立法會
Legislative Council

LC Paper No. CB(2)242/14-15(09)

Ref : CB2/PL/HS

Panel on Health Services

Information note prepared by the Legislative Council Secretariat for the meeting on 17 November 2014

Quality management of pathology report in the Hospital Authority

The subject of quality management of pathology report in the Hospital Authority ("HA") has not been discussed by the Panel on Health Services ("the Panel"). On 11 August 2014, the United Christian Hospital ("UCH") announced an incident of pathology report deviations, whereby 118 out of the 2 153 pathology reports issued independently by a pathologist during the period from October 2013 to May 2014 were found to require content revision. Among these 118 reports, 17 of them were misdiagnosis, leading to minor adjustment of treatment plans for 15 patients and significant revision in treatment plan for two patients. The incident has aroused wide public concern over the quality management of pathology report in public hospitals.

2. According to HA, an independent expert panel was appointed by UCH to investigate the incident and make recommendations on improvement measures. In its report submitted to the HA Head Office and UCH, the expert panel concluded that the discrepancies found in the 118 pathology reports mainly included false-negative misdiagnosis and contained inadequate or incorrect information. These discrepancies were largely due to lapses of sustained vigilance. Hence, the occurrence of the incident was mainly due to personal performance issue. The expert panel agreed that UCH had implemented timely follow-up actions to the 17 patients that required change in clinical management plan after public disclosure of the incident. The expert panel also agreed that the causes of death of the seven cases among the other 101 cases requiring revisions in the pathology reports were all due to their serious underlying diseases, and were not related to any erroneous diagnosis in the reports. While

recognizing the effort made by the pathology department of UCH from late May to early August 2014 to review all the 2 153 pathology reports issued independently by the pathologist concerned and take follow-up actions such as informing clinicians to revise the relevant clinical management plans, the expert panel was of the view that the reporting of the incident to the hospital management should not have delayed until the end of the review process.

3. To enhance patient safety and prevent recurrence of similar incident in future, the expert panel has made the following recommendations -

(a) an appropriate system should be enforced to monitor the performance of trainees; targeted coaching and training should be given to trainees with track record of unstable performance; the utmost importance of sustained vigilance should be emphasized to every trainee via various channels;

(b) communication between hospital management and the pathology department should be enhanced to improve the effectiveness of incident management; and

(c) a clear reporting line and review mechanism should be developed to strengthen coordination among departments involved and to enhance the efficiency of incident management process, particularly for incident that may have major impact on patient care.

4. According to HA, UCH has accepted the above findings and recommendations, as well as has taken the following measures -

(a) the pathology department has decided to cease the pathologist concerned from issuing report independently; the department will arrange a senior pathologist to closely supervise the concerned pathologist and provide remedial trainings for the concerned pathologist;

(b) the pathology department has implemented a mentoring system, under which every trainee in the department will be assigned with a senior pathologist "mentor" who will provide one-on-one coaching and assistance to the trainee;

(c) the pathology department will enhance case meeting mechanism with other clinical departments to review and discuss cases regularly;

(d) the Kowloon East Cluster will introduce the "Crew Resource Management" training by end of 2014; and

(e) the hospital management will strengthen incident reporting mechanism to ensure the efficiency information management when incident is reported in future.

5. The press releases concerning the incident and the investigation issued by UCH on 11 and 21 August, and 8 October 2014 are in **Appendices I, II and III** respectively. The relevant media reports are in **Appendix IV** for members' reference.

Council Business Division 2
Legislative Council Secretariat
11 November 2014

Appendix I

基督教聯合醫院
UNITED CHRISTIAN HOSPITAL
香港九龍觀塘協和街一百三十號
130 Hip Wo Street, Kwun Tong, Hong Kong

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圖文傳真： 29496400

(Press Release)

Monday, 11 August 2014

Attention News Editor:

Regarding a rare incident of pathology report deviations, the spokesperson of the United Christian Hospital (UCH) today (11 August) made the following announcement:

During a Pathology Department internal meeting held in late May for routine review of pathology reports, three pathology reports issued by the same pathologist were found to be inaccurate. The Pathology Department found the incident rare and decided to proactively review all pathology reports issued independently by the pathologist from October 2013 to May 2014. The Department also suspended the pathologist's duty to issue report independently since then.

The department completed the review of a total of 2,153 pathology reports last week, among which 118 of them were found to require content revision. Among the reports which required revisions, 17 of them concerned misdiagnosis, leading to minor adjustment of treatment plans for 15 patients and significant revision in treatment plan for two patients.

The UCH is in the process of contacting the 17 affected patients and will advance their medical appointments and examinations required as early as possible. Case doctors will explain the incident and the revised treatment plan in details to the patients affected. The doctors, together with the Patient Relations Office, will render all necessary assistance and support to the patients such as advancing their medical and examination appointments. The 17 affected patients are from various specialties including Surgery, Obstetrics & Gynecology and Medicine. The Hospital has set up an enquiry hotline 3949-7994.

The UCH reported the incident to the Hospital Authority Head Office (HAHO) last week. An independent investigation panel will be established to look into the incident. The investigation report with recommendations on improvement measures will be completed and submitted to HAHO within eight weeks.

The pathologist concerned is now on leave. The UCH will consider appropriate follow up action if needed in accordance with HA's prevailing human resources policy after the investigation. The UCH would like to express sincere apology to all patients and their families affected by the incident.

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Media enquiry: 39494000

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(Press Release)

Thursday, 21 August 2014

Attention News Editors:

Regarding a pathology report incident announced earlier, the spokesperson of the United Christian Hospital (UCH) announced the following update today (21 August):

Following the announcement made on 11 August, the UCH had conducted a thorough check of the concerned 118 pathology reports against the patients' medical records again. In addition to the three death cases previously announced, another four cases of death were identified. There was no pathology diagnostic error in the four reports, only minor adjustments had been made. There was also no change in the treatment plan for the four patients. The death of these patients had no relation to the revision of the pathology reports.

The independent investigation panel set up for the incident will complete the investigation and make recommendations in the report to be submitted to the Hospital Authority Head Office within eight weeks.

The UCH Patient Relations Team will continue to provide assistance to the patients concerned. The enquiry hotline (Tel: 3949 7994) will continue to operate to answer patients queries.

The UCH expresses sincere apology to all patients and relatives concerned again.

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Media Enquiry: 7371 5172

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(Press Release)

Wednesday, 8 October 2014

United Christian Hospital announces investigation report of a pathology report incident

The spokesperson of United Christian Hospital (UCH) today (8 October) made the following announcement on the investigation report of a pathology report deviation incident.

The independent expert panel was appointed by UCH after the announcement of an incident relating to pathology report deviation on 11 August. The expert panel has completed the investigation with a number of recommendations on improvement measures. The report has also been submitted to the Hospital Authority (HA) Head Office and UCH. The UCH has accepted the recommendations made by the panel and implemented a number of improvement measures immediately to enhance patient safety and to prevent recurrence of similar incident in future.

The independent expert panel, comprising pathology experts, has interviewed all concerned staff and reviewed all pathology reports with deviations and relevant pathology slides in the past eight weeks, the spokesperson remarked. The panel has also reviewed thoroughly all relevant materials such as duty arrangement, workflow procedure and quality assurance mechanism of the pathology department.

During a pathology department internal meeting held in late May for routine review of pathology reports, three reports issued by the same pathologist were found to be inaccurate. The pathology department decided to proactively review all 2,153 pathology reports issued independently by the pathologist concerned since October 2013. The department has identified 118 reports requiring content revision in early August. Among the reports which required revisions, 17 of them were misdiagnosis, leading to minor adjustment of treatment plans for 15 patients and significant revision in treatment plan for two patients.

The spokesperson said, “the investigation report pointed out that making pathological diagnosis requires high level of attentiveness. The occurrence of the incident was mainly due to personal performance issue. The discrepancies made in the pathology reports were largely due to lapses of sustained vigilance. The investigation report suggested the department should keep the pathologist concerned to work under close supervision of senior pathologist, while no independent reporting should be allowed. The pathology department should arrange remedial trainings with focus on areas of weakness for the concerned pathologist.”

The investigation has considered other information provided by the department such as workload, work allocation and duty arrangement of specific doctors and found that they are not contributory to the incident. The investigation confirmed that the UCH’s proactive measure to review all pathology reports issued by the pathologist concerned was valid and justified, while proving the effectiveness of the department’s quality management measure in identifying this incident.

Besides, the panel agreed that UCH has implemented timely follow-up actions to the 17 patients that require change in clinical management plan after open disclosure of the incident. The panel also agreed the causes of death of the seven cases identified were all due to their serious underlying diseases, and were unrelated to any erroneous diagnosis in the pathology reports.

In analysing the 118 reports with deviations, it is evident to the panel that no false-positive misdiagnosis was found. No patient thus had received unnecessary treatment. The panel concluded that the discrepancies found in the 118 reports mainly included false-negative misdiagnosis and contained inadequate or incorrect information.

The panel noted that it was a major undertaking for the department to review 2,135 pathology reports. A lot of follow up action was needed such as to inform clinicians to revise clinical management plan. However, the panel opined that the reporting of the incident to the hospital management should not have delayed until the end of the review process.

The investigation panel has made the following recommendations:

- An appropriate system should be enforced to monitor the performance of trainees; targeted coaching and training should be given to trainees with track record of unstable performance; the utmost importance of sustained vigilance should be emphasised to every trainee via various channels

- Communication between hospital management and the pathology department should be enhanced to improve the effectiveness of incident management

- A clear reporting line and review mechanism should be developed to strengthen coordination among departments involved and to enhance the efficiency of incident management process, particularly for incident that may have major impact on patient care

The spokesperson said that UCH has accepted the findings and recommendations made in the investigation report. The UCH has taken a number of immediate measures to enhance patient safety and to prevent recurrence of similar incident again. The measures are as follows:

- The pathology department has decided to cease the pathologist concerned from issuing report independently; the department will arrange a senior pathologist to closely supervise the concerned pathologist; remedial trainings, with focus on areas of weakness, will be arranged for the concerned pathologist to enhance quality of diagnosis

- The pathology department has implemented a mentoring system. Every trainee in the department will be assigned with a senior pathologist "mentor", who will provide one-on-one coaching and assistance to the trainee. When trainees come across difficulties at work or in training, support can be given promptly

- The pathology department will enhance case meeting mechanism with other clinical departments to review and discuss cases regularly

- The Kowloon East Cluster (KEC) will introduce the "Crew Resource Management" training by end of 2014 to enhance quality

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圖文傳真：

- The hospital management will strengthen incident reporting mechanism to ensure the efficiency information management when incident is reported in future

The spokesperson said that with reference to the investigation report, the UCH will commence human resources proceedings in accordance with prevailing HA policy. The UCH also expresses deep apology to all patients affected again and has already offered all necessary examination and treatment to the 17 patients requiring clinical management plan adjustment. The UCH will continue to follow the conditions of all patients affected. The UCH would like to express heartfelt appreciation to the chairman and members of the panel for their effort contributed during the investigation.

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Media enquiry: 7371 5172

文章總數: 1 篇

1 .信報財經新聞 | 2014-08-12
報章 | A17 | 獨眼香江 | 獨眼香江 | By 紀曉風

聯合醫院逾百報告出錯 睇漏癌細胞

聯合醫院昨天公布嚴重的病理報告出錯事故，一名病理科女醫生竟然於去年10月至今年5月期間，錯誤分析118名病人的病理報告，當中17份有明顯錯誤，包括「睇漏」2名女病人可能有癌細胞，因而未能及時作出適當治療；另外有3名病人死亡，但院方強調跟病理報告出錯無直接關係，並已成立委員會跟進調查。

有病理學教授坦言，在2000多個病理報告中，竟有100多個出錯，比率之高實屬罕有，令人難以接受，因病理科醫生被譽為「醫生的醫生」，其判斷直接影響臨床醫生對病人的診斷和治療。有病人組織認為，當局要檢討現行抽查病理報告的密度和比例。

涉事的病理科女醫生，由去年10月至今年5月期間，共簽發了2153份病理報告，當中有118份報告有偏差，其中17份有明顯錯誤，涉及8名外科、5名婦科及4名內科病人，當中2名女病人更因此要跟進修改治療方案。

連串錯漏女醫生正休假

九龍東醫院聯網總監徐德義表示，已就事件向病人及家屬致歉，並向醫管局上報事件，成立委員會調查事故原因，預料8星期內完成。

徐德義強調事件中沒有病人接受不必要的治療程序。醫院病理部顧問醫生梁松英承認，今次事件涉及同一醫生連串的出錯，包括很多遺漏，是不可接受。

梁松英指出，該部門在5月底的工作會議中，發現有3 份病理報告出現偏差，並由同一名醫生簽發，院方遂覆核該名醫生簽發的所有報告，由4 位資深病理科醫生逐一詳細覆檢，當發現問題嚴重性後，便即時停止該醫生的簽發工作。目前該女醫生正在休假中，直至11月初。

徐德義強調，今次是在恆常抽查機制下揭發事件，該院每年有1.9萬份病理報告，院方定期隨機抽查10%進行覆檢，但他拒絕回應該醫生是否經驗不足或工作量過多。徐德義指出，該醫生經過6年病理專科訓練，去年9月獲得病理學院士資格，10月才開始獨立簽發病理報告。

嚴重出錯的兩份病理報告，其中一份涉及一名外科女病人。聯合外科部主管周譚連指出，該名女病人因乳房有硬塊而入院，經切除並進行組織化驗，病理報告指為纖維瘤，但院方覆檢後發現纖維瘤周邊有少量低等級的原位癌細胞，遂立即安排病人接受乳房造影檢查，訂出下一步治療方案。周譚連表示，原位癌細胞一般要5至6年才變成癌症，故有信心目前給予病人適當治療，可完全控制病情。

難評論是否構成延醫

另一份報告涉及一名婦產科女病人，她去年11月因經期不定和不規則出血入院，其後發現有子宮內

膜瘜肉；經化驗後，病理報告指她患慢性子宮內膜炎，但院方覆檢後，上月發現病人有子宮內膜異常增生，病人昨晨覆診，並作抹片檢查，同意於9月接受微創手術切除整個子宮。

聯合婦產科主管杜榮基表示，病人若長時間無適當治療，一般有5%至10%機會惡化，但暫時未發現該病人有惡化迹象，有信心現時給予適合治療，可將影響減至最低。

婦產科專科醫生靳嘉仁表示，子宮內膜異常增生情況有複雜與簡單之分，複雜的有機會變子宮內膜癌，簡單的服藥已可治療，故難以評論病理報告出錯是否構成延醫問題。另一婦產科專科醫生梁國齡指出，前線醫生倚賴病理報告，但有責任的醫生亦會引證報告，覆核所有事情，與病理科醫生溝通後，才決定治療方案。梁國齡認為，病理報告有偏差，不一定對病人造成影響。

港大病理學系講座教授及系主任吳呂愛蓮認為，今次事件極為罕有。以瑪麗醫院為例，每月有約2800個病理報告，即每年有3萬多個；她認為，若在幾千至幾萬個報告中，有一至兩個出錯是可以接受，但在1000 至2000 個報告中有百多個出錯，就難令人接受，因病理報告影響主診醫生對病人的診斷，不容出錯。

病人組織籲加密抽查

關注病人權益的社區組織協會幹事彭鴻昌認為，病理報告涉及內容極為專業，病人難參與討論，只能完全信賴醫生，若醫生的分析出錯，對病人影響極大，認為當局要檢討抽查報告的密度，並提升抽查比例。

紀曉風

文章編號: 201408125306049

文章總數: 1 篇

1 .明報 | 2014-08-12
報章 | A01 | 要聞

病理科醫生報告 不需審批易錯漏

聯合醫院病理部一年處理1.9 萬份病理報告，透過抽查1%報告的恆常檢測，發現3個報告有偏差，從而揭發有新晉專科醫生錯漏百出事件。有病理科專科醫生解釋，1%恆常檢測屬國際認證標準，每月隨機抽查，再由其他醫生輪流審批。不過，據悉，不是每間公立醫院都採用抽查制度，一名公院病理科醫生稱，醫生取得獨立寫報告資格後，一般也是靠個人判斷，主管不會主動要求呈交報告，易有錯漏。

恆常1%抽查非每間跟足聯合醫院病理部顧問醫生梁松英表示，該院每年分12次隨機抽取1%病理部的已完成報告來覆核，評估部門工作水平。過去數年，亦有額外在未能獨立簽發報告的醫生病理報告中抽取10%覆核，若無發現明顯錯誤，才會向該醫生批出專科資格。

香港病理學專科學院院長張雅賢說， 大部分公立醫院，都有沿用每年抽查1%病理報告的恆常檢測，多數用在活檢報告檢測，做法是每月由沒參與診斷的化驗室職員隨機抽查，過程間會隱去負責寫報告的醫生姓名，再由有獨立寫報告資格的醫生審批。相信今次是因審批醫生在某次抽查發現涉事醫生的報告出錯率高，才另行查閱該醫生其他報告。

公院病理醫：判斷靠經驗有「龍頭」公立醫院的病理科醫生表示，取得專科資格的病理科醫生可獨立寫報告，其他較高級醫生不會要求審批，因此判斷是否正確靠醫生的個人經驗，若遇到「疑難雜症」，部門主管會不定期召開「龍頭會議」，由幾名可獨立寫報告的醫生共同「睇鏡」判斷病情，但只屬自願性質，承認易有錯漏。據他了解，醫管局沒有明文指引規定用什麼方法審批病理科報告。

本報曾詢問醫管局有關其他公立醫院的病理報告覆核制度，至截稿未有回覆。

文章編號: 201408120040003

文章總數: 1 篇

1 .香港經濟日報 | 2014-08-12
報章 | A22 | 港聞 | By 楊玉珠

威院複檢率逾5% 聯院僅1%

聯合醫院病理科專科醫生過百份報告出錯，聯院昨指每年抽查1%報告複檢；但威爾斯醫院普通症如良性腫瘤，複檢比率亦達5%至10%。

考試嚴謹 英澳專家審核

對於已考取病理學專科資格的醫生卻嚴重出錯，被質疑水平欠佳，香港病理學專科學院院長張雅賢昨形容，這次是個別事件，猶如考取駕駛執照，但依然有醉駕、藥駕。張又澄清，病理學考試制度嚴謹，要完成6年培訓，以及完成筆試、臨床技巧、解剖及口試4個各有兩部分的考試，而每個考試除有本港來自不同部門包括醫管局、衛生署和私人執業的病理學資深專科醫生參與審核外，亦包括來自英國和澳洲皇家學院病理學院的專家。

張說，本港病理學都有認證制度，每個醫院或單位每月要隨機抽取1%的報告了解是否有問題，其他如冰凍切片、胃活檢等則複檢比率要求更高。

威院腎臟複檢 達百分百

中大醫學院病理解剖及細胞學系系主任杜家輝則指，威院對複檢的比率，就算一般如良性腫瘤及普通病理，亦達5%至10%，而冰凍切片或腎臟複檢則要達百分百，而不少都要與不同科的主診醫生會診，複檢報告。

中大醫學院上消化道外科主任吳國偉和威院婦產科部門主管張德康均指，病理報告正確對跟進治療十分重要，影響下一步的治療和正確處方藥物，但主診醫生如發覺報告和臨床診斷有很大矛盾，會要求病理部再複檢。

文章編號: 201408125316165

文章總數: 1 篇

1 .大公報 | 2014-08-12
報章 | A01 | 新聞

醫生團體指監管現漏洞

【大公報訊】記者張婕舒報道：有前線公立醫院醫生認為，今次事故超出合理範圍，反映整體醫療系統監管機制出現問題。對於成績平平的專科新畢業生，醫院卻無硬性規定由資深醫生監督。而且公院醫生工作量超出國外10倍之多，重壓之下醫療質量亦難保證。有病人權益組織代表亦認為，今次事件可能是醫生工作量過大所致。

前線醫生聯盟副主席蕭旭亮昨日接受本報訪問時表示，今次事件的出錯數量明顯超出合理範圍，不僅是該名醫生的問題，亦凸顯本港公立醫療系統監管出現漏洞。對於剛剛獲取專業病理學資格的醫生，可能在校期間成績「麻麻」，剛好過線通過考試，但醫院管理局卻無法定機制審核他們的工作，內部缺乏標準化制度規範。

蕭旭亮又指，本港公院醫生的工作負荷較英國等先進國家多出近10倍，在超負荷工作下，醫生難以確保質量。社區組織協會病人權益幹事彭鴻昌也指出，今次事件可能是醫生工作量過大所致，「醫生面對的工作量非常龐大，工作卻似乎缺乏背後的支援，管理層亦有可能忽略了他們的工作壓力，當他們發聲要求增撥資源時亦鮮受理會」。

公院首季爆14事故

另外，公立醫院近年事故頻生。根據醫管局上月發布的最新《風險通報》，公院今年首季至少發生14宗嚴重醫療事故，較去年第四季增加三宗。近月事故亦比比皆是，包括於本月初，伊利沙伯醫院涉開重藥，令一名患有心臟功能衰竭的男病人死亡。事實上，今次發生嚴重醫療事故的主角聯合醫院於今年初就有劣跡，一名女病患疑被錯誤處方長期類固醇，最終離世。

聯院於年初公布一宗嚴重醫療事故，涉及一名患有末期腎衰竭等長期病患的66歲女病人。該病人去年10月因支氣管炎入院，4日後出院並獲處方6日類固醇藥，療程完結後覆診，再獲發3個月類固醇藥。病人服藥至今年1月初，因為嚴重肺炎入院，住院11天後，於月中因急性心臟衰竭在醫院離世。醫管局相信，病人被錯誤處方長期類固醇。

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文章總數: 1 篇

1 .香港經濟日報 | 2014-08-13
報章 | A20 | 港聞

醫委倡有經驗病理醫生 監察新手

【本報訊】一名聯合醫院病理科醫生被揭處理118份報告時，分析出錯。

病理學專科學院院長張雅賢認為事件罕見，但指現行資格考核、醫院複檢制度均沒有問題；惟醫務委員會主席劉允怡則建議檢討制度，加入有經驗醫生監察「新手」。

聯院出錯 專家指罕見

醫生需經過6年病理科培訓，接受兩次考試，再通過海外及香港專家批准，才可以得到院士資格。負責考核資格的病理學專科學院院長張雅賢形容，聯院報告出錯事件罕見、特殊，強調考核嚴格。

對於聯院女醫生不但把惡性腫瘤當作良性，她還把死胎組織當作受賀爾蒙影響的子宮內膜變化，張認為即使未取得專科資格，只是初訓練的病理醫生，都不會犯這個錯誤，認為與培訓、考核制度無關。

她又認為聯合醫院複查個案的比例為1%，做法合理，與外國一樣。至於是否要增加人手來覆核，她表示要交由社會討論。

「有必要檢討制度」

不過，劉允怡則認為有必要檢討整個制度，指一般醫生接受培訓並通過考試，才能轉任病理科醫生，故可以考慮像考車牌制度般，醫生獲發牌一段時間後，要由有經驗的病理科醫生一齊出報告。

他又認為要調查出錯原因，例如醫生是否受家庭、精神等因素影響判斷。

聯合醫院病理部顧問醫生梁松英說，該醫生出錯比例「異常地高」，透露事故後院方已增加覆核報告的數量，醫生在具獨立簽發資格的一年內，會被複查其10%的報告；至於整體病理報告每年抽查1%報告的做法，他認為符合本港要求。

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文章總數: 1 篇

1 .東方日報 | 2014-08-13
報章 | A20 | 港聞

醫委會倡轉介跟進公院庸醫

聯合醫院女醫生八個月內寫錯一百一十八份病理報告事件，震驚醫學界。監管醫生專業水平的醫務委員會主席劉允怡昨明言，不論醫生來自公或私營醫療機構，若犯錯涉及嚴重過失，顯示醫療水準未達標，醫委會一律公正審訊。醫院管理局過往以病人私隱為由，甚少轉介個案予醫委會聆訊。劉允怡表示，將約見醫管局主席梁智仁討論設轉介制度，由醫委會跟進「離譜醫生」個案。

公立醫院不時發生醫療事故，醫管局甚少轉介事故予醫委會跟進。

劉允怡昨表示，高度關注聯合醫院病理專科女醫生「寫錯報告」事故。劉在一○年出任醫委會初級偵訊委員會主席時，已發現醫管局公布醫療事故多，但主動轉介醫委會跟進的個案卻少：「有時一年都無一宗，唔信一宗醫生失德都無。」

醫管局公眾投訴委員會處理個案

醫管局私隱為由拒交資料

醫委會曾去信倡醫管局改善，對方以病人私隱作回應。劉認為，不論醫生來自公立或私家醫院，若犯錯涉及嚴重過失，顯示醫療水準未達標，未盡醫生應有職務，例如「冇做扮有做」、「無睇到扮有睇到」，應受懲處。劉將約見梁智仁討論設轉介制度跟進「離譜醫生」個案，若不成事，或循法律途徑釐清醫管局是否可拒交資料。

曾任職公立醫院的醫委會成員佘達明認為，聯合醫院涉事女醫生犯下明顯專業失德，醫管局應將個案轉交醫委會跟進。另一醫委會成員謝鴻興稱，醫生《專業守則》中「醫學倫理國際守則」，列明「遇有不道德行醫、能力低劣的醫生，應向適當主管當局舉報」，故若有醫院發現醫生醫術不濟，應轉介醫委會跟進。

專科考核制度或需要檢討

劉認為，醫生接受專科培訓及通過專科考試仍然出錯，有需要檢討專科考核制度。院方要調查涉事醫生背景，例如有否受家庭、精神等因素影響專業判斷。

社區組織協會幹事彭鴻昌同意為保障病人安全，所有醫療機構發現醫生懷疑專業失德，機構有責任主動向醫委會舉報。醫管局以病人私隱為由拒絕轉介，個人資料私隱專員公署應跟進。

聯合醫院病理部顧問醫生梁松英承認，涉事醫生出錯比例「異常地高」，決定提升覆核報告的數量。由一般抽百分之一的報告覆核，在醫生取得專科資格一年內抽查百分之十的報告覆檢。院方恒常抽查百分之一報告覆檢，符合香港病理專科學院的標準，但承認不同醫院各有做法。

列印

文章總數: 1 篇

1 .明報 | 2014-08-14
報章 | A12 | 港聞

高永文撐醫委主動查公院醫生

【明報專訊】聯合醫院女醫生涉撰寫及簽發118份有問題病理報告，醫務委員會主席劉允怡日前倡議將涉及醫療事故的醫管局醫生資料轉交醫委會處理，食物及衛生局長高永文昨表示支持有關做法。他認為醫委會的角色不應純粹被動，若條例阻礙醫委會主動介入受公眾關注的個案，即使需要修例也值得考慮。

高：要修例也值得考慮

高永文昨接受商台《在晴朗的一天出發》訪問，被問及醫管局鮮有轉交涉醫療事故的醫生資料給醫委會跟進。高說，雖然條例訂明醫委會接收投訴，但這不代表醫委會不能主動跟進公眾關注的個案，醫委會若要展開調查，醫管局會配合。

但高說醫管局也要先做調查，判斷涉事醫生可能專業失德才可轉介醫委會。以聯合醫院事例，現階段必須先完成調查，有了判斷才決定是否將個案轉介醫委會。

對於聯合醫院今年5 月發現女醫生涉病理報告出錯，卻延至本周一才公布，高永文解釋，覆核所有涉事報告需時，但亦認為聯合醫院做法不符合最佳處理程序。他說醫院應早些通報醫管局總部，若總部質素及風險管理部介入，相信可更有效率處理。

聯合醫院昨公布6 人調查委員會名單，主席由醫管局病理學中央統籌委員會代表李錦昌擔任，委員包括香港病理學專科學院院長張雅賢，及醫院管理局總行政經理（病人安全及風險管理）林潔宜等。

另外，本報昨向醫管局查詢以往公眾關注的醫療事故涉事醫生的懲處，及有關醫生是否仍在醫管局任職。事故包括2007 年威爾斯親王醫院一名血癌女病人，被一名女醫生打錯化療針入脊髓死亡事件，2011 年屯門醫院3 名醫生涉看漏病人腦出血，開錯藥令病人死亡事件，以及2013 年瑪麗醫院兩名資深醫生為病人換錯心，病人在數月後死亡事件。

醫管局回應，過去5 年，每年員工接受處分的宗數約200 至300 宗。醫管局會視乎事件的嚴重性作處分，包括口頭警告、嚴重行為不檢可遭解僱。據了解，上述屯門醫院兩名涉事的內科及心臟科醫生已離職。

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文章總數: 1 篇

1 .明報 | 2014-08-22
報章 | A04 | 港聞

聯合病理報告出錯 再揭涉4病人死亡

【明報專訊】聯合醫院一名新晉病理專科女醫生，早前被揭發其獨立簽寫的118 份病理報告出現錯漏，有3 名病人死亡；該院昨確定再多4 名病人先後離世。院方強調該4 宗報告均沒有出現診斷錯誤，病人死亡與病理報告修正無關，但無透露死因。

另外，聯合醫院在事故後成立查詢熱線（3949 7994），至今已接獲94 宗查詢，主要是了解該批報告與自己有否關連，但並未收到病人投訴。

聯合醫院發言人表示，本月11 日公布事故後，已將涉事的118 份病理報告及患者病歷檔案反覆核對，並確定再有4 名病人已先後離世，分別為3 男1 女。該院稱，事件已進入調查階段，故不會公布死者年齡、死因等資料。稱4 個案不涉誤診

該院強調，4 宗個案的病理報告沒有出現診斷錯誤，只需輕微修正內容，病人的治療計劃亦沒變更，4 人的死亡均與病理報告修正無關。院方再次向受影響病人及家屬致歉，並指獨立調查小組會在8周內完成調查及提出改善建議。

醫管局早前委任6 人小組調查事故，由該局病理學中央統籌委員會代表李錦昌任主席。小組成員、香港病理學專科學院院長張雅賢昨接受查詢時表示，小組將展開調查會議，會否傳召涉事醫生要待正式會議後決定，現未能透露詳情。

聯合醫院本月11 日公布一宗病理科嚴重醫療事故，一名取得病理學專科資格不足一年的女醫生，去年10 月至今年5月，曾撰寫及簽發118 份有問題的病理報告，當中17 份涉及錯誤診斷，3 名曾獲涉事醫生診斷的病人死亡，3 人死因分別為胃癌、直腸癌及肺炎，院方稱死亡與出錯無直接關係。

文章編號: 201408220040113

1 .香港經濟日報 | 2014-10-09
報章 | A26 | 港聞 | By 劉雅艷

聯院錯病理報告 涉醫生欠警覺

基督教聯合醫院病理部女醫生錯誤簽發118份病理報告的事故，專家小組已完成調查，認為事件是因為該名女醫生持續警覺不足所致，建議繼續停止她獨立簽發病理報告，須由資深醫生督導。

至於是否受處分，則待稍後內部紀律聆訊處理。

是否處分 紀律聆訊處理

該院病理部今年5月底已發現3份病理報告出錯，惟直至8月初覆檢涉事醫生餘逾2,000份病理報告，才將事件通報院方行政總監及醫管局。調查報告只建議加快處理事故效率。

不過香港病理學院專科學院副會長馬紹鈞認為，病理報告出錯而影響病人治療方案，如「輸錯血」般嚴重，當局應規定若發生同類型事故，須在24小時內通報醫管局。

聯合醫院早前就事故成立6人專家調查小組。調查報告指，事件主要涉及有關醫生的個人表現，很大程度是由於該醫生持續警覺不足所致，與病理部的工作量、工作分配等無關。

小組認為病理部應繼續停止該病理科醫生獨立簽發病理報告，由資深病理科醫生繼續督導。病理部亦須為該女醫生提供針對其工作弱點的培訓。

17涉事病人 獲跟進治療

據悉，涉事女醫生現正值產假。聯合醫院回應指，該女醫生仍在放假，今年11月初才結束假期。醫管局指，待女醫生復工後，會展開內部紀律聆訊程序，討論處分方法。

報告指，發現誤差的118份病理報告，主要包括假陰性錯誤診斷，和報告包含不適當或錯誤資料等。院方已及時為17名需要調整治療計劃的病人，提供合適的跟進治療。

另外，小組審視7位離世病人的病理報告及病歷，確認他們均因本身患有嚴重疾病離世，與病理報告出現誤差無關。

小組建議病理部應制定制度，持續監察病理科受訓醫生的工作表現，輔導及培訓表現不穩定的受訓醫生。

聯合醫院病理部每月會恒常抽檢該月發出的1%作覆檢，發言人指，院方未有計劃提升覆檢比率，但會加強與其他臨床部門定期討論及覆核個案。此外，病理部亦已引入「師友計劃」，由資深病理科醫生為每位受訓醫生提供一對一的輔導及協助。

列印

文章編號: 201410095312117

1 .南華早報 | 2014-10-09
報章 | CITY1 | CITY | By Emily Tsang and Elizabeth Cheung

Doctor had lapse in vigilance, panel says

A pathologist who made mistakes in the health reports of 118 patients and led 17 into incorrect treatment at the United Christian Hospital had "a lapse of sustained vigilance", an independent review panel said.

The panel of experts, set up to investigate the blunders at the hospital in Kwun Tong, concluded that it was mainly due to poor personal performance.

The mistakes included failing to detect cancer cells and confusing medical terms.

"The investigation report pointed out that making pathological diagnosis requires a high level of attentiveness," a Hospital Authority spokesman said. "The ... incident was mainly due to a personal performance issue."

The unnamed doctor, who obtained her specialist qualification last year, is on leave until November after the department suspended her from issuing reports independently.

The hospital will soon begin a human resources proceeding and decide on a course of disciplinary action.

Meanwhile, the spokesman said the hospital had decided to stop the doctor from issuing her own reports, and to arrange a senior pathologist to supervise her.

The hospital announced the blunders after it conducted a comprehensive review of all 2,153 reports the doctor had issued independently from October last year to May, when the pathology department found three inaccuracies in a routine review.

After completing the review, the hospital last month revealed the inaccuracies in 118 patients' reports, which led to a change of treatment for 17.

The panel criticised the hospital for delaying reporting of the incident until the end of the review process.

Seven of the 118 patients died, but the panel concluded that the large-scale misdiagnosis was not linked to the deaths.

It suggested the hospital enforce a system to monitor trainees, and maintain a review mechanism to strengthen coordination between departments.

Alex Lam Chi-yau, vice-chairman of the Hong Kong Alliance of Patients' Organisations, urged the Medical Council to follow up on affected cases if any complaints were received. "This is a lot of cases, and the impact could be huge," Lam said.

列印

文章編號: 201410095329839