continue to produce more album?

**T**: Retox’D is the latest musical adventure for me and the group consists of a rapper, a vocalist and me being responsible for composing and programming dance beats. We had a great release with our title track “Year of the dragon” reaching no. 8 in the CRHK 903 English Charts. We’ve sold around 300 albums and had over 7000 downloads in KK box. This year, we are in the midst of arranging some overseas performances in Taiwan, Macau, Malaysia and also China. Hopefully, we could end up having a mini-tour to promote the album further. We have also started recording music for the second album which is much more edgy and deeper sounding.

**W**: Did your parents against your music career during your medical school days?

**T**: Well my parents on one hand pretended to be very supportive of me but when I went back home with long hair and earrings, they certainly weren’t very impressed at all. But, to me the bottom line is, I actually much preferred my way of working professionally in music as leisure or hobby. Because my experience of working in the commercial music world has taught me that that kind of a lifestyle is not really about music most of the time.

**W**: To be a musician & surgeon, how do you adjust your life & time? How do you find your music influence your medical career?

**T**: Well, I’ve had this dual identity for almost half of my life, so it’s not that difficult to balance. I’m always busy but I can also always find time to do what I want to do.

**W**: Now you are the father of 2 kids, how is your family feelings on your music? Did you play them lullaby?

**T**: My son loves my music and he dances and sings along the rap!

**W**: Any other things you like to tell us?

**T**: SUPPORT original music!
You need to be persistent to succeed!
Pls like my page: https://www.facebook.com/RetoxD
For more videos: http://www.youtube.com/user/Retox’dhk/videos

**Interview with CRHK**

**Dr Simon WONG**
**Prince of Wales Hospital**
Sharing the happiness of Dr Colin Wai-ho CHU for his new-born baby girl

Congratulations to Dr. Colin Chu, who has a little princess Gladys Chu joining their family on 27th Jun, 2013
Prof. Joseph Wan-yee LAU, the Past President of the College of Surgeons of Hong Kong, incumbent Director of the Department of China Affairs of the College, Chairman of the Medical Council, has been bestowed the Silver Bauhinia Star (SBS) of the 2013 Honours List.

Prof. LAU is awarded the SBS in recognition of his long and outstanding community services in the medical and health field, as well as his profound contribution to the work of the Medical Council of Hong Kong.

Holding many important positions in the Government, Professional Associations, worldwide medical organizations and universities and Hospitals, Prof. LAU not only commits profoundly to the development of health service, but also acts as a passionate teacher in surgical training and an excellent writer in numerous medical researches, books and journals. Also, the success of the accreditation exercise and collaboration with the Mainland Centres of the College is attributed to Prof. LAU’s leadership in laying down a solid foundation which is always appreciated by the College.

With much gratification, the College wished to extend our congratulations to Prof. LAU on his well-deserved achievement.

Congratulations to Prof. Michael Ka-wah LI, upon his splendid accomplishments in receiving the Bronze Bauhinia Star (BBS) of the 2013 Honours List. Prof. LI is awarded for his contribution in medical and surgical field. Prof. LI renders distinguished services in surgical community by undertaking numerous significant roles in various professional surgical organizations. He advocates the highest standard in surgical care and surgical training which benefit the community. The College is grateful for his previous committed service in the Council.

Heartiest congratulations to Prof. LI on his outstanding achievement.
# Council of the College

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<tr>
<th>Position</th>
<th>Name</th>
<th>Hospital</th>
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<tbody>
<tr>
<td>President</td>
<td>Stephen W K CHENG</td>
<td>Queen Mary Hospital</td>
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<tr>
<td>Vice President (External Affairs)</td>
<td>Edward C S LAI</td>
<td>Private Practice</td>
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<td>Vice President (Internal Affairs)</td>
<td>Enders K W NG</td>
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<td>Hon. Secretary</td>
<td>Chi-wai MAN</td>
<td>Tuen Mun Hospital</td>
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<td>Hon. Treasurer</td>
<td>Philip W Y CHIU</td>
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<td>Censor-in-Chief</td>
<td>Paul B S LAI</td>
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<td>Ex officio Councillor</td>
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<td>Private Practice</td>
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## Structure of the College

### COMMITTEE

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<tr>
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<td>- &amp; Editorial Board of Cutting Edge</td>
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<td>- Women’s Chapter</td>
<td>Ada TL NG</td>
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<td>- Younger Fellows Chapter</td>
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<td>Administration Committee</td>
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<td>- Website Development</td>
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### DEPARTMENT

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<td>Department of China Affairs</td>
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### SECRETARIAT

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<tr>
<td>General Manager</td>
<td>Stephanie HUNG</td>
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Souvenir Collection Catalogue

Souvenirs for Sale

1. College Tie available in various colors $180@

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

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

2. College Scarf $150@

3. T-shirt $80@

   Size of the displayed: M

4. Polo shirt $100@

   Size of the displayed: M

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

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<tr>
<td>(D) ____ piece(s)</td>
<td>(E) ____ piece(s)</td>
</tr>
<tr>
<td>(G) ____ piece(s)</td>
<td>(Full set) ____ set(s)</td>
</tr>
<tr>
<td>2. College Scarf</td>
<td>Unit: _____</td>
</tr>
<tr>
<td>3. T-shirt</td>
<td>Size (S): ____ piece(s) Size (M): ____ piece(s) Size (L): ____ piece(s)</td>
</tr>
<tr>
<td>4. Polo Shirt</td>
<td>Size (S): ____ piece(s) Size (M): ____ piece(s) Size (L): ____ piece(s)</td>
</tr>
<tr>
<td>5. Mini Wireless Mouse</td>
<td>Unit: _____</td>
</tr>
</tbody>
</table>

**TOTAL PAYMENT**

**Collection Method** (Tick as appropriate)

- [ ] In person (College Secretariat Office)
- [ ] Courier (to mailing address)

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

**Contact Information**

Title _______ Surname ___________________ Given Name ___________________

Mailing Address ______________________________________________________

Contact no. _________________________ Email Address _______________________

Payee signature ___________________ Date ___________________

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

**Payment**

Delivery of your purchase would be valid upon 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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肝美靈

Otsuka
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- Superior efficacy in the management of NERD
- Effectively maintaining healed erosive esophagitis and improving quality of life
- Lifestyle-friendly PPI: once daily, taken with or without food
- Acceptable safety and tolerability profiles with less clopidogrel interaction

For further information, consult full prescribing information.

References:

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