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THE HONG KONG 香港醫訊  
*MEDICAL DIARY*

VOL.24 NO.1 January 2019

*Medical Law and Mediation*



# Comprehensive and Convenient Treatment for Osteoporosis



Persistence with treatment over 5 years was highest in patients receiving monthly bisphosphonates<sup>1</sup>.



## Comprehensive protection against fractures

### Vertebral fractures



**69%**

risk reduction vs placebo<sup>2</sup>

### Non-vertebral fractures



**74%**

risk reduction vs placebo<sup>3</sup>

### Hip fractures



**43%**

lower incidence vs alendronate<sup>4</sup>

<sup>1</sup> Risedronate 5 mg daily vs placebo at 1 year (95% CI 22% to 88%; p<0.05)

<sup>2</sup> Risedronate 5 mg daily vs placebo after 1 year (95% CI 37% to 90%; p=0.001)

<sup>3</sup> Risedronate 35 mg once-a-week vs alendronate 70 mg once-a-week after 12 months (95% CI 13% to 63%; p=0.01)

CI=confidence interval.

References: 1. Kishimoto H, Maehara M. Compliance and persistence with daily, weekly, and monthly bisphosphonates for osteoporosis in Japan: analysis of data from the CISA. Arch Osteoporos. 2015;10:27. 2. Roux C, Seeman E, Eastell R, et al. Efficacy of risedronate on clinical vertebral fractures within six months. Curr Med Res Opin. 2004;20:433-9. 3. Harrington JT, Ste-Marie LG, Brandt ML, et al. Risedronate Rapidly Reduces the Risk for Nonvertebral Fractures in Women with Postmenopausal Osteoporosis. Calcif Tissue Int. 2004;74:129-35. 4. Silverman SL, Watts NB, Delmas PD, et al. Effectiveness of bisphosphonates on nonvertebral and hip fractures in the first year of therapy: The risedronate and alendronate (REAL) cohort study. Osteoporos Int. 2007;18:25-34.



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## The Cover Shot



The picture on the cover of this issue is that of the Yellow Pumpkin, a very famous art work by Japanese artist Yayoi Kusama (草間彌生). Installed here in 1994 on the pier on Naoshima's South Beach, it has become the official symbol of the island as well as the Benesse Art Site Naoshima. This artwork has become so well-loved by everyone that, several years ago, Louis Vuitton produced a series of items featuring a yellow/black dot-design similar to it. Also, in 2018, a replica of the artwork was exhibited at the Victoria Harbour Front in Hong Kong for two months.



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Editors



Dr Danny WH LEE

It is trite to say that medicine is not an exact science. Despite technological advancement, we are seeing an alarming rise in complaints and litigations related to healthcare practices. In this issue of the Medical Diary, we are honoured to have experts in this area to share with our readers their knowledge on and insights in various challenging issues related to medical law and dispute resolution.

The journey to a successful civil claim of medical negligence is long and arduous, as it often involves complex legal elements and multi-dimensional expert testimony. To begin with, Dr Abraham Wai, Clinical Assistant Professor at the University of Hong Kong, has outlined succinctly what medical practitioners need to know about the law on negligence. Next, an article revealing the current legislation and case laws on the conduct of expert works is presented, and aims to address some practical caveats to colleagues who would like to take up this daunting job. As far as risk management is concerned, comprehensive and contemporaneous medical records are always considered our 'good friends' in the defence of medico-legal claims. In this regard, Dr KL Ong, Consultant Emergency Physician at Tuen Mun and Pok Oi Hospitals, has given us valuable advice on how to keep good records in our daily practice.

Contrary to popular belief, studies have shown that patients who lodged claims against their healthcare professionals did not always receive negligent treatments. In fact, when adverse outcomes occur, many patients or their relatives demand truthful explanation and accountability, honest and sincere apologies, well-formulated management plans, and in some circumstances, financial compensation, rather than lengthy and often unrewarding legal battles. It is crystal clear that timely and effective communications represent an important risk management strategy to prevent the escalation of tension between patients and healthcare professionals in the aftermath. Thus, Dr NC Sin, Hospital Authority's Chief Manager of Quality and Safety, has enlightened us on the rationale and strategy in managing the communication between healthcare professionals and patients (and the public) after medical mishaps. Further, Dr James Chiu, who was a member of the Working Group on Apology Legislation, has highlighted the power of apologies and the application of the newly enacted Apology Ordinance in Hong Kong.

Medical negligence claims are always emotion-laden. Monetary compensation aside, it is difficult for a court of law to adjudicate on the humane and emotional side of a dispute. Mediation is an alternative means to resolve medical disputes outside the courtroom. Dr Ludwig Tsoi, President of the Hong Kong Society for Healthcare Mediation, has given us an enlightening account on how to use mediation to settle medical related disputes. I must also thank Dr CL Law for his article and pictures presented in the lifestyle section; I myself have found Naoshima, Japan a must go.

I hope colleagues would enjoy reading this particular issue of the Medical Diary, in which we have presented a wide range of medico-legal topics that are generic for all clinical specialties. Last but not least, I would like to express my heartfelt gratitude to the authors for their unflinching support in making this issue a reality.



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# Medical Expert Witness – Duty, Independence, and Immunity

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This article has been selected by the Editorial Board of the Hong Kong Medical Diary for participants in the CME programme of the Medical Council of Hong Kong (MCHK) to complete the following self-assessment questions in order to be awarded 1 CME credit under the programme upon returning the completed answer sheet to the Federation Secretariat on or before 31 January 2019.

## INTRODUCTION

Medical expert opinions are essential tools for establishing liability, proving causation and assessing quantum in claims of clinical negligence as the court does not usually possess the necessary professional knowledge to adjudicate complex medical practices. In high profile claims, it is not uncommon to see multiple experts having been instructed to give evidence on various clinical aspects. Apart from obvious concerns for monetary and time costs, it has long been observed that medical experts have acted too often as partisan advocates for their instructing parties rather than independent opinion givers<sup>1</sup>. Thus, under the Civil Justice Reform 2009, the court is now given a variety of case management powers imposing greater control on the use of expert evidence<sup>2</sup>. Specifically, experts are now stated to owe an overriding duty to the court but not to the instructing clients. This article aims to share with potential medical experts the developments of relevant legislation and English case laws in three inter-related areas of the conduct of expert work - duty, independence, and immunity.

## EXPERT'S OVERRIDING DUTY TO COURT

Conceivably, experts would submit opinions, consciously or subconsciously, in favour of their instructing parties. At times, medical experts might be viewed as 'hired guns' when they presented themselves as advocates in submitting *Bolam*-defensible cases<sup>3</sup>. Potential experts should be mindful of the legal requirements which dictate that despite being paid by their instructing clients, experts owe an overriding duty to assist the court on the matters within their expertise<sup>4</sup>. The instructing lawyers shall provide the expert with a copy of the code of conduct for expert witnesses set out in the Appendix D of the Rules of High Court (Cap 4A, Laws of Hong Kong) as soon as practicable. The expert needs to make a declaration in the report that i) he has read the code of conduct and agrees to be bound by it; ii) he understands his duty to the court; and iii) he has complied with and will continue to comply with that duty<sup>5</sup>. An expert report without such a declaration is not admissible as evidence in court<sup>5</sup>. Further, the expert report must be verified by a 'Statement of Truth'<sup>6</sup>,

which means the expert believes that the facts stated in the document are true and the opinion expressed in it is honestly held. Again, without a statement of truth, it is likely that the report will not be admissible as evidence in court<sup>6</sup>. On the other hand, if an expert has made a statement of truth falsely, he may be subjected to proceedings for contempt of the court<sup>7</sup>.

Apart from procedural rules, it is equally important to observe the common law duties and responsibilities of expert witnesses, which were laid down by Cresswell J in the judgment of the case: *The Ikarian Reefer*<sup>8</sup>. A summary of these principles is listed in Table 1 for easy perusal.

## INDEPENDENCE OF EXPERT – ADMISSIBILITY AND WEIGHT OF EVIDENCE

It is clear that the court is looking for an independent and impartial expert opinion to assist it in understanding of the evidence submitted in a negligence claim. When there are conflicting opinions, the court has to decide which opinion it prefers and why. The issue of independence of the expert is usually a factor that the court would consider how much 'weight' is to be put on the expert's opinion.

It has been established by the English Court of Appeal (CA) that prior working or personal relationships between the instructing party and the expert did not automatically disqualify the expert. The key question is whether the expert opinion is independent of the parties and the pressure of litigation<sup>9</sup>. The recent case of *EXP v Barker* is illustrative in this regard<sup>10</sup>. The defendant expert had had a long working history with the defendant doctor but nevertheless that was not disclosed at any stage of the court proceedings. The trial judge, though reluctantly admitted the expert's opinion, gave little or no weight to it. The defendant lost the case. The CA upheld the trial judge's decision. Lord Justice Irwin reiterated<sup>10</sup>:

*Our adversarial system depends heavily on the independence of expert witnesses, on the primacy of their duty to the Court over any other loyalty or obligation, and on the rigour with which experts make known any associations or loyalties which might give rise to a conflict.*



In practice, the instructing lawyer will check with the potential expert on any potential or actual conflicts of interest prior to the issue of instruction letter. Medical experts are reminded to disclose any material conflicts of interest as early as practicable during the course of writing the report or court hearing. An accurate *curriculum vitae* of the expert containing the details of professional affiliation (including academic publication) and working history with the instructing party (or other related parties), which might give rise to a conflict of interest, should be produced together with the expert report.

## NO EXPERTS IMMUNITY – CIVIL AND DISCIPLINARY

In *Jones v Kaney*<sup>11</sup>, Jones sued his expert for submitting a negligent report leading to a significant lower sum of damages that would otherwise have been offered to him in a personal injury claim. The expert applied to the court for the lawsuit to be struck out, relying on the argument of ‘immunity from civil suit’ – a long established common law concept where witnesses are free from legal actions due to public policy reasons. By a majority of five to two, the English Supreme Court removed the protection that gave experts immunity from suit for breach of duty, whether in contract or tort. Drawing an analogy with advocates, the majority views of the English highest judiciary considered that the removal of immunity for experts would not deter experts from giving evidence in court in fear of being sued, and that the decision would not open the floodgates to vexatious claims or multiplicity of actions against experts. Simply put, experts are now no longer immune from civil actions for their lapses or egregious failures in preparing the reports or appearing in court. It remains conjectural as to whether experts will be deterred from doing the job in fear of vexatious claims brought by disgruntled clients.

Five years before the decision of *Jones*, the CA was asked a similar question on whether an expert witness should be entitled to immunity from disciplinary proceedings held by the General Medical Council (GMC)<sup>12</sup>. The legal challenge originated from a complaint to the GMC. Briefly stated, Professor Meadow was an eminent paediatrician who had given expert evidence in support of a criminal prosecution of murder. The evidence was later found to be misleading and to have contributed to a wrongful conviction of the accused for murder. The accused’s father made a complaint to the GMC alleging ‘serious professional misconduct’ on the part of Professor Meadow. The Fitness to Practise Panel of the GMC heard the complaint and concluded Professor Meadow was guilty of serious professional misconduct and ordered an erasure of his name from the GMC register. The decision was quashed by the High Court after the appeal by Professor Meadow. The GMC appealed to the CA. At issue was whether experts should be given immunity in disciplinary hearings. The CA decided that professional regulatory bodies such as the GMC should have statutory responsibilities to investigate an allegation that a medical expert is unfit to practise. The CA was of the view that to offer blanket immunity in the circumstances would limit the power and duty of the GMC. In short, no disciplinary immunity should

be offered to doctors who take up the work of an expert witness. Nevertheless, the CA upheld the trial judge’s decision in *Meadow* to set aside the GMC’s decision because the expert evidence was given in an honest, albeit mistaken, manner and that the strike off penalty was disproportionate.

## CONCLUSION

It cannot be over-emphasised that the duty of expert witnesses is to the court, not the instructing parties. Thus, experts should act objectively, independently and impartially when submitting their opinions. Potential medical experts should also take note of the new procedural provisions on the court’s management power of expert evidence. Before taking up the expert work, it is important to check and disclose any potential or material conflicts of interest with the instructing parties. Nowadays, experts no longer enjoy the immunity for suit and it is possible that experts are sued for breach of duty out of their works. Civil liability aside, professional regulatory bodies may also bring disciplinary actions against medical experts who have submitted inaccurate or negligent reports in the course of court proceedings. It is thus paramount for potential experts to check with their own professional indemnity organisations on the liability coverage in connection with the expert work.

*Table 1. Duties and Responsibilities of Expert Witnesses*

1. Expert evidence presented to the court should be, and should be seen to be, the independent product of the expert uninfluenced as to form or content by the pressure of litigation.
2. An expert should provide independent assistance to the court by way of objective unbiased opinion in relation to matters within his expertise. An expert should never assume the role of an advocate.
3. An expert should state the facts or assumptions upon which his opinion is based. An expert should consider all material facts.
4. An expert should make it clear when a matter falls outside his expertise
5. If an expert’s opinion is not properly researched because of insufficient data are available, then this must be stated with an indication that the opinion is no more than a provisional one. Where the expert could not assert his report ‘contained the truth, the whole truth, and nothing but the truth without some qualification’, such qualification should be stated in the report.
6. If, after exchange of reports, an expert changes his view on a material matter having read the other side’s expert’s report or for any other reason, such a change of view should be communicated (through legal representatives) to the other side without delay and when appropriate to the court.
7. Where expert evidence refers to photographs, plans, calculations, analyses, measurements, survey reports or other similar documents, these must be provided to the opposite party at the same time as the exchange of reports.

*Summary from the case of ‘The Ikarian Reefer’<sup>8</sup>*



References

1. Access to Justice Final Report, The Right Honourable the Lord Woolf. 2006. (Accessed September 18, 2018 at <http://webarchive.nationalarchives.gov.uk/20060214041428/http://www.dca.gov.uk/civil/final/sec3c.htm#c13>.)
2. Civil Justice Reform. 2009 (Accessed September 18, 2018 at <https://www.civiljustice.hk/eng/home.html>.)
3. Bolam v Friern Hospital Management Committee [1957]1 WLR 582.
4. Rule 35A, Cap 4A, Order 38, Evidence, The Rules of the High Court, Laws of Hong Kong.
5. Rule 37C, Cap 4A, Order 38, Evidence, The Rules of the High Court, Laws of Hong Kong.

6. Rule 37A, Cap 4A, Order 38, Evidence, The Rules of the High Court, Laws of Hong Kong.
7. What are Statements of Truth. Guide to General Civil Proceedings in High Court and District Court. (Accessed at September 18, 2018 [https://rcul.judiciary.hk/documents/eng/Leaflet\\_06\\_Eng.pdf](https://rcul.judiciary.hk/documents/eng/Leaflet_06_Eng.pdf).)
8. The Ikarian Reefer [1993] 2 Lloyd’s Rep. 68.
9. Toth v Jarman [2006] EWCA Civ 1028.
10. EXP v Barker [2017] EWCA Civ 63.
11. Jones v Kaney [2011] UKSC 13.
12. Meadow v General Medical Council [2006] EWCA Civ 1390.

MCHK CME Programme Self-assessment Questions

Please read the article entitled “Medical Expert Witness – Duty, Independence, and Immunity” by Dr Danny WH LEE and complete the following self-assessment questions. Participants in the MCHK CME Programme will be awarded CME credit under the Programme for returning completed answer sheets via fax (2865 0345) or by mail to the Federation Secretariat on or before 31 January 2019. Answers to questions will be provided in the next issue of The Hong Kong Medical Diary.

Questions 1-10: Please answer T (true) or F (false)

1. In medical negligence claims, expert witnesses are only required to assist the courts to understand what the current medical practice is.
2. A medical expert witness owes an overriding duty to his instructing party to present the evidence in court.
3. A medical expert needs to make a declaration in his report that he has read the code of conduct stipulated by the law and agrees to be bound by it.
4. A medical expert should assume the role of an advocate to present a Bolam-defensible submission.
5. A medical expert should know the limit of his expertise, and make it clear to the court when a matter falls outside his expertise.
6. If a medical expert has made a ‘Statement of Truth’ falsely in the expert report, he may be subjected to proceedings for contempt of court.
7. A medical expert will be automatically disqualified if he has worked with his instructing party in the same unit before.
8. Medical expert witnesses are still able to enjoy ‘immunity from civil suit’ after the English Supreme Court case: Jones v Kaney.
9. Medical expert witnesses will be given blanket immunity in relation to expert works in professional disciplinary proceedings held by regulatory bodies.
10. It is advisable for potential medical experts to check with their professional indemnity organisations with regard to the liability coverage arising from the expert work.

ANSWER SHEET FOR JANUARY 2019

Please return the completed answer sheet to the Federation Secretariat on or before 31 January 2019 for documentation. 1 CME point will be awarded for answering the MCHK CME programme (for non-specialists) self-assessment questions.

Medical Expert Witness – Duty, Independence, and Immunity

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# Hong Kong Apology Ordinance (Cap. 631) - Applications and Limitations

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Dr James SP CHIU

## INTRODUCTION

In any community, conflicts and disputes are unavoidable, and the healthcare sector is no exception. When these arise, there are different ways to resolve them before they escalate to litigation. Court proceedings are well known to be expensive, time-consuming, and stressful for both parties. One of the options to resolve disputes is to offer an apology. Very often, the heat of the moment so commonly found in a dispute could have been extinguished (or at least reduced) by an apology or an expression of sympathy or regret, thus preventing the escalation of the dispute into legal action or making it more likely for the legal action to be settled<sup>1</sup>.

## WHY DON'T PEOPLE WANT TO APOLOGISE?

It appears there is a common concern that any apology or a simple utterance of the word "sorry" may be used by a plaintiff in civil or other non-criminal proceedings (such as disciplinary proceedings) as evidence of *fault or liability* by the defendant for the purpose of establishing legal liability. Further it is not uncommon that a party may have concerns that an *insurance policy* covering the incident giving rise to the dispute may be rendered void or otherwise adversely affected by an apology because of clauses in the policy that prohibit the admission of fault by the insured<sup>2</sup>.

The question is how to make it safe to apologise without fear of any repercussion. A legislation which protects all forms of apology will be most reassuring.

## APOLOGY ORDINANCE

The first wave of apology legislation in the world started in 1986 in the State of Massachusetts in U.S.A., and was designed to enhance settlement. It has spread to the majority of other states in the U.S. The second wave was in Australia in the early 2000s. The third and the fourth waves spread to Canada and the U.K. in the late 2000s. The Hong Kong Apology Ordinance came into operation on 1 December 2017. It is the first apology law in Asia, and may be the beginning of the fifth wave worldwide<sup>3</sup>. It is also the most comprehensive apology legislation in the world.

The object of the Ordinance is to promote and encourage the making of apologies with a view to preventing the escalation of disputes and facilitating their amicable resolution<sup>4</sup>.

The Steering Committee on Mediation of the Department of Justice considers that an apology given at an early time would help to reduce the hostility and negative feelings of the injured person, who may then be more willing to communicate and engage in settlement negotiations with the person causing the harm. Indeed, the legislative intention is not just to cover settlement efforts where there exist other mechanisms such as, without prejudice, communication and mediation. The intention of the proposed apology legislation is to encourage the making of apologies irrespective of whether legal proceedings have commenced and whether settlement is contemplated. This would hopefully bring about a change in people's mindset and conduct in that more would be willing to make apologies so as to reduce the escalation and enhance the settlement of disputes. However, it would still be an individual's own decision based on different factors as to whether he should make the apologies<sup>5</sup> and how to make them.

In this Ordinance, an apology means an expression of the person's regret, sympathy or benevolence, and includes an express or implied admission of the person's *fault or liability* or a statement of fact in connection with the matter<sup>6</sup>.

To achieve its objective, the Ordinance protects apologisers in three important aspects by stating clearly that an apology (i) *does not constitute an express or implied admission of fault or liability*<sup>7</sup>; (ii) *must not be taken into account in determining fault, liability or any other issue in connection with the matter to the prejudice of the person*<sup>8</sup>; and (iii) *is not admissible as evidence for determining fault, liability or any other issue in connection with the matter to the prejudice of the person*<sup>9</sup>.

## APPLICATIONS

The Ordinance applies to *judicial, arbitral, administrative, disciplinary and regulatory proceedings*<sup>10</sup>, but does not include criminal proceedings or proceedings specified in the Schedule<sup>11</sup>.

Sub-section 10(1) of the Ordinance expands to state that any insurance cover, compensation or other form of benefit under a *contract of insurance or indemnity* are not affected. This appears to be an important component of the apology legislation because it responds to reported anecdotal evidence of defendants and their lawyers that apologies are often not made because of the fear that doing so will render insurance coverage void or

otherwise affected to the detriment of the defendants. This fear has been identified as a real and significant barrier to offers of apology<sup>12</sup>.

In a medical setting, one reason why many doctors have been reluctant to openly discuss an adverse event with a patient or their family is that by doing so they might be compromising the defence of the claim without the consent of their insurer. Other fears include that what they say may be treated as an admission of liability in an ensuing trial and in any subsequent *disciplinary proceedings*. The protective provisions of the Apology Ordinance now apply in both of these circumstances<sup>13</sup>.

To avoid any potential loophole in the legislation, the Steering Committee considered it desirable to explicitly prohibit the contracting out of the apology legislation. Further, apart from insurance contracts, the proposed apology legislation should also expressly cover indemnity. After considering all the responses received during the consultation, the Steering Committee recommended that the apology legislation should expressly provide that an apology shall not affect any insurance cover or indemnity that is, or would be, available to the person making the apology and that any contracting out of the apology legislation should be prohibited or declared void<sup>14</sup>.

Increasingly hospital systems are requiring disclosure of adverse incidents to patients and often this is combined with words of apology or regret. Incident disclosure (or "open disclosure") therefore raised the likelihood that facts will be disclosed. Thus, in the context of medical liability, the definition of apology as including a statement of facts is significant<sup>15</sup>.

Section 8(2) provides that, if there is an exceptional case (for example, where there is no other evidence available for determining an issue), the *decision maker*<sup>16</sup> may exercise a *discretion to admit a statement of fact* contained in an apology as evidence in the proceedings, but only if he is satisfied that it is just and equitable to do so, having regard to the public interest or the interests of the administration of justice. The responsibility to make such discretion is heavy on the decision maker. In such a case, he has to separate an apology containing expression of regret or sympathy and an admission of fault (which is inadmissible) from factual contents (which he has to admit) first. "This requires a contextual analysis of the words used and the statements each separate and distinct thoughts or messages"<sup>17</sup>. Having done this, he will then have to decide whether it is 'just and equitable, having regard to the public interest or the interests of the administration of justice' to admit the factual statements he has identified or not. Such decisions are not difficult to make for judges and arbitrators who are well-qualified in law and who can easily exercise discretion with all those criteria in mind. This was demonstrated in the Canadian cases of *Robinson v Cragg*<sup>18</sup> and *Cormack v Chalmers*<sup>19</sup>. However, it may be difficult for those decision makers who do not have any legal training, such as those in some disciplinary tribunals.

The Steering Committee considered that it was clearly in the public interest to have the apology legislation applicable to the *Government*<sup>20</sup>. In healthcare settings, it means that apologies made by practitioners from both

the public as well as the private sectors are protected by the Ordinance.

## LIMITATIONS

Section 6(2)(a) of the Ordinance provides that applicable proceedings do not include *criminal proceedings*. In other words, an apology made in connection with a matter for the purposes of criminal proceedings is admissible as evidence of an admission for the purpose of determining guilt of an offence.

Section 4(4) provides that that an apology *made on behalf of another person* has the same meaning of an apology made by the person himself. This usually takes place in individuals of the same team and made by a more senior person. It is ill-advised for someone to apologise on behalf of a member of a different team. For example, it is not advisable for a pathologist, who has performed an autopsy, to apologise to a patient's relatives or friends on behalf of the doctor who did the operation. It is especially dangerous if there may be an element of *criminal* offence involved, such as illegal abortion or manslaughter.

Section 6(2)(b) provides that applicable proceedings do not include the four proceedings specified in the *Schedule*. The proceedings which concern healthcare sectors are those conducted under the Coroners Ordinance (Cap. 504). The reason is that these are fact-finding in nature without any determination of liability. According to s44(1)(a) of the Coroners Ordinance, neither a coroner nor a jury at an inquest shall frame a finding in such a way as to appear to determine any question of civil liability. Since these proceedings do not involve any determination of legal liability, and the number of such proceedings is relatively few when compared with other civil proceedings, the Steering Committee took the view that it would not defeat the objectives of the legislation if these proceedings were to be excluded<sup>21</sup>.

## CONCLUSIONS

The same as before the enactment of the Apology Ordinance, one may apologise on a without-prejudice basis or in mediation. The objective of the Ordinance is to promote and encourage the making of apologies with a view to preventing the escalation of disputes and facilitating their amicable resolution. It provides more protection to apologies made in civil procedures as well as in disciplinary and regulatory proceedings than before, but is not applicable to criminal cases. It extends the protection beyond mediation. To be effective, apologies have to be sincere and made voluntarily. The law does not compel any person to apologise. If there is any uncertainty about whether or how to apologise, one should consult a senior colleague or a knowledgeable lawyer before making an apology.

Although the Hospital Authority has an effective system of complaints management in place, with the enactment of the Apology Ordinance, this is perhaps the right time to review its policies and procedures. It is also advisable for private hospitals to develop and enhance their complaint-handling systems.



## References

1. Steering Committee on Mediation, Department of Justice, the Government of the Hong Kong Special Administration Region. Consultation Paper: Enactment of Apology Legislation in Hong Kong, 2015; 4.
2. Steering Committee on Mediation, Department of Justice, the Government of the Hong Kong Special Administration Region. Consultation Paper: Enactment of Apology Legislation in Hong Kong, 2015; 3.
3. James Chiu. Apology Legislation, in Hong Kong Civil Procedure 2018: A Collection of Considerations - Special Release, Sweet & Maxwell 2017; 1
4. Apology Ordinance (Cap. 631) s2
5. Steering Committee on Mediation, Department of Justice, the Government of the Hong Kong Special Administrative Region. Enactment of Apology Legislation in Hong Kong: Final Report and Recommendations. November 2016; 84
6. Apology Ordinance (Cap. 631) s4(1), (3)(a) and (3)(b)
7. Apology Ordinance (Cap. 631)s7(1)(a)
8. Apology Ordinance (Cap. 631)s7(1)(b)
9. Apology Ordinance (Cap. 631)s8(1)
10. Apology Ordinance (Cap. 631)s6(1)(a)
11. Apology Ordinance (Cap. 631)s6(2)
12. Steering Committee on Mediation, Department of Justice, the Government of the Hong Kong Special Administrative Region. Executive Summary of the Consultation Paper: Enactment of Apology Legislation in Hong Kong, 2015; 82, para 5.63
13. Robyn Carroll, James Chiu and Prue Vines. Apology Ordinance (Cap. 631) Commentary and Annotations. Sweet & Maxwell 2018; 89 and Footnote 299. Apology Ordinance (Cap. 631 s6(1)(a)
14. Steering Committee on Mediation, Department of Justice, the Government of the Hong Kong Special Administrative Region. Enactment of Apology Legislation in Hong Kong: Report & 2nd Round Consultation. February 2016; 52-53
15. Robyn Carroll, James Chiu and Prue Vines, Apology Ordinance (Cap. 631) Commentary and Annotations. Sweet & Maxwell 2018; 31
16. Section 8 defines a decision maker as "the person (whether a court, a tribunal, an arbitrator or any other body or individual) having the authority to hear, receive and examine evidence in the proceedings"
17. Cormack v Chalmers [2015] ONSC 5599.
18. Robinson v Cragg 2010 ABQB 743.
19. Cormack v Chalmers [2015] ONSC 5599.
20. Steering Committee on Mediation, Department of Justice, the Government of the Hong Kong Special Administrative Region. Enactment of Apology Legislation in Hong Kong: Report & 2nd Round Consultation. February 2016; 43
21. Steering Committee on Mediation, Department of Justice, the Government of the Hong Kong Special Administrative Region. Enactment of Apology Legislation in Hong Kong: Final Report and Recommendations. November 2016; 23-24.

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## Dermatology Quiz



## Dermatology Quiz

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 Specialist in Dermatology & Venereology



Dr Lai-yin CHONG



Fig.1: Annular erythematous lesions with central clearing

Fig.2: Serpiginous papulosquamous lesions

This 3-month-old baby developed these skin lesions over her face soon after birth (Fig.1 & 2). There were no skin lesions elsewhere. She had been treated with topical steroid and topical antifungal by various doctors. However, the lesions persisted despite treatment. Her mother was well all along during the pregnancy. There was no significant family history.

## Questions

1. What is your clinical diagnosis and differential diagnoses?
2. What investigations should you perform as soon as possible?
3. What is the prognosis of her disease?

(See P.36 for answers)

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# Framework of Open Disclosure and Public Disclosure after Clinical Incidents

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## Section 1. OPEN DISCLOSURE

Open disclosure is an essential part of clinical management. Healthcare providers have the responsibility to maintain honest communication with patients/family/carers even when things go wrong.

### DEFINITION

Open disclosure is an open discussion or a series of open discussions with patient/family/carers about an incident which could have resulted or did result in harm to that patient while he was receiving medical care. The purpose of open disclosure is to ensure communication between the patient/family/carers and healthcare providers and to maintain the trust, confidence and relationship between both parties.

The following elements must be included in the open disclosure while respecting the confidentiality of the patient:<sup>1</sup>

- An acknowledgement that a clinical incident has occurred;
- A factual explanation of what happened;
- A discussion of the potential consequences of the event;
- An explanation of the steps being taken to manage the event; and
- A description of the follow-up plan on managing the patient and the incident.

As part of an effective communication process, patients/family/carers have to be given the opportunity to relay their experience during the open disclosure process. An expression of sympathy or apology by the clinical team regarding the encounter/incident should be offered where appropriate.

### THE PROCESS

#### WHEN TO DISCLOSE

Open disclosure should be done in an open and honest manner. It should take place as soon as practicable, taking into account the patient's psychological and physical conditions, time to collect essential information and plan for disclosure.<sup>2</sup> There should be a formal discussion, documenting justifications and joint decision amongst members of the clinical team and the hospital management on the timing of the open disclosure. Unreasonable delay will likely increase

the patient's/family's anxiety, frustration or anger, which may jeopardise the effectiveness of subsequent communication.

#### WHO TO DISCLOSE

For incidents being classified as Sentinel Events (SEs) or Serious Untoward Events (SUEs) (see Annex1 for details), the open disclosure process should be performed by a senior member of the clinical team/department or by a staff under the supervision and in the presence of a senior member of the clinical team/department. In the Hospital Authority setting, the Cluster Quality and Safety Office or the Patients Relations Office should be involved during the open disclosure process for SEs and SUEs. It is said that the staff directly involved in the clinical incident is the "second victim" besides the patient. The staff is usually under tremendous stress after the mishaps. Psychologically, the staff is constantly overwhelmed by guilty feelings and self-blaming. During the emotional turmoil, the attitude of the involved staff may be punctuated by denial and defensive mode towards the patient or family members. This is a natural defense mechanism of human beings. As such, unless stipulated by the hospital chief in exceptional situations, it will not be advisable for the staff directly involved in the clinical incident to perform the open disclosure process.<sup>3</sup>

#### RECORD AND DOCUMENTATION

The open disclosure process should be documented. The documentation is for the benefit of all parties involved. It should also be noted that the hospital will be obliged to provide copies of the documentation of the open disclosure meeting, if so requested by the patient and/or the participants of the meeting.

#### APOLOGY ORDINANCE

The Apology Ordinance took effect in Hong Kong on 1 December 2017.<sup>4</sup> Although clinical staff carry no legal obligation to offer an apology under the Ordinance, an apology may be made when an apology is considered appropriate. The purpose of the Apology Ordinance is to promote and encourage the making of apologies with a view to preventing the escalation of disputes and facilitation of amicable resolution. Under the Ordinance, the apology (including statement of facts in connection with the matter expressed as part of the apology) shall not constitute an admission of fault or liability in connection with the matter for the purposes of applicable proceedings (see Table 1 for the definition and scope of applicable proceedings).

**Table 1: What are applicable proceedings (reproduced with permission from Hospital Authority Head Office Operation Circular No. 9/2018 "Open Disclosure Policy for Clinical Incidents")**

What are "applicable proceedings"?	
Inclusions	Exclusions
<ul style="list-style-type: none"><li>- Judicial, arbitral, administrative, disciplinary and regulatory proceedings (whether or not conducted under any Ordinance or subsidiary legislation) (e.g. court proceedings, proceedings before Medical Council, Nursing Council and other professional disciplinary proceedings)</li><li>- Other proceedings conducted under any Ordinance or subsidiary legislation</li></ul>	<ul style="list-style-type: none"><li>- Criminal proceedings</li><li>- Proceedings conducted under Control of Obscene and Indecent Articles Ordinance (Cap. 390) (not likely to be relevant to HA)</li><li>- Proceedings conducted under the Commissions of Inquiry Ordinance (Cap. 86) (e.g. inquiry into excess lead in drinking water)</li><li>- Proceedings conducted under the Coroners Ordinance (Cap. 504) (death inquests)</li><li>- Proceedings of the Legislative Council, its committee, panel or subcommittee (e.g. inquiry by LegCo Select Committee)</li></ul>

## Section 2. PUBLIC DISCLOSURE

### BACKGROUND

Looking at Hong Kong's current socio-political landscape, we can see the growing expectations of the public and ongoing scrutiny by the media and citizens towards public institutions and major corporations. Therefore, timely, open and transparent communication is necessary to maintain the trust and confidence of the public. When a clinical incident occurs, in addition to open disclosure to patient and/or family, public disclosure, where appropriate, is crucial in maintaining public confidence in service standards.

### REGULAR PUBLIC DISCLOSURE

The HA has regularly disclosed severe clinical incidents to the public through quarterly and annual reports since 2008. These quarterly and annual reports are available to the public and the media. The contributing factors leading to the incidents and the recommendations for risk mitigation strategies are highlighted in this regular public disclosure in an anonymised fashion to promote learning and sharing.

### PROMPT PUBLIC DISCLOSURE

There are situations where a healthcare institution, such as the HA, needs to initiate a prompt disclosure of clinical incidents to the public through the media. There are no universal nor concrete rules guiding the decision for prompt public disclosure. Good judgement needs to be made based on the individual circumstances of each clinical incident, guided by the following considerations:

- **SEVERITY OF THE INCIDENT AND IMPACT ON PUBLIC HEALTH**

In general, an incident with severe consequences elicits a greater response from patients and the public. For example, incidents that could have contributed to patient death are likely to attract public interest and the public expects to know about such severe events. A prompt public disclosure in a proactive manner is often necessary in such severe incidents to maintain public trust.

In addition, public disclosure is often indicated when a large number of patients are affected or are potentially affected by the incident. For example, when a system error leads to erroneous lab results, a large number of patients may be affected by this laboratory machine malfunction. Therefore, a potentially large number of patients may need to be contacted within a short period of time for assessment and further treatment. The potentially large-scale impact would justify prompt public disclosure in this case.

In the interest of public well-being, alerting staff and the public to the situation in a timely fashion is a must in order to upkeep patient safety in certain situations. Following these clinical incidents, an accountable and responsible healthcare institution, may consider public disclosure as the most effective method for alerting own staff and the public. For example, when a particular batch of medication was found to be contaminated with fungus, alerting staff and the public increases the chances of early detection and subsequent treatment of any fungal infection in immunocompromised patients.

- **VIEWS OF PATIENT AND/OR PATIENT'S FAMILY**

A patient's views and privacy should be respected and his/her family's wishes should be honoured where appropriate. Following a clinical incident, the patient and family members are often primarily concerned with the patient's ongoing treatment. The trust and working relationship between the patient and his/her healthcare workers need to be maintained for the ongoing care. It is important to consider that public disclosure may cause secondary trauma to the patient and family members, who are already under stress from the clinical incident. The patient and family members are better off being spared of the extra stress from further media attention and from being "under the spotlight" while coping with the illness and the road to recovery.

- **VIEWS OF THE CARE TEAM**

Regular public disclosure is anonymised for the learning and sharing. However, in prompt public disclosure, often the involved hospital and department are disclosed. The staff involved, often trapped in self-blaming behaviour, are highly stressed and upset. It is important for the hospital management to consider the stress and anxiety borne by the care team, brought on by the occurrence of clinical incidents, and to provide psychological support to the care team and staff involved in the event.

Nonetheless, the care team should stay focused on providing the best care and support for the patient and the family involved in the clinical incident. This commitment would promote doctor-patient trust, which in turn paves the way for effective care provision following the clinical incident.

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4 Mar	Diet, Calcium and Vitamin D, Exercise and Fall prevention	Ms. Penny CHOI Dietitian, Tuen Mun Hospital Dr. Eddie SL CHOW Specialist in Rehabilitation, Tuen Mun Hospital
11 Mar	Medications for Osteoporosis	Dr. Benjamin YT AU YEUNG Specialist in Endocrinology, Queen Elizabeth Hospital Dr. Ka Kui LEE Specialist in Endocrinology in Private Practice
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The healthcare institution, such as the HA, should foster an environment of psychological safety where staff could confidently report an incident to the hospital management and to share their experience freely. This “Speak-up” culture is of utmost importance for patient safety. When contemplating whether or not to issue a prompt public disclosure, the potential impact on the “Speak-up” culture should be considered.

#### • **PUBLIC CONCERN AND PUBLIC EXPECTATIONS**

The public holds high expectations of accountable and responsible healthcare institutions such as the HA with respect to her openness, transparency, responsiveness and public accountability. Sometimes adverse events can lead to serious negative outcomes, and the public holds the expectation that the healthcare institution would communicate with the public promptly. Hence, timely, open and transparent communication is necessary to maintain public trust and to facilitate learning and sharing.

Sometimes, healthcare institutions should consider taking a proactive role in public disclosure, to ensure timely and accurate information reaches the public. It can be difficult, if not impossible, to change “misperceptions” once they are built, especially in this modern-day society flooded with information. Therefore, a balanced view and representation of facts is important to orientate the media and the public towards reasonable expectations with fair perspectives.

### **DECISION PROCESS FOR PROMPT PUBLIC DISCLOSURE**

The deliberation process should involve prompt engagement of key stakeholders who share key information. Each incident should be independently assessed for prompt public disclosure with reference to the four major considerations mentioned above. Even if the clinical scenario is similar to previous clinical incidents, the specific details of the situation can be very different and call for a complex and tedious decision-making process.

While the involved unit and the clinical team will have a better understanding of the patient’s and family’s views, the team with expertise in public communication, such as the Hospital Authority Head Office Corporate Communication team, often has a better grasp of the public concerns and the likely impact on the perceived trustworthiness of the concerned healthcare institution. Therefore, a collaborative approach is required across multiple teams within the healthcare institution. If we take the example of an HA hospital, in the event of a clinical incident, good communication across the following teams is essential:

- The care team
- The cluster or hospital Quality and Safety team
- The cluster Media Relations staff

- The HA Head Office Corporate Communication Department, and
- The HA Head Office Patient Safety and Risk Management Department

### **FORMATS OF PUBLIC DISCLOSURE**

#### • **PRESS RELEASE**

The press release is a written statement presenting a factual account of the incident together with the necessary follow-up action. It should be precise and concise, without any judgmental paraphrase.

#### • **MEDIA STAND-UP SESSION**

For more complex incidents which may be difficult to present clearly in written formats, a Media Stand-up Session should be considered.

#### • **PRESS CONFERENCE**

The key features are mostly similar to those in the Media Stand-up Session, except that the duration will be longer and usually lasts one hour or less. The press conference will be conducted inside a decent venue with the designated spokespersons speaking at the head table in front of the press seating.

Disclosure is an ongoing process in which multiple “disclosure conversation” may occur over time, including an initial disclosure and a post-analysis disclosure.

#### • **CONTENT OF PUBLIC DISCLOSURE**

During the process, it should be emphasised that the aim of the clinical incident management is for learning and sharing. Rather than to establish blame, the goal of clinical incident management is to determine what happened; how and why it happened; what can be done to reduce the risk of recurrence and to render care safer; and what can be learned. These additional details are often made available in the post-analysis disclosure. Prevailing human resources policy can be referred to should there be any issues about the performance of an individual member of staff.

The public disclosure process usually involves the following components:

- 1) Acknowledgement that the clinical incident occurred +/- apology and expression of regret if appropriate.
- 2) Showing empathy and explaining that disclosure of everything we know has been undertaken to the patient and family, while emphasizing that the patient and family will be updated and supported throughout the follow-up process.
- 3) Credibility should be maintained by telling the facts. Speculation holds no place in public disclosure.
- 4) The healthcare institution will take responsibility for the event and ensure that the patient has the best possible care following the clinical incident.



- 5) The healthcare institution will undertake a conscientious effort to investigate why the in-place systems have failed and will look into what steps are required to prevent future system failures.
- 6) The healthcare institution strives for excellence as an accountable organisation. The staff have come to work every day with the goal of providing the best possible care, and they are continuously seeking ways to improve.
- 7) The healthcare institution will use this untoward incident/tragedy to make this organisation a better and safer place for the patients, family, staff and community.

## MANAGEMENT AFTER PROMPT PUBLIC DISCLOSURE

### 1) Psychological services for staff

Disclosure of clinical incidents can have a significant adverse impact on the staff involved. Healthcare workers' common reactions towards disclosure include shame; guilt; difficulty in coping with anger from patients/public; fear of adverse publicity; and fear of potential damage to career and reputation. They are also likely to be concerned about the disciplinary processes and litigation. Evidence indicates that psychological support has to be provided to the care team and staff involved immediately and throughout the incident management process.

To promote psychological support for staff, the hospital should recommend some or all of the 4-tiered psychological services below to the team and staff involved:

- i. **Self-help materials:** It is helpful to send the staff involved a "Psychological Therapeutic Kit", which includes psycho-education materials to promote their own awareness of common symptoms, online self-assessment and adaptive self-coping strategies.
- ii. **Supervisors:** To minimise staff's re-traumatisation, supervisors are advised to receive training on psychological first aid to staff, psychological preparedness and communication skills for open disclosure and root-cause analysis, and the like.
- iii. **Peer support:** Staff can be referred or encouraged to receive peer emotional support services provided by Critical Incident Support Team (CIST), which is formed by staff volunteers from various disciplines in their hospitals. They are trained and supervised by designed expert team (such as the Oasis in the HA setting) to support their colleagues.
- iv. **Professional support:**
  - In the HA setting, if professional services are needed, staff can contact the Oasis or Critical Incident Psychological Services (CIPS) Centre directly (no referral is required) for evidence-based intervention from the Clinical Psychologist of Oasis or the Social Worker of CIPS Centre to facilitate their recovery.

- Again in the HA setting, to promote team resilience and manage acute stress reactions for the department involved, the staff psychological services units (Oasis, CIPS Centre and CIST) can collaborate to provide group and individual crisis intervention services. Supervisors may call any of the above service units for enquiry and service arrangement.

### 2) Ongoing patient care and support to the family

Illness and clinical incidents can have severe consequences on the health and well-being of the patient and the family. It is often a stressful time and therefore the needs of the affected patients and family members should be of utmost importance. In addition to showing empathy, the clinical team, the patient relations office and the hospital management should be sensitive to the needs of the patients and family, while also providing the patient with the best possible care. For the care of the bereaving family, chaplaincy and emotional support should be arranged. Formal psychological support and counselling should be made available if required. A point of contact should be made available to the family for further questions. As an example, family members often further reflect or discuss after public disclosure.

Following further investigations, the patient and family are often interviewed again to discuss the findings and recommendations. The victims often find comfort in knowing that another person is less likely to suffer in the same way that they did. Therefore, it is important for the patient and family to hear about the positive changes that have been made; and that the concerned healthcare institution is committed to service quality and patient safety.

Additionally, the patient and family should be informed of any plans for further public disclosure of the investigation findings.

### 3) Investigation and organisational learning

Following an incident, formal investigations are performed, often in the form of root cause analyses (RCA) to understand the underlying cause of the incidents. For the Hospital Authority, the investigation results and recommendations are included in the HA quarterly and annual reports. Existing protocols and best practices should then be reviewed and enhanced to improve patient safety and to avoid a repeat of similar incidents.

To enhance learning and sharing, briefing sessions for staff should be arranged to explain how the clinical incident happened and to highlight lessons learnt from the incident. Healthcare executives' skills in prompt public disclosure can also be enhanced through regular media and crisis management training.

The "Speak-up" culture should be reinforced so that staff are assured that they could confidently report an incident and share their experience freely

without fear of blame. We should emphasise that reporting severe clinical incidents to management should not be seen as negative. In fact, it is a positive initiative to allow the issues to be rectified in a timely fashion and ensure the best outcome for the patient and family involved. Furthermore, by bringing in more support from the management team and relevant administrative leaders, the staff involved can receive proper expert assistance in dealing with the crisis and hopefully reduce their stress.

To enhance public awareness and understanding, the concerned healthcare institution should explain what had happened and highlight lessons learnt from the incident through appropriate channels to the public. Where appropriate, the said party should brief the public again after investigation of the incident has concluded.

## CONCLUSION

Open disclosure and public disclosure are important elements of crisis management framework of a healthcare institution for dealing with severe clinical incidents.

It is important to point out that given this internet era, medical knowledge is no longer solely owned by an elite group of healthcare professionals. Everyone nowadays has access to a wealth of medical information, bearing in mind some sources of information are more accurate and reliable than others. Patients, their families and the public have a right to know about severe clinical incidents which affect or can potentially affect them and to conduct their own research. Through disclosure and education, we can assist them in increasing their awareness and understanding of medical issues.

Along with new medical discoveries, clinical practices evolve; along with the advent of new technology, our best practices also need to evolve. Healthcare workers should not hesitate to speak up when they have new ideas or suggestions on how their healthcare institution can improve in response to change of the times.

The framework espoused in this writing is designed to both assist healthcare workers in dealing with a crisis arising from a clinical incident as well as address the concerns of the patients, their families and the public. We should keep this framework in mind and strive to balance the interests of the stakeholders involved when deciding whether to publicly disclose the incident or not.

### Annex-1

#### Definition of Mandatory Reporting Events in the Hospital Authority Hong Kong

##### Sentinel Events

1. Surgery / interventional procedure involving the wrong patient or body part
2. Retained instruments or other material after surgery / interventional procedure
3. ABO incompatibility blood transfusion
4. Medication error resulting in major permanent loss of function or death
5. Intravascular gas embolism resulting in death or neurological damage
6. Death of an in-patient from suicide (including home leave)
7. Maternal death or serious morbidity associated with labour or delivery
8. Infant discharged to wrong family or infant abduction
9. Other adverse events resulting in permanent loss of function or death (excluding complications)

##### Serious Untoward Events

1. Medication error which could have led to death or permanent harm
2. Patient misidentification which could have led to death or permanent harm

### References

1. Patient Safety and Risk Management Department, Hospital Authority. Hospital Authority Head Office Operation Circular No. 9/2018 – Open Disclosure Policy for Clinical Incidents. Hospital Authority; 2017
2. [http://www.patientsafetyinstitute.ca/en/toolsResources/disclosure/Documents/CPSI Canadian Disclosure Guidelines.pdf](http://www.patientsafetyinstitute.ca/en/toolsResources/disclosure/Documents/CPSI%20Canadian%20Disclosure%20Guidelines.pdf)
3. <http://www.patientsafetyinstitute.ca/en/toolsResources/InformingMediaAdverseEvent/Documents/Communicating%20After%20Harm%20in%20Healthcare.pdf>
4. <https://www.elegislation.gov.hk/hk/cap631/en-zh-Hant-HK.pdf>
5. Conway J., Federico F., Stewart K., et al. Respectful Management of Serious Clinical Adverse Events. IHI Innovation Series white paper. Cambridge, Massachusetts: Institute for Healthcare Improvement; 2010.
6. Leape L. Apology for Errors: Whose Responsibility? In *Frontiers of Health Services Management* (Vol. 28, No. 3 Spring 2012).
7. Fromson, J. A., & Kenney, L. K. The Disclosure Dilemma – Large-Scale Adverse Events. *New England Journal of Medicine* (2010), 363(25), 2471-2471. doi:10.1056/nejmc1011109;
8. Gandhi TK., Kaplan GS., Leape L., et al. Transforming concepts in patient safety: a progress report. *BMJ Qual Saf* 2018;0:1-2. Doi:10.1136/bmjqs-2017007756
9. [https://www1.health.nsw.gov.au/pds/ActivePDSDocuments/PD2017\\_012.pdf](https://www1.health.nsw.gov.au/pds/ActivePDSDocuments/PD2017_012.pdf)
10. Corporate Communication Department, Hospital Authority. Hospital Authority Corporate Communication Strategy. Hospital Authority; 2017.

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## Abbreviated prescribing information<sup>2,3</sup>

**Tivicay Tablets (Dolutegravir) 50mg Therapeutic indication:** Indicated in combination with other anti-retroviral medicinal products for the treatment of Human Immunodeficiency Virus (HIV) infected adults and adolescents above 12 years of age. **Posology and method of administration:** Patients infected with HIV-1 without documented or clinically suspected resistance to the integrase class. Tivicay 50 mg (1 tablet) orally once daily. Co-administered some medicines for example efavirenz, nevirapine, tipranavir/ritonavir, or rilpivirine. Missed doses: Take Tivicay as soon as possible. Do not take the next dose if not due within 4 hours. If next dose is due within 4 hours, patient should not take the missed dose and simply resume the usual dosing schedule. **Adolescents (aged from 12 to 17 years and weighing > 40 kg) infected with HIV-1 without resistance to the integrase class:** Tivicay 50mg once daily. Elderly: Limited data available. No evidence that elderly patients require a different dose than younger adult patients. **Renal impairment:** No dosage adjustment required for patients with mild, moderate or severe (CrCl <30 mL/min, not on dialysis) renal impairment. **Hepatic impairment:** No dosage adjustment required in patients with mild or moderate hepatic impairment (Child-Pugh grade A or B). Use with caution in patients with severe hepatic impairment (Child-Pugh grade C). Children aged <12 years or weighing <40 kg: Safety and efficacy not yet established. Oral use: Taken with or without food. In the presence of integrase class resistance, Tivicay should preferably be taken with food to enhance exposure (particularly in patients with Q148 mutations). **Contraindications:** Hypersensitivity to the active substance or to any of the excipients. Co-administration with dofetilide. **Warnings & precautions:** Integrase class resistance of particular concern: Decision to use dolutegravir in the presence of integrase class resistance should take into account that dolutegravir activity is considerably compromised for viral strains harbouring Q148>2 secondary mutations from G140A/C/S, E138A/K/T, L74I. **Hypersensitivity reactions:** Discontinue dolutegravir and other suspect agents immediately if signs or symptoms of hypersensitivity reactions develop (including, but not limited to, severe rash or rash accompanied by raised liver enzymes, fever, general malaise, fatigue, muscle or joint aches, blisters, oral lesions, conjunctivitis, facial oedema, eosinophilia, angioedema). Monitor clinical status including liver aminotransferases and bilirubin. **Immune Reconstitution Syndrome:** Monitoring of liver biochemistry is recommended in patients with hepatitis B or C co-infection. Particular diligence should be applied in initiating or maintaining effective hepatitis B therapy when starting dolutegravir-based therapy in hepatitis B co-infected patients. **Opportunistic infections:** Patients remain under close clinical observation of these associated HIV diseases by physicians. **Drug interactions:** Avoid factors that decrease dolutegravir exposure in the presence of integrase class resistance (e.g. magnesium/aluminum-containing antacid, iron and calcium supplements, multivitamins and inducing agents, efavirenz (without boosted protease inhibitors), tipranavir/ritonavir, rilpivirine, St. John's wort and certain anti-epileptic drugs). A dose adjustment of metformin should be considered when starting and stopping co-administration of dolutegravir with metformin. **Osteonecrosis:** Patients should be advised to seek medical advice if they experience joint aches and pain, joint stiffness or difficulty in movement. **Interactions:** Avoid factors that decrease dolutegravir exposure in the presence of integrase class resistance. Medicinal products that induce enzymes UGT1A3, UGT1A9, CYP3A4, P-gp, and BCRP may decrease dolutegravir plasma concentration and reduce the therapeutic effect of dolutegravir. Co-administration of dolutegravir and other medicinal products that inhibit these enzymes may increase dolutegravir plasma concentration. Absorption of dolutegravir is reduced by certain anti-acid agents. Co-administration with St. John's wort is strongly discouraged. Magnesium/aluminum-containing antacid, calcium supplements, iron supplements or multivitamins should be taken well separated in time from the administration of dolutegravir (minimum 2 hours after or 6 hours before). **Pregnancy & lactation:** Limited amount of data in pregnant women. Use during pregnancy only if the expected benefit justifies the potential risk to the foetus. Not recommended HIV infected women to breast-feed their infants under any circumstances in order to avoid transmission of HIV. No data on effects on human fertility. **Adverse reactions:** Very common: Headache, Nausea, Diarrhoea. Common: Insomnia, Abnormal dreams, Depression, Dizziness, Vomiting, Flatulence, Upper abdominal pain, Abdominal pain, Abdominal discomfort, Rash, Pruritus, Fatigue, Alanine aminotransferase (ALT) and/or Aspartate aminotransferase (AST) elevations, Creatine phosphokinase (CPK) elevations. **Overdose:** No specific treatment for overdose. Patient should be treated supportively with appropriate monitoring as necessary. Abbreviated Prescribing Information based on PI version GD506v1(hk)/EME20150818.

**3TC 150 mg film-coated tablets (Lamivudine). Therapeutic indication:** 3TC is indicated as part of antiretroviral combination therapy for the treatment of Human Immunodeficiency Virus (HIV) infected adults and children. **Posology and method of administration:** 3TC may be administered with or without food. The tablets should ideally be swallowed without crushing. 3TC oral solution is available for children over three months of age and who weigh less than 14 kg or for patients who are unable to swallow tablets. Alternatively, for patients who are unable to swallow tablets, the tablets may be crushed and added to a small amount of semi-solid food or liquid, all consuming immediately. Adults, adolescents and children (weighing at least 25kg), the recommended dose of 3TC is 300 mg daily. This may be administered as either 150 mg twice daily or 300 mg once daily. Children weighing > 20 kg to <25 kg, the recommended dose is 225 mg daily. Children weighing 14 to <20 kg, the recommended dose is 150 mg daily. Children from three months of age: It is recommended that the 3TC 150 mg scored tablet formulation is used. Children less than three months of age, the limited data available are insufficient to propose specific dosage recommendations. Patients changing from the twice daily dosing regimen to the once daily dosing regimen should take the recommended once daily dose approximately 12 hours after the last twice daily dose, and then continue to take the recommended once daily dose approximately every 24 hours. Older people, no specific data are available; Renal impairment, lamivudine concentrations are increased in patients with moderate to severe renal impairment due to decreased clearance. The dose should therefore be adjusted, using oral solution presentation of 3TC for patients whose creatinine clearance falls below 30 ml/min. Hepatic impairment, data obtained in patients with moderate to severe hepatic impairment shows that lamivudine pharmacokinetics are not significantly affected by hepatic dysfunction. Based on this data, no dose adjustment is necessary in patients with moderate or severe hepatic impairment unless accompanied by renal impairment. **Contraindications:** Hypersensitivity to the active substance or to any of the excipients. Not recommended the combination of lamivudine with didanosine. **Warnings & precautions:** 3TC is not recommended for use as monotherapy. Renal impairment: In patients with moderate to severe renal impairment, the dose should be adjusted. Pancreatitis: Pancreatitis has been observed in some patients receiving lamivudine. Treatment with 3TC should be stopped immediately if clinical signs, symptoms or laboratory abnormalities suggestive of pancreatitis occur until pancreatitis excluded. Lactic acidosis/severe hepatomegaly with steatosis: Lactic acidosis and severe hepatomegaly with steatosis, including fatal cases, have been reported with the use of antiretroviral nucleoside analogues either alone or in combination, including lamivudine. A majority of these cases have been in women. Caution should be exercised when administering lamivudine, particularly to those with known risk factors for liver disease. Treatment with lamivudine should be suspended in any patient who develops clinical or laboratory findings suggestive of lactic acidosis with or without hepatitis (which may include hepatomegaly and steatosis in even in the absence of marked transaminase elevations). Serum lipids and blood glucose: Serum lipid and blood glucose levels may increase during antiretroviral therapy. Immune Reconstitution Syndrome: In HIV-infected patients with severe immune deficiency at the time of initiation of anti-retroviral therapy (ART), an inflammatory reaction to asymptomatic or residual opportunistic infections may arise and cause serious clinical conditions, or aggravation of symptoms. Typically, such reactions have been observed within the first few weeks or months of initiation of ART. Relevant examples are cytomegalovirus retinitis, generalised and/or focal mycobacterial infections and Pneumocystis jirovecii (P. carinii) pneumonia. Any inflammatory symptoms must be evaluated without delay and treated initiated when necessary. Autoimmune disorders (such as Graves' disease, polymyositis and Guillain-Barre syndrome) have also been reported to occur in the setting of immune reconstitution, however the time to onset is more variable, and can occur many months after initiation of treatment and sometimes can be an atypical presentation. Patients co-infected with Hepatitis B virus: Clinical trial and marketed use of lamivudine, have shown that some patients with chronic hepatitis B virus (HBV) disease may experience clinical or laboratory evidence of recurrent hepatitis upon discontinuation of lamivudine, which may have more severe consequences in patients with decompensated liver disease. If lamivudine is discontinued in a patient with HIV and HBV coinfection, periodic monitoring of both liver function tests and markers of HBV replication should be considered. Oral solution: Diabetic patients should be advised that an adult dose contains 3 g of sucrose. Children: Children who at anytime received lamivudine oral solution concomitantly with other antiretroviral oral solutions in clinical trials experienced lower rates of virological suppression, had lower plasma lamivudine exposure and developed viral resistance more frequently than children receiving tablets. **Interactions:** Lamivudine is predominantly eliminated by active organic cationic secretion. The possibility of interactions with other medicinal products administered concurrently should be considered, particularly when their main route of elimination is active renal secretion via the organic cationic transport system (e.g. trimethoprim). Other active substances (e.g. ranitidine, cimetidine) are eliminated only in part by this mechanism and were shown not to interact with lamivudine. Zidovudine: A modest increase in Cmax (28%) was observed for zidovudine when administered with lamivudine, however overall exposure (AUC) was not significantly altered. Zidovudine had no effect on the pharmacokinetics of lamivudine (see Pharmacokinetics). Trimethoprim/sulphamethoxazole: Administration of trimethoprim/sulphamethoxazole 160 mg/800 mg (co-trimoxazole) causes a 40% increase in lamivudine exposure because of the trimethoprim component. However, unless the patient has renal impairment, no dosage adjustment of lamivudine is necessary (see Dosage and Administration). Lamivudine has no effect on the pharmacokinetics of trimethoprim or sulphamethoxazole. The effect of co-administration of lamivudine with higher doses of co-trimoxazole for the treatment of Pneumocystis carinii pneumonia has not been studied. Zalcitabine: Lamivudine may inhibit the intracellular phosphorylation of zalcitabine when the two medicinal products are used concurrently. Lamivudine is therefore not recommended to be used in combination with zalcitabine. Emtricitabine: Lamivudine may inhibit the intracellular phosphorylation of emtricitabine when the two medicinal products are used concurrently. Additionally, the mechanism of viral resistance for both lamivudine and emtricitabine is mediated via mutation of the same viral reverse transcriptase gene (M184V) and therefore the therapeutic efficacy of these drugs in combination therapy may be limited. Lamivudine is not recommended for use in combination with emtricitabine-containing fixed dose combinations. **Pregnancy & lactation:** Lamivudine has been evaluated in the Antiretroviral Pregnancy Registry in over 11,000 women during pregnancy and postpartum. Available human data from the Antiretroviral Pregnancy Registry do not show an increased risk of major birth defects for lamivudine compared to the background rate. However, there are no adequate and well-controlled trials in pregnant women and the safe use of lamivudine in human pregnancy has not been established. Studies in humans have confirmed that lamivudine crosses the placenta. Use in pregnancy should be considered only if the benefit outweighs the risk. Although the results of animal studies (see Non-Clinical Information) are not always predictive of human response, the findings in the rabbit suggest a potential risk of early embryonic loss. Health experts recommend that where possible women infected with HIV do not breast feed their infants in order to avoid the transmission of HIV. In settings where formula feeding is not feasible, local official lactation and treatment guidelines should be followed when considering breast feeding during antiretroviral therapy. In a study following repeat oral dose of either 150 mg lamivudine twice daily (given in combination with 300 mg zidovudine twice daily) or 300 mg lamivudine twice daily, lamivudine was excreted in human breast milk (0.2 to 8.2 micrograms/ml) at similar concentrations to those found in serum. In other studies following repeat oral dose of 150 mg lamivudine twice daily (given either in combination with 300 mg zidovudine or as Combivir or Trizivir) the breast milk:maternal plasma ratio ranged between 0.6 and 3.3. Lamivudine median infant serum concentrations ranged between 18 and 28 ng/ml and were not detectable in one of the studies (lamivudine sensitivity 7 ng/ml). Intracellular lamivudine triphosphate (active metabolite of lamivudine) levels in the breastfed infants were not measured therefore the clinical relevance of the serum concentrations of the parent compound measured is unknown. **Adverse reactions:** Common: Headache, insomnia, cough, nasal symptoms, nausea, vomiting, muscle pain or cramps, dizziness, fatigue, malaise, fever. **Overdose:** No additional safety issues have been identified in paediatric subjects receiving either twice daily dosing or once daily dosing. No additional safety issues have been identified in paediatric subjects receiving either twice daily dosing or once daily dosing. Data are available on the consequences of ingestion of acute overdoses in humans. If overdose occurs the patient should be monitored, and standard supportive treatment applied as required. Abbreviated Prescribing Information based on PI version: HK012017/GDS22/eM20160714.

## Important Safety Information:

- The recommended dose of dolutegravir is 50 mg (one tablet) twice daily for patient with resistance to integrase class (documented or clinically suspected)
- 3TC is not recommended for use as monotherapy.
- Precautions on occurrence of pancreatitis and Immune Reconstitution Syndrome and increased serum lipids, blood glucose.

Please read the full prescribing information prior to administration. Full prescribing information is available on request from GlaxoSmithKline Ltd, 23/F, Tower 6, The Gateway, 9 Canton Road, Tsimshatsui, Kowloon, Hong Kong. For adverse events report, please call GlaxoSmithKline Limited at (852) 9046 2498. This material is for the reference and use by healthcare professionals only.

**References:** 1. Cahn P et al. Presented at: International AIDS Conference; July 23-27, 2018; Amsterdam, Netherlands. 2. Tivicay Hong Kong Prescribing Information 2017. 3. 3TC Hong Kong Prescribing Information 2017.

ARV, antiretroviral; DTG, dolutegravir



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# Medical Negligence - What Clinicians Need to Know?

## Dr Abraham WAI

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Dr Abraham WAI

## INTRODUCTION

The recent medical incidents in different healthcare settings in town have impacted community confidence in the local healthcare system. The community has asked questions about why adverse outcomes or errors have happened repeatedly. A negligence claim usually reflects a breakdown of the doctor-patient relationship, and is potentially damaging to the relevant doctors in terms of an image of failure, the financial burden of compensation, and the risk of disciplinary action. Common areas of clinical practice which are at high risk of negligence include:

1. Failure to diagnose or an undue delay in diagnosis;
2. Failure to undertake timely referral, or failure to refer at all;
3. Failure to explain an intended treatment sufficiently in obtaining consent for that treatment;
4. Failure to take necessary steps in providing care or interventions;
5. Failure to prescribe or supply the correct medication;
6. Failure to offer alternative options in investigations or treatment;
7. Failure to monitor patients closely;
8. Failure to take necessary precautions to avert untoward adverse events;
9. Failure to arrange for the necessary investigations;
10. Failure to interpret investigation results correctly;
11. Failure to follow up with necessary action; and
12. Failure to install the necessary safety systems in place.

In this article, I would like to introduce the principles of medical negligence, as well as its latest developments, so that clinicians may manage the risk with better confidence.

## THE PRINCIPLES OF MEDICAL NEGLIGENCE

We all make mistakes in life, and healthcare workers make no exception. However, not every mistake should be regarded as negligence. The usual definition of negligence is that it is a conduct, or a failure to act, that breaches duty of care. To establish negligence as a cause of action under tort law requires the claimant to prove, in an incident concerned:

1. There was, at the time of the incident, a *duty of care* between the claimant and the defending doctor<sup>1</sup>;
2. The action concerned - or the omission - has fallen below the standard expected of a reasonably competent doctor. That is to say, there is *breach of duty*; and
3. The breach has caused personal injury or property damage.

## DUTY OF CARE

*Duty of care* owed by doctors towards patients is a known and well-accepted category of duty in the Common Law system. Such duty commences when a doctor starts to care for an accepted patient. In most of medical negligence claims, the duty is straightforward. Consider the judgment in *R v Bateman* (1925) 94 LJ KB 791,

*"If he (the doctor) accepts the responsibility and undertakes the treatment and the patient submits to his discretion and treatment accordingly, he owes a duty to the patient to use diligence, care, knowledge, skill and caution in administering the treatment. No contractual relation is necessary, nor is it necessary that the service be rendered for reward."*

This duty will involve all aspects of the care of the patient i.e. examination, diagnosis, referral, advice, counseling, etc. so that a legal action alleging negligence may be related to a failure on the part of the doctor to attend, to examine properly, to diagnose correctly, to refer promptly or to offer appropriate advice or explanation.

The treatment during resuscitation is more complicated. It was suggested in *Capital & Counties plc v Hampshire CC* [1997] 2 All ER 865 that the only duty is not to make things worse – obiter; Courts will look at facilities available to doctors in emergency setting of Good Samaritan. The "Good Samaritan" role is one that the English law does not insist a doctor should assume. There is no compulsion to rescue a stranger and negligence law requires a proximate connection between the parties, which would not be found in a doctor-stranger relationship<sup>2</sup>.

This decision appears at odds with the judgment in *Barnes v Crabtree* [1955] 2 BMJ 1212 where the judge ruled,

*"In a case of real emergency a doctor under the National Health Service scheme was under an*



*obligation to treat any patient who was acutely ill; for example if there was a motor accident and someone was lying seriously injured."*

but here the obligation to intervene appears to be a matter of the doctor's usual "terms of service" in public healthcare system rather than a legal imperative.

Under the tort law in the common law system, a doctor would not be negligent in law (merely morally culpable) by not intervening but assumes the potential to be held negligent if he does intervene. However, there is a strong ethical imperative to intervene in any emergency situation and a doctor who stood idly by at such time could find himself called upon to justify his inaction to the GMC.

The doctor's duty of care can be extended beyond the patient to certain third parties, usually close relatives of the patient. In *Tredget v Bexley Health Authority* (1994) 5 Med LR 178, the parents of an infant who died after a traumatic and negligent delivery were awarded damages on account of their psychological distress and psychiatric illness resulting from the incident. However, the Courts use proximity to limit those who can recover by drawing a distinction between those present at and witnessing a traumatic event and those who hear or read about it<sup>3</sup>.

In addition to civil liability, breach of duty of care can lead to criminal consequences (e.g. gross negligence manslaughter), and coronial (usually a verdict of misadventure, occasionally neglect)<sup>4</sup>.

## BREACH OF DUTY

In deciding if there is any *breach of duty*, the court has to determine the standard of care, through which a doctor is assessed if he/she is up to par for certain practices. The landmark case for this would be *Bolam v Friern Hospital Management Committee* [3] in which a patient claimed compensation for sustaining a fracture during electroconvulsive therapy without muscle relaxant. McNair J adapted the reasonable man standard in general tort law to the medical profession and said

*"The test is the standard of the ordinary skilled man exercising and professing to have that special skill; it is well established law that it is sufficient if he exercises the ordinary skill of an ordinary competent man exercising that particular art. A doctor is not guilty of negligence if he has acted in accordance with a practice accepted as proper by a reasonable body of medical men skilled in that particular art."*

This is known as the "Bolam Test". The court has inevitably to rely on medical expert witnesses for whether a certain way of practice is acceptable, practically leaving itself no discretion to say that there is negligence whenever there is a medical expert endorsing the defendant.

The Bolam Test begs the question of who decides whether the doctor has breached this standard. It seems that the answer would be his fellow doctors, and the defence would be to demonstrate, through expert testimony, that the defendant doctor's actions were not

out of line with that of his peers. If different opinions are offered by experts on behalf of the defendant and the plaintiff respectively, the court will usually give the benefit of doubt to the doctor as per *Hunter v Hanley* (1955) SC 200 when the ruling was,

*"The true test for establishing negligence in diagnosis or treatment on the part of a doctor is whether he has been proved guilty of such failure as no doctor of ordinary skill would be guilty of, if acting with ordinary care."*

The Bolam test is not inviolate. Courts are free not to apply it to a particular case. The Law Lords in *Bolitho v City and Hackney Health Authority* [1997] 1 WLR 1151 made statements which have been interpreted to suggest that today there is greater judicial willingness to scrutinise the opinion expressed by the body of professional practice. For example, Lord Browne Wilkinson stated,

*"In particular where there are questions of assessment of the relative risks and benefits of adopting a particular medical practice, a reasonable view necessarily presupposes that the relative risks and benefits have been weighed by the experts in forming their opinions. But if, in a rare case, it can be demonstrated that the professional opinion is not capable of withstanding logical analysis, the judge is entitled to hold that the body of opinion is not reasonable or responsible. I emphasise that in my view it will be very seldom right for a judge to reach the conclusion that views genuinely held by a competent medical expert are unreasonable."*

Subsequently some commentators went so far as to suggest that Bolitho overturned Bolam. However, this was not totally true. Overturning the responsible body of professional opinion is, in practice, likely to be quite difficult. What the decision in Bolitho did was to send out a signal and one which has been followed in later cases. In the Bolitho case Lord Brown Wilkinson excluded from his discussion the issue of disclosure of risk. However, the courts have latterly applied the Bolitho case to diagnosis and treatment. In *Pearce v United Bristol NHS Trust*, Lord Woolf held that

*"If there is a significant risk which would affect the judgment of a reasonable patient, then in the normal course it is the responsibility of a doctor to inform the patient of that significant risk if the information is needed so that the patient can determine for him or herself as to what course that he/she should adopt."*

## BREACH OF DUTY AND CAUSATION

The complainant must show that the harm or injury suffered was indeed the result of the doctor's breach of duty. Usually the complainant must prove that the harm or injury would not have occurred in the absence of negligence on the part of the doctor – the "but for" test. Moreover, the harm was a reasonably foreseeable consequence of the negligence rather than one which was too remote<sup>5</sup>.

In some cases, there are self-evidently the breach causes the harm- such as the *res ipsa loquitur* (the things rests)



cases, meaning that the causation of harm by the doctor is very clear even though the exact details of the whole incident could not be delineated.

Novus actus interveniens- the broken chain of causation- is another special condition in negligence. In this situation, even if the defendant can be shown to have acted negligently, there will be no liability if some new intervening acts break the chain of causation between that negligence and the loss or damage sustained by the complainant. In *Rahman v Arearose Ltd & UCL NHST* [2001] QB 351, Mr Rahman was assaulted but his subsequent negligently-performed eye surgery caused his blindness. In this case, the attending surgeon rather than the original assaulters of the patient was deemed responsible for the blinding.

In *Barnett v Chelsea and Kensington Hospital Management Committee* (1969) 1 All ER 1068, Nield J held that, although a hospital emergency doctor failed to see, examine and admit a poisoned patient to the ward for treatment, the claim was failed because, on the evidence, the patient would have died anyhow even if he had been admitted and treated with all due care.

Reasonable foreseeability rarely arises as an issue. However, in *Emach v Kensington and Chelsea Area Health Authority* [1985] 3 All ER 910, a woman had a failed sterilisation operation and was not aware of her subsequent pregnancy until 20 weeks of gestation. She declined the offer of a termination, which her doctors felt would have remedied the situation at that stage. In judgment Slade J commented on the defendant doctors thus,

*For the reasons which I have attempted to give, I think that they could, and should, have reasonably foreseen that if, as a consequence of the negligent performance of the operation, she would find herself pregnant again, particularly after some months of pregnancy, she might well decide to keep the child.*

Some other important factors are limitation, proximity and loss of a chance.

Proximity is relatively complicated legal concept. In the leading case *Caparo v Dickman* [1990] 1 All ER 568, a three-stage test held for establishing a duty of care requires (i) foreseeability of damage, (ii) a relationship characterised by the law as one of proximity, and (iii) that the situation should be a one where the court considers it would be just and reasonable that the law should impose a duty of care on one party for the other.

Concerning limitation, the Limitation Ordinance limits the time period for claims generally to 3 years from personal injury or awareness that an injury occurred; or 6 years for general tort.

Loss of a chance – in *Gregg v Scott* [2005] UKHL 2, damages will not be paid if medical negligence doesn't cause an almost certain deterioration in the chance of a recovery to below 50% of what they were. Thus, actions by claimants whose chances of recovery from lymphoma have been reduced from 42% to 25% due to delayed detection of cancer. It was held that such a delay in diagnosis could not claim damages because

his chances were already too slim for the delay to have worsened his position.

## LATEST DEVELOPMENT OF NEGLIGENCE

For a long time, the Bolam test applied to all aspects of a doctor's practice: i.e., diagnosis, advice and treatment. However, since *Montgomery*, the Bolam test applies to determining only whether a doctor has been guilty of negligent diagnosis or treatment. A new legal test applies to determining whether a doctor was negligent in advising the patient: the "Montgomery test".<sup>6</sup> A patient receiving advice is not simply a passive recipient of care (as one would be when one's ailment is being diagnosed and treated). The patient plays an active role because ultimately the patient should decide on the course of treatment (if any); and the patient can make an informed judgment only if he/she has sufficient advice and information. The crux of the Montgomery test is whether the doctor has given the patient sufficient advice and information. The Montgomery test will be applied on the facts and circumstances as they existed at the time the material event occurred. It takes three stages:

1. The patient must satisfy the court that relevant and material information was withheld from him.
2. If yes, the court will determine whether the doctor had that information in the first place.
3. If yes, the court will determine whether it was justifiable for the doctor to withhold that information from the patient.

Stage 1 of the Montgomery test asks whether the patient failed to receive any relevant and material information. Doctors ought to disclose:

1. information that would be relevant and material to a reasonable patient in that particular patient's position; and
2. Information that the doctor knows is important to that particular patient in question.

The relevance and materiality of information is assessed essentially from the perspective of the patient. Relevant and material types of information would include (but are not limited to):

1. the doctor's diagnosis;
2. the prognosis with and without medical treatment;
3. the nature of the proposed treatment;
4. the risks associated with the proposed medical treatment; and
5. the alternatives to the proposed medical treatment and their advantages/risks.

The court will apply a common-sense approach to determining whether specific information was relevant and material. Doctors will have to walk the fine line between:

1. taking reasonable care to ensure that the patient receives all relevant and material information – failing which the patient would be unable to make an informed decision; and

- not indiscriminately bombarding the patient with every iota of information – failing which the patient may simply be left more confused and also unable to make an informed decision.

During the communication, the doctor will have to deliver the information using language and at a pace that allows the patient to absorb.

In the explanation of an invasive procedure / surgery, whether a risk has to be disclosed depends on the severity of the potential injury and its likelihood. Hence the risk of a likely but slight injury should be disclosed; and so will the risk of an unlikely but serious injury. But importantly, the risk of a very severe injury would not have to be disclosed, if the possibility of its occurrence was extremely slim. Moreover, a doctor must advise the patient with the information that he knows would be important to that particular patient, due to various socio-economic reasons.

When a doctor decides to withhold information from the patient, the law court would consider the justification by comparing to the practice of a reasonable and competent doctor. However, this is not in Bolam standard, as the focus is not on whether other respectable doctors would have considered it appropriate to withhold that information, but on whether it was objectively reasonable in the circumstances to have done so. Examples of such justification include expressed rejection of receiving information by the patient, emergency conditions in which the patient is incapable without a legal guardian, and therapeutic privilege.

### References

1. Donoghue v Stevenson [1932] UKHL 100
2. Lee, R. G. (1979). Hospital admissions: Duty of care. NLJ, 129, 567.
3. Alcock v Chief Constable Sth Yorks Police [1992] 1 AC 310
4. R (Davies) v HN Deputy Coroner for Birmingham [2003] EWCA Civ 1739
5. Caparo v Dickman [1990] 2 AC 605
6. Montgomery v Lanarkshire Health Board [2015] UKSC 11

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# Mediation in Healthcare Disputes

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## INTRODUCTION

In health care, disputes can arise from the dissatisfaction with the outcome or with the practitioner himself. Although most of the dissatisfaction can be addressed by prompt and careful explanation, a small proportion will eventually end up as formal complaints, and some may even go to the courtroom. In Hong Kong, like most other common law jurisdictions, the victim of a medical mishap could seek redress through litigation under the tort law. However, the process is long-drawn, inefficient, and costly. Most importantly, victims do not necessarily get what they want through the legal process.

## WHAT IS MEDIATION?

Mediation is an alternative means to resolve disputes. It is a process whereby an impartial third party (i.e. the mediator) will communicate, negotiate and help the disagreeing parties to resolve disputes. Mediation is applicable in many areas, and is well known for resolving disputes in commerce/finance, consumer/business, labour/employment, community, land, personal injury, school, health care and even international affairs. Mediation is characterised by the following features:

- The mediator is a trained/qualified and impartial third party.
- The process is voluntary.
- The negotiation is confidential.
- The settlement agreement is reached by mutual consent.

So in a nutshell, mediation is a voluntary process in which the disagreeing parties come together, and, with the assistance of a mediator, systematically dissect the disputed issues in order to develop options, and to come up with a settlement agreement both parties can agree amicably.

## RECENT LEGAL DEVELOPMENT

In 2009, the Hong Kong Judiciary introduced Civil Justice Reform, with a clear objective to settle civil disputes fairly, efficiently and effectively. And pursuant to the introduction of Practice Direction 31, legal practitioners have to inform their clients the availability of mediation as an alternative means of dispute resolution. For the client, he may also

face adverse costs order if it is found that he fails to engage in mediation even when he wins the case. The enactment of the Mediation Ordinance (Hong Kong Law, Cap 620) in January 2013 and subsequently the Apology Ordinance (Cap 631) in December 2017 provided further fuel to push the use of mediation to settle medical malpractice lawsuits.

## MEDIATION IN HEALTH CARE

The use of mediation in health care was first reported in the United States in the mid-80s after a rise in malpractice claims.<sup>1</sup> In Hong Kong, the first successful malpractice mediation was reported in 2006.<sup>2</sup> There are some good reasons why mediation is more desirable than litigation in medical disputes. From the clinician's perspective, the mediation process is confidential; it saves the professional image of the accused; from the patient's side, the same holds true when the disease carries a stigma. Furthermore, the communication during mediation is not admissible as evidence. Hence, the doctor and patient can communicate and negotiate freely without any fear of the other party using the information obtained for litigation purposes. Another good reason is that the doctor-patient relationship could potentially be preserved via amiable engagement of both parties in the process of working out the settlement agreement.

To optimize the mediation process, adequate training of the mediator in effective communication and negotiation is a must, such training will encompass skills in active listening, reframing, acknowledgement of feelings/emotions, and expression of empathy; these skills are also applicable and relevant to the clinical setting, and are essential soft skills for bedside work. Healthcare workers who attended communication training courses often found the learning experience worthwhile.<sup>3,4</sup>

When a patient complains, there usually exist two important triggering factors: miscommunication between the healthcare professional and the patient, and perception of a cavalier attitude. Communication will even be more challenging when there is mishap or unexpected outcome in the delivery of care. Healthcare workers are not well trained to communicate with the patient or family following an event/incident. And before the introduction of the Apology Ordinance, the typical advice from a legal advisor is to avoid communication with the patient for the fear that the communication be used as evidence of admission of fault and liability. This initial silence may generate mistrust and suspicion that will often lead to formal complaints and even litigations.

The mediation skill set can be employed to de-escalate the emotions of the patient/family. By active listening, the underlying concern of the patient can be better understood (e.g. social impact of the disease). By reframing, the negative energy can be chipped away, and the opposing parties can be brought to look at the issue from a new perspective. By acknowledging the emotions of the patient/family, the false perception of cavalier attitude can be demolished. And the “medical care” rendered is once again “medicine” and “care”. Expressing of empathy is another important soft skill for the frontline worker to handle emotionally charged patients. It has been shown that effective communication per se following medical malpractice can reduce the number of legal actions against the doctor.<sup>5</sup>

## MEDIATION vs LITIGATION

The common law system is robust in dealing with tort of negligence. It ensures people can assert their rights in a medical malpractice lawsuit. However, it is also well known that this legal process is complicated, lengthy, expensive and psychologically exhausting. Furthermore, patients may not get what they want or deserve in the process. A study identified the following factors for patients’ decision to take legal actions: doctors’ unavailability, discounting patient/family’s concerns, poor delivery of information, lack of understanding, perceived cavalier attitude, and lack of collaboration.<sup>6</sup> Unfortunately, none of these can be addressed in the present legal system. On the other hand, mediation can address these issues and allow the settlement to include non-monetary terms. Hence, apart from being more flexible and less formal, mediation allows apology to be tendered, honest explanation to be given, and even system-wide preventive measures to be included.<sup>7</sup>

## THE WAY FORWARD

Along with the recent legal development, it is high time for a paradigm shift from the adversarial approach to resolve medical malpractice disputes to a more relationship-centred approach. At the time of writing, the Legislative Council has just passed the bill on Private Healthcare Facilities. With the establishment of a new Office for Regulation of Private Healthcare Facilities under the Department of Health, it is hoped that the Government will seize this opportunity to include the use of mediation as one of the models to resolve disputes in the private sector. Secondly, in order for the general public to know and use mediation as a means to resolve dispute, the Government must continue her efforts in promoting mediation via various channels. Thirdly, the Hospital Authority should continue to invest in human capital, sponsoring her workers to be trained in mediation/communication courses so as to broaden the mediation-aware workforce. Lastly, given that the Government has supported the establishment of a Financial Dispute Resolution Centre in the past, it is time for the Government to consider establishing similar centres for healthcare dispute now.

## References

1. Hickson GB, Pichert JW, Federspiel CF, Clayton EW. Development of an early identification and response model of malpractice prevention. *Law Contemp Probl* 1997;60:7-29.
2. Chiu JS. Medical and dental negligence mediation in Hong Kong. *Asian Dispute Review* 2010;July:85-8.
3. Trumble SC, O’Brien ML, O’Brien M, Hartwig B. Communication skills training for doctors increases patient satisfaction. *Clinical Governance* 2006;11:299-307.
4. Liebman CB, Hyman CS. A mediation skills model to manage disclosure of errors and adverse events to patients. *Health Aff (Millwood)* 2004;23:22-32.
5. Kraman SS, Hamm JD. Risk management: extreme honesty may be the best policy. *Ann Int Med* 1999;131:963-7.
6. Beckman HB, Markakis KM, Suchman AL, Frankel RM. The doctor-patient relationship and malpractice. Lessons from plaintiff depositions. *Arch Intern Med* 1994;154:1365-70.
7. LEE DWH, LAI PBS. The practice of mediation to resolve clinical, bioethical, and medical malpractice disputes. *Hong Kong Med J* 2016 21(6):560-4.

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# Medical Records and Documentation

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## INTRODUCTION

Medical records are documented accounts in which healthcare personnel record essential information about patients' health status and the investigations, treatment and procedures provided.

In this current age, medical records are not limited to handwritten clinical notes but other forms such as scanned records, consent forms, text messages, email correspondences, verbal correspondences between healthcare professionals, laboratory results, radiographs, clinical photographs, video and audio recording, and any printouts from monitoring equipment.<sup>1</sup> With the widespread use of Information Technology, Electronic health records (EHR) are being used in many countries and have the potential to revolutionise medical documentation and patient management. EHR has been widely used to collect and document patients' health information; it has improved communication between different healthcare providers by making the personal health record accessible at any time with the use of a computer. In Hong Kong, public and private sectors are actively developing and enhancing the use of electronic health records to access patient data, which makes sharing of pertinent clinical information between different parties easier.

Thus, in healthcare services, good medical record documentation is an integral part of good professional practice and the delivery of quality health care as it demonstrates the providers' accountability and records their professional practice. In fact, complete medical records are the most important asset of a good healthcare system.<sup>2</sup>

## ROLE OF MEDICAL DOCUMENTATION

It is important for healthcare providers to follow the rule "if you did not write it down, you didn't do it." and every medical document should provide enough essential information so that if a new provider, for example, a different physician were to review the medical record, he would know exactly what the patient was being seen for, including treatment and plan of future action.<sup>2</sup>

Medical records play an extremely important role in medical lawsuits as defendants often have to prove their side of the story based on the documentation they made at the time of contact.<sup>2</sup> From a litigation point of view, even if everything was done correctly at the time of an incident, if it has not been documented, it has not been

done. This makes even the best of doctors difficult to defend.<sup>1</sup> Hence, it is an important piece of evidence in the establishment of a medical malpractice case.

## LIMITATIONS IN THE LOCAL SCENE

In Hong Kong, in the absence of a national health service scheme, patients are given free choice in their point of care, and many patients end up having more than one point of care, with ease of movement from one point of care to another, such as from a private clinic to a public clinic or vice versa, and with ease of switching from one private practitioner to another. It is therefore important for their healthcare information to be made available at all points of care.<sup>3</sup>

However, currently in Hong Kong, there are limitations in obtaining all healthcare information of a certain patient especially between different sectors of healthcare practitioners. The laudable lead taken by the government to establish electronic health record (eHR) and to enable sharing of eHR with the private sector has set the very first step for enabling a more comprehensive medical record system in the public sector which is accessible to non-public point of care providers.

## GOOD CLINICAL DOCUMENTATION

What constitutes good clinical documentation and how to achieve it? This is a typical question asked by many young healthcare practitioners. Good clinical record keeping under emergency circumstances can sometimes be really challenging as, for example, in the case of a patient with unexpected deterioration, sometimes life-threatening in the middle of the night, with various specialties involved and with several difficult background discussions taking place at the same time with family members. What then is considered adequate? Usually, there is great variability in the format of entries into clinical notes among different healthcare professionals and hospitals in different countries and influenced by other factors such as the practitioners' years of experience, any previous incidents and relevant circumstances of the case.<sup>4</sup>

Critical and life-threatening situations aside, there are some general guiding principles that can be applied for medical documentation and they are not difficult to achieve.

### 1. Handwriting

Legible handwriting is important for handwritten records because it may be a means in which different



healthcare personnel communicate at one point in time and also for subsequent care of the patients. This will reduce the risk of potential of medical incidents occurring due to inability to read the handwriting and administering wrong treatments, for example, medications. This issue on handwriting can be avoided when using electronic records.

## 2. Relevant clinical findings and details of the patient, date, and time of record

The proper inclusion of details of patients is fundamental in record keeping but it is not unusual to find missing patients' data on records and entries without date and time. This must be avoided as it greatly increases the risk of misfiling, leading to loss of records and confidentiality issues. It is not possible to clearly account for the various event sequences without proper date and time for the entry of the notes. This certainly poses potential litigation risks.

For documentation of clinical findings, it is important to include the following information in the clinical records:

1. Reason for the consultation/visit
2. Types of examination done with positive examination findings and pertinent negative examination findings
3. Main abnormal test findings
4. Diagnosis and clear management plan with treatment details
5. Medication administered, prescribed and allergies or adverse reactions to any drug
6. Future treatment plan or referral to another healthcare personnel, if applicable
7. Written or verbal instructions and/or educational information given to the patient
8. Documentation of communications with patient and family
9. Recommended return visit date, if applicable
10. Clear documentation and justification for certain action or plan, if applicable (for example, "Do not resuscitate" status)

## 3. Avoid abbreviations

This can be difficult to avoid completely as medical terms can be long and it is almost universal that doctors write abbreviations and some which have common usage are usually understood and acceptable among the medical fraternity. However, it is important to avoid non-standardised abbreviations as they can be ambiguous and misinterpreted.

## 4. Alteration of an entry

In the event that there is an alteration or addition of the clinical notes after the initial entry, the reasons must be explained and with the date and time specified as well as signed by the person who made the alterations or additions. In instances such as critical deterioration of a patient when the doctor is actively involved in resuscitation and not able to document the events immediately, the entry of the events, clinical findings and treatment can be added as soon as possible after the clinical stabilisation of the patient or when the patient is handed over to another doctor. Again, it is important to state the date and time of the event that is

deterioration and the date and time in which the clinical documentation is made.

What must be totally avoided is trying to disguise an addition to the clinical notes to make it appear as if it is part of the original entry. Even if this is done without untruthful intention, it will be misconstrued as trying to hide some untoward events or incidents. This act is indefensible should litigation arises.

## 5. Avoid unnecessary comments

It is important to avoid unnecessary comments not related to the clinical condition of the patient. Any words that are offensive or deemed personal could damage the credibility of the healthcare personnel. It is important to remember that patients have a right to access their records and a flippant comment in a patient's notes might be difficult to explain later on.

## 6. Data protection policy and practice

It is important to be familiar with Data Protection Ordinance/Act. In Hong Kong, the medical records are governed by the Personal Data (Privacy) Ordinance Chapter 486, in which medical records are kept for the purposes of providing patient care including medical treatment/consultation, counselling, rehabilitation etc.

With the development of the EHR, an Electronic Health Record Sharing System Ordinance (Chapter 625) now provides the legal basis for the collection, sharing, use and safe keeping of patients' health data under the Electronic Health Record Sharing System between the public and private sectors.

## CONCLUSION

With the increasing complexity and advances of medical treatment, the management of many disease entities has changed. However, medical documentation still remains as one of the fundamentals of medical management. The recent advances in technology improve and help reduce errors in our medical documentation. It is essential that the clinical records are well documented as they not only contain information relating to the physical and/or mental health of a patient but are valuable documents to audit the quality of healthcare services. In the event of untoward incidents, these records are the basis for investigations.

## References

1. Abdelrahman W., Abdelmageed A., Medical record keeping: clarity, accuracy, and timeliness are essential. *BMJ* 2014; 345
2. Murphy B.J., Principles of good medical record documentation. *The Journal of medical practice management*; 2001 Mar-Apr;16(5):258-60.
3. Management of patient information Trends and challenges in Member States. *Global Observatory for eHealth series - Volume 6*, Geneva - Switzerland: World Health Organization (WHO). 2012:17-21.
4. Mathioudakis A., Rousalova I., Gagnat A.A., et al. How to keep good clinical records *Breathe (Sheff)*; 2016 Dec; 12(4): 369-373.

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References: 1. Teva, Generics R&D. [http://www.tevapharm.com/research\\_development/rd\\_integrated/generics/](http://www.tevapharm.com/research_development/rd_integrated/generics/). Accessed Mar 2018.  
2. Teva, Annual Report 2014. [http://www.tevapharm.com/files/about/lobby/annual\\_report\\_2014.pdf](http://www.tevapharm.com/files/about/lobby/annual_report_2014.pdf). Accessed Mar 2018.  
3. Teva, Integrated R&D. [http://www.tevapharm.com/research\\_development/rd\\_integrated/biologic/](http://www.tevapharm.com/research_development/rd_integrated/biologic/). Accessed May 2018.

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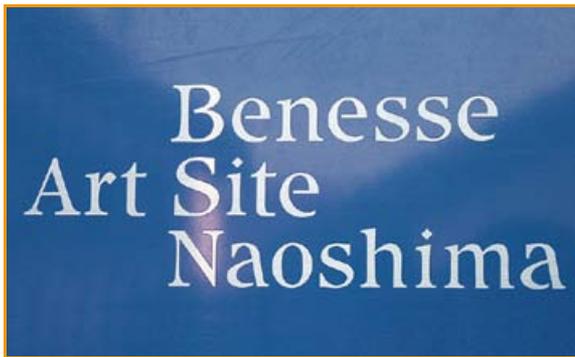
## Naoshima - Of Art, Architecture and Nature

**Dr Chi-lim LAW**

MBBS (HK), FHKAM (Obs and Gyn)



Dr Chi-lim LAW



### SOUNDS LIKE AN ISLAND SOMEWHERE IN JAPAN, RIGHT?

Naoshima(直島) is one of the 3,000-odd small islands dotting the Seto Inland Sea(瀬戸内海) in southwest Japan. It is really not a big place. The whole island is about 8 km<sup>2</sup> (you can walk around the island in about 2 hours), with a population of about 3,000. But it is really a remarkable and unique place as there are more art museums and art installations on this island than any other place on earth within one given area. Together with an (almost) Mediterranean atmosphere: sandy beaches and a lay-back rural feel, Naoshima has become a Mecca for art-lovers (well, as well as non-art-lovers, of course) in recent years.

### HOW HAS IT BECOME AN ART ISLAND?

In its previous life, Naoshimawasan was an Island with small fishing villages and a refinery centre for heavy industries like Mitsubishi. Re-inventing it as an art site was the brain-child of Tetsuhiko Fukutake, the Founding President of Fukutake Publishing, and Chikatsugu Miyake, the Mayor of Naoshima way back in 1985. The first museum, the Benesse House Museum was opened in 1992. After 30 years of development, the island now boasts multiple modern art museums with art sites and installations dotted all over the island. In time, the world has come to recognise Naoshima as the new Mecca in modern art. In 2010, the Setouchi Triennale (瀬戸國際藝術祭) was inaugurated with artists from all over the world invited to participate in creating modern art objects (permanent or temporary) not only on Naoshima but on a number of islands nearby.

### WAIT A MINUTE, DID YOU SAY MODERN ART? I SEEM TO REMEMBER I AM ALLERGIC TO IT?

Indeed, many people do recoil in horror whenever the name modern art is mentioned. However, the art pieces on Naoshima that you will encounter are not some high-brow, hard-to-understand, 無厘頭, or pretentious stuff that are sometimes the cause of "allergy"/aversion in viewers. In fact, the majority of the artwork (paintings, sculptures, installations) on Naoshima and its neighbouring islands are readily approachable and can be enjoyed by anyone whether you are an art-lover or not. All you really need is an open and curious mind, and a willingness to be guided by your own emotions that may arise when you view an art piece. Sometimes, of course, you need to know a little about the background to appreciate why the art piece was made and how it relates to the location. This is particularly relevant on Naoshima as many of the art objects are so-called "site-specific" where the art creation would mean nothing if it was taken away from its place of display and transplanted elsewhere.

### OK, LET'S HEAR MORE ABOUT IT...

Take for example the Art House Project. Beginning in 1998, some of the empty houses (plus one temple) in the Homura district (本村) on the island have been renovated and artworks installed in them. Visitors now have the chance to visit seven such sites all within walking distance of one another. While walking through the Homura district and experiencing first-hand how people on Naoshima lived (and live), visitors not only engage themselves with the artwork but also develop a sense of history interwoven with layers of time.

### CAN YOU CUT THE MUMBLE- JUMBO AND BE MORE CONCRETE?

OK, then, let me tell you about the Kadoya(角屋). In 1998, a two-hundred-year-old house was restored to its original splendid self. Inside it, artist Tatsuo Miyajima installed an artwork called Sea of Time '98. The whole floor of the centre of the house was converted into a shallow water pond in which hundreds of LED lights could be seen blinking at different speeds. Each LED light represents one villager of Honmura who had been asked to set the speed at which the LED light would be blinking. As a result, each of the multicoloured LED



lights blink at a different speed just like the different ways each individual would view the pace of his/her life. When the original resident passes away, the LED light set by him/her would be removed. I first visited the Kadoya in 2007. When I re-visited it again in 2018, the number of LED lights was significantly smaller. In time, the whole artwork would be just an empty pond. Visitors to the house can sit on the benches along the four sides of the pond and gaze at the blinking LED lights and contemplate on the passage of time and life.



## THAT SOUNDS INTERESTING ENOUGH, TELL ME MORE...

There are a total of 7 Art Houses that you can visit in the Honmura Art House Project Area. In order not to spoil your fun, I will just mention one more: the Go'ō Shrine (護王神社). The original shrine dates back several hundred years ago to the Edo Period. It was completely rebuilt by artist Hiroshi Sugimoto in 2002. In addition to the main hall above ground, a glass staircase connects it to an underground stone chamber. Visitors can go underneath the shrine and view it through the translucent glass staircase with light emitting from above as if there is a connection between heaven and earth. Needless to say, this artwork must be viewed during daylight, and the passage to the underworld is not for the claustrophobic!



## YOU SAID THERE ARE MANY MUSEUMS ON NAOSHIMA, WHAT ABOUT THEM?

Naoshima is sometimes jokingly referred to as "Ando Island" as the complex of museums to the south of the

island have all been designed by the famous Japanese architect, Tadao Ando (安藤忠雄), who is renowned for his minimalist building style using concrete slabs, his meticulous attention to form and light, and the resultant harmony with the environment.

One of the museums, the Chichu Art Museum (地中美術館), as inferred by its name, is actually built underground cleverly using natural light to highlight the art pieces. The Chichu Art Museum (opened in 2004) is no doubt the top-draw among all the museums on Naoshima. Unlike museums elsewhere where you normally have a building first and then the artworks, here the museum has been designed with the artworks in mind. Thus, there is an enormous gallery with natural lighting where five paintings of Water Lilies by Monet are hung on the walls. Nowhere on this planet are you required to remove your shoes before going into the gallery and you can actually sit down on the cool white marble floor (made up of a million pebble-size square pieces) to enjoy the masterpiece at your leisure. The white wall and floor allow viewers to focus completely on the artworks without distraction. And where else on earth you can enjoy Monet's paintings bathing in natural light which would change with the seasons and time of the day, just as you would view lily ponds in the physical world?



The two other major works in the museum are the ones by renowned modern art artists: James Turrell and Walter De Maria. These works are truly amazing and awe-inspiring and have to be seen (actually "experienced" is the more appropriate word) for one to understand what I am talking about. In order not to spoil your enjoyment, I probably should not disclose too much here.

The Chichu Art Museum itself is a work of art. Visitors will be impressed by the minimalist design with concrete (with its surface smooth and cool like marble), steel glass and wood. The labyrinth of walkways and the play with light and shadow will have any photographer itching to sneak a shot although photography is officially prohibited inside the museum. There are two other museums near the Chichu Art Museum. The Benesse House Museum is the first museum that was built in 1992, and the Lee Ufan Museum (opened in 2010) show-casing the artworks of Korean artist Lee Ufan (李禹煥). Both are well worth visiting --- the Le Ufan Museum for the Zen pieces by

the artists, and the Benesse House museum where you can actually stay overnight in.



### WHAT? YOU CAN STAY OVERNIGHT IN A MUSEUM, LIKE IN THE MOVIE 'NIGHT AT THE MUSEUM'?

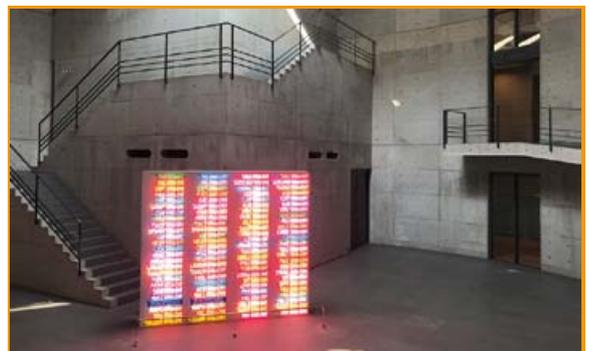
The Benesse House Museum was designed to integrate a museum with a hotel with a café as well as a restaurant. There are paintings, sculptures, photographic works, and installations. Many of the artworks there are site-specific. Take for example Kan Yasuda's The Secret of the Sky which is a series of photographs of the sky and sea taken at various places all over the world. In contrast to other photographic works that would have been framed and put inside a museum, these works are hung outside on two concrete walls built at an angle with a view of the Seto Inland Sea. It is both a photographic work and installation as the horizon depicted in the photos is aligned with the horizon and the sea outside. In addition, at a distance from the museum, there is an additional photo hung on a cliff aligned in the same way. This installation work effectively takes the museum to the nature outside. Furthermore, as the photographs are hung outside and are exposed to the elements, it will change with time, just like the geographic landscape outside that will also inevitably change with time.



Another work that has a similar effect is Jennifer Barlett's Yellow and Black Boats. This painting depicts a sandy beach with two boats, one yellow and the other black. Two similar boats are put on the floor adjacent to the painting, producing a three-dimensional effect. On the opposite side of the painting is a big window with unobstructed view of the sandy beach below. On the beach, there are two similar boats placed in the same manner as in the painting. Another example of the museum's concept of "coexistence of nature, art and architecture".



Guests staying in the museum hotel have free access to the artworks 24 hours a day, and will be able to visit the art pieces there outside opening hours in peace and quiet without the crowd. Obviously, while the official policy is for no photo-shooting inside the museum, if you are a hotel guest and there is just you alone in the whole museum, then perhaps.....



Unfortunately (or fortunately, if your prerogative is exclusiveness), there are only 10 rooms/suites in the museum itself and all rooms have a balcony that opens to the sea. There is also an extension called the Benesse House Oval (with 6 rooms/suites) that is accessible only by a short uphill monorail from the museum. Staying in



the Oval will cost you, but this architectural beauty (also designed by Ando) has to be seen to be believed.

The hotel rooms in the Benesse Museum are open for booking only 6 months in advance and they are usually gone within minutes of booking opening. Do not despair if you cannot book a room there. Accommodation is also available in the Benesse House Park (41 rooms/suites) and Benesse House Beach (8 suites) down by the beach that offer fantastic view of the Seto Inland Sea. These accommodation options give you a sense of beach-living. You can also visit the various sculptures and installations placed around the beach and the lawn around, which include, of course, the famous Yellow Pumpkin by Japanese artist Yayoi Kusama (草間彌生).

## YOU SAY THAT THERE ARE 3,000 ISLANDS IN THE SETO SEA, WHAT ELSE IS THERE TO SEE APART FROM NAOSHIMA?

Lots. The Benesse Art Site Naoshima in fact includes the many museums, art sites and installations on the island of Teshima (豊島) and Inujima (犬島), both accessible by ferries from the mainland as well as from Naoshima island itself. The Teshima Art Museum, a flat oval-shaped concrete shell with two huge oval sky window openings that connect the museum with nature (wind, sounds and light) outside is a real marvel for visitors to experience. Another experience not to be missed is the Storm House on Teshima Island which gives visitors a ten-minute intense experience with what would happen to an old house in an ancient Japanese fishing village during a severe storm complete with howling wind gusts, shaking of the house, thunder rumbling, pounding rain, and flickering lights. To get to the Storm House, one needs to walk for some 5 minutes from the road outside along some narrow alleys in a fishing village that must have remained unchanged for the last one hundred years. This would set the mood for visitors to make their experience more surreal. This installation simply would not have worked if transported to, say, a theme park like the Disney World.



The Inujima Seirenscho Art Museum on Inujima (犬島精練所美術館), a museum rebuilt from an old copper refinery, is well worth a visit. To disclose too much about the installation art piece inside is really unfair to you. Suffice to say that you should spend half a day on the island because of the art house projects there as well as the museum. As there would be no guided tour, you may want to read up on the history and development of the project to allow you to fully appreciate the place and the artworks therein.

In addition to the three islands mentioned above, every three years, during the Setouchi Triennale Art Festival there will be modern art installation/events happening on 12 islands and 2 ports in the Seto Inland Sea. The next festival will be held in 2019, starting at the end of April. Details are now already available on their website.

## OK, I AM SOLD. BUT ISN'T NAOSHIMA QUITE OUT OF THE WAY AND DIFFICULT TO GET TO?

One used to need to fly to Osaka Kansai airport and take a 3 hours bus ride to Takamatsu port (高松港) which is one of the gateways to the islands. The other gateway is Uno port (宇野港) via Okayama (岡山) and it is 2 plus hours from Kansai but you need to change train a few times. These days, there are regular direct flights from Hong Kong to Okayama and Takamatsu and getting to Naoshima is a breeze for us from Hong Kong.

## WHAT ELSE DO I NEED TO KNOW?

1. Plan your trip early and try to stay in the Benesse Museum for at least 2 nights. It will not be exactly cheap but well worth it.
2. The Chichu Museum is the most popular among all the museums, so be there before 10 am when the door opens or, better still, book your entry ticket on line. Go early at opening.
3. Practically everything closes on Mondays on Naoshima, so avoid going there on that day. Also try to avoid weekends and Japanese Holidays.
4. For visits to Teshima, if you have a group of people, you may find it worthwhile to arrange private transfer to the island as well as on the island. It will be costly, but it will be worth it as it will save you a lot of time travelling and you can see more things. Try to book lunch at the seaside restaurant there. The food is quite decent and the seaside ambience relaxing.
5. A visit to Inujima needs careful planning because of the ferry schedule. You need at least the better part of half a day there. Depending on your walking pace, you may or may not have time for lunch. Lunch option is limited on the island, anyway, so consider bringing your own picnic lunch and find a spot along the waterfront and enjoy the sea and the breeze. The Art museum on the island is closed from Tuesday to Thursday from December 1 to the last day of February.
6. For the Setouchi Triennale 2019, go early in the season (end of April) to avoid the crowd. The ferry tickets to Inujima (犬島) can be difficult to get, so you really need to organise your travelling logistics well.
7. The best time to go to Naoshima is spring (for the flowers) and autumn (for the autumn colours) but you will be with the crowd. Christmas is a bit cold (but without snow) with few flowers around, but you often have blue sky, and fewer tourists around. However, the ferries to Inujima may not be operational. In addition, from mid-January onward, snow can seriously disrupt transportation in this part of Japan.



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Date / Time	Function	Enquiry / Remarks
<b>2</b> WED 8:00 PM	<b>HKMA Choir Family Concert</b> Organiser: The Hong Kong Medical Association; Chairman: Dr. YEUNG Hip Wo, Victor; Venue: Concert Hall, Hong Kong City Hall, 5 Edinburgh Place, Central	Ms. Sandy WONG Tel: 2527 8285
<b>3</b> THU 7:00 PM	<b>FMSHK Certificate Course in Ophthalmology</b> Organiser: The Federation of Medical Societies of Hong Kong; Venue: Lecture Hall, 4/F, Duke of Windsor Social Service Building, 15 Hennessy Road, Wan Chai, Hong Kong	The Secretariat of FMSHK Tel: 2527 8898 Fax: 2865 0345
<b>8</b> TUE 1:00 PM	<b>HKMA-HKS&amp;H CME Programme 2018 -2019</b> Organiser: Hong Kong Medical Association & Hong Kong Sanatorium & Hospital; Speaker: Dr. Chan Chung Yan, Tommy; Venue: HKMA Central Premises, Dr. Li Shu Pui Professional Education Centre, 2/F, Chinese Club Building, 21-22 Connaught Road Central, HK	HKMA CME Dept. Tel: 2527 8285 1 CME Point
1:00 PM	<b>HKMA Yau Tsim Mong Community Network - Changing Diabetes Care: Reducing CV Mortality in Patients with Type 2 Diabetes</b> Organiser: HKMA Yau Tsim Mong Community Network; Chairman: Dr. CHAN Wai Keung, Ricky; Speaker: Dr. LAU Chun Leung; Venue: Crystal Ballroom, 2/F, The Cityview Hong Kong, 23 Waterloo Road, Kowloon	Ms. Candice TONG Tel: 2527 8285 1 CME Point
8:00 PM	<b>FMSHK Officers' Meeting</b> Organiser: The Federation of Medical Societies of Hong Kong; Venue: Gallop, 2/F, Hong Kong Jockey Club Club House, Shan Kwong Road, Happy Valley, Hong Kong	Ms. Nancy CHAN Tel: 2527 8898
9:00 PM	<b>HKMA Council Meeting</b> Organiser: The Hong Kong Medical Association; Chairman: Dr. HO Chung Ping, MH, JP; Venue: HKMA Wanchai Premises, 5/F, Duke of Windsor Social Service Building, 15 Hennessy Road, HK	Ms. Christine WONG Tel: 2527 8285
<b>9</b> WED 7:30 AM	<b>The Hong Kong Neurosurgical Society Monthly Academic Meeting -To be confirmed</b> Organizer: Hong Kong Neurosurgical Society; Speaker(s) : Dr HO Wing Kiu, Joanna; Chairman: Dr CHAN Kwong Yau; Venue : Seminar Room, G/F, Block A, Queen Elizabeth Hospital	1.5 points College of Surgeons of Hong Kong Dr. WONG Sui To Tel: 2595 6456 Fax. No.: 2965 4061
2:00 PM	<b>Course on Community Nephrology (Facebook CME Live)</b> Organiser: The Hong Kong Medical Association; Chairman: Dr. HO Chung Ping, MH, JP; Speaker: Dr. HO Chung Ping, MH, JP	Mr. Jeff CHENG Tel: 2527 8285 1 CME Point
<b>10</b> THU 1:00 PM	<b>HKMA Hong Kong East Community Network and the Centre for Health Protection of the Department of Health - Antibiotic Stewardship Programme in Primary Care</b> Organiser: HKMA Hong Kong East Community Network and the Centre for Health Protection of the Department of Health; Chairman: Dr. WONG Chun Por; Speaker: Dr. Leo LUI; Venue: HKMA Wanchai Premises, 5/F, Duke of Windsor Social Service Building, 15 Hennessy Road, HK	Ms. Candice TONG Tel: 2527 8285 1 CME Point
7:00 PM	<b>FMSHK Certificate Course in Ophthalmology</b> Organiser: The Federation of Medical Societies of Hong Kong; Venue: Lecture Hall, 4/F, Duke of Windsor Social Service Building, 15 Hennessy Road, Wan Chai, Hong Kong	The Secretariat of FMSHK Tel: 2527 8898 Fax: 2865 0345
<b>12</b> SAT 2:15 PM	<b>Refresher Course for Health Care Providers 2018/2019 - Home Physiotherapy</b> Organiser: Hong Kong Medical Association; HK College of Family Physicians; HA-Our Lady of Maryknoll Hospital; Speaker: Ms. Dora FUNG; Venue: Training Room II, 1/F, OPD Block, Our Lady of Maryknoll Hospital, 118 Shatin Pass Road, Wong Tai Sin, Kowloon	Ms. Clara Tsang Tel: 2354 2440 2 CME Point
<b>15</b> TUE 1:00 PM	<b>HKMA Kowloon West Community Network: Update on Management of Irritable Bowel Syndrome</b> Organiser: HKMA Kowloon West Community Network; Chairman: Dr. TONG Kai Sing; Speaker: Dr. SZE Wan Chee; Venue: Fulum Palace, Shop C, G/F, 85 Broadway Street, Mei Foo Sun Chuen	Ms. Antonia LEE Tel: 2527 8285 1 CME Point
1:00 PM	<b>HKMA Tai Po Community Network and the Centre for Health Protection of the Department of Health - Antibiotic Stewardship Programme in Primary Care</b> Organiser: HKMA Tai Po Community Network and the Centre for Health Protection of the Department of Health; Chairman: Dr. CHOW Chun Kwan, John; Speaker: Dr. Leo LUI; Venue: Jade Garden, Shop 302, 3/F, Tai Wo Plaza Phase 1, 12 Tai Wo Road, Tai Wo	Ms. Candice TONG Tel: 2527 8285 1 CME Point
<b>16</b> WED 1:00 PM	<b>HKMA Central, Western &amp; Southern Community Network - Transforming Diabetes Care: Reducing CV Mortality in Patients with Type 2 Diabetes</b> Organiser: HKMA Central, Western & Southern Community Network; Chairman: Dr. YIK Ping Yin; Speaker: Dr. Enoch Wu; Venue: HKMA Central Premises, Dr. Li Shu Pui Professional Education Centre, 2/F, Chinese Club Building, 21-22 Connaught Road Central, HK	Ms. Antonia LEE Tel: 2527 8285 1 CME Point
<b>17</b> THU 1:00 PM	<b>HKMA Kowloon East Community Network: Approach to Autistic Children</b> Organiser: HKMA-Kowloon East Community Network; Chairman: Dr. TING Ka Chu; Speaker: Dr. LIN Hoi Yun, Candy; Venue: Lei Garden Restaurant, Shop no. L5-8, apm, Kwun Tong, No. 418 Kwun Tong Road, Kwun Tong, Kowloon	Ms. Antonia LEE Tel: 2527 8285 1 CME Point
7:00 PM	<b>FMSHK Foundation Meeting</b> Organiser: The Federation of Medical Societies of Hong Kong; Venue: Council Chamber, 4/F, Duke of Windsor Social Service Building, 15 Hennessy Road, HK	Ms. Nancy CHAN Tel: 2527 8898
8:00 PM	<b>FMSHK Executive Committee Meeting</b> Organiser: The Federation of Medical Societies of Hong Kong; Venue: Council Chamber, 4/F, Duke of Windsor Social Service Building, 15 Hennessy Road, Wanchai, Hong Kong	Ms. Nancy CHAN Tel: 2527 8898
<b>18</b> FRI 1:00 PM	<b>HKMA Kowloon City Community Network - Doctor, is it Frozen Shoulder?</b> Organiser: HKMA Kowloon City Community Network; Chairman: Dr. CHIN Chu Wah; Speaker: Dr. TAM Kin Ming, Kelvin; Venue: President's Room, Spotlight Recreation Club, 4/F., Screen World, Site 8, Whampoa Garden, Hunghom, Kowloon	Ms. Candice TONG Tel: 2527 8285 1 CME Point
<b>23</b> WED 2:00 PM	<b>Course on Community Nephrology (Facebook CME Live)</b> Organiser: The Hong Kong Medical Association; Chairman: Dr. HO Chung Ping, MH, JP; Speaker: Dr. CHAN Siu Kim	Mr. Jeff CHENG Tel: 2527 8285 1 CME Point



Date / Time	Function	Enquiry / Remarks
<b>24 THU</b> 1:00 PM	<b>HKMA Hong Kong East Community Network - Updates on Surgical Treatment for Obstructive Sleep Apnea</b> Organiser: HKMA Hong Kong East Community Network; Chairman: Dr. LEUNG Kwan Kui, Terence; Speaker: Dr. TANG Chi Ho; Venue: HKMA Wanchai Premises, 5/F, Duke of Windsor Social Service Building, 15 Hennessy Road, HK	Ms. Candice TONG Tel: 2527 8285 1 CME Point
<b>25 FRI</b> 1:00 PM	<b>HKMA Yau Tsim Mong Community Network - Overview of Common Menstrual Disorders and the Benefits and Risks of Hormonal Treatment as an Effective Treatment Option</b> Organiser: HKMA Yau Tsim Mong Community Network; Chairman: Dr. HO Lap Yin; Speaker: Dr. FAN Hiu Lan; Venue: Crystal Ballroom, 2/F, The Cityview Hong Kong, 23 Waterloo Road, Kowloon	Ms. Candice TONG Tel: 2527 8285 1 CME Point
1:00 PM	<b>HKMA Shatin Doctors Network and the Centre for Health Protection of the Department of Health - Antibiotic Stewardship Programme in Primary Care</b> Organiser: HKMA Shatin Doctors Network and the Centre for Health Protection of the Department of Health; Chairman: Dr. MAK Wing Kin; Speaker: Dr. Leo LUI; Venue: Diamond Room, 2/F, Royal Park Hotel, 8 Pak Hok Ting Street, Shatin	Ms. Candice TONG Tel: 2527 8285 1 CME Point
<b>26 SAT</b> 7:00 PM	<b>The 14th HKMA Sports Night</b> Organiser: The Hong Kong Medical Association; Chairman: Dr. CHAN Hau Ngai, Kingsley, Dr. IP Wing Yuk, Dr. YEUNG Hip Wo, Victor; Venue: Scout Association of Hong Kong	Ms. Sinn TANG Tel: 2527 8285
<b>29 TUE</b> 1:00 PM	<b>HKMA Kowloon West Community Network - An Overview of Common Developmental Problems in Children</b> Organiser: HKMA Kowloon West Community Network; Chairman: Dr. WONG Wai Hong, Bruce; Speaker: Dr. LEE Mun Yau; Venue: Fulum Palace, Shop C, G/F, 85 Broadway Street, Mei Foo Sun Chuen	Ms. Antonia LEE Tel: 2527 8285 1 CME Point
<b>30 WED</b> 1:00 PM	<b>HKMA Central, Western &amp; Southern Community Network - Advances in Hypertension Guideline</b> Organiser: HKMA Central, Western & Southern Community Network; Chairman: Dr. CHAN Hau Ngai, Kingsley; Speaker: Dr. CHOW Hoi Fan, Danny; Venue: HKMA Central Premises, Dr. Li Shu Pui Professional Education Centre, 2/F, Chinese Club Building, 21-22 Connaught Road Central, HK	Ms. Antonia LEE Tel: 2527 8285 1 CME Point
<b>31 THU</b> 1:00 PM	<b>HKMA Kowloon East Community Network - Antibiotic Stewardship Programme in Primary Care</b> Organiser: HKMA-Kowloon East Community Network; Chairman: Dr Leo LUI; Speaker: Dr. MA Ping Kwan, Danny; Venue: V Cuisine, 6/F., Holiday Inn Express Hong Kong Kowloon East, 3 Tong Tak Street, Tseung Kwan O	Ms. Antonia LEE Tel: 2527 8285 1 CME Point
1:00 PM	<b>HKMA New Territories West Community Network - Update on Management of Non-Valvular Atrial Fibrillation in Primary Care</b> Organiser: HKMA New Territories West Community Network; Chairman: Dr. TSANG Yat Fai; Speaker: Dr. CHOI Man Chun; Venue: Atrium Function Rooms, Lobby Floor, Hong Kong Gold Coast Hotel, 1 Castle Peak Road, Gold Coast, Hong Kong	Ms. Antonia LEE Tel: 2527 8285 1 CME Point



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## Answers to Dermatology Quiz

### Answers:

1. Neonatal lupus erythematosus (NLE) is the most likely clinical diagnosis. Other differential diagnoses include infantile eczema, tinea faciale, annular psoriasis and erythema multiforme. Apart from infantile eczema, all the other possibilities are very unlikely according to the clinical context.

NLE can present with annular papulosquamous (45%), congenital heart block (45%), or both (10%). However, 60% of mothers are asymptomatic at delivery, while others may have arthritis or sicca syndrome.

2. Blood tests including anti-Ro, anti-La, antinuclear factor and anti-ds-DNA should be done for both the baby and her mother. In this case, anti-Ro was positive in both the patient and her mother. Electrocardiography, and if indicated, echocardiography and 24-hour Holter monitoring should be done for the patient as soon as possible to exclude heart block.

Both the baby & mother usually have negative antinuclear factor, but anti-Ro is positive in 98% baby and in most mother. Heart block can be detected as early as 16-weeks of gestation, mostly with complete heart block.

3. The prognosis of the baby is good if there is absence of heart involvement. Skin lesions are prominent during the first six months and then resolve spontaneously. However fibrosis at cardiac conduction system can be permanent. The mother has one-third chance of developing systemic lupus erythematosus in the future, and 25% chance with second affected baby.

### Dr Lai-yin CHONG

MBBS(HK), FRCP(Lond, Edin, Glasg), FHKCP, FHKAM(Med)  
Specialist in Dermatology & Venerology

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# THE GLOBAL GENERICS LEADER



## Hong Kong

- **No.1** multi-national generic drug company<sup>5</sup>
- **300+** products registered<sup>5</sup>
- Supply **70+** items in HA<sup>5</sup>
- Serve **2500+** customers in private sector and pharmacies<sup>5</sup>



## Canada

**1 in 6** generic prescriptions filled with our products<sup>1</sup>



## United States

We are responsible for **13% of generic savings** in the healthcare system<sup>2</sup>



## United Kingdom

We are the **largest single medicines provider** of the NHS<sup>3</sup>



## Europe

Our generic medicines **save €8 billion/year** in the European healthcare budget<sup>4</sup>



## Japan

**Top 3** generic pharmaceutical companies<sup>6</sup>

