



# THE HONG KONG COLLEGE OF PATHOLOGISTS

## 香港病理學專科學院

The Hong Kong College of Pathologists, Incorporated in Hong Kong with Limited Liability

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## Message from the President

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The year 2003 certainly will go down in history as a turning point for the practice of medicine and pathology in Hong Kong. SARS has caught us almost unprepared, and we have paid the price. But at the same time, we have shown to the world how the whole health care profession of Hong Kong has been braving this assault with complete professionalism and dedication. I am especially proud of achievements of our fellows, with their contributions in making timely diagnosis, in advising treatment, in prevention and surveillance, and in infection control. In particular, our fellows have demonstrated how we measure up in research prowess as the first one in the world to track down the cause of SARS by identifying the SARS Coronavirus, and developing the diagnostic tests.

In the aftermath of SARS, we are facing immense pressure to ensure our preparedness for the next episodes of emerging infectious diseases that are always round the corner. We need to rethink our role and how we best serve our patients. In the process, microbiologists often found themselves need to work more and more outside the laboratory and becoming actively involved in the direct patient management. At the same time, however, infectious disease physicians are also aware the importance of having a better grip on the use of the laboratory and making advises in infection control practices. The border between microbiologists and ID physicians, therefore, appears somewhat fuzzy in some areas. Similar overlapping in practices have actually been occurring increasingly more common and between many clinical pathology

subspecialties and their bedside counterparts. Point-of-care testing facilities in clinical areas and small special research labs that are not uncommonly found in university clinical departments are other signs that the boundaries between pathology and other clinical specialties are becoming blurred.

Even inside the laboratory, some feel the distinction between pathologists and the laboratory scientists is no longer as clearly defined as it once was. Fueled by the incipient implementation of the laboratory accreditation scheme, which is sponsored by the Hong Kong Accreditation Service of the government, there were great concerns and heated debate regarding who can or cannot be the laboratory director. Now it seems pathologists are being caught in the middle in all these arguments and developments - on the one side we see non-medically qualified technologists and scientists becoming more and more assertive and gradually creep into the management role of the laboratory, and on the other side many of us are worried of the increasing shared areas of practice with the bedside clinicians that one day our unique role will be eroded and the whole profession of pathology marginalized.

One may ask, then, "What exactly are the things a pathologist can do that other professionals cannot?" In other words, what actually is our core business that distinguishes us from everybody else? I think this is a very relevant question intimately related to our future and it calls for a wide debate among all of us. The answer of which

should help us to understand what we are and what we should do next. Meanwhile, it is instructive to look back into our own history to get some food-for-thought.

Pathology, as the foundation of scientific medicine, has been established as a specialty almost four centuries ago, largely due to the ability to observe of tissue changes in disease states that followed the invention of the microscope. Quite unlike what we do today working full-time in the laboratory, "pathologists" then were mostly bedside clinicians who wanted to better understand the basis of the patient's symptoms and signs, and the cause of their deaths. Under the influence of the visionary leader Rudolf Virchow and his many enlightened pupils, pathologists had become the bearers of scientific medicine, largely through their works in autopsy studies. The first physicians to become full-time pathologists were the autopsy pathologists of the 19<sup>th</sup> century. By then, autopsy became a highly visible professional, educational activity through the efforts with academic pursuit and was the key to much advancement in medicine. At the same time, however, the academic pathologists had also become less and less clinically and diagnostically oriented.

Modern Surgical or Anatomical Pathology had barely been conceived by 1900 and there were very few pathologists engaged in full-time practice anywhere in the world. The role of the pathologist in the operating room or even in the examination of surgically removed specimens was negligible. Standard practice more often than not was to discard specimens without examination, and I have been told that we had similar practice of inspect-and-discard in many local hospitals even as late as the 1970's. The surgeons' of the early 20<sup>th</sup> century in some large centres in the United States and also in Europe obviously did not feel satisfied; and so they often served as their own pathologists. In their demand to know what a tumour was as early as possible, they started to do their own examinations under the microscope, and often did their own frozen sections. At that time few academic pathologists and none of the standard pathology textbooks regarded the use of frozen sections during operations as an important technique. It was in fact through these surgeon-cum-pathologists that the techniques had been improved and brought into routine intra-operative use for the first time.

And so the discipline of modern surgical pathology was born, through the convergence of scientific tenets of the academic pathology and the clinical necessity to making correct diagnosis before it is too late. The 19<sup>th</sup> century academic pathology, while given us the bedrock of scientific medicine, faded away as not being

able to deliver the answers to the clinicians and their patients at the right time when the information is most needed.

So part of our heritage in fact come from being practiced as beside clinicians, and in deed we have never been going very far away from the bedside – all along the pathologist remains very much part of the clinical medical team. Like all physicians, the pathologists must take full responsibility for their patients through the reports generated by them or from their laboratories. In many subspecialties of pathology, they may also be involved in direct patient care through holding clinics, admission of patients and in-patient care. Cytopathologists, for example, run fine needle aspiration clinics for the management of various conditions. Pathologists have taken full charge of infectious, metabolic, hematological, immunological, and other specialized areas of direct medical care. The tendency of overlapping in practices between the pathology subspecialties and those of other clinical disciplines is just a natural result of specialty development and subspecialization on either side. To serve the changing needs of the patients better, therefore, we need to understand what each specialty has to offer, and the training in pathology must be constantly being reviewed and modified. Pathologists need to have more collaboration with their bedside colleagues in terms of education and training so as to deliver the best services to the patients. The College Council, in fact, has been actively exploring the pros and cons of engaging in joint fellowship programs with other Colleges, particularly the Hong Kong College of Physicians.

Not only is the division between pathology and some clinical specialties becoming blurred, the borders among different pathology subspecialties are also no longer as clear-cut as they once were. Technological advances, for example, in molecular biology have already undermined the traditional divisions of pathology. Nucleic acid based techniques such as PCR are now common to all pathology subspecialties and can be applied to the detection of microorganisms, genetic diseases, and cancers. These advances that cross subspecialty boundaries call for a rethink of the usefulness of the conventional subspecialty divisions.

The entire landscape of medical practice is changing and traditional divisions and barriers have been torn down or are beginning to fall while new ones are erected. Pathology is no exception to this process. The merits of retaining or perpetuating traditional divisions of pathology need to be reexamined in terms of effectiveness and relevancy to patient care, among other things. Why we need a paediatric anatomical pathologist, for example, to assess the morphological changes of a metabolic disorder, and then another chemical

pathologist who is specialized in paediatric chemistry to sort out the underlying enzymatic abnormalities? Why not just one paediatric pathologist who can offer consolidated reporting on histopathological, biochemical, and genetic aspects of the conditions and serves as the consultant to everything that is "laboratory" to the patients with metabolic disorders in a more integrated way? The fact is, our current system of training and specialty subdivision, which is somewhat specimen or process-based, could be too rigid to produce such new breed of pathology specialists. Perhaps, it is time to take a more holistic view of the practice of medicine and pathology, in order to appreciate more, the interdependence of the various traditional divisions.

We therefore should not let ourselves be bounded by the laboratory, and repeat the fate of the 19<sup>th</sup> century academic autopsy pathologists. The laboratory should not hold us custody, and neither should we consider ourselves the custodian of the laboratory. The laboratory is only our kitchen, our tool. It is our knowledge in scientific medicine that makes us unique among our clinical colleagues, and a valuable asset in any medical team in the diagnosis and management of patients.

Pathologists did come from the bedside to the bench side, but we should never forget the bedside, and for some of us, be ready to take the full circle back from the bench side to the bedside when circumstance requires.

A challenge could be a threat but it could also be an opportunity, depending whether one would look at it as a cup half filled or a cup half empty, and I am optimistic that the importance of pathology will continue to grow in the changing times just like what have happened over the past centuries. Using the analogy of a tree; clinical practices, which are the leaves, flowers and fruit cannot grow without nourishment channeled through the stem, which is pathology. Equally, the roots, which are basic sciences, cannot transmit nourishment from the soil direct to the leaves and flowers in the absence of the pathology stem. Thus, the pre-eminent position of the pathologist in the medical team does not change, but our individual role may undergo modifications dictated by changes in medical practice occasioned by technological advancement and the needs of the society.

## HKCPATH College Council 2004

### President:

**Dr LEE Kam Cheong,**  
Department of Pathology,  
Princess Margaret Hospital,  
Lai Chi Kok, Kowloon.  
Phone: 2990 1804; Fax: 2370 0969  
Email: kcllee@ha.org.hk

### Vice-Presidents:

**Dr MONG Hoi Keung**  
P.O.Box 20449,  
Hennessy Road Post Office, Hong Kong.  
Phone: 2860 2468; Fax: 2804 1714  
Email: drmong@drmong.com

### Dr NG Wing Fung

Department of Pathology,  
Tseung Kwan O Hospital,  
Tseung Kwan O, Kowloon.  
Phone: 2208 0888; Fax: 2623 6075  
Email: ngwf@ha.org.hk

### Registrar:

**Dr SUEN Wang Ming, Michael**  
Department of Pathology,  
Alice Ho Miu Ling Nethersole Hospital,  
Tai Po, NT.  
Phone: 2689 2605; Fax: 2664 1515  
Email: suenwm@ha.org.hk

### Deputy Registrar:

**Dr SO Chi Chiu, Jason**  
Department of Pathology,  
North District Hospital, NT.  
Phone: 2683 8145; Fax: 2683 8176  
Email: jasonccso@hotmail.com

### Honorary Treasurer:

**Dr YU Hon Wai**  
Room 1148,  
NT Regional Police Headquarters,  
6 On Po Lane, Tai Po, New Territories.  
Phone: 2761 2410; Fax: 2713 2022  
Email: sfp-nt-fps@police.gov.hk

### Immediate Past-President:

**Dr Robert John COLLINS**  
Department of Pathology,  
Queen Mary Hospital,  
Pokfulam Road, Hong Kong.  
Phone: 2855 4009; Fax: 2872 8098  
Email: rcollins@hkucc.hku.hk

### COUNCIL MEMBERS:

**Dr CHOI Chung Ho**  
Department of Pathology,  
United Christian Hospital,  
130 Hip Wo Street, Kwun Tong, Kowloon.  
Phone: 2379 4322; Fax: 2772 0917  
Email: achchoi@ha.org.hk

### Dr HO Pak Leung

Department of Microbiology,  
The University of Hong Kong,  
Queen Mary Hospital,  
102 Pokfulam Rd, HK.  
Phone: 2855 4193; Fax: 2855 1241  
Email: plho@hkucc.hku.hk

### Dr IP Margaret

Department of Microbiology,  
Chinese University of Hong Kong,  
Prince of Wales Hospital,  
Shatin, N.T.  
Phone: 2632 2306; Fax: 2647 3227  
Email: margaretip@cuhk.edu.hk

### Dr MA Shiu Kwan, Edmond

Department of Pathology,  
The University of Hong Kong,  
Queen Mary Hospital,  
102 Pokfulam Road, Hong Kong.  
Phone: 2855 4570; Fax: 2817 7565  
Email: eskma@hkucc.hku.hk

### Dr LOKE Shee Loong

The Laboratory,  
St. Teresa's Hospital,  
327 Prince Edward Road, Kowloon.  
Phone: 2711 2120; Fax: 2761 1798  
Email: sthl@l-cable.com

### Dr QUE Tak Lun

Department of Clinical Pathology,  
Tuen Mun Hospital, Tuen Mun, N.T.  
Phone: 2468 5465; Fax: 2468 5467  
Email: quehl@ha.org.hk

### Dr CHAN Ho Ming

Room 34008, 1/F,  
Department of Chemical Pathology,  
Prince of Wales Hospital, Shatin, N.T.  
Phone: 2632 2326 Fax: 2636 5090.  
Email: hmchan@med.cuhk.edu.hk

### Dr WONG Koon Sang

Rm 1149,  
NTN Regional Police Headquarters,  
6 On Po Lane, Tai Po, N.T.  
Phone: 2666 4225; Fax: 2667 3565  
Email: wongks@graduate.hku.hk

### CHAIRMEN OF COLLEGE COMMITTEES:

Training and Examination Committee:  
Dr. W.F. Ng

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## REPORT OF INTERNATIONAL LIAISON COMMITTEE OF PRESIDENTS, HONG KONG 1st and 2nd DECEMBER, 2003

**Participants:** Sean O'Briain, Dean Faculty of Pathology, Royal College of Physicians of Ireland; Stewart Bryant, Vice-President, Royal College of Pathologists of Australasia; Vince Caruso, President, Royal College of Pathologists of Australasia; Robert Collins, President, Hong Kong College of Pathologists; Mary Kass, President, College of American Pathologists; David Keren, President, American Society for Clinical Pathology; Lee Kam Cheong, Vice-President, Hong Kong College of Pathologists; Kenneth McClatchy, World Association of Societies of Pathology; Mikel Mong Hoi Keung, Vice-President, Hong Kong College of Pathologists; LoAnn Petersen, President-Elect, American Society for Clinical Pathology; Thomas Sodeman, President-Elect, College of American Pathologists; James Underwood, President, Royal College of Pathologists; Russell Young, Chairman of Council, Association of Clinical Pathologists

### Determining suitability of doctors entering programs for a career in pathology

In Ireland and the UK training generally consists of a basic first part and an advanced second part. Since 2002 trainees are subjected to an Aptitude Assessment conducted towards the end of the first year of training. Trainees are assessed on the basis of an interview, review of diagnostic reports and assessment of supervisors' reports. It is not an examination, and trainees are advised and counselled regarding a career in pathology. There is no assessment prior to entering training. The ensuing discussion raised the question of legal implications of adverse findings following the Aptitude Assessment.

Amongst other factors, the recruitment of trainees may be adversely affected by low income (no overtime is available as in clinical specialties). There was virtually unanimous agreement that the content of pathology in the undergraduate curriculum had markedly decreased as a result of curriculum changes, especially Problem Based Learning (PBL). Under this system there is no structured pathology content. The importance of role models and other public relations exercises was emphasized. One suggested solution was to offer short elective attachments to medical students to increase understanding of the role of pathology.

### Assessment of residency programs

Residency programs are assessed in a variety of ways

with some assessed by government accrediting bodies (Post-Graduate Medical Education and Training Board in U.K.; Australian Medical Council in Australia). The length of training programs ranges from six years in Hong Kong (similar for all specialties and determined by the Hong Kong Academy of Medicine), five years in the UK, Ireland and Australia to four years in the USA where the year of clinical internship prior to pathology training is no longer required.

The Board Exams in the USA are taken after four years of training and there is a minimum requirement of training time of at least 18 months in Anatomical Pathology and 18 months in Clinical Pathology with the additional year usually spent in Anatomical Pathology. Several additional individual specialty board exams are available such as Dermatopathology, Cytopathology, etc. It is generally expected that three years of training is required to practice solely in Surgical Pathology.

In the UK training positions have been significantly expanded due to increased funding by the government but there is a shortage of space and trainers in the hospitals. The Anatomical Pathology posts for training positions are being filled with many being taken by overseas trained doctors. Vacancies exist in training positions in other specialties, such, as Chemical Pathology. Training posts are accredited by the College in the U.K. and Hong Kong, but by a separate body in the U.S.

### Examination standards and pass rates (especially in Anatomical/Surgical Pathology)

The recent examination pass rate of approximately 40% in the Part I of the RCPA's Anatomical Pathology was considered by all to be unsatisfactory and reflected a deficiency in either the training program including the role of supervisors, the selection of trainees, the examination system, or a combination of the above. The pass rate for the Board Examinations in the USA is close to 90%.

### Assessing competency of pathologists-in-training and beyond

The American Society of Clinical Pathology has developed a program of assessment that trainees undertake on a yearly basis. Candidates indicate the various segments of the curriculum in which they have received training. Although they can participate in all

segments, their score is ignored for those segments in which they have not officially received training. The individual scores are compared with the aggregate scores for the particular year of training.

These assessments were originally introduced as self-assessment exercises and the results were not released to anyone else, however, for the last year the scores have also been released to supervisors in order for them to become aware of any deficiencies so that they can advise trainees and instigate remedial action where indicated.

### **Multi-professional teams in pathology services: what is the role of the medically-qualified pathologist?**

Because the UK has one of the lowest population densities of doctors in the 'developed world', role redesign and multi-professional working are being actively pursued as one element of the program to increase capacity in the National Health Service. The Royal College of Pathologists (RCPATH) is almost unique among the UK's medical Royal Colleges in that a significant proportion (c. 20%) of its membership comprises non-medical clinical scientists. The RCPATH is also working closely with the Institute of Biomedical Science to develop extended roles for biomedical scientists (e.g. equivalent to pathologists assistants in the USA). This has led the RCPATH to consider the role and function of medically-qualified pathologists and to produce a discussion paper for wider consultation and adoption. Defining the role of medical graduates in pathology services could facilitate the further delegation of some tasks and responsibilities to non-medical scientists.

In discussion, the following activities were regarded as defining the medical role in pathology services:

- Integrating medical practice with laboratory science, with the clinical role being dominant.
- Clinically-relevant interpretation of qualitative data.
- Ensuring the most economical and clinically effective use of laboratory resources.
- Performing audit and initiating remedial actions.
- Making independent decisions on often complex clinical and laboratory evidence.
- Deciding between investigational and diagnostic options, often in complex cases.

### **Recognition of pathology subspecialties: Does this restrict or exclude more generally qualified pathologist from practice in the area?**

Concerns were raised about the competence of pa-

thologists who sub-specialise, but occasionally may be asked to practice outside their organ or body system of interest. It was conceded that was an increasing problem as sub-specialisation becomes more common.

The ILCP meeting indicated that doctors should seek to confine their practice to what they were competent to do, as defined by:

- Participation in appropriate EQA schemes.
- Minimum number of cases per year for safe practice.
- Appropriate CPD.
- Clinical audit.

### **Manpower shortage in pathology**

The manpower (workforce) shortage in pathology services appears to be an international problem, often affecting turnaround times and capacity. The workforce shortage is not just medical; in some pathology services, the delays are due to insufficient technical and clerical staff. The UK's global recruitment campaign risks depleting some countries of their already scarce pathology workforce. There may be scope for improving efficiency in pathology services through 'work smarter, not harder' solutions. Professor Underwood also commended the RCPATH's evidence-based review of histopathology workloads to identify investigations of limited or no clinical utility.

Recruitment seems to be a perpetual problem (discussed almost 30 years ago by the ILCP!). As pathology becomes less visible in the medical curriculum, young doctors may be insufficiently aware of the pathology specialties as career opportunities. The place of pathology in the curriculum has to be advocated locally, but pathology organizations could help by producing central guidance.

### **Demand management in pathology**

Demand management can be used to curtail clinically unnecessary increases in the laboratory workload. The ILCP felt that this was a major responsibility of the medical specialists in the pathology service who, in consultation with clinical users, could take steps to censor various investigations (or investigations repeated with unnecessary frequency) that had no clinical benefit. Computer-based requesting could also be used to manage demand.

### **The "image" of pathology and pathologists - how we are perceived by the public, by fellow doctors and by managers**

Russell Young presented an overview of the percep-

tion of pathology and pathologists by those outside the specialty, such as the public, other specialists, and health managers, particularly from the UK perspective. There was general agreement that this was a significant problem internationally and that it accounts for difficulties in recruitment to the pathology specialties and in gaining governmental and institutional support for the specialty. The external perception of pathology is too often dominated by post-mortems, especially the forensic aspects, whereas most of the specialty's professional activity is directed towards living patients and the public health.

Pathology professional organizations should take active steps to improve public awareness. Recent activities undertaken by the RCPATH including exhibiting at the Chelsea Flower Show ('Plants and Pathology') and working with radio and TV on documentaries.

#### **Suspension of consultants / staff members by hospital or health board authorities**

Suspension of staff in pathology services may be increasingly common to avoid the risk of clinical harm or litigation resulting from substandard professional performance. Although suspension is often claimed to be a 'neutral act', it can be damaging to the morale of the suspended consultant. Suspension is sometimes a knee-jerk reaction to a single or small number of coincidental errors; health-service managers often do not understand that pathology is not an exact science and that errors are an intrinsic component of any human decision-making.

The ILCP suggested that more should be done to raise awareness of unavoidable non-negligent error in pathology services and the steps taken to reduce errors to the lowest attainable frequency. Pathology organisations should also offer advice and support (e.g. mentorship) to colleagues who are suspended and under investigation.

#### **Portability of qualifications: with a requirement to spend 5 years in training (and with practice not considered training), can pathologists who fulfilled the shorter period of training required for American Boards have their qualifications recognised in countries which require a longer training period?**

Ireland uses qualifications of the RCP. The length of the residency in equivalent disciplines is now being questioned. ABP requires 4 years of training to sit for Boards. Ireland requires 6. Theoretically two people could graduate from Med School; one could do residency in USA, take American Boards and be recognized to practice in Ireland; another could take resi-

dency in Ireland for six years, take certification exam and enter practice two years later than the individual who went to US for residency.

EU countries must recognize a candidate who has satisfied his nation's requirements. However, there is also a European Board of Pathology that administers an exam. Recently a candidate took the certifying exam in Ireland and failed and subsequently took the European Board and passed. Question: Does Ireland have to recognize the European Board when the candidate has failed its own Board? That has not been answered and fortunately the person is retaking the Irish Board and hopefully will pass.

#### **International reciprocal recognition of College membership by equivalence of training and competence**

James Underwood reported that the Royal College of Pathologists now invites into membership consultants whose professional training has been outside the UK. The criteria are: training and qualification judged to be equivalent to UK standards; appointed to a consultant post on the recommendation of a committee on which the College was represented; sponsored by two Members or Fellows of the College; and, finally, approved by the Council of the College. Prof Underwood requested that other Colleges represented on the ILCP develop similar routes to membership of their Colleges. This was broadly supported and specifically, Dr. Caruso agreed to consider this in the Royal College of Pathologists of Australia.

Prof. Underwood stated that the European Board of Pathology is publishing in Virchow's Archives a comprehensive comparison of training requirements in all EU countries. Conferees decided that it would be a good idea for US, Australia and Hong Kong to submit their requirements, in a format similar to that already put in the Archives article, and publish this. It was thought this would be helpful in promoting understanding as well as serving as a source document for trainees as well as program directors. Prof Underwood will e-mail everyone a copy of the article. Drs. Kass, Sodeman, Peterson, and Keren will collaborate on writing the US requirements; Drs. Caruso and Bryant will collaborate on Australia's requirements; and Drs. Collins, Mong and Lee will collaborate on those of Hong Kong. These will include both AP and CP. Dr. Young will take care of the CP aspect for the UK. These will all be emailed to Dr. Kass. We will then decide how these will be written and submitted.

Dr Collins also suggested that perhaps it would be good to create a website for the ILCP where interna-



tional and local opportunities could be posted for the exchange of all trainees.

### Supervision / accreditation of laboratories and key performance indicators

There was an extensive discussion of lab accreditation and the setting of performance standards especially for cytology in Australia. James Underwood revealed that appropriately trained cytotechnologists were now allowed to sign out cytology specimens including abnormal ones. This was necessitated by the severe shortage of pathologists in the UK. In Australia they have set performance standards for labs based on percentages of normal, unsatisfactory, etc. These norms have no scientific basis that is known and tend to be very strict. Their validity was questioned and information was sought as to what other countries did. Prof Underwood stated that in UK the CPA (Clinical Pathology Accreditation) has the responsibility for accrediting all labs and setting performance standards. The RCPATH is a shareholder and has representation on that Board and therefore has input into standards that are created

### Quality Assurance Programs and the IVDD Regulations

The TGA (Therapeutic Goods Authority) [similar to FDA (Food and Drug Administration) in US] has created the National Serologic Reference Lab, which was initially to validate HIV POC tests, but now wants to expand its authority to all tests involving blood and blood products including pre-market and post-market validation. Dr. Bryant is concerned about the "creeping" regulation that seems to be apparent.

### Review of the national representation on the International Liaison Committee of Pathology Presidents

Prof Underwood stated that in preparation for this meeting he found records of this group going back to the early 1970's. He wondered as to how the composition came about and was there any interest in expanding it. It was decided that Dr Kass would contact Dr. Loyd Wagner and get all available history and any agreements among participants. This information will be sent to all participants.

This will be an agenda item in Australia. Next meeting will be held on Saturday and half day Sunday in Sydney just before the IAP meeting. ILCP 2005 will be in London and possibly 2006 will be back in Australia to celebrate an Anniversary of the Australasia Pathology Society.

## CEPA: IMPACT ON MEDICAL PROFESSION

Following the implementation of CEPA, two announcements from the Chinese Ministry of Health are relevant to the medical profession in Hong Kong, and they are attached in this newsletter.

Document number 331 states that medical practitioners who are registered in Hong Kong or Macau and who are permanent residents of these special administrative regions can have short-term registration in Mainland China for a period of not more than 3 years, which can be renewed.

Document number 333 mentions registration examinations for permanent residents of Hong Kong and Macau. According to the Hong Kong Medical Council, the Chairmen of the Medical, Dental and Chinese Medicine Councils have agreed with the Health, Welfare and Food Bureau and the Mainland side that the three Council Secretariats will assist in receiving, collating and transmitting applications for the Registration Examinations from applicants in Hong Kong. Detailed arrangements are being worked out with the relevant authorities in Mainland and Macau SAR. The Chinese authorities will issue formal announcement in due course.

## 卫生部文件

卫医发〔2003〕331号

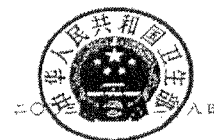
### 卫生部关于修改《外国医师来华短期行医暂行管理办法》第十八条的通知

各省、自治区、直辖市卫生厅局，新疆生产建设兵团卫生局：

为落实《内地与香港关于建立更紧密经贸关系的安排》和《内地与澳门关于建立更紧密经贸关系的安排》，经研究，决定对《外国医师来华短期行医暂行管理办法》（1992年卫生部令第24号）第十八条进行修改。

第十八条修改为：“香港、澳门、台湾的医师或医疗团体参照本办法执行。”

具有香港或澳门合法行医权的香港或澳门永久性居民在内地短期行医注册的有效期不超过3年。注册期满需要延期的，可以重新办理短期行医注册手续。”



抄送：国家中医药管理局，总局卫生部。

卫生部办公厅

2003年11月26日印发

校对：熊雅群

卫生部  
国家中医药管理局 文件  
国务院港澳办

卫医发〔2003〕333号

关于落实《内地与香港关于  
建立更紧密经贸关系的安排》和  
《内地与澳门关于建立更紧密经贸关系的安排》  
中医疗及牙医服务有关问题的通知

各省、自治区、直辖市卫生厅局，中医药管理局，港澳办，新疆生产建设兵团卫生局：

为落实《内地与香港关于建立更紧密经贸关系的安排》和《内地与澳门关于建立更紧密经贸关系的安排》，根据《中华人民共和国执业医师法》等有关法律、法规的规定，现将医疗及牙医服务贸易领域有关事项通知如下：

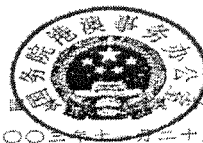
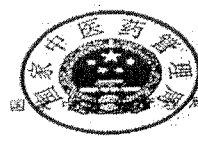
- 一、香港或澳门与内地合资合作举办的医疗机构所聘用的医务人员大多数可为香港或澳门永久性居民。
- 二、符合条件的香港、澳门永久性居民可以申请参加内地临床、中医、口腔类别的国家医师资格考试（考试具体规定见附件），成绩合格者，发给相应的《医师资格证书》。
- 三、取得内地《医师资格证书》的香港、澳门永久性居民来内地短期执业的有关规定另行制定。

四、《关于取得内地医学专业学历的台湾、香港、澳门居民申请参加国家医师资格考试有关问题的通知》（卫医发〔2001〕249号）和《关于取得中国医学专业学历的外籍人员和取得内地医学专业学历的台港澳居民参加医师资格考试补充规定的通知》（卫医发〔2002〕52号）中与本通知不一致的，以本通知为准。

五、本通知及《关于香港、澳门永久性居民参加国家医师资格考试的规定》由卫生部负责解释，涉及中医的有关规定由国家中医药管理局负责解释。

六、本通知及《关于香港、澳门永久性居民参加国家医师资格考试的规定》自2004年1月1日起施行。

附件：关于香港、澳门永久性居民参加国家医师资格考试的规定



二〇〇三年十二月二十八日

主题词：卫生 医疗 通知

抄送：总局卫生部、公安部。

卫生部办公厅

2003年12月3日印发

校对：焦雅辉

**Cancellation of the 23rd International Tutorial on Clinical Cytology and Biomarkers**

This tutorial is cancelled and registrants will be refunded later.

**New CME cycle**

The HKAM council has decided that all Fellows will start the new CME cycle afresh on 1 January 2005, in order to synchronize with the issue of annual practicing certificates. Further information will be given by the Education Committee at a later date.

**Newsletter production**

Editor: Dr. Ma Shiu Kwan, Edmond

Advisor: Dr Rob Collins

**CHANGING ADDRESS?**

If you are changing address, please write down your new address below and send to :

**Dr Michael SUEN,**  
Registrar,  
The Hong Kong College of Pathologists

c/o Department of Pathology,  
Alice Ho Miu Ling Nethersole Hospital,  
11 Chuen On Road, Tai Po  
New Territories  
Fax: 2664 1515

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: ( ) \_\_\_\_\_ Fax: ( ) \_\_\_\_\_

Email Address: \_\_\_\_\_

Effective Date: \_\_\_\_\_