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Development of surgery in Hong Kong

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It is a great honour to be invited to give the GB Ong lecture at this Annual Scientific Meeting of College of Surgeons of Hong Kong (HK). I feel privileged to have known GB Ong throughout my own surgical career, meeting him initially during one of his visits to Edinburgh some 40 years ago and being fortunate enough to see him again during my many visits to HK. You are indeed fortunate to have had a leader of such vision, inspirational quality, determination and surgical skill. He built a secure platform that enabled HK to rank in the first division of international surgery. As surgeons working in Scotland we have enjoyed a close association with HK during these exciting years and have benefited from GB Ong's wisdom and foresight by association with your University departments and your College.

My comments on the development of surgery in HK are based on this long association and on my participation in the Hospital Authority (HA) Review of Surgical Services in December 2000 and the recent follow-up visit of December 2002. Many of your surgical concerns are familiar to me as someone who has spent a life of surgery in Scotland and many of your organizational considerations also seem familiar to me from my time as Chief Medical Officer in Scotland. Indeed, the Acute Services Review that I chaired in Scotland in1998 faced many of the same issues that you face today in HK. How can one deliver surgical services of uniformly high quality to the entire population in an era of increasing specialization, increasing public awareness and constrained resources?

It takes courage to commission a Review from a group of internationally recognized experts and it takes even greater courage to invite them back after 2 years to comment on progress. In our initial visit I was impressed by the openness with which the review was conducted and at our second visit I was just as impressed by the serious way in which you had begun to address many of our recommendations. The remarks that follow are offered diffidently (after all it is much easier to comment critically on someone else's health service than sort out one's own) and should be interpreted against a background of admiration for the developments now underway in HK.

What then are my key observations?

First, HK like Britain, needs to spend more of its gross domestic product (GDP) on health and healthcare if surgeons are to provide services of high quality. In the UK we now have a government who appreciate this fact and who are determined to take health spending from the bottom of the European league table to at least a mid-table position. In percentage terms this means an increase from approximately 4–5% to 8–9% of GDP. By 2000 the UK spend had risen to 7.3% of GDP on health in contrast to a European average of 8.0% and a spend of 9.3% by the G7 group of industrialized countries. In Scotland where expenditure has traditionally been higher than in England, total health spending in 2000 was £5.2 billion, four times more than the expenditure in 1981, and is currently set to reach £6.7 billion in the current financial year. By contrast I understand that at the time of our HA Review in 2000, HK spent 5% of GDP on healthcare, 2.7% of this in the public sector and 2.3% in the private sector. I appreciate that we live in a rapidly changing world and that the balance between these two sectors has changed. However, the overall message is clear. Hong Kong needs to follow the international trend in health spending if it is to have surgical services of quality.

Second, HK surgeons in their laudable drive to service development need to remember that they are but one element in health spending. The health dollar will always have to stretch a long way and spending on high profile, expensive, tertiary and quaternary surgical services needs to be balanced against spending on areas such as preventive medicine and primary care. This is not to say that medicine in HK needs to be reduced to a lowest common denominator. On the contrary if you are to maintain and develop a quality service you need to maintain peaks that can compete internationally with the very best. Perhaps the important message here is that the strategic planning role of the HA needs to be paramount – HK cannot afford creeping, unplanned and expensive development of specialist services that pays no regard to the overall health needs of the community.

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Third, surgical services must be organized so that there is equity of access. If a patient needs surgical care in HK it should not matter which door he goes through to gain access to the service. Local access is of course desirable (and desired by the public at large) and should be provided whenever possible but never at the expense of quality. This means that every highly specialized service cannot and should not be provided at every hospital in the HA domain. Even if such services were affordable, manpower considerations would render them unsustainable, particularly in the case of services with a significant out-of-hours component. I applaud the strategic decision to develop megaclusters as the way of structuring of surgical services in HK. This does not mean that every megacluster will necessarily provide every specialized service. In my view HK still has too much duplication of tertiary/quaternary surgical services and while I can understand how this has come about, its continuation cannot be justified if health dollars are to be spent wisely while robust services of high quality are ensured. How can HK with its population size and annual workload continue to justify four renal transplant units and two liver transplant units?

Fourth, the quality of surgical services must be monitored by audit and action must be taken whenever areas for improvement are identified. I commend the HA and its surgeons for the increasing focus on data collection and audit. I have been privileged to see the early audits on esophagectomy, liver resection and liver transplantation and your overall results compare well with those of other developed countries. However, this does not provide grounds for complacency and inevitably, such audits throw up uncomfortable truths (or in the absence of statistical significance, uncomfortable pointers) when individual units are compared. There is increasing evidence that service volume is an important factor in determining outcome (although by no means the only factor) and audit information now available in HK already provides a basis for further rationalization. Units which are obtaining substandard results in respect of a given operation either need to stop doing that operation or come up to an acceptable standard through prompt remedial action. Underlying these considerations is the need to have sustainable services provided by a critical mass of trained personnel. Overlying them is the need for a strategic template developed by the HA.

Fifth, we live in an era of increasing accountability and public awareness. The UK has lagged behind the USA in this regard and I suspect that the public/patient voice in HK has until recently been even quieter than in the UK. A run of recent high profile medical 'scandals' in the UK (e.g. Bristol paediatric cardiac surgery, the activities of Dr Harold Shipman, the Alder Hey organ retention scandal) have altered the doctor-patient relationship for all time. The very principle of professional self-regulation by the General Medical Council has been called into question and medical litigation has risen exponentially. I sense that we are currently in a window of opportunity in the UK and that a more open approach to patient information and the admission of medical error has gone some way to reclaim lost ground. My message for the surgeons in HK is to be proactive in improving the doctor-patient relationship in a spirit of informed partnership. As doctors (in the UK at least) we lost self-belief, yet the truth is that we remain the most respected profession, vying only with nursing in the league table. When asked annually 'who do you trust to tell you the truth?' about 90% of the British public trust their doctors. Clergymen fare slightly less well, government scientists fare much less well, and journalists grapple with politicians for the bottom position. Of course, taking the public with you is never easy, particularly when it comes to controversial service rationalization. The recent furore surrounding the attempt to rationalize liver transplantation in HK provides a good exemplar. As doctors we have an important responsibility to society and must not allow sectoral interest to cloud development based on objective appraisal and need for the greater good.

Sixth, we must nurture our seed corn and value our trainees fully. We must not assume that there is an unlimited supply of young people who will compete for places in medical school. In the UK we are expanding medical school output at a time when applications have fallen from 3.4 (1973/74) to 1.44 individuals per place (2000). Have we talked down our profession and our job satisfaction inappropriately or without really meaning to? Have we come to terms with the fact that over 50% of our new graduates are women and that we have an increased need for more flexible training and working? The proportion of graduates wishing to pursue a surgical career has also fallen slightly in the UK recently while the attractiveness of general practice has risen. While we have seen welcome emphasis on structured training and competence-based curricula, we have still to come to terms with the implications. In the UK, the impending implementation of the European Working Time Directive (no-one to work more than 58 h a week by 2004 and 48 h by 2009) has profound implications for our trainees and for the service that they have provided. Will the next generation of surgeons leaving the production line have the same levels of competence as their predecessors and if not, what are we to do about it? The Colleges have a vital role in training and in the UK I sense a welcome if somewhat belated recognition on

the part of the Colleges of their role as organizations concerned with more than setting standards and conducting examinations. In the UK we are about to see the introduction of a Postgraduate Medical Education and Training Board answerable to the Secretary of State and removing primacy from the Royal Colleges. My reading of the situation in HK is that the Colleges and the parent Academy have done a great deal of good work in respect of curriculum development, training programmes and standards that should avoid the unappetizing situation now facing the UK colleges.

Finally, I have always enjoyed the spirit of enquiry that has pervaded surgery in HK. Some of the clinical research being pursued here has established your international reputation for excellence and I have no doubt that this will continue. Having participated recently in a HK University Research Assessment Exercise, I know something of the outstanding quality of your surgical departments and the moves afoot to strengthen the link between clinical research and that emanating from the laboratory. In 2003 it is a universal truth that surgery cannot stand alone in the pursuit of scientific excellence but it can more than hold its own in active partnership and collaboration. I trust that HK surgeons will continue to demonstrate continuing commitment and leadership in the field of scientific endeavour and that this strand of activity will continue to be valued by the surgical community at large.

It has been a great privilege to give the GB Ong Lecture in 2003 and receive Honorary Fellowship of the College of Surgeons of Hong Kong. I close by once again saluting GB Ong and by extending grateful thanks to the many friends in HK surgery who have contributed so much to my own continuing professional development. Surgery in Hong Kong has had a magnificent past and I do not doubt for one moment that it will have a magnificent future.