ACHC 亞洲癌症及血液專科中心 Asia Cancer & Haematology Centre

張明智 醫生
Dr. Michael M. C. Cheung
臨床腫瘤科專科醫生
Specialist in Clinical Oncology

陳子敏 醫生
Dr. Chan Tze Mun
臨床腫瘤科專科醫生
Specialist in Clinical Oncology

陳以天 醫生
Dr. Chen Yi Tin
血液及血液腫瘤科專科醫生
Specialist in Haematology & Haematological Oncology

黃舜雯 醫生
Dr. Wong Shun Man, Irene
臨床腫瘤科專科醫生
Specialist in Clinical Oncology

Healthcare Planning and Development Office
Food and Health Bureau
19/F, East Wing,
Central Government Offices
2, Tim Mei Avenue, Tamar,
Hong Kong

13 March 2015

By mail and email

Dear Sir,

**RE: Regulation of Private Healthcare Facilities**

I am writing to comment on the Government Consultation Document on Regulation of Private Healthcare Facilities (PHFs) proposed by the Food and Health Bureau (FHB) in December 2014.

I am a specialist in Clinical Oncology since 1999. Although the Consultation Paper covers major issues in regulating private hospitals and certain private healthcare facilities, there are significant deficiencies, which continue to put the public interest and health at risk.

**Regulation of 'non high-risk' PHF are not included**

According to the Administration, a new legislation regulating PHFs will replace Cap. 165 and Cap. 343. The new legislation should be comprehensive with a broad coverage to include ***all*** PHFs, instead of just the three classes mentioned in the document.

I propose regulation on a 4th class encompassing solo practice private medical practitioners, group practice private medical practitioners and all PHFs not providing high-risk procedures. This class comprises of more than 2/3 of private medical practitioners.

I opine that the regulatory aspects such as A1 (Person-in-charge), B6-8 (standards of facilities), C9 (service delivery and care process) and D15 (provision of fee schedule) should apply to this 4th class in the era of modern healthcare management and increasing expectation on public safety.

Relying on the ethics and self-discipline coupled with sanctions via the Medical Council (under Medical Registration Ordinance Cap 161) for the 4th class is inadequate due to the low efficiency of the Medical Council (average time to hand disciplinary cases is 2-3 years) and its limited authority on sanction (no power on imprisonment).

Issues discussed in the proposed new legislation do not seem to be well-covered in the original MRO Cap 161.

張明智醫生 Dr. Michael M. C. Cheung 臨床腫瘤科專科醫生 Specialist in Clinical Oncology
陳子敏醫生 Dr. Chan Tze Mun 臨床腫瘤科專科醫生 Specialist in Clinical Oncology
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黃舜雯醫生 Dr. Wong Shun Man, Irene 臨床腫瘤科專科醫生 Specialist in Clinical Oncology

It is prejudiced that for different private medical practitioners to be regulated by different ordinance / legislation merely due to the difference in the type of services provided (many major regulatory aspects mentioned above should apply to all private medical practitioners). The new legislation, coupled with the setup of new regulatory authorities, should oversee all private medical practitioners to provide a comprehensive protection for the public, instead of the proposed three classes only, which constitute less than 1/3 of private medical practitioners.

**Person-in-Charge**

I support the mandatory appointment of a person-in-charge (PIC) for all private hospitals (class 1) and PHFs under the management of incorporated bodies (class 3) due to the operational risk. Qualifications and duties of the PIC should be clearly defined. However, for PHFs providing high-risk medical procedures, many are co-owned and co-managed by several medical specialists. They do not carry the operational risk like that of class 1 & 3. Exemption to appoint PIC should be granted to class 2 PHFs if they are "owned, managed, operated and serviced solely by identical registered medical practitioners" (exemption to appoint PIC is granted to class 3 PHFs if they are owned, managed, operated and serviced solely by identical registered medical practitioners – refer to point 16 of executive summary on P.10 of consultation document). Even if PIC is appointed, he / she should only be responsible the operation of the PHF, instead of the medical liabilities of other clinic partners.

Different levels of sanctions should be defined for different aspects of regulation violation.

**Definition of "High Risk Procedures" and Regulatory Authorities**

With the advancement in medical technology and rapid changes in medical practices, definition of "high-risk procedures" and facility standards specific to certain procedures (e.g. haemodialysis, endoscopy, chemotherapy) should be reviewed on a regular basis. The input from private professional organizations and PHFs are important as they can provide valuable real life practical opinions to supplement the proposal by academics from universities and HKAM college representatives.

The proposed new regulations impose stringent requirements on medical practitioners delivering "high-risk procedures" in ambulatory setting. I propose to tighten the regulation on qualified medical practitioners eligible to deliver certain "high-risk procedures".

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Chemotherapy should ***only*** be delivered by oncologists (clinical oncologist, medical oncologists, heamatological oncologists, paediatric oncologists). All private hospitals should ***only*** allow qualified oncologists to deliver chemotherapy (currently, some breast / gastrointestinal tract surgeons, gynaecologists etc deliver chemotherapy in their clinics or in hospitals).

**Summary:**

Overall, I welcome the proposal in the consultation document. However, at least 2/3 of medical practitioners working as solo practice or "non high-risk" PHFs are not included in the current proposal and are only regulated by "ethics and self-discipline".

Appointment of a PIC should be exempted in PHF providing parenteral chemotherapy treatment in the community run and own by individual specialist or by small groups of specialists.

Chemotherapy should only be allowed to be administrated by specialists with appropriate and adequate training and qualifications.

Yours Sincerely,

Dr CHAN Tze Mun
Specialist in Clinical Oncology