香港醫務委員會
THE MEDICAL COUNCIL OF HONG KONG

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Professional Code and Conduct

Since the last issue of the newsletter, the Ethics Committee has reviewed Sections 4, 13 & 16, and worked out the draft of a few new sections on important issues for inclusion in the Code. Before finalising these sections, the Council would like to seek views from members of the profession.

4. Abuse of dangerous or scheduled drugs

4.1 Medical practitioners are advised to adhere to the Guidelines on the Proper Prescription and Dispensing of Dangerous Drugs promulgated by the Medical Council. Disciplinary proceedings may be taken in any case in which a medical practitioner prescribes or supplies drugs of addiction or dependence otherwise than in the course of bona fide and proper treatment.

4.2 Medical practitioners are required to maintain proper records of ALL dangerous drugs, whether supplied, dispensed, or administered and in strict accordance with the statutory forms under the Dangerous Drugs Regulations (Cap. 134). Failure to follow the above requirements of the Medical Council may result in disciplinary action.

(Note : In addition, medical practitioners should, in their own interest, familiarize themselves with the laws of Hong Kong governing the supply of dangerous drugs, in particular, Regulations 5 and 6 of the Dangerous Drugs Regulations (Cap. 134) on the criminal sanction for any failure to keep proper records and requirements as to registers of dangerous drugs supplied. Please refer to Appendix C for samples of the Form of Register contained in the First Schedule of the Dangerous Drugs (Amendment) Regulation 1996. It should also be noted that if the Director of Health is of the opinion that it is in the public interest to do so, the Director may, under section 33 of the Dangerous Drugs Ordinance, withdraw absolutely from any person the authorization for the possession, supply or manufacture of certain or all dangerous drugs.)

4.3 Disciplinary proceedings will be taken against medical practitioners convicted of offences against the Dangerous Drugs Ordinance, Cap. 134 and the Regulations made thereunder committed in order to gratify the medical practitioner's own addiction.

4.4 Disciplinary proceedings may be taken against any registered medical practitioner who permits unqualified assistants to be left in charge of any place in which scheduled poisons or preparations containing scheduled poisons are supplied to the public.

13. Relationships between the medical profession and the pharmaceutical and allied industries

13.1 Advertising and other forms of sales promotion by individual firms within the pharmaceutical and allied industries are necessary for their commercial viability and can provide information which is useful to the profession. Nevertheless, a doctor when prescribing should not only choose but also be seen to be choosing the drug or appliance which, in his independent professional judgement and having due regard to cost effectiveness, will best serve the medical interests of his patient. Doctors should therefore avoid accepting any pecuniary or medical inducement which might compromise, or be regarded by others as likely to compromise, the independent exercise of their professional judgement in matters pertaining to patients' management. The seeking or acceptance by doctors of unreasonable sums of money or gifts from commercial firms which manufacture or market drugs or diagnostic or therapeutic agents or appliances may be regarded as improper.

13.2 The medical profession and the pharmaceutical industry have common interests in the research and development of new drugs or appliances of diagnostic or of therapeutic value and in their production and distribution for clinical use. Medical practice owes much to the important advances achieved by

the pharmaceutical industry over the recent decades. In addition, much medical research and postgraduate medical education are facilitated by the financial support of pharmaceutical firms.

13.3 It is improper for individual doctors to accept from a pharmaceutical firm monetary gifts or loans or equipment or other expensive items for their personal use.

13.4 Some exceptions can, however be made to grants of money or equipment by firms to institutions such as hospitals, health care centres and university departments, when they are donated specifically for purposes of patients' services, education or approved research.

13.5 Clinical trials of drugs and appliances :

It is improper for a doctor to accept directly or indirectly payments from a pharmaceutical firm in relation to a research project such as the clinical trial of drugs and appliances, unless the payments have been specified in a protocol for the project which has been approved by the relevant local ethical committee. It is improper for a doctor to accept directly or indirectly payments under arrangements for recording clinical assessments of a licensed medicinal product, whereby he is asked to report reactions which he has observed in patients for whom he has prescribed the drug, unless the payments have been specified in a protocol for the project which has been approved by the relevant ethical committee. It is improper for a doctor to accept payment in money or kind which could influence his professional assessment of the clinical value of drugs or appliances. Legitimate payment from pharmaceutical companies over cost incurred in conducting approved clinical studies is acceptable.

16. Improper financial transactions

16.1 A doctor may not receive any payment by way of commission, rebate or otherwise from another doctor or organisation for referring a patient for consultation or treatment. A doctor may not offer or pay any commission, rebate or otherwise to another doctor, person or organisation who refers a patient to him for consultation or treatment.

16.2 A doctor shall not share his fees with any person other than the bona fide partners of that practice.

16.3 A doctor shall not receive any rebate from diagnostic laboratories or similar organisations to whom he refers patients.

16.4 If a doctor has financial or commercial interest in organisations providing health care or in pharmaceutical or other biomedical companies, these must not affect the way he prescribes for, treats or refers patients.

16.5 A doctor, before taking part in discussion with patients or their relatives about buying goods or services, must declare any relevant financial interest or commercial interest which he or his family may have in the purchase.

16.6 The seeking or acceptance by a doctor from such an institution of any inducement for the referral of patients to the institution, such as free or subsidised, consulting premises or secretarial assistance, is considered improper. Similarly the offering of such inducements to colleagues by doctors who manage or direct such institutions may be regarded as improper.

16.7 Sponsorship from commercial organisation for participation in scientific meetings, educational and charitable services is acceptable provided the amount sponsored is reasonable and not excessive.

New sections to be added to the Code

Care for the Dying and Euthanasia

1. Active euthanasia is not supported and is considered unethical.

2. Withholding of resuscitation procedure is essentially a medical decision which should be based on risk and benefit analysis and whether such withholding would be in the best interests of the patient concerned. Doctors should exercise careful clinical judgement and whenever they are in doubt or cannot make a decision, the matter should be referred to the ethics committee of the hospital concerned or relevant authority for consideration. In case of further doubt, seek direction from the court as necessary.

3. It is important that the rights of the dying patients or their relatives be respected. The decision should have sufficient participation of the patient himself or, if this is impossible, his relatives should be provided with full information relating to the circumstances and the doctor's decision.

4. Doctors may seek further reference from the Hospital Authority, the Hong Kong Medical Association and the relevant colleges of the Hong Kong Academy of Medicine.

Pre-natal Diagnosis and Intrauterine Intervention

1. Prenatal diagnosis is done for diagnosis, treatment, and detection of disease. The procedures must be safe. The

result must be reliable and the result has to be discussed with colleagues and the parents concerned.

2. Prenatal treatment has to balance the risk of intervention and the consequence of not having such intervention.

3. Care for the pregnant woman and the foetus are equally important.

4. Procedures of prenatal intervention are well documented. The matter is whether the medical condition justifies intervention.

5. In certain western countries, prenatal screening is conducted on the basis of family history and known incidents of certain disease in the community.

6. In Hong Kong, prenatal screening is done mainly on index patients, i.e. those who have family history of the disease, or pregnant women above a certain age.

7. Sex selection for social/cultural or other non-medical reasons is not supported.

8. Sex selection may be indicated in cases when it was known that certain diseases do affect male foetus more than female foetus.

9. The advice for termination of pregnancy would be given in case the foetus is liable to or has a seriously handicaping disease.

10. A foetus who has defects but is in the group of normal survival recommendation for termination of pregnancy would not normally be given.

11. If, after having discussed with colleagues, the existence of the disease in the foetus of the index patient is confirmed, discussion with the pregnant woman concerned would then be conducted; and termination of pregnancy would proceed with the pregnant woman's consent.

12. Hence, prenatal diagnosis and subsequent intervention can be justified if the following important steps or factors are thoroughly examined :-

    * indications;

    * nature of the disease;

    * reliability of the diagnosis;

    * risk of the procedure;

    * result and discussion with the parents concerned.

13. Prenatal diagnosis do not necessarily end in termination of pregnancy. Sometimes the known disease of the foetus can be managed by prenatal transfusion of blood, which can be one form of treatment.

14. Medical practitioners performing termination of pregnancy must observe the principles laid down in the laws of Hong Kong governing this aspect, particularly those relevant provisions in the Offences Against the Persons Ordinance, Cap. 212.

15. The decision as to whether the pregnancy should be terminated is medical decision or medical judgement; the matter is also protected under the law, but the decision to do prenatal diagnosis is separate issue which should be governed by other considerations as mentioned above.

16. Medical practitioner may refer a patient to another colleague for advice or decision on termination of pregnancy as he or she considers appropriate.

17. Prenatal diagnosis is done not for determination of the status of the foetus, but for health care. Informed consent from the pregnant woman concerned is important in the decision of prenatal diagnosis. Likewise, the pregnant woman has the right to decline prenatal screening.

18. Specific advice or views from the College of Obstetricians and Gynaecologists and the College of Paediatricians should also be sought regarding the subjects under consideration.

19. Counselling is considered necessary and the following points should be noted:

    (a) Termination of pregnancy after prenatal diagnosis should be available as a choice. Proper counselling should be offered to the pregnant women and families to prepare them for possible physical and psychological sequelae.

    (b) Pre and post tests counselling should be an integral part of the procedure.

    (c) Full information should be disclosed at all stages of counselling. Such information should include facts about the fetal condition and the risks, limitations and accuracy of the proposed procedure.

    (d) Parents should be fully respected in their perception and judgement of the severity of the fetal disorders, and a decision on further management of pregnancy should be made by the parents. The final decision should be that of the pregnant woman. The medical professionals are, however, under no obligation to perform termination of pregnancy against their own beliefs or if their views on the severity of the fetal disorder differ from those of the parents.

Religion

1. All religions should be respected in all respects.

2. The patient's clinical benefit is of the utmost importance. If

a medical practitioner, because of his own religious belief, should have any objection to a procedure which is beneficial to the patient, he should give a full explanation to the patient and ask the patient to seek advice from another qualified medical practitioner.

3. Special demands from special religious groups concerning medical treatment should be seriously considered .

Patient's Privacy and Confidentiality

1. Medical records

Medical records are notes including history, physical examination findings, investigation results and other relevant information maintained by medical practitioners on their patients. They encompass both written and electronically stored information.

All doctors have a responsibility to maintain clear, accurate and contemporaneous medical records of their patients and to keep them secure. This includes ensuring that unauthorized persons do not have access to the information contained in the records and that there are adequate procedures to prevent improper disclosure.

Doctors should be aware of the provisions of the Personal Data (Privacy) Ordinance (Cap. 486), and have due regard to their responsibilities and liabilities under that Ordinance. In particular they should be aware of the patient's rights of access to and correction of the information in the medical record and the circumstances when these rights may be refused.

2. Medical examinations and subsequential reporting

Whenever a doctor conducts a health check-up on a person there exists a doctor-patient relationship which should be respected at all times. The medical information should not be disclosed to a third party without the prior consent of the patient. If a consent is withdrawn, the doctor must respect this.

A doctor is advised to ensure that the patient fully understands what may be involved in furnishing a medical report; and that his contractual liabilities with the third party, should consent to disclose the medical information not be available, are clear.

3. Handling of medical record upon transfer or cessation of practice

It is the responsibility of the doctor who intends to stop practising medicine, either generally or in a particular area, to ensure that his patients' medical records are properly handled and preserved. This could be achieved either by giving the medical record or a copy of it to the relevant patient, if appropriate, or by transferring the record to another doctor who was, in his opinion, competent to look after the patient.

The patients should be made aware of the change of circumstances and the arrangements that have been made in respect of their medical records. Options that are available to the doctor who transfers or ceases practice include:

(1) making an individual announcement to each patient, whether in person or by written notification;

(2) making a public announcement in the newspapers;

(3) displaying notices in his office for the patients' attention

The doctor who assumes custody of the medical records has a responsibility to inform the patient of the transfer of the record to him whether upon enquiry or upon the patient attending the practice. He must seek the patient's consent to his taking over the patient's medical care and his custody of the medical record. Before obtaining such consent, unless in the best interests of the patient, the succeeding doctor should not make reference to a patient's medical record under his custody.

A doctor who employs a locum doctor in his stead should display a notice to this effect inside the office and ensure that patients are informed about the change of doctor prior to any consultation.

4. Disclosure of medical information to third parties

A doctor should obtain consent from a patient before disclosure of medical information to a third party not involved in the medical referral.

In exceptional circumstances medical information about a patient may be disclosed to a third party without the patient's consent. Examples are: (i) disclosure in the public interest or in the interests of an individual may be justified where the failure to disclose the appropriate information would expose the patient, or someone else, to a risk of death or serious harm; (ii) when required by law to do so.

However, before making such a disclosure a doctor must weigh carefully the arguments for and against disclosure and be prepared to justify the decision. If in doubt, it would be wise to discuss the matter with an experienced colleague or to seek help from a medical defence society, a professional association or an ethics committee.

Consent

A medical practitioner should observe the following principles:

1. Consent is part of quality care and also a legal requirement. Consent has to be informed and proper which means that patients should be properly informed about the general nature, effect and risk of medical procedures.
2. Consent is normally given by the patient himself/herself or by a designated person under specific circumstances. Views of the family members should be considered provided that such views are compatible with (a) the patient's best interest; and (b) the patient's right of self-determination.
3. Consent should preferably be recorded in a document. Though legally, a consent in written form is not absolutely necessary. The need for written consent becomes necessary under specific statutory provisions.
4. A patient has the right to refuse to give consent to treatment, provided that the patient is able to exercise his/her judgement clearly and freely. The refusal should be respected and preferably documented.

Views or comments on these sections are welcome. Please forward your views or comments to the Medical Council Secretariat at the following address :

4/F., Hong Kong Academy of Medicine Building,

99 Wong Chuk Hang Road, Aberdeen, Hong Kong

Fax : 2554 0577

Finalised sections for inclusion in the Code

Following the deliberation of the Medical Council, the finalised version of section 14.2 on contract medicine and managed care and section 9.2.3.1 concerning size of signboards are set out below :-

14.2 Contract medicine and Managed care

A doctor who is an owner, a director or an employee of, or in a contractual relationship with, an organisation which, either directly or indirectly, provides medical services or administers medical schemes, may only continue such association provided that the organisation conforms to the following principles:-

14.2.1 The principles on advertising mentioned in paragraph 14.1.1 must be observed.

14.2.2 Doctors should exercise careful scrutiny and judgement of medical contracts and schemes to ensure that they are ethical and in the best interest of patients. Doctors should dissociate themselves from organisations that provide substandard medical services, infringe patients' rights and contravene the Professional Code and Conduct.

14.2.3 When administrators, agents, brokers, middlemen etc are involved in a medical contract, information pertaining to the financial arrangements must be readily available to all parties on request.

14.2.4 Medical schemes and contracts often involve administrative costs. Doctors should do their best to ensure that these administrative costs are reasonable. Nevertheless, each doctor is to retain 100% of the professional fees which he or she charges the patient. Payment by credit card, of that amount payable to the credit card company, is acceptable.

14.2.5 Commercial pre-paid capitation schemes (whereby a doctor or a group of doctors undertake(s) certain insurance-type of financial risks) which may be incompatible with a high standard of medical practice should not be entered into.

14.2.6 Doctors in accepting contracts to provide service should avoid taking on unreasonable financial risk as in the case of low capitated payment. It will be unacceptable for doctors who provide substandard service to use capitated medical scheme which they joined as their excuse.

Section 9.2.3.1 concerning size of the signboards

Generally Permitted

Every registered medical practitioner is permitted to exhibit one signboard on or beside that door which gives immediate and direct access to his surgery. The size of the signboard beside that door must not exceed ten square feet.

Additional Signboard Permitted

1. No additional signboard exhibited below First Floor level may exceed ten square feet.
2. No additional signboard exhibited at Mezzanine Floor or First Floor level may exceed thirteen square feet.
3. No additional signboard exhibited at a level above First Floor level may exceed twenty square feet.

A brief report on the forum of the Ethics Committee

The forum of the Ethics Committee was successfully held on 19 May 1999 in the Conference Room on 4/F of the Hong Kong Academy of Medicine Building. Eight representatives of managed care organisations and medical associations attended the forum to exchange views with members of the Ethics Committee on section 14.2 concerning contract medicine and managed care. Their views are summarized below :-

(a) One representative was of the view that the Medical Council should set up rules to regulate contract medicine schemes and such rules should apply to all medical practitioners. Another representative opined that the Council should recognize the necessity for the existence of contract medicine and set up guidelines to allow doctors competing in a controlled environment. It was suggested that the Hong Kong Medical Association could scrutinize and approve the contract medicine schemes.

(b) One representative commented that information pertaining to the financial arrangement of contract medicine should be supplied to all parties concerned. In response to his comment, another representative considered that financial arrangement should only be made available to the parties concerned upon request. However, three representatives considered that the disclosure of financial arrangement was not practicable because there were a lot of parties involved in contract medicine and doctors could not be expected to have access to medical scheme contracts to which they were not direct parties. One of them stressed that the Medical Council can force the doctors to release financial information but it can not force the insurance company or broker to do so because these commercial practices are out of its jurisdiction. The issue on locum arrangement was also raised.

(c) One representative opined that the interest of the employer had not been sufficiently addressed to in section 14.2.

(d) Regarding the issue on canvassing, one representative queried why the HMOs were allowed to approach their potential clients whereas solo practitioner was strictly forbidden to do so.

(e) One representative was of the opinion that capitation was the most effective means of controlling rising healthcare cost but it has moral hazards for doctors, patients and standard of practices. He commented that capitation passed the insurance risk from the insurance company onto the medical groups as well as doctors and would jeopardize doctor-patient relationship. He advised that as medical groups were not under the control of Insurance Authority, there was always the danger of insufficient fund.

(f) Some representatives opined that the Medical Council should recognize the existence of administration fee in contract medicine. One representative suggested that the administration fee and the fee reimbursed to doctors should be clearly stated in the receipts in order to increase the transparency to patients. However, another representative pointed out that the actual administrative cost was always hidden and not readily available unless the company was carefully audited.

(g) Most of the representatives agreed that the meaning of some words in section 14.2 like "substandard" and "unreasonable" were not clearly defined and the Medical Council might open itself to dispute in future.

(h) One representative considered that the position of the Hospital Authority, as a publicly funded organization, was different from the commercial managed care organization. If the Hospital Authority was limiting the professional freedom of physicians, they were only using professional means, not purely administrative means.

(i) Three representatives agreed to add a paragraph on over-servicing which should be included in other relevant section of the Professional Code.

(j) One representative advised that the push towards capitation in Hong Kong was being driven by insurance companies and employers who viewed it as an effective way of controlling healthcare cost. He mentioned that if medical groups were not allowed to provide capitated schemes, insurance companies would capture a very significant part of the healthcare market in Hong Kong.

After listening to the views of those invited parties, the two lay members of the Ethics Committee found that HMO was a complicated issue because it involved many parties, transactions and interests. One of them expressed concern over the bankruptcy of HMOs, the hazards to doctors and the standard of practice. The other opined that HMOs must be controlled because market force could not be expected to effectively control the standard of practice when the number of medical practitioners involved was large.

After the forum, the Ethics Committee decided that it could not support the commercial prepaid capitation scheme because there was at present no law dealing with the moral hazards of capitation.

It was agreed that doctors should be allowed to continue practising capitation if they were already involved in prepaid capitation scheme and they would not be found guilty of professional misconduct just because they were practising capitation. Other factors like the quality of service would also be taken into consideration before coming to a judgement.

In response to the comment that the interest of the employer had not been sufficiently addressed, the Committee considered that the Code was only meant for the medical practitioners, not the employers. Although the meaning of some words in section 14.2 might not be well-defined, the Committee agreed that it was impracticable to have a definite meaning acceptable to all parties.

Reminders

The Council takes this opportunity to remind all medical practitioners to pay particular attention to the following rules as set out in the existing Code to avoid the danger of inadvertently transgressing accepted codes of professional ethical behaviour which may lead to disciplinary action by the Medical Council:-

Labelling of dispensed medicines (Section 5)

All the drugs dispensed by a medical practitioner should be individually identifiable with the following essential information:-

* name of patient
* date of dispensing
* trade name or pharmacological name of the drug
* dosage per unit
* method and dosage of administration; and
* precaution where applicable

You are advised to make use of the Department of Health's publication "Compendium of Pharmaceutical Products" which lists all the drugs registered in Hong Kong.

Proper record of dangerous drugs (Section 4.2)

Medical practitioners are required to maintain proper records of ALL dangerous drugs, whether supplied, dispensed, or administered and in strict accordance with the statutory forms. (You are also advised to balance the book regularly.)

Medical certificates (Section 17.1)

Any medical practitioner who in his professional capacity gives any certificate or similar document containing statements which are untrue, misleading or otherwise improper renders himself liable to disciplinary proceedings. In particular, medical practitioners are warned that the signing of blank certificates is prohibited by the Council.

Dissemination of information about professional services to patients (New Section 9.2.4.5)

It is not permissable to exhibit anything other than those permitted by the Medical Council at the front door of a doctor's office such as the exhibit of medical or ancillary services, medical insurance schemes and charges.

Patients' privacy and confidentiality (New Section)

It would be in the doctor's interest to specify in any contract with consulates and insurance companies his entitlement to remuneration and his obligation for confidentiality.

Patient Records

Medical practitioners should ensure that all records including electronically stored information are not lost.

The 1999 Election of the Medical Council of Hong Kong

For the 1999 Election to fill the offices of three members of the Medical Council of Hong Kong, eight candidates are validly nominated. They are

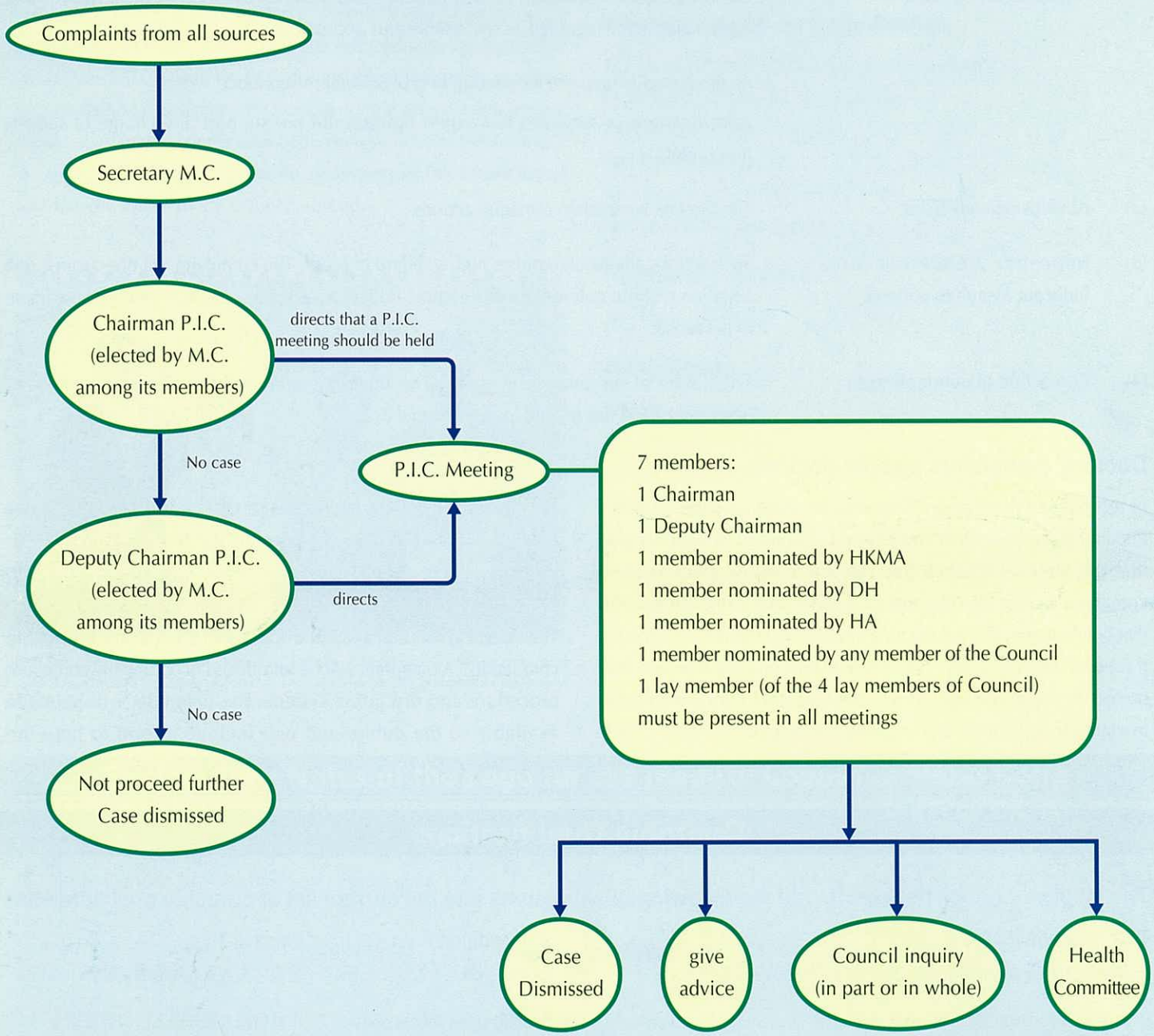
1. Dr. Tse Hung Hing
2. Prof. Chiu Fung Kum Helen
3. Prof. Liang Hin Suen Raymond
4. Dr. Yuen Natalis Chung Lau
5. Prof. Leung Ping Chung
6. Prof. Lau Yu Lung
7. Dr. Ip Kit Kuen
8. Prof. Wei William Ignace

Result of nomination and ballot papers will be issued on 8 October 1999. Electors are invited to cast their votes and return the ballot paper by post to the Medical Council Secretariat on or before 8 November 1999.

Please do exercise your right and cast your vote!

MRO 161 Part IIIE
The Working of Preliminary Investigation Committee

The following flowchart illustrates how the Preliminary Investigation Committee handles complaints:



The major category of complaints is under section (2) of the Code, i.e. Disregard professional responsibility to patients. This category can be further classified as:

* unexpected death of a patient
* complications resulting from surgical procedures
* unsatisfactory outcome of treatment
* delay of treatment
* inappropriate surgery
* wrong diagnosis
* side-effects of drugs
* failure to delegate or provide adequate professional care
* inadequate explanation or information

Complaints mostly arising out of misunderstanding or breakdown of communication

Nature of cases dismissed by the Preliminary Investigation Committee in 1998

Reasons of dismissal

(1)	Disregard professional responsibility to patients	* Patients' dissatisfaction, eg. inappropriate surgery or poor result, arising from the communication breakdown between doctors and patients. Doctors' medical records and explanation were regarded as reasonable and acceptable; * no gross negligence, not amounting to professional misconduct; * complications of surgeries but expert opinion did not support any charge of serious misconduct
(2)	Advertising/canvassing	* The doctors have taken remedial actions
(3)	Improper behaviour or indecent assault to patients	* Such serious allegation requires high standard of proof. The complaint is a one-against-one situation without collaborative evidence. Police investigation ruled insufficient evidence to prosecute.
(4)	Conviction of minor offences	* The nature of the offence is minor. The doctors committed the offences because of negligence, and not related to professional practice.

Doctors' complaints against doctors

In response to the Harvard Report's comment on page 58 of the Report that "some doctors interviewed by the Harvard team revealed that the Medical Council had refused to allow them to file a complaint against the misconduct of other physicians, on grounds that only patients, but not doctors, have the right to file a complaint. If medical professionals cannot report misconduct, how are they protecting the public against it?", the Medical Council would like to clarify that it had in fact received, in the past five years (1994-1998), a total of 68 cases of doctor(s) filing a complaint against another doctor(s). This figure consists of 7 cases in 1994, 13 cases in 1995, 17 cases in 1996, 17 cases in 1997 and 14 cases in 1998.

Helping the complainants

The Medical Council has plans to assist the public in lodging complaints. A pamphlet will be introduced to outline the complaint procedure and discipline system. The pamphlet will be made available to the public and will include a form to help the complainant.

Quotable Qualifications

The Medical Council decided to add the following qualifications into the current list of quotable qualifications:

Title of Qualifications	Abbreviation	Chinese Title
1. Diploma in Family Medicine, Chinese University of Hong Kong	DFM(CUHK)	香港中文大學家庭醫學文憑
2. Master of Science in Respiratory Medicine, University of London	M Sc(Respirat Med)(Lond)	英國倫敦大學呼吸系統科醫學碩士
3. Diploma in Public Health, University of Auckland	DPH(Auckland)	紐西蘭奧克蘭大學公共衛生學文憑
4.Fellow of Royal College of Surgeons of Edinburgh (Surgical Neurology)	FRCS(SN)(Edin)	英國愛丁堡皇家外科醫學院院士 (腦外科)
5. Diploma in Child Health, University of Sydney	DCH(Sydney)	澳洲雪梨大學兒科文憑
6. Master of Paediatrics, University of New South Wales	M Paed (New South Wales)	澳洲新南威爾斯大學兒科碩士
7. Fellow of Royal College of Paediatrics and Child Health	FRCPCH	英國皇家兒科醫學院榮授院士
8. Fellow of Hong Kong College of Anaesthesiology (Intensive Care)	FHKCA(Intensive Care)	香港麻醉科醫學院危重病學院士
9.Diploma in Pain Management, Hong Kong College of Anaesthesiology	Dip Pain Mgt (HKCA)	香港麻醉科醫學院疼痛科文憑

Logo of the Medical Council of Hong Kong

The Medical Council of Hong Kong is pleased to announce the adoption of its official logo.

Last year, all doctors were invited to submit designs. Out of the 12 submissions received, the Council has selected a design submitted by Dr. Alex LAI Chi-wai. Dr. LAI's design was subsequently modified by a professional designer who worked out the final version (please see the explanatory notes attached). As a symbol of the Council, the logo will enhance the public awareness of the Council and promote the image of the Council abroad.

Prof. Felice LIEH-MAK (in second-right), the Chairman of the Medical Council, accompanied by Dr. Lilian LEONG (in second left) and Mr. Leo KUNG (in the left), presented a Certificate of Appreciation to Dr. Alex LAI Chi-wai (in the right)

The Council would like to take this opportunity to thank the following persons for their assistance:

Working Group on Logo Design

Dr. Lilian LEONG FUNG Ling-yee (Convenor)
Prof. Sydney CHUNG Sheung-chee
Prof. Grace TANG Wai-king
Mr. Robert KWOK, JP
Mrs. Mariana CHENG CHO Chi-on
Mr. Leo KUNG Lin-cheng

Honourary Adviser

Mr. Henry STEINER

Participants

Dr. Alex LAI Chi-wai
Dr. CHONG Yu-hoi
Dr. William HAN
Dr. K C YU
Dr. Buddy T M WONG
Dr. KHOO Nyunt Tin
Dr. John WONG Wing-hing
Dr. CHOW Wing-cho
Dr. YAU Wing-ho
Dr. MING Shiu-kow

Explanatory Notes of the Logo for the Medical Council of Hong Kong

The logo for the Medical Council of Hong Kong is made up of a few key components which include a coiled serpent, a pair of beam balance, two stars and the Chinese and English titles of the Council - neatly layout within an oval shape in blue.

The centre image of the logo is a serpent coiled around the backbone of a beam balance, providing support to the whole structure. The proportion of the serpent is deliberately made larger than the scale to reflect the origin and power of justice.

As a traditional medical symbol, serpent is guardian of the springs of life and of immortality. It is also an ally of monsters and Gods, with its sinuous form like the waves of the sea embracing every secret and mystery of life. The wisdom of the Gods was the knowledge of the serpent. In the cult of Aesculapius - the God of Medicine and Healing, the serpent coiled around the staff depicted the constant self-renewal of life. As good is balanced by evil, so must health be offset by sickness, and the brass serpent of Moses was the healer of the wound caused by the serpent. (Reference from the Element Encyclopedia of Symbols by Udo Becker, 1994, page 343 and The Book of Symbols by Jane Garai, 1974, page 143.)

The beam balance reflects quasi-judicial function of the Council to regulate the discipline and maintain good and ethical standards of practice of the medical profession.

The two stars that separate the Chinese and English titles of the Council symbolize the return of Hong Kong to China.

Oval shape is chosen because of its representation of stability, harmony and balance.

The colour of blue, with its neutral nature that projects a calm and harmonious image is a perfect choice for the logo.

Printed by the Printing Department
(Printed on paper made from woodpulp derived from renewable forests)