立法會
Legislative Council

LC Paper No. CB(2)1368/14-15
(These minutes have been seen by the Administration)

Ref : CB2/PL/HS

Panel on Health Services

Minutes of meeting
held on Monday, 17 November 2014, at 4:30 pm
in Conference Room 3 of the Legislative Council Complex

Members present	:	Prof Hon Joseph LEE Kok-long, SBS, JP, PhD, RN (Chairman) Dr Hon LEUNG Ka-lau (Deputy Chairman) Hon Albert HO Chun-yan Hon WONG Ting-kwong, SBS, JP Hon CHAN Kin-por, BBS, JP Hon Albert CHAN Wai-yip Hon YIU Si-wing Hon CHAN Han-pan, JP Hon Alice MAK Mei-kuen, JP Dr Hon KWOK Ka-ki Dr Hon Fernando CHEUNG Chiu-hung Dr Hon Helena WONG Pik-wan Dr Hon Elizabeth QUAT, JP Hon POON Siu-ping, BBS, MH Hon Christopher CHUNG Shu-kun, BBS, MH, JP
Member attending	:	Hon WONG Kwok-hing, BBS, MH
Members absent	:	Hon Vincent FANG Kang, SBS, JP Hon CHEUNG Kwok-che Hon Charles Peter MOK, JP

Public Officers attending : Item III

Dr KO Wing-man, BBS, JP
Secretary for Food and Health

Miss Fiona CHAU
Principal Assistant Secretary for Food and Health (Health) 1

Dr LEUNG Ting-hung, JP
Controller, Centre for Health Protection
Department of Health

Dr Edwin TSUI
Chief Port Health Officer
Department of Health

Dr Derrick AU
Director (Quality and Safety)
Hospital Authority

Dr N C TSANG
Chief Infection Control Officer
Hospital Authority

Dr Owen TSANG
Medical Director (Infectious Disease)
Hospital Authority

Mr YU Man-fung
Senior Superintendent (Cleansing and Pest Control)
Food and Environmental Hygiene Department

Mr YUEN Ming-chi
Pest Control Officer i/c
Food and Environmental Hygiene Department

Items IV and V

Professor Sophia CHAN Siu-chee, JP
Under Secretary for Food and Health

Ms Angela LEE
Principal Assistant Secretary for Food and Health (Health) 2

Item IV

Dr CHEUNG Wai-lun
Director (Cluster Services)
Hospital Authority

Dr LO Su-vui
Director (Strategy and Planning)
Hospital Authority

Dr C K LEE
Consultant, Hong Kong Red Cross Blood Transfusion Service
Hospital Authority

Mr Donald LI
Chief Manager (Capital Planning)
Hospital Authority

Item V

Dr Derrick AU
Director (Quality and Safety)
Hospital Authority

Dr Rebecca LAM
Chief Manager (Patient Safety and Risk Management)
Hospital Authority

Dr T Y CHUI
Cluster Chief Executive, Kowloon East Cluster
Hospital Authority

Dr N C SIN
Cluster Service Director (Quality and Safety), Kowloon East Cluster/Deputising Hospital Chief Executive, Haven of Hope Hospital
Hospital Authority

Dr Michael CHAN
Consultant (Chemical Pathology), Prince of Wales Hospital
Hospital Authority

Clerk in attendance : Ms Maisie LAM
Chief Council Secretary (2) 5

Staff in attendance	:	Ms Janet SHUM Senior Council Secretary (2) 5 Ms Priscilla LAU Council Secretary (2) 5 Ms Michelle LEE Legislative Assistant (2) 5

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I. Information paper(s) issued since the last meeting

Members noted that no information paper had been issued since the last meeting.

II. Items for discussion at the next meeting
[LC Paper Nos. CB(2)242/14-15(01) and (02)]

2. Members agreed to discuss the following items proposed by the Administration at the next regular meeting scheduled for 15 December 2014 at 4:30 pm -

(a) Retention of the two supernumerary directorate posts of the Electronic Health Record Office for three years;

(b) Legislative proposal to prohibit sex selection using reproductive technology; and

(c) Colorectal Cancer Screening Pilot Programme.

III. Measures for the prevention and control of Ebola virus disease and dengue fever
[LC Paper Nos. CB(2)242/14-15(03) to (06)]

3. Secretary for Food and Health ("SFH") briefed members on the Administration's latest measures for the prevention and control of Ebola virus disease ("EVD") and the Administration's measures for the prevention and control of dengue fever ("DF"), details of which were set out in the Administration's papers (LC Paper Nos. CB(2)242/14-15(03) and (04)).

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4. Members noted the background brief entitled "Prevention and control measures against Ebola virus disease" (LC Paper No. CB(2)242/14-15(05)) and the information note entitled "Dengue fever situation in Hong Kong" (LC Paper No. CB(2)242/14-15(06)) prepared by the Legislative Council ("LegCo") Secretariat.

Prevention and control of EVD

Port health measures

5. Mr Albert CHAN asked whether there was any rapid test for Ebola virus, and if so, whether consideration could be given to implementing random health check against inbound travellers from certain cities of the Mainland, such as Guangzhou, at the boundary control points ("BCPs"). He was concerned about the risk of imported cases of EVD given the increasing number of Africans working in or travelling to the Mainland and the long incubation period of EVD which ranged from two to 21 days.

6. SFH advised that there was no recommendation from the World Health Organization ("WHO") on conducting random health check against inbound visitors from or recently travelled to the EVD affected countries. At present, the Public Health Laboratory Services Branch of the Centre for Health Protection ("CHP") was capable of providing preliminary test results for EVD within three hours. In view of ongoing spread of EVD overseas, the Department of Health ("DH") had already implemented a series of port health measures. EVD-related health promotion messages were broadcasted at the Hong Kong International Airport ("the Airport") and other BCPs to alert inbound travellers about the disease. Arriving passengers at the Airport would be requested to complete a health surveillance questionnaire providing personal information, travel history, health status and contact history with EVD patients if they had travelled to the EVD affected countries in the past 21 days or were holding travel documents issued by the EVD-affected countries starting from 20 October 2014. This measure was extended to arriving cross-boundary passengers at the Hung Hom Control Point on the day of the meeting given that most visitors from Guangzhou would take Intercity Through Trains. DH would closely monitor the latest development concerning EVD and implement the measure at other BCPs if necessary.

7. Mr CHAN Han-pan asked whether the completion of the health surveillance questionnaire by the above visitors would be made mandatory. SFH explained that imposing mandatory health declaration for diseases that would give rise to stigmatization, such as EVD, might bring negative effect. To strike a proper balance, immigration officers at the Airport and Hung

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Hom Control Point would assist in identifying incoming passengers holding travel documents issued by the EVD-affected countries and invite them to the counters to fill in the health surveillance questionnaire, whereas visitors who had travelled to the affected countries in the past 21 days would be reminded to fill in the questionnaire through messages broadcast at the Airport and other BCPs.

8. Mr CHAN Han-pan was concerned about how the Administration could contact these travellers when necessary if they did not provide in the health surveillance questionnaire their contact information in Hong Kong. Mr WONG Kwok-hing asked whether the Administration would make reference to the practice of Guangzhou to provide mobile phones to inbound travellers from the EVD-affected countries to facilitate tracking down of the travellers concerned as and when necessary. SFH replied in the negative, adding that the Administration had already implemented a series of prevention and control measures to safeguard Hong Kong against EVD. In response to Dr Elizabeth QUAT's enquiry about whether there was any notification mechanism with the Mainland health authorities in place to enable timely notification of any suspected or confirmed cases identified in the two places, SFH replied that both places had been maintaining a close dialogue on infectious diseases.

9. Noting that WHO recommended conducting exit screening of all persons departing the EVD-affected countries, Mr Albert HO asked whether similar measure would be implemented in Hong Kong if there was a confirmed EVD case. SFH advised that exit screening should be conducted when there was evidence of local Ebola transmission in an area. In case an imported case of EVD was identified in Hong Kong, DH would conduct contact tracing and put contacts of the case under quarantine or medical surveillance.

Drills for concerted interdepartmental actions

10. Mr POON Siu-ping enquired about the number of interdepartmental drills held and planned to be held to test the preparedness of relevant departments for the prevention and control of EVD. Dr KWOK Ka-ki was concerned about whether table top exercises alone could ensure that frontline healthcare personnel were well-prepared to handle the EVD cases.

11. SFH advised that apart from the large-scale table top exercises which involved a number of bureaux and Government departments, other drills of smaller scale among DH, the Hospital Authority ("HA") and the concerned parties and stakeholders in close partnership had been held. Controller, CHP supplemented that a household disinfection exercise, an investigation and

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disinfection exercise conducted in a guesthouse setting, a table top exercise, as well as a ground movement session simulating the conveyance of a suspected EVD case by an ambulance of the Fire Services Department to the Accident and Emergency Department ("AED") of a public hospital and then to the Hospital Authority Infectious Disease Centre had been held in the last few months. Director (Quality and Safety), HA ("D(Q&S), HA") and Chief Infection Control Officer, HA advised that another drill to test the handling of suspected EVD patients at AED and clinical waste was under planning. In addition, efforts had been made by HA to ensure that the frontline medical, nursing and supporting staff of AED, isolation wards and medical wards of public hospitals, as well as those of the public general outpatient clinics, were well-prepared to handle suspected EVD cases.

Personal protective equipment for frontline HA staff

12. Dr KWOK Ka-ki was concerned about HA's provision of personal protective equipment ("PPE") for its frontline healthcare personnel. Dr Elizabeth QUAT asked whether HA had provided any training to its staff on the proper procedure for gowning and degowning PPE. D(Q&S), HA advised that HA had centrally co-ordinated PPE procurement to a 90-day PPE contingency stockpile for EVD. A dedicated intranet webpage on EVD was set up by HA to disseminate all relevant information on EVD, including infection control measures and the stockpile, use and standards of PPE for staff's access. Training on the sequence of removal of PPE had been and would continuously be provided to staff of HA.

Health education

13. Dr Elizabeth QUAT expressed concern that members of the public might not be aware of how to handle suspected EVD case. SFH advised that members of the public should call 999 immediately for arrangement of consultation in AED if they had developed EVD clinical symptoms. Targeting the local African community, CHP had visited guesthouses in relevant buildings to deliver health talks and briefings on the latest disease situation and the above message.

Prevention and control of DF

Local DF cases

14. Mr CHAN Han-pan expressed concern about whether there was a mutation of dengue virus, as the three recent DF local cases occurred in non-rainy season albeit that the Monthly Ovitrap Indexs for Aedes albopictus in 2014 were in general lowered than the average figure for the period of 2000

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to 2013. SFH responded that in view of the recent confirmation of three local cases of DF and the fact that the number of DF cases in neighbouring areas continued to stay at a high level, efforts had been and would continuously be made to strengthen the anti-mosquito work at the district level throughout this winter season.

15. Mr Albert HO enquired about the number of DF local cases which would warrant an area to be considered endemic of dengue infection. SFH advised that whether an area would be considered as endemic of dengue infection would depend on whether there was a continuous circulation of the virus resulting in the prevalence of local cases. Locally, apart from the last DF cluster recorded in September 2010, all DF cases in 2011, 2012 and 2013 were imported from endemic areas. Given that the three recent DF local cases in 2014 had revealed that there were Aedes albopictus infected with two distinct serotypes of dengue viruses at least in the two localities concerned, the Food and Environmental Hygiene Department ("FEHD") had strengthened mosquito prevention and control at the district level with a view to eliminating the current and future sources of infection and hence, preventing an outbreak of DF in Hong Kong. For all the notified cases, arrangement of patient isolation would be made to prevent secondary spread in case the patient was febrile.

16. Dr KWOK Ka-ki expressed concern about why it took ten days for the reporting of the second DF local case after the onset of symptoms. SFH explained that symptoms of the first infection of DF were usually mild. Hence, some patients might not seek medical consultation. Controller, CHP supplemented that the case concerned was not reported earlier as the symptoms developed by the patient were mild. It should also be noted that the patient concerned was not very clear about when the symptoms first developed.

Mosquito control work

17. Mr CHAN Han-pan was concerned about whether the cap added to cover the ovitraps, which were placed at selected locations for detecting the larval breeding rate of Aedine mosquitoes, in recent years to prevent tampering cases would affect their accuracy in detecting mosquito breeding. Pest Control Officer i/c, FEHD assured members that experience revealed that the adding of caps had not affected the effectiveness of ovitraps in detecting mosquito breeding.

18. Citing cases of serious mosquito bites in the public housing estates in the Kai Tak Development Area where many construction works were in progress as examples, Dr Helena WONG asked whether FEHD would

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conduct inspection and evaluate the effectiveness of the mosquito prevention and control work carried out by the management companies of the public housing estates. In particular, she was concerned about why ovitraps were not placed in the public areas nearby to monitor the situation of mosquito breeding in this more populated area. Noting that both patients of the first two recent local DF cases had been working at the same construction site, Mr POON Siu-ping asked whether FEHD would actively inspect the construction sites to detect whether there was any breeding of mosquitoes or it would only act upon complaints.

19. Mr Albert CHAN urged the Administration to make it mandatory that vent pipes of septic tanks for small village houses in the New Territories had to be covered with screen mesh to avoid causing mosquito problems in the areas concerned. Referring to the mosquito control work carried out by FEHD in Chung Mei Lo Uk Tsuen in Tsing Yi where the patient of the third local case lived, Miss Alice MAK held the view that maintaining good environmental hygiene, such as cleanliness of refuse stations and clearing of stagnant water to eliminate mosquito breeding grounds, was conducive to the prevention of DF in village houses.

20. Senior Superintendent (Cleansing and Pest Control), FEHD responded that the District Environmental Hygiene Offices of FEHD were responsible for, inter alia, the day-to-day mosquito preventive measures in public areas. They would also regularly inspect public housing estates and construction sites to ensure that good environmental hygiene measures were implemented properly. It would give technical advice to the parties responsible for managing the venues assisting them in carrying out mosquito prevention and control work in areas within their ambit. In case breeding of mosquito larvae or accumulation of water which might lead to mosquito breeding was found during inspection, FEHD would take appropriate enforcement action against the parties concerned. SFH added that the Development Bureau had disseminated advice on the importance of sustained anti-mosquito efforts at construction sites to their contacts in the local construction industry. The parties responsible for managing the construction site where the patients of the first two confirmed cases had worked had also agreed to strengthen their mosquito prevention and control work at the site concerned. As regards mosquito problems in specific areas and the clean-up of environmental hygiene black spots, SFH advised that the Administration would meet with the District Council committees regularly and follow up on comments and suggestions made. It would follow up the cases as referred to by members.

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Health Education

21. Miss Alice MAK suggested that the Administration should enhance publicity and health education territory-wide to raise public awareness about the threat posed by DF, in particular the need to take preventive measures of DF when travelling to neighbouring areas where the number of DF cases remained at a high level, such as Singapore.

22. SFH advised that he personally had taken every opportunity to encourage community actions to prevent vector-borne diseases, as well as reminding the public of the rapidly increasing DF cases in the Guangdong Province and Singapore. Members of the public could visit DH's Travel Health website for updated information and travel health advice on DF. The Administration was also considering the suggestions made by the District Councils on the need to renew the relevant Announcements in Public Interest ("API") and gear up the displaying of posters in this regard in the residential estates. Controller, CHP supplemented that to echo the World Health Day 2014 with the theme of vector-borne diseases, DH, together with about 50 partners including supporting organizations from health care and related sectors, and eight government departments or bureau, had launched a territory-wide publicity and public education campaign in April 2014. The enhanced publicity included, among others, newspaper and media interviews, animated videos and television and radio APIs.

IV. Expansion of Hong Kong Red Cross Blood Transfusion Service Headquarters

[LC Paper No. CB(2)242/14-15(07)]

23. The Chairman reminded members that in accordance with Rule 83A of the Rules of Procedures, they should disclose the nature of any direct or indirect pecuniary interests relating to this funding proposal before they spoke on the subject.

24. Members noted the Administration's proposal to expand the Hong Kong Red Cross Blood Transfusion Service Headquarters ("the BTS HQs"), details of which were set out in the Administration's paper (LC Paper No. CB(2)242/14-15(07)).

25. Mr CHAN Kin-por expressed support for the proposed expansion of the BTS HQs. Noting that HA had invited tenders for carrying out the proposed expansion works in October 2014 and the Administration's plan was to seek funding approval from the Finance Committee ("FC") in February 2015 with a view to commencing the construction works in March

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2015 for completion in July 2019, he asked whether the Administration had any contingency plan in case it could not seek the funding approval from FC as scheduled due to the use of filibuster by some Members to stall funding proposals submitted to FC. Expressing support for the proposal, Dr KWOK Ka-ki held the view that the Administration should change the order of the items of business to be included in the agenda of FC to give priority to those items which were important to people's livelihood, such as healthcare-related items.

26. Under Secretary for Food and Health ("USFH") stressed that the existing BTS HQs building was built 30 years ago in 1984. The services provided by the Hong Kong Red Cross Blood Transfusion Service ("BTS") had expanded in volume, scope and complexity over the years. Hence, there was a genuine need to take forward the proposed expansion of the BTS HQs which was aimed at providing adequate space to cope with its projected level of services, and ensuring a safe working environment. It was hoped that funding approval could be sought from FC as scheduled with Members' support. Consultant, Hong Kong Red Cross Blood Transfusion Service, HA supplemented that while efforts had been made by BTS to cope with its workload under the existing constraints of insufficient space and outdated design of the BTS HQs, it would not be able to meet with the projected increase in demand for blood collection in the coming years. Dr KWOK Ka-ki sought explanation for the reason why the projection of service demand was estimated based on the population of 2020 (viz. a projected population of 7.6 million) but not that of the year of 2044. Director (Cluster Services), HA ("D(CS), HA") responded that in view of the rapid development of medical technology in the use of blood and plasma products, an estimation on the service demand in the next decade would be more appropriate.

27. Dr KWOK Ka-ki noted that the public cord blood bank operated by BTS would be expanded after the redevelopment of the BTS HQs. Pointing out that there was an increase in the number of private umbilical cord blood storage providers in recent years which charged local parents a high storage fee, he asked whether consideration could be given to allowing members of the public to store umbilical cord blood at the redeveloped BTS HQs for private use.

28. Replying in the negative, D(CS), HA explained that the establishment of the public cord blood bank was aimed at assisting patients suffering from diseases who required stem cell transplantation as treatment, such as bone marrow disorders and leukaemia, to find unrelated matched haematopoietic stem cells. It was expected that the expanded public cord blood bank, which would store some 10 000 umbilical cord blood units, could provide matched

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umbilical cord blood units to about 95% of these patients. Dr KWOK Ka-ki urged the Administration and HA to step up publicity on the availability of a public cord blood bank for allogeneic stem cell transplantation.

29. In closing, the Chairman concluded that the Panel supported the submission of the proposal to the Public Works Subcommittee and FC for consideration.

V. Quality management of pathology reports in the Hospital Authority

[LC Paper Nos. CB(2)242/14-15(08) and (09)]

30. USFH and D(Q&S), HA briefed members on the system in place in HA for the quality management of pathology reports and the handling of a recent pathology report deviation incident at the United Christian Hospital ("UCH") ("the pathology report incident") respectively, details of which were set out in the Administration's paper (LC Paper No. CB(2)242/14-15(08)).

31. Members noted the information note entitled "Quality management of pathology report in the Hospital Authority" (LC Paper No. CB(2)242/14-15(09)) prepared by the LegCo Secretariat.

The UCH incident

Immediate actions taken by UCH

32. Mr Albert HO sought the reason about why the Independent Expert Panel ("the Expert Panel") was set up by UCH itself to investigate the pathology report incident. D(Q&S), HA advised that while the Expert Panel was set up by UCH, its composition was subject to approval by HA Head Office. The Expert Panel comprised, among others, a senior pathologist in the Princess Margaret Hospital, the President of the Hong Kong College of Pathologists ("HKCP") and a member of the Quality Assurance Subcommittee of HA's Coordinating Committee in Pathology, with the latter two experts belonging to the University of Hong Kong and the Prince of Wales Hospital respectively.

33. In response to Mr Albert HO's enquiry about the follow-up actions taken by HA on the affected patients, D(Q&S), HA advised that the Department of Pathology of UCH had proactively reviewed all of the 2 153 pathology reports issued independently by the pathologist concerned upon discovery of the issue in late May 2014. The review, completed on 7 August 2014, had identified 118 cases (or 5.5% of the reports under review)

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requiring revisions. Among these reports, 17 of them (or 0.8% of the reports under review) were found to be having significant discrepancies requiring changes in treatment plans. The patients concerned were contacted for their revised treatment plans and follow-up appointments as appropriate prior to the open disclosure of the pathology report incident.

Human resources proceedings

34. Mr Albert HO noted the findings of the Expert Panel that the occurrence of the pathology report incident was mainly due to personal performance issue involving the lapses of sustained vigilance in a task that required high level of attentiveness. He asked whether the Expert Panel had ruled out the possibility that the pathologist concerned did not have the capability and experience required in analyzing the relevant tissues, cells and body fluid samples, and if so, whether the lapse of sustained vigilance of that pathologist was caused by system factors, such as heavy workload, or personal problems. Holding the view that the resources allocated to the Kowloon East Cluster was comparatively less than other hospital clusters, Dr KWOK Ka-ki sought information about the establishment and the actual strength of pathologists of the pathologist departments of UCH and other public hospitals.

35. USFH responded that the discrepancies found in the pathology reports concerned were not generally considered difficult by pathologists and the majority of the discrepancies would not have been made by a vigilant pathologist. The monthly caseload of the pathologist concerned was on par with that of other pathologists in UCH and other public hospitals, which stood at 250 to 300 cases per pathologist on average. During the period concerned, the Department of Pathology of UCH had nine doctors, and seven of them were Fellows of HKCP and the Hong Kong Academy of Medicine ("HKAM"). The Expert Panel had concluded that workload did not contribute to this incident. USFH agreed to provide the information requested by Dr KWOK Ka-ki after the meeting. Dr LEUNG Ka-lau said that to his understanding, most pathologists in HA considered the existing level of workload consistently high. Hence, it was understandable that a pathologist would have difficulty to cope with the workload when there was a change in one's physical conditions. D(Q&S), HA advised that working environment and the health status of the staff concerned were two of the various factors HA would take into account in the human resources proceedings.

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36. Mr Albert HO held the view that it was likely that the performance of the pathologist concerned constituted professional misconduct. Holding the view that HA should refer cases concerning professional conduct of its doctors involved in sentinel events to the Medical Council of Hong Kong

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("MCHK") for disciplinary inquiry, Miss Alice MAK asked whether HA had been doing so.

37. D(Q&S), HA advised that for each sentinel event reported to HA Head Office, the issue of whether there was a case of possible professional misconduct of the doctor concerned and the need to provide the relevant information to MCHK for investigation would be considered under HA's human resources proceedings. He, however, stressed that many medical incidents were caused by system rather than human factors, and only those acts which had fallen short of the standards expected among members of the profession would be regarded as misconduct in a professional respect. A meeting between HA and MCHK had recently been held to exchange views on the handling of cases concerning possible professional misconduct of doctors employed by HA. At the request of Miss Alice MAK, D(Q&S), HA undertook to provide after the meeting information on the number of disciplinary actions taken by HA against its doctors arising from sentinel events reported to HA Head Office in the past five years, and among these doctors, the number of those who were referred to MCHK for investigation as to whether or not a disciplinary inquiry should be conducted.

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Clinical standards for quality of pathology reports

38. Noting that only 5.5% (i.e. 118 cases) of the 2 153 pathology reports issued by the pathologist involved in the pathology report incident required revisions and among these reports, only two cases required significant revisions in treatment plans of, but without leading to irreversible damage to, the patients concerned, Dr LEUNG Ka-lau opined that the performance of the pathology concerned should not be considered as far below standard. He asked about the yardstick for measuring whether the quality of pathology reports had met the clinical standards.

39. D(Q&S), HA advised that the management of medical incidents was not focused on whether or not there was irreversible damage to the patients concerned. A report revision rate of 5.5% was considered not common for pathologists who had attained Fellowship and accreditation by HKCP and HKAM and in practice, could issue pathology reports independently. As mentioned earlier at the meeting, for the pathology report incident, the cases with discrepancies in the pathology reports were not generally considered difficult by pathologists and the majority of the discrepancies would not have been made by a vigilant pathologist. A case in point was the failure to diagnose Helicobacter pylori in the specimen from the stomach of a patient suffering from gastric ulcer. Dr LEUNG Ka-lau held the view that whether or not there was irreversible damage to the patients concerned should be a factor to be taken into account by HA when determining the seriousness of a

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medical incident. Making reference to a medical incident in Queen Mary Hospital in 2013 whereby the doctors concerned had failed to note the blood type incompatibility between the donor and recipient of heart transplant, he cast doubt on the appropriateness for HA to jump to the conclusion that the vigilance of the pathologist involved in the pathology report incident was not high.

[At this juncture, the Chairman informed members of his decision to extend the meeting for 15 minutes beyond its appointed time to allow more time for discussion of this item.]

40. Mr CHAN Han-pan held another view. He considered it important for pathology reports to be accurate as they had a direct bearing on the diagnosis of clinicians and hence patient safety. Given that an inaccurate pathology report might result in a different treatment plan developed to address the particular condition of a patient, Dr Helena WONG held the view that a 5.5% revision rate was unacceptably high. She asked whether improvement measures would be implemented in all public hospitals with pathology departments or laboratories with a view to attaining "zero error" in future. USFH advised that the improvement measures implemented by UCH after the pathology report incident included, among others, implementing a mentoring system for trainees, enhancing the case meeting mechanism between pathology and other clinical departments to review and discuss cases regularly, and strengthening the incident reporting mechanism. Dr LEUNG Ka-lau remarked that while all pathologists should pay every effort to minimize errors and report accurately, HA should manage the expectation of members of the public as it was unrealistic to expect "zero error" in any healthcare practices. Mr Albert HO said that notwithstanding that different doctors might have different clinical judgments about the best treatment for a patient, judgments which had fallen short of the standards expected among members of the profession were professional misconduct.

Internal clinical audits

41. Dr KWOK Ka-ki noted that at present, pathology departments in HA would randomly select 1% of pathology reports in histopathology service for internal clinical audit, irrespective of the years of experience of the pathologists concerned. He held the view that reports issued independently by those pathologists having less than three years of experience since their attainment of Fellowship and accreditation by HKCP and HKAM, as well as those reports concerning diagnosis of brain cancer and leukaemia should be subject to a higher percentage of random audit or cross checking by another experienced pathologist.

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42. USFH responded that the existing percentage of audit check on pathology reports in histopathology service of HA was on par with the international standard. In addition, clinical auditing would be performed for all high risk or complex cases. It was during the regular internal clinical audit that the Department of Pathology of UCH discovered three incorrect pathology reports with potential clinical impacts issued by the pathology involved in the pathology report incident. D(Q&S), HA supplemented that the six-year specialist training for pathologists was divided into two phases, i.e. an initial phase of basic training of not less than three years, followed by another phase of higher training. While trainees who had just completed the higher training and satisfied the requirements of the exit assessment for becoming a Fellow of HKCP and HKAM (which carried full formal recognition of specialist status in Hong Kong) could, in principle, issue pathology reports independently, the existing practice of HA was to assign them with the more straight-forward and less complex cases. That said, he agreed to relay Dr KWOK Ka-ki's suggestion of introducing a higher percentage of audit check for reports issued by pathologists of less experience to HA's Coordinating Committee in Pathology for consideration.

43. Dr KWOK Ka-ki sought clarification about the media reports that the percentage of pathology reports in histopathology service subject to audit was 5%, rather than 1%, in some public hospitals. Mr CHAN Han-pan raised a similar concern. Consultant (Chemical Pathology), Prince of Wales Hospital, HA advised that the requirement of 1% audit check was adopted by the College of American Pathologists, the Hong Kong Accreditation Service and the National Association of Testing Authorities, Australia, which were the accrediting authorities providing independent assurance of operational standards and technical competence of the anatomical pathology laboratories in HA. This was applied across the board to all anatomical pathology laboratories in HA, which had been accredited for medical testing. He explained that given that all high risk or complex cases, such as frozen section and renal biopsy, would be audited, the actual average rate of clinical audit in some public hospitals would be higher, say, at the level of 5% in some public hospitals.

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44. Mr Albert HO requested the Administration to provide after the meeting written information on the existing mechanism adopted by HA to ensure accuracy of forensic pathology reports and the percentage of audit check on pathology reports issued under the forensic pathology service of the Department of Health.

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Mentoring system

45. Dr KWOK Ka-ki enquired how the mentoring system implemented by HA could enhance patient safety and prevent the recurrence of the pathology report incident. Miss Alice MAK raised a similar question. Cluster Service Director (Quality and Safety), Kowloon East Cluster/Deputising Hospital Chief Executive, Haven of Hope Hospital, HA advised that under the mentoring system, mentors who were senior pathologists in HA would closely supervise and assist, on a one-to-one basis, the trainees throughout the six-year specialist training programme which included rotational training. The stable and close relationship afforded by the mentoring system would enable an earlier and better identification of the strengths, weakness and special training needs of the trainees. Mr CHAN Han-pan asked whether there was adequate number of senior pathologists to underpin the mentoring system. D(Q&S), HA replied in the affirmative.

46. There being no other business, the meeting ended at 6:45 pm.

Council Business Division 2
Legislative Council Secretariat
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