



# THE HONG KONG COLLEGE OF PATHOLOGISTS

## 香港病理學專科學院

May / June 1999 Volume 8:2

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

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## PRESIDENT'S MESSAGE

Our College is in the process of forming six Specialty Boards (Anatomical Pathology, Chemical Pathology, Forensic Pathology, Haematology, Immunology, Microbiology and Infection) which will replace the existing Specialty Advisory Panels although the Advisory Panel on AP/CP will be maintained.

The importance of the Boards is apparent from their terms of reference:

1. To review, from time to time, the regulations on postgraduate training of the specialty.
2. To provide overall supervision of the training and examination in the specialty under the co-ordination of the TEC.
3. To advise the College Council on the training, education, development and other aspects of the specialty.

The working relation with the Council and the Training & Examinations Committee will remain more or less the same.

The tasks for the Specialty Boards include:

1. To recommend criteria for registration in the specialty for the Council's endorsement.
2. To recommend revisions to the "Regulations on Postgraduate Training and Examinations".
3. To recommend a detailed training program for trainees in the specialty.

The nominated composition of the various Specialty Boards is shown later in this Newsletter although the Boards are free to co-opt additional members, for endorsement by the Council, and they will elect their own chairpersons. It is hoped that this will result in greater involvement of fellows in College activities and tap their experience and suggestions. If you have opinions on these or other matters please contact the relevant Board member(s).

You will be aware of the Consultancy Report on Hong Kong's Health Care Financing and Delivery System by the Harvard University Consultancy Team as well as the Chinese Medicine Bill. These may have far reaching effects on all aspects of Medicine, including Pathology. Please give your opinions.

## TRAINING & EXAMINATIONS COMMITTEE

20 November 1999 (Sat.) at HK Academy of Medicine Building— TB TEOH Foundation Lecture, Fellows Admission Ceremony, AGM & Annual Dinner.

<i>Inside This Issue</i>	Page
<b>1. Final Exam Schedule</b>	2
<b>2. ILCP Report—'98 Meeting</b>	2-9
<b>3. Training and Examination Matters</b>	2-3
<b>4. Courses and Meetings</b>	4-5

## Composition of the College Specialty Boards & Program Advisory Panel

### (1) Anatomical Pathology

1. Dr Robert John COLLINS\*
2. Dr CHAN Kwok Cheung, John
3. Dr CHEUNG Nga Yin, Annie
4. Dr LEE Kam Cheong
5. Dr NG Chi Sing
6. Dr NG Ho Keung
7. Dr PANG Siu Wah, Alwin#
8. Dr TSUI Man Shan

### (2) Chemical Pathology

1. Dr CHAN Yan Wo, Albert\* #
2. Prof Nils Magnus HJELM
3. Dr MAK Wing Lai, Tony
4. Dr SHEK Chi Chung
5. Dr TAM Chi Fai, Sidney

### (3) Clinical Microbiology and Infection

1. Prof Augustine F CHENG\*
2. Dr LIM Wei Ling, Wilina
3. Dr NG Tak Keung
4. Dr SETO Wing Hong
5. Dr TSANG Ngai Chong, Dominic
6. Dr YUNG Wai Hung, Raymond

### (4) Forensic Pathology

1. Dr MONG Hoi Keung\*
2. Dr BEH Swan Lip
3. Dr WONG Hon Man
4. Dr WONG Koon Sang#

### (5) Haematology

1. Dr WONG Kit Fai\*
2. Dr CHOW Yu De, Eudora
3. Dr CHU Wan, Raymond#
4. Dr LAM Chun Kit, Clarence
5. Dr LIU Hing Wing
6. Dr NG Heung Ling, Margaret

### (6) Immunology

1. Dr CHAN Yuk Tat, Eric\*#
2. Prof LAWTON, John W M

### (7) Program Advisory Panel on Combined AP/CP program

1. Dr Elaine GWI\*
2. Dr. P.K. HUI #
3. Dr Arthur K C LEE
4. Dr WONG Kit Fai
5. Dr. C.S. FENG
6. Dr. Fernard LAI
7. Dr. Raymond YUNG
8. Dr. Sidney C.F. TAM

(\* Chief Examiner, # Co-ordinator)

With effect from 12 June 1999 for two years.

## International Liaison Committee of Presidents, Summary of Meeting Discussions, Academy of Medicine Building, Hong Kong, November 30 - December 1, 1998,

The discussions at this meeting were wide-ranging and touched upon a broad range of matters relevant to pathology. The full report is included in this Newsletter with the aim of both informing and stimulating discussion.

The 1998 meeting of the International Liaison Committee of Presidents was hosted by the Hong Kong College of Pathologists in their offices in the building of the Academy of Medicine. The topics covered were quite diverse and are summarized below.

[The participants were: Dr Paul Bachner, President-Elect, College of American Pathologists; Dr Chan Keeng Wai, Vice President, Hong Kong College of Pathologists; Dr Robert Collins, Vice President, Hong Kong College of Pathologists; Dr David Davies, Vice-President, Royal College of Pathologists of Australasia; Dr Jack Hamer, President, Royal College of Pathologists of Australasia; Dr Lilleyman, President, Association of Clinical Pathologists; Dr Roddy MacSWEEN, President, Royal College of Pathologists; Dr Mak Wai Ping, President, Hong Kong College of Pathologists; Dr Lloyd Wagner, ILCP Coordinator, College of American Pathologists; Dr Thomas Wood, President, College

of American Pathologists; + + + +

## EXAMINATIONS 1999

### (a) Written papers -

**16th August 1999.**

### (b) Anatomical Pathology:

**Practical exams -**

**4th October 1999**

### (c) Anatomical Pathology:

**Oral exam -**

**5th October 1999**

## PATHOLOGY ORGANIZATIONAL INTERACTIONS

### Relations of Hong Kong Academy and College of Pathologists:

Discussion was opened by Dr. Mak with a historical review of the medical structure in Hong Kong. The HK education basically follows the British system. Medical school curriculum is 5 years in length. There are 40 Hospital Authority-run hospitals in HK with the largest comprising 1600 beds. While most specialists have traditionally been trained in the United Kingdom, in recent years many have been trained in Australia. There are no formal training programs in HK. The Hong Kong Pathology Society was formed in the early 1980s, while the HK College of Pathologists was formed in 1990 with its major role being to determine and maintain standards of training and examinations. The HK Academy of Medi-

cine oversees all areas of training. It has 15 Colleges, with the College presidents sitting on the Council. It was formed under charter of the Hong Kong government. While the HK Medical Council controls the registry of specialists, much of this responsibility has been passed to the HKAM. Specialists are essentially re-certified every three years, based on continuing medical education. The College of Pathologists recommends who should be on the specialty register. While CME is required, some pathologists do not report their CME hours. A concern in HK is how CME requirements interact if validation or certification is from an overseas country, e.g. the UK. Pathologists in the UK have agreed to move to re-validation or re-certification. The problem of who should remove a specialist from the registry has not been solved. In New Zealand, re-certification will be mandatory by 2001. In Australia, efforts to form an Academy of Medicine, as in the UK, failed due to opposition from certain specialists although the role and resources of the present Committee of Presidents of Medical Colleges is being upgraded. In the United States, the American Board of Medical Specialties (ABMS), which oversees all specialty Boards, has urged re-certification, but it has no mechanism to enforce such a requirement. The American Board of Pathology (ABP) has put in place a voluntary system of re-certification through multiple pathways. Control is much more decentralized in the US with the multiple states. Some states mandate CME for continued licensing, while others do not. HMOs are becoming more active in evaluation of specialists for participation in their programs. A number of organizations are attempting to carve out turf for credentialing physicians, such as the AMA. Hospitals are becoming increasingly concerned about the qualifications of physicians practicing within their institutions as well. Assessment of actual performance is a difficult problem. Pathology may have some objective data on which to base such assessment. Other specialties have little basis on which to assess, e.g. psychiatry, internal medicine, etc. In the US, non-physician personnel are seeking a role in the assessment of quality of practice. There is consensus that medicine must have its own house in order if it is to maintain control of its own destiny.

### **Role of Pathology Organizations in Dissemination of Information to the Public:**

In the discussion, the definition of the public was broad, ranging from patients to physicians. In the UK College, a patient liaison group has been formed to aid communication with the lay public. Dr. MacSween expressed the feeling that the government should play an active role in education of the general public in regards to reasonable expectations from pathology and medicine in general. Public expectations of perfection are particularly problematic in the field of cytopathology.

### **Distributed Learning:**

Concerns were expressed about the World Wide Web, the amount of information available to the public, and how it is presented. This plethora of information may feed unrealistic expectations. The question was raised about the role of pathology in preventive medicine. As we attempt to educate the public, how do we reach those who need education the most? Dr. Davies stressed the need for interaction between the profession and government prior to the implementation of public health preventative medicine campaigns--the profession must be able to respond appropriately. There was consensus that the Internet probably is more useful in educating the profession than in educating the public.

### **World Association of Societies of Pathology:**

Dr. George Hoffman, secretary of WASP, reviewed the activities and structure of organization, including the Bureau, and the Administrative and other Secretariats. He indicated that the World Congresses did little to actually link societies. Also explained was the World Pathology Foundation and the Gordon Signy Fellowships, etc. Financial support comes only from dues, and the corporate sponsors who are largely responsible for the ability to have the administrative secretariat. Support of WASP by most societies is minimal, and only about 40% actually pay their dues. The Global Medical Network was described. Each program on the GMN costs approximately \$3000 to produce. Discussion of the organization of WASP followed. While recognizing the potential beneficial impact of WASP in standard setting with ISO and the WHO, there was consensus that the present structure hampered this ability. At present, the value of WASP was perceived to be low, leading to questions about continued support by the represented societies.

### **Is Current Single Discipline Training and Examination Appropriate or Adequate?:**

Dr. Hamer's introductory remarks follow: "Background: 'A human being should be able to change a diaper, plan an invasion, butcher a hog, conn a ship, design a building, write a sonnet, balance accounts, build a wall, set a bone, comfort the dying, take orders, give orders, cooperate, act alone, solve equations, analyze a new problem, pitch manure, program a computer, cook a tasty light meal, fight efficiently, die gallantly. Specialization is for insects.' (Robert A Heinlein quoted in Wired, August 1998 and as an Endpiece BMJ Vol 317 24 Oct 1998) Like many other occupations in modern society, pathologists are confronted with apparently conflicting demands. "Consumerism" often backed by law of tort continually demands multiskilling and adaptability to change. In medicine the response in the face of these challenges has been of ever increasing specialization. This is particularly the case where manual dexterity in performing invasive diagnostic or therapeutic procedures.

However as "the consultant's consultant", the pathologist often is expected to be conversant with the essentials of pathology of a number of specialties and sub-specialties and to be able to give advice in the case of those disorders which inconveniently can crop up in more than one or across the boundaries of different modern specialties. RCPA traditionally has offered training for Fellowship in either a single discipline of pathology or a general training in two or more disciplines. In some disciplines training may be slanted, e.g. to forensic pathology in Anatomic Pathology. However all trainees now must pass an examination in "Pathological Sciences". RCPA also has had in the past 3 years to consider processes by which persons trained in one discipline can undergo post-fellowship re-training in others. Finally requirements of continuing professional development require registration of activities relevant to current practice rather than to original training. Issues: 1. Are there likely to be benefits in training programmes that are more broadly based than current single discipline programmes? 2. How much should pathologists with a 'major' in one discipline be (a) expected or (b) permitted to know and do in another? How will this be evaluated? 3. What should be offered for re-training and re-certification for a major shift in pathology specialty? 4. Are these general issues more pertinent to some countries than others? 5. Are there some common characteristics which define a 'core pathologist'? Recommendations: 1. Pathology training could be redefined into 'modules'. 2. Some could be delineated as essential or major and others as optional or minor. 3. Fellowship/specialist recognition could be awarded on the basis of a person qualifying with a predetermined set of major and minor modules." Dr. Davies discussed the concept of modular training, with some modules mandatory, others elective. Modular training might solve the problem of supervisory duties for areas in which pathologists had not been previously trained. At present, the RCPA will approve re-training by participation, but will not examine in a new discipline.

Dr. Lilleyman indicated that problems are encountered in the UK accreditation program when pathologists are asked to supervise without specific qualifications, e.g. an anatomic pathologist asked to supervise hematology or chemistry. Also stressed was the need for cross-discipline training to supervise laboratories too small to justify single discipline specialists. Dr. Bachner expressed concerns about training which is too narrowly focused--will it cause "Balkanization" of the profession? In the UK, anatomic pathology has a fairly prominent role in clinical medicine, primarily in the area of oncology. While AP will remain with a strong laboratory focus, it is perceived that clinical pathology is moving more into the clinician/laboratorian mold. In the US, the ABP instituted a 5th year of training intended to be a clinical year to foster more involvement of pathologists in a clinical role. This intended result has not occurred.

### Continuing Medical Education:

Dr. Mak indicated that pathologists in Hong Kong need a prescribed number of CME points in each 3 year cycle to retain Fellowship in the HKAM. Individual Colleges are responsible for the design of CME programs. Programs must be approved by the HKAM, but the College of Pathology is to ensure compliance and may recommend suspension of a Fellow by the HKAM for non-compliance with CME. This may ultimately result in removal of the practitioner's name from the Specialist Register maintained by the HK Medical Council. Points must be achieved in at least two areas of participation. The College will assist pathologists in gaining access to CME and will record CME credits. The mechanism to deal with non-compliance is not yet fully developed, and there will be an appeal mechanism. Fellows are required to submit annual reports of CME and be able to produce evidence of compliance if requested.

### PATHOLOGY PRACTICE

#### Acceptable Error Rates in Histopathology & Cytopathology:

Discussion was opened by Professor MacSween relating the public scrutiny arising from a so-called "Kent/Canterbury Incident" and an inquiry regarding cytology problems. The College was asked to investigate whether the same problems existed in histopathology. The RCPA was faced with the challenge of evaluating some 24,000 cases covering a 4 year period in one hospital with 4 pathologists. The major question was how could one determine if there were problems. Some 1/2 dozen papers in the literature outlined the following approaches:

1. Circulation of slides among pathologists--method not popular in the UK. It did not answer question whether 5% variance outside the 95% consensus rate was bad practice.
2. Retrospective review of reported cases--2% random sample reviewed by pathologist not on service during a certain month. In some 500 cases, a 4% error rate was considered unsatisfactory.
3. CPC conferences. The diagnosis was changed in 9% of cases. 3.8% were minor variances, but 5% were considered significant.
4. Double reporting--there was a 1 to 2% variance.
5. Review by 'experts' in an oncology referral practice. In 270 cases, there was an 8% variance. No cases varied from benign/malignant. Most variances were in lymphoma, melanoma, and soft tissue tumors.
6. Re-review by a panel of 15 consultants. Some tended to over diagnose, while others under diagnosed. Reported a 20.8% variance. The error rate in lymphoma ranged from 1 to 10%. However, when a lymphoma is referred for definitive diagnosis, this is considered good practice. Project K is designed to study cases in the Kent/Canterbury hospital over a 4 year period, looking at



100% of the lymphomas, 50% of breast cases, 30% of cervicals, and 50% of colorectal cases, for a total of 2500 cases. Two reviewers are to arrive at a consensus diagnosis and compare to the original diagnosis. The study is attempting to determine what is a significant error rate. The results of the study are expected in 2 to 3 months. In the following discussion, several issues were raised. What is a significant variation in cytology in view of the varied nomenclature? Does workload impact the error rate? A concern was voiced about the Project K methodology due to the environment in which review is carried out—the reviewers know they are reviewing cases while the original pathologist is under pressure to report the diagnosis. Dr. Wood suggested "error" rates be avoided, and that we talk instead about confidence levels, concurrence rates, etc. Dr. Davies presented a concept of "critical" values—e.g. review when the anticipated therapy has a major impact on functionality of the patient such as laryngectomy in a patient with CA of the larynx. When do we need a second opinion?

### **Emerging Infections & Environmental Pathology:**

Contamination from agriculture, mining, etc. degrades the quality of the water supply, leading to problems with cryptosporidium and other organisms. Question raised as to whether pathologists should play a more active role in ensuring water quality. If there is testing and a problem is discovered, must determine if it poses a problem to the public and what should be done about it. Should every finding of an organism lead to treatment of the water supply? The standards of such testing must be determined as to when to test, methodology, etc. One must also be aware of unexpected consequences for there are not only medical but political and economic impacts as well. The Hong Kong chicken flu situation was cited as an example.

### **Genetic Testing:**

The Australian Human Tissue Acts control the use of human tissue removed at autopsy for educational and research purposes in addition to determination of the cause of death. Surgical tissues are regarded as human waste, and legal requirements only address safe disposal. The issue of ownership of retained blocks or tissue has not really been addressed although there is mounting pressure for greater restriction on the use of human tissue. In New Zealand there have been problems with disposal of organs retained from autopsy cases. There is also pressure to require informed consent for use of retained tissue for research purposes, particularly nucleic acid studies. It was suggested that if the imprimatur of a greater number of other medical societies on the US consensus document could be gained, it would go far in promoting international consensus. In the UK, the RCP has adopted the US position paper and added footnotes indicating where UK laws apply. The consensus of the group was any guideline should be rather loose, rather than allowing

proscriptive rules to develop.

### **Viability of Immunology as a Discipline in Pathology:**

The history of immunology in Australia was reviewed, particularly as it relates to training and the establishment of examination for Fellowship in the RCPA. Over time, technology and equipment have evolved so that special immunology skills are no longer needed. Also, immunology now has significant overlap with chemistry and microbiology. In the US, the number of ABP examinees for special competency in immunology have dwindled to insignificant numbers and the examination is no longer given as it has become a technique and spreads across all disciplines. The movement to core laboratories based on similarity of instrumentation, turn-around times, etc. has also played a role in diminishing the role of immunologists. In the UK, immunology still persists but has a greater clinical orientation toward HIV and other immunodeficiency diseases. Allergy will be given its own status separate from immunology. Immunology tends to focus more on the pediatric population than the adult. In the US, rheumatology has links to immunology in the adult population. Immunology in Hong Kong does not have a designated laboratory in most hospitals.

### **Pathology Assistants for "cut-up" or "grossing":**

In Australia, the role of pathology assistants has been debated since the 1980s. RCPA policy affirmed that grossing should be done by pathologists or those in training, but allowed lesser trained individuals a role if an entire specimen was simply placed in cassettes, e.g. endometrial curettages. Although not mandated by a legal decision, the RCPA revised its policy in 1998 to allow delegation to assistants if: 1. the pathologist was available to inspect the specimen; 2. the assistant was properly trained; 3. a procedure manual was available to guide the dissection; and 4. the non-pathologist must be identified in the report. All steps are still the responsibility of the pathologist. In the US, the original CLIA regulations were interpreted as forbidding grossing by residents, but this has been modified. There are concerns that payment under Medicare could be affected when specimens are grossed by a non-pathologist or resident. As payments and government support for training decreases, the number of residents has diminished, e.g. Los Angeles County Hospital has gone from 40 to 20 residents. Training of pathology assistants has not been well defined, but educational levels have been improved. Dr. Chandor will check on distributing the NCAALS training requirements. PAs have not yet requested recognition under the ASCP medical technologist system. Their function is, however, addressed in the Laboratory Accreditation Program with rules similar to those listed for Australia. There are concerns about the role of PAs in forensic pathology. In the UK, the responsibility for all steps in anatomic pathology remain with the pathologist.

## LABORATORY DIRECTION--WHO RUNS THE SHOW?

### Changing Roles of Personnel Within the Laboratory:

Dr. Lilleyman reviewed the attempts within the UK to coordinate all the various pathology and laboratory players. Evolving from academic locales, an association of pathologists was formed in the early 20th century. At the same time, assistants and technicians also organized. The advent of the National Health System 50 years ago brought about the designation of four major disciplines--anatomic pathology, microbiology, chemistry and hematology. It also established the levels of personnel, i.e. pathologists, technicians, degreed scientists. During the past 50 years, most research and development occurred in the commercial arena, i.e. machines. Changes also occurred in the terms identifying personnel, with the emergence of technicians to medical service laboratory officers, biomedical scientists, etc., with defined training and degrees. Scientists became clinical scientists with some carving out positions as consultants, e.g. in genetics. The borders between the various personnel have blurred.

Even education tends to overlap, but the NHS keeps personnel on different career paths. In Hong Kong, laboratory personnel seem to have upward mobility, being able to move from the technician to the technologist level. These have different jobs and salary levels. Academics are viewed as having status superior to hospital pathologists. 20% of the HKCAP members are clinical scientists, not pathologists. In the US, there are different educational levels for technicians versus technologists. CLIA has imposed other categories for testing personnel. The director must be either a pathologist or PhD scientist. Each test has a complexity level assignment which determines what level of personnel is needed for performance. Under the present conditions, medical technologists are being replaced by lesser trained individuals, a process driven by both fiscal and governmental restraints. Many corporate laboratories have management trained individuals as directors, not pathologists, although management skill is the determining factor. Directorship may also vary according to state law. In Australia, a pathologist director is still required, although at least one laboratory is run by a clinical scientist. Under consideration is the possible development of a Faculty of Medical Scientists within the RCPA, whose members (Fellows of the Faculty) might be medical or non-medical. A Faculty with a similar structure has recently been established for oral pathologists who may be both medical and non-medical (dentists). Fellows of the Faculties would not be full Fellows of the College but the Chairman of the Faculty Committee is/will be a full member of the College Council. Under Commonwealth law, medical practice cannot be regulated, but it can be controlled by regulating who can be paid under Medicare. There is also an accreditation requirement for payment. Various states have differing controls on and roles for pathologists. In sum-

mary, tension occurs when it comes to money.

### Clinical Governance of the Laboratory:

In the UK, there is pressure by the government to design performance review in order to ensure corporate responsibility for quality. The RCP is discussing a flow diagram for performance review presented by Dr. MacSween. It is felt that monitoring and maintenance of professional performance will be necessary. The RCPA has a professional performance review committee on the books, but it is on hold pending the implementation of an appeal mechanism (Board of Review). It would deal first with complaints from various sources. In New Zealand, the process is tied to incidents of malpractice. In the US, control of medical practice is largely the purview of individual hospital staffs. State boards of medical examiners/licensure can also take action when there is poor or questionable professional performance. Present systems in all countries address problems after the fact of discovery of bad medical practice. The systems do not address the issue of monitoring performance to become proactive and institute remediation before a problem becomes serious.

### Who Controls the "Core" Laboratory?:

The trend seems to be toward running these laboratories with non-pathologists. Core laboratories vary in organization depending upon its focus on technology or on clinical concerns. Rapid response is necessary and clinical input is critical to be certain that the lab is responsive and responsible. Cross-training of personnel was identified as one of the most difficult challenges in developing and operating a core laboratory. Relationships with intensive care and point of care laboratories vary, and in some core labs, accessioning is central with functions distributed. The concept appears to be driven almost totally by turn around times.

### Changes in Organization of Laboratory Based Medicine and Automation in Pathology:

Much of the discussion focused on robotics and automated PAP screening. It was the consensus that robotics seemed to be cost-effective in the area of specimen preparation. The volume of testing is a critical factor in determination of the degree of automation, and that in many situations, the cost/benefit ratio is marginal. Automated PAP screening may pick up added cases of cervical cancer but at a major cost. Initial capital costs are large and there must be a large throughput of cases. Dr. Bachner reported the findings of Diane Davey, MD, that the ThinPrep seems to be very good in reducing the ASCUS rate, particularly in high risk populations. False negative findings are of major concern in the US and has become a major political issue. Cost of automation is a factor in either initial screening or in secondary screening and quality control. Many equipment decisions are being driven by external forces such as advertising and political pressure. It is felt in Australia that there will be greater

benefit in extending PAP smear availability to those not previously screened. In Hong Kong, only 10 to 20% of the women are screened. A lack of cytotechnologists may bring about more automation in the future.

### **Changing Practice Characteristics of US Pathologists:**

Dr. Wood reported on the practice surveys conducted by the CAP, the third of which is now underway. Previous surveys have revealed the following trends: 1) Groups are merging because hospitals are merging, resulting in better cost control and increased income; 2) There is an increase in laboratory management organizations ranging from simple advice to partial or complete ownership; 3) Pathologist income is increasing commensurate with other physicians; 4) Payment rates are trending down; 5) Pathologists are working harder; 6) Negotiations with managed care organizations may or may not be effective; 7) National contracts with HMOs are increasing; 8) Physicians cannot refer to labs of choice. There are increasing problems with large laboratories being too remote from physicians, which in some areas is causing a reverse trend back to local laboratories. Mergers are largely stimulated by cost savings and the need to negotiate with HMOs. It was the perception that as laboratories become too large, they become less responsive to physician needs. Geography also controls size—rural areas may not be well served by consolidation. There was no consensus on what the ideal size of a lab would be.

## **GOVERNMENT, FINANCES, POLITICS**

### **Political and Economic Status of US Pathologists:**

The top issues with pathologists in the US are HMO impact, government regulations, payment rates, and the need to raise the awareness of the public as to what a pathologist is and does. The CAP has a public relations effort directed toward proper recognition of pathologists. A major effort has been a Partnership for Annual Pap Smears—a coalition with non-medical groups. There are also major efforts to gain increased compensation for Pap smears through the CAP Key Contact program, contact with the AMA, and spokesperson training for media interaction. In Hong Kong, efforts are under way to have members of the College call themselves pathologists first, and hematologists or microbiologists second. Once again, it was noted that a problem in medical schools is that students do not know what a pathologist is.

### **The Australian 3-year Experience:**

Payment for pathology in Australia is funded partially by 'capped' grants from the state and territorial government to public hospitals and health services and by an 'uncapped' fee-for-service system (Medicare) to community based private practices. The dual system is exploited by attempts to cost shift. Spending for pathology has been characterized by bursts of spending followed by draconian cuts by the government. In 1996, pathology

approached the government and agreed that if fee-for-service would be retained, the schedule of payments would be adjusted to keep within the budget. This has resulted in a leveling of utilization and costs. Coming in under budget has allowed the readjustment and equalization of some fees. The RCPA is now negotiating a second 3-year agreement. Good data is emerging on which tests are increasing and where guidelines are needed. The atmosphere has changed from adversarial to cooperative. Pathology is well-positioned from its leadership role, and the government is now attempting to gain similar agreements with other specialties.

### **Pathology as a Business:**

The 'free market' philosophy has permeated all levels of society in the past ten years, based on the concept that competition will control costs. In Australia, there are a number of anti-competitive statutes and boards charged with enforcement of the same. The National Competition Council has advocated total abolition of medical registration boards and regulation of the profession with nothing more than minimum competency standards. The relationship between the provider and recipient of a professional service has been reduced to a purely commercial one. A result is interference with accreditation activities, teaching, and participation in professional societies. The question is raised of how to ensure that competition does not degrade ethical professional practice and teaching. In all states in Australia, there is open access to patients in any 'public' hospital with degradation of after-hours service. In the US, the original CAP Code of Ethics dealt with many issues of conduct within the profession, but was abolished under an anti-trust consent decree in 1968. More recent ethical focus in the CAP has been on patient/pathologist relationships. Hong Kong has no compulsive accreditation and anyone may open a laboratory.

### **SNOMED:**

Dr. Bachner presented an overview of the CAP SNOMED project and system. Having origin in the 1960s with SNOP (Systematized Nomenclature of Pathology), it has grown to the present SNOMED (Systematized Nomenclature of Medicine). It is a multi-faceted system which allows very specific coding of diagnoses. Efforts are underway to gain acceptance of SNOMED as an international coding system for all of medicine. It is extremely useful for capturing data for outcome analysis. Negotiations are underway to combine SNOMED with the UK National Health System's Read method which is superior to SNOMED regarding clinical symptoms and signs, but the combination of the two would produce a very robust coding system. While the CAP would like to recover costs, there is no intent that SNOMED should become a major revenue source. The major advance in the next generation (SNOMED-RT) will be – in addition to the hierarchic nature of the system – the description logic and terminology model.

Some concerns were expressed about data capture, namely who would code the data. It is felt that secondary vendors would address this issue.

### **Challenges to US Academic Pathology Departments:**

Dr. Bachner reviewed the present status of academic departments in the US. The pathology service mission was described as high cost in a price sensitive market, dealing with uncompensated care and high acuity, bureaucratic and decentralized, burdened with training costs, being inflexible with high inertia, needing clinical income to survive, and with grave threats to education and research. For the teaching mission, there are decreased incentives and support in the face of labor intensive demands of undergraduates and a high student/faculty ratio. The role of residents in service and education varies as do levels of responsibility of residents. There are decreasing numbers of residents. In regards to research there is decreased revenue and support despite a 15% increase in research dollars at the National Institutes of Health. As clinical service loads increase, there is less clinical research with support directed at high profile research efforts. Faculty recruitment is suffering because of increased clinical and teaching workloads, decreased protected time, and problems with retention, promotion, and rewards as tenure becomes less the norm in academia, with a redefinition of tenure. The pool of US pathology applicants has shrunk considerably. An article in JAMA showed that 14.7% of recent graduates were unemployed. Funding for graduate medical education (GME) is decreasing with no funding for the 5<sup>th</sup> year of training. Much medical care in both urban and rural settings is now provided by international medical graduates (IMG). Also of note is that there is a 40% decrease in the number of new pathology positions with fewer retirements and resignations. Positions are lost as mergers occur and business volume drops. In the future, it is predicted that medical schools will fill certain niches, e.g. family practice. Schools will move to control all GME. Research will be avoided. There will be fewer basic science units with different and targeted funding, e.g. for clinical research. As for pathology training, there will be fewer programs and residents with training caps and changed funding. There will be fewer IMGs in US training. In the UK, research funding will go to the best research facilities. Research will be funded separately from the rest of laboratory payments. There will probably be efforts to identify funding for clinical research combined with service. "Teaching pathologists" will be identified. In Australia, there is some increase in educational funding as there is a perceived shortage of anatomic pathologists. One emerging problem is the production of too many PhDs who have no positions. The number of residents and PhD trainees is frequently driven by the need for workers rather than market forces.

### **Objectives and Membership of ILCP:**

The participants perceive that ILCP is fulfilling a needed function of communication. Expanded membership was again discussed. Communication with South Africa after the Sydney meeting and again this past summer keeps open the invitation to that country to join when they feel they have the financial resources to participate. Dr. Hamer will send the coordinator the name and address of a contact in Singapore to once again invite that society to join the group.

### **Future Meetings:**

It was decided to meet in London on May 12 & 13, 2000, followed by a meeting in Quebec City, Canada in June, 2001. A meeting in Australia was tentatively agreed upon in 2002 following the International IAP meeting in Queensland.

### **Closing Comments:**

The participants thanked Drs. Mak, Collins and Chan for the excellent arrangements for both the meeting and social events in Hong Kong. Both the Hong Kong Academy of Medicine and the College of Pathologists received best wishes for their continued success.



**THE SCHOOL OF POSTGRADUATE MEDICAL  
EDUCATION AND TRAINING  
FACULTY OF MEDICINE  
THE UNIVERSITY OF HONG KONG**

**A Guest Lecture**

**on**

**MULTIPLE SITES OF MELATONIN ACTION  
ON THE REPRODUCTIVE SYSTEM**

**will be delivered**

**by**

**Professor SF Pang  
Department of Physiology  
The University of Hong Kong**

**on**

**Wednesday 19th May, 1999**

**Time: 4:30 pm Reception (sponsored by Organon (HK) Ltd)**

**5:30 pm Lecture**

**Venue: Reception in Room GO2  
Lecture in The Lecture Room (GO5)  
G/F Patrick Manson Building South Wing  
Faculty of Medicine  
The University of Hong Kong  
7 Sassoon Road  
Hong Kong  
ALL ARE WELCOME**

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