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Elective Report – Plastic Reconstructive Aesthetic Surgery at Prince of Wales Hospital, Hong Kong

Patient-doctor relationship is very **different** between Hong Kong and the UK. In Hong Kong, patients are generally more passive. They prefer doctors taking a paternalistic role. For example, a patient with sebaceous cyst is offered treatment options, excision or observation. The doctor explains risks and benefits of both options. Patient is asked to make a decision. He/she would reflect the question back to the doctor and follow doctor's preference. This appears more commonly in the elderly patients. This may be due to the lack of education in their generation. So they respect and look up to "doctors", who have higher education levels. Or, this may be due to the traditional patient-doctor relationship in Chinese medicine. In Chinese medicine, the doctors examine, diagnose and make a treatment plan for each patient when patients only have the options of taking the treatment or not. With patients coming to the clinic, there is an implied consent that they are taking the treatment. Hence in Chinese medical consultations, doctors tend to "tell" patients what to do than explaining things. As a habit, the elderly patients might have applied the paternalistic roles of Chinese medical doctors onto Western medical doctors. In UK, it is more of a patient-centred relationship. Patient would make decisions based on their own concerns and ideas along with their understanding of the doctors' advice. Hence, the final decision is based on patient's preference while it is more of a doctor's preference in Hong Kong.

Public health services between the two places are very diverse. Hong Kong has a population of 7 million people and, as a city, is part of China and next to Macau. With a high population density in Hong Kong, there is a substantial demand in medical resources. In addition to this, some people would travel the distance from China or Macau to Hong Kong for medical consultations and treatments. Hence, hospital beds and outpatient appointments are in high demand. For instance, it is common to have halfday follow-up clinics of up to 80-90 patients for 3-4 doctors. Whereas the UK, there is an average of no more than 60 patients per halfday clinic.

Also, Hong Kong has no standardized GP system. Patients with chronic illnesses and minor problems are managed in hospitals as outpatients or at A&E. In the UK, the national GP system manages patients with chronic illnesses and minors in the community, which helps the reduction in the demand of A&E and outpatient appointments at the hospital.

Having been born and brought up in Hong Kong, I am looking into working here in the future. During this elective, I learned about the surgical training pathway in Hong Kong. Following graduating from medical school, there is one year of internship, which consists of 6 months of medical placement and 6 months of surgical placement. Then, there is the basic surgical training of 2 years, with 4 different rotations. Afterwards, the higher surgical training is 4 years, which would be in the specialty of interest. In total, there is 7 years of training after medical school to become a specialist in Hong Kong. In comparison to the 10 or 11 years long training after medical school in the UK, the route to be a surgical specialist is shorter in Hong Kong.

Being on a surgical placement, I have found an interesting difference at the operation theatres between the two places. At Prince of Wales Hospital, there is no preparation room within the operation theatres. The anaesthetists carry out general and regional anaesthesia within the operation theatres. Adding on the cleaning time, it can take up to an hour between finishing one surgery and starting the next one. This experience let me appreciate how the preparation room improves time efficiency in the operation theatres.

During my 5-week electives, there was teaching week on plastic surgery with local medical students. Having no formal teaching before, this was a great opportunity. There were tutorials, lectures, and bedside teachings on common topics like burns and skin lesions. Personally, the highlight of the week was the visit to the Skin Bank. It was very interesting to see how different skin graft (porcine skin and cadaver skin) are harvested and how skin cells are grown in the laboratory.

Overall, I have learned differences in the public health services, surgical training pathways and culture between Hong Kong and the UK. With the teaching week and regular clinical teachings, I have learned more about what plastic surgery is.

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Elective Report 2012

I chose to undertake my elective in Harlow studying the diagnosis and treatment of facial skin cancer. I have previous experience seeing a few patients in clinics and taking punch biopsies but had few opportunities to observe their removal or reconstruction. The oral and maxillofacial department in Harlow was ideal for my choice of subject as it has a joint dermatology and maxillofacial clinic run every week, an MDT once a week and plenty of operating sessions. I already had close links with the department and know my supervisor from ongoing on call commitments. Although UK based and close to home, I aimed to improve my understanding and exposure to this increasingly common condition in order to aid in future career.

Being based at home I commuted to Harlow on a daily basis and observed and assisted in the clinics and operating lists not just for the skin cancer patients but more general oral and maxillofacial patients as well. The operating lists I observed were mainly those removing and reconstructing facial tumours under local anaesthetic. This technique provides a rapid turnaround of patients and the possibility of operating on all age groups and medically compromised patients. As one of the key risk factors for this disease is age, this ability to operate without general anaesthetic enables almost all of these cancers to have surgical treatment. Other operations being undertaken were salivary gland, dento-alveolar and trauma. It was clear to me the resection of most facial skin cancers is usually relatively straightforward to the experienced surgeon. The more difficult aspect is aesthetic reconstruction. Operating on the face, the planning of the incisions requires not just experience and knowledge of the skin structure but also the patient's wishes. Some elderly patients are more willing to accept reconstruction with skin grafts that may not be accepted in younger patients. The tension the skin can be placed under alters with age and subsequent revisions may be required to achieve the best possible result.

A large majority of the cases seen in the department were basal cell carcinomas but there was also SCC and melanoma. The link between facial skin cancer and sun exposure is widely documented. The other main risk factor is age. The cumulative impact of UV exposure especially in the younger years of life leads to a large increase in rick of SCC and BCC. Currently the number of new cases is increasing possibly due to increasing intensity of radiation form the sun and an increase in foreign travel, especially holidays. Traditionally BCCs were considered to be a disease of the elderly but I observed many younger patients attending the clinic, some in their 30's.

The typical referral pattern of skin cancer patients in the UK follows attendance to the GP referral to a dermatology clinic, biopsy, review, referral to surgeon then excision. The initial referral is usually under a 2 week wait but then there is a delay following the initial assessment and being seen by the surgeons. Most of this delay is logistical in nature, waiting for letters to be dictated and posted and processed. At Princess Alexandra Hospital there is a joint dermatology and oral and maxillofacial clinic. This eliminates the

delay enabling a smoother patient experience. It also enables there to be a discussion surrounding different treatment modalities resulting in optimal patient care. The once weekly MDT with histopathologists, dermatologists, oncologists and surgeons enables in depth discussion for each skin cancer patient coming through the trust. These links between specialities, although difficult to set up initially, provides a much faster and more efficient service and is a good model for many departments nationwide. The ability to discuss diagnosis and treatment at one visit eliminated a lot of worry from the patient and I observed them relaxing with this extra information, without a worrying delay.

The surgical treatment of facial skin cancer is performed by many different surgeons with an interest in the field from oral and maxillofacial specialists to general surgeons to plastic surgeons to dermatologists. Each NHS trsut utlilises its own preference which is usually historical in origin. The Oral and Maxillofacial Surgeons are becoming increasingly involved in ths area not only due to their extensive work on the face and knowledge of aesthetics but also as trained dentists they have extensive experience of treatment under local anaesthetic. However the training pathway in Oral and Maxillofacial Surgery does not encompass aesthetic reconstruction and trainees usually have to seek out opportunities for practice.

My time spent in Harlow has vastly increased my knowledge of patient presentations and the demographics of the disease. I also found out about alternative techniques, such as photodynamic therapy, with which I was unfamiliar. The flap design for aesthetic reconstruction remains an area I would aim to work on more throughout my training process for which I would like to maintain the contacts forged during the elective.