

Point of View: Top-down or Bottom-up? A Cardiologist's View Point on the Proposed Hospital Authority Initiative in Safe Introduction of New Interventional Service

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In this issue of the Journal, Chang et al¹ describes a proposal mechanism for introducing new interventional procedure in the Hospital Authority (HA). As practising cardiologists, we would like to express a different view on the proposed mechanism.

It is important first to define the scope of the current initiative. The initiative addresses the territory-wide application of new interventional procedures in HA hospitals. As such, these procedures should be relatively well established, with either international or local evidence. Indeed, a formal ethics committee approval is unnecessary, because this introduction is service-oriented and is not a clinical trial. Chang et al¹ quoted the application of brachytherapy as an example, a procedure that has already been shown to be efficacious and safe in several international randomized controlled trials.²⁻³ New innovations which may be novel treatment, usually carried out as a clinical trial would need to go through hospital (or university) ethics committee as stated in the current proposal, and these trials will not need to go through the proposed HA initiatives.

The proposed HA initiative is a typical "top-down" mechanism by which an administrative unit in the HA, in conjunction with a few interested chosen experts in the field, takes up "the governance and management approval procedure" for new interventional

procedures. Such a structure has the advantage of ensuring a uniform protocol and training requirements for all centers, and a central monitoring of quality. The disadvantage of this mechanism is the "representativeness" of the chosen experts, and the necessary delay introduced by the administrative process. For instance, a 6-month delay was encountered between the application for β -brachytherapy to treat coronary restenosis and the first case performed. In addition, because of the rapid evolution of technology, it may be necessary to repeat the whole process should a close alternative be introduced. Thus, the mechanism should build in an alternative is more expedite process, to allow similar procedures to be approved. In some hospitals such as the Queen Mary Hospital and Prince of Wales Hospital, a third mechanism is operative: a hospital based "Technology and Therapeutic Subcommittee" is available to "approve" new interventional procedures at the hospital level.

Traditionally, new interventional cardiology procedures are introduced in Hong Kong by local experts in the field, usually in the form of a clinical trial. For example, the first radiofrequency ablation in the Asia-Pacific region for paroxysmal supraventricular tachycardia was introduced in Hong Kong in 1990.⁴ With training in the technique from the initiating center in Hong Kong and centers overseas, this procedure is now generally available in most of the HA hospitals with catheterization laboratory. This process of "evolution" from "bottom-up" has the advantage of being highly flexible with minimal administrative cost and burden, and with professional freedom that all of us are used to and would like to continue. Patients' welfare is safeguarded by the requirement of the ethics committee, and by the expertise of the initiating cardiologists. The quality of the service in subsequent

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centers are guaranteed by appropriate training, often with participation of the cardiologists from the more experience centers in the initial cases. Quality assurance and accountability are in the hands of the practising cardiologists and centres concerned. In the present funding limitation in the HA in which there are little additional funds for new procedures/services, these procedures are introduced with "productivity gain" by the unit concerned and is highly cost-effective.

Which system should we adopt? We think that the "old" and "new" are not mutually exclusive, but complementary. Most of the innovative treatments will be carried out as clinical trials, under the auspicion of individual hospital/university ethics committee. When these innovations have matured to wider clinical application, or when an established new interventional procedure is for introduction, there may be a choice between the "top-down" and "bottom-up" approach. We believe that the clinicians, acting in the best interests of

the patients should have a freedom of choice in their initiatives. Should additional funding from the HA be available for introduction of new procedures, a "top-down" initiative would be a logical option.

References

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