通識新世代 第230期

漢 中文基本功

中文分工比較精細 次長次官不容混淆

八月十八日看有線電視新聞，聽得主播把台灣一名次長稱爲次官，顯出其中文修養不足。

看新聞，知來自外電；而次長和次官，英文都是vice-minister，譯爲次長、次官，乃至副部長都可以，但要看當時當地的官制而選擇之。比方，行君主制的，可譯爲次官，行共和制的，就不能用官字。台灣官制沿襲六十年前大陸，是用次長，所以譯爲次官就不對。

有線新聞部門誤譯次官，是重英輕中的結果。惟其如此，以爲中文用字可像英文那樣籠統，不知中文分工比較精細。這是就用字來說的。

如有興趣追溯歷史，就知道一個英文詞可譯爲三種中文詞的原因。

在中文來說，上述行君主制的稱謂，始於日本，部長稱大臣，簡稱相（如外務大臣簡稱外相），副部長稱次官；行共和制的稱謂始於辛亥革命，推翻帝制建立民國，那時部長稱總長，副部長稱次長，由南京臨時政府到北洋政府都是這樣。國民政府成立後，總長改稱部長、次長稱謂照舊。中華人民共和國成立，部長稱謂照舊，次長改稱副部長。

長期以來，把外國正副部長官名翻譯爲中文，君主制的稱大臣（相）、次官，共和制的，稱部長、副部長（台灣仍稱次長）。這一點，可以說是時事通識，但如果不重視中文，不知中文比英文分工精細，就會茫然無知，看到英文時就會單憑直覺亂譯了。

容若

放眼天下

A 五星級英文

Dinosaurs Part 1

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I once wrote a story about dinosaurs. It was an exhibition in the Science Museum. I am going to use it as an example to talk about writing.

To make the story more interesting, I have put something from Shakespeare in the opening line. Even for those who have never read Shakespeare, the line to be or not to be might come up in their mind when they read my story.

To lend or not to lend? That has always been the big question for mainland museums that want to lend their dinosaur fossils but worry that they may be damaged in transit.

That fear was realized for the Inner Mongolia Autonomous Region Museum when one precious exhibit – a shoulder blade of the biggest dinosaur discovered in Asia – was smashed after arriving at the Hong Kong Science Museum for the "Soaring Dinosaurs – Chinese Dinosaurs and Prehistoric Life" exhibition.

Broken once before when exhibited in the US in 1995, the scapula of the 26-metre-long, 7.7-metre-tall Nuoerosaurus chaganensis hasn't been on loan until now. Just days before the show opened, the 2.4 metre-long fossil looks like a bandaged patient, tied together with string and white plaster.

世「數」社經

中國入世貿7年 出口增5倍

國家統計局在新中國60周年發表了不同項目的系列報告，較受國際關注的是國家對外貿易的發展情況。事實上，在國家加入世貿後，出口總值7年來翻了幾番，增長接近5倍；令國際不得不將經濟焦點轉移到中國。

新中國60年，前30年的出口商品泰半是初級產品；後30年改革開放，國家生產力在質量上皆有提高，出口商品產生了結構性變化，其中工業製造成品出口比重大幅增加，替代了初級產品。90年代，國家科技發展步伐加快，提升了產品質量，由1990年機電產品出口110.9億美元，增加至1998年的665.4億美元，佔出口總值36.2%，成爲國家出口第一大類商品。

2001年加入世貿後，出口產品進一步產生變化，以資訊科技產業爲核心的高新技術出口平均每年增長幅度爲36.8%，由2002年到2008年的出口總值比重由20.8%增加至29.1%。

此外，加工貿易在出口總值的比重由1981年的6%增加至1998年的53.4%爲最高峰，2008年則回落至41.1%。加工貿易本是小規模，後來成爲國家主要的對外貿易方式，如今雖然按比例回落，但仍然發揮其重要力量。

展望將來，中國對外貿易仍然有偌大增長空間，出口的質量及產品結構也愈來愈在國際市場具備競爭力，倘持續這股動力，中國要在三幾個年代後成爲貿易強國，指日可待。

專業教育培訓顧問 呂康

Liberal Studies

Editorial

New measures might not reduce medical accidents

In regard to a **spate** of clinical **blunders** recently, the Hospital Authority has submitted a report to the Food and Health Bureau proposing to improve patient safety in six respects, including introducing a new accident handling system and a peer review and patient feedback system, strengthening medication management, adopting advanced technology to reduce human error, reducing medical staff's workload and reviewing the current disciplinary actions against negligent staff.

The six proposals will certainly be of some help to reduce medical accidents and improve patient safety. From the proposals, it can be seen that many of the existing regulations are outdated, incapable of satisfying the general public's demand and aspirations for medical care services nowadays. Under the current accident management system, taking for example a case of **mixing up** babies, if this incident is detected in time and corrected before a baby is discharged, there is no need to report the case to the Hospital Authority. Similarly, a case of oral morphine being mistakenly used for injection is not required to be reported if the mistake causes no immediate threat to the life of the patient concerned. Obviously these are loopholes.

In such cases, although mistakes are detected and corrected in time without causing more serious consequences, it does not mean such mistakes are acceptable or forgivable. In fact, there must be causes why such accidents happen. Thus it is of utmost importance to find out the causes and make specific redress to ensure that similar blunders do not recur. The consequences of such mistakes are secondary. Such is the gravity of a baby mix up! How can it ever be treated lightly just because the mistake was detected before a mixed up baby was discharged from hospital? While mistakenly using oral morphine for injection may not immediately threaten a patient's life, the long-term effect remains uncertain. But the crux of the problem is this: how is it that medicine to be injected into a patient is not seriously checked and verified first? Surely it doesn't mean that only when such a patient dies then it can be called a big accident?

Thus it is absolutely reasonable and necessary for the new medical accident handling system to expand the medical incident reporting mechanism, requiring mistakes such as in the baby mix-up and medicine mix-up cases to be reported even though they are detected and corrected in time. A reporting mechanism as lax as the existing one virtually encourages more medical accidents.

Nevertheless, whether the six proposed measures can better protect patient safety at public hospitals, whether medical accidents would be significantly reduced or completely avoided, we shall have to **wait and see** at this stage.

As a matter of fact, the six proposed measures at best can be said to make improvements in mechanism, equipment and manpower. But safety accidents may not necessarily result from these factors. In other words, these factors may not be decisive in an accident

For instance, according to the proposals, advanced technology will be applied more extensively. 2D (2-dimensional) barcodes will be adopted more extensively to reduce human errors such as patient misidentification and mix-ups of blood specimens. Radio-frequency identification in babies and bodies will also be explored to reduce chances of misidentification. But doesn't advanced technology like 2D barcodes or radio-frequency identification need to be operated by human beings? If the persons in charge are not conscientious and responsible, putting a baby into another cot without even having a look or, as in last year's serious accident of losing a baby's remains, then it is in vain to adopt whatever advanced technology. Did a foundling home or a midwife have access to 2D barcode technology in the old days? They would simply tie a piece of coloured string or cloth around the ankle of a baby, and very seldom did they make any mistake in the identification of a baby. They were clearly aware of their duties and fully understood how important a newborn life was to the family and parents.

From this perspective, it is necessary to work out and launch the six new measures and they must be strictly carried out, so as to strengthen protection of patient safety through improved mechanisms and equipment. What is more important, however, is still the attitude of medical staff towards their work. To cure a disease, to save a person's life as well as to help deliver a new life: all are sacred works. Medical workers are respected by society. It is only medical workers who can console and give hope to sick citizens in times when they are at greatest pain and most **in want of** help. There is a need to enhance moral and medical ethics education among public medical staff to promote and glorify the lofty sentiments and culture shown by the heroes in the battle against SARS (severe acute respiratory syndrome).

09 September 2009

WORDS AND USAGE

① **Spate** (noun) - An unusually large number of events, especially unwanted ones, occurring at about the same time.
Examples: 1. Police are investigating a spate of burglaries in this housing estate. 2. A swine flu pandemic could trigger a spate of heart attacks, doctors warn.

② **Blunder** (noun) - A big mistake, usually caused by lack of care or thought.
Examples: 1. He said that the tax increase was a major political blunder. 2. I made a bit of a blunder by spelling his name wrongly.

③ **Mix something / someone up** (phrasal verb) - To fail to identify two people or things correctly by thinking one person or thing is the other person or thing.
Examples: 1. People often mixes us up because we look alike. 2. I think you are mixing me up with my twin brother.

④ **Wait and see** (idiom) - Be patient and wait to find out about something later.
Examples: 1. There's nothing we can do about it right now. We just have to wait and see. 2."Where are you taking me?" "Wait and see."

⑤ **In want of something** (idiom) - In need of something.
Examples: 1. The present system is really in want of a review. 2. He appeared very tired and in want of a shave.

社評

六項措施未必能減少醫療事故

針對公營醫院近日不斷發生醫療事故，醫管局已向食物及衛生局提交報告，建議循六個方面加強病人的安全保障，包括引進新的事故管理制度、收集員工及病人意見、加強藥物安全、多用科技減少人爲錯誤、改善員工工作量以及檢討紀律處分程序。

六項建議，對減少醫療事故、加強病人安全當然都會有一定作用，而從有關內容可以看出，目前的有關規定不少已過時落伍，完全追不上現今公衆對醫療服務的期望與訴求。在現行事故管理制度下，如調錯嬰兒事件，如果「錯嬰」未出醫院門口已被及時發覺及改正，就不用向醫管局呈報；同樣，將口服嗎啡當針藥注射，如果病人無生命危險，也不用呈報。這就明顯是存在漏洞的。

蘇利民（左）及胡定旭講述醫管局如何改善現有嚴重醫療事故的處理機制 （資料圖片）

有關失誤，雖被及時發覺挽回或並未造成重大危機，但並不等於事情的發生就是可以接受或原諒的；事實是，事故之所以會發生，一定有其根源，找出原因「對症下藥」、避免再有同類事故發生才是最重要的，結果如何反而是次要。嬰兒身份被錯調，是何等嚴重的大事，難道僅僅因爲嬰兒未出醫院門口，就可以被當作小事來處理了嗎？將口服嗎啡當針藥注射，病人生命雖無即時危險，但長遠影響存疑，而且問題的嚴重性在於爲病人注射藥物前竟沒有認眞核對清楚，難道要病人「兩腳一伸」才叫大件事嗎？

因此，新的事故管理制度擴大申報範圍，包括未出醫院門口或「未死人」的都要報，是完全合理和有必要的，否則，如「舊制」般寬鬆，實有助長事故發生之嫌。

然而，從宣布的六項措施看來，今後公營醫院病人的安全是否就有更充分保障了，事故的發生是否就會大大減少以至絕跡了，看來現階段仍只能是「姑妄言之」、「以觀後效」。

事實是，六項措施，只能說是從機制、設備以至人手上作出了加強，但安全事故的發生，有時卻未必與此有關，或者說未必是這些因素在起決定作用。

比如說，新措施決定廣泛採用先進科技，如引入「二維條碼系統」處理病人身份及血液樣本，採用「射頻鑑辨技術」來處理嬰兒的身份及病人遺體，以減少出錯的機會。但「二維條碼」也好、「射頻鑑辨」也罷，不也是需要人手來處理及確認的嗎？如果人員工作不認眞、不負責，看都不看一眼就把嬰兒放到了另一張「BB」床上，或者如年前的嚴重事故般整具嬰兒屍不見了，那麼，再先進的科學手段也是枉然和徒勞的。以前的育嬰院以至「接生婆」，何來「二維條碼」？她們只會在嬰兒腳上綁條顏色繩或綁塊布，但嬰兒的身份卻不輕易被換錯，因爲她們清楚知道自己的職責，更清楚知道一條新生命對一個家庭、父母是何等的重要。

因此，六項新措施的出台和制訂，是有必要的，應予切實執行，從整體機制、設備上加強對病人的安全保障；但更重要的原因始終是人員的工作態度問題。救死扶傷，包括迎接新生命，是神聖的工作，醫護人員是受到社會尊重的，不幸患病的市民在最痛苦、最有需要時只有醫護人員能給他們以安慰和希望。公營醫療有需要加強醫療道德品格上的教育，提倡和建立如「沙士」英雄般那樣高尚的情操和文化。

2009/09/22 大公報社評

通識記憶體

求診者110萬人次 事故1萬宗

醫院管理局的數據顯示，2008年本港公立醫院約有110萬求診人次，約發生1萬宗醫療事故，佔整體的0.9%，九成爲輕微事故，近一成爲中度事故，0.7%爲嚴重事故。從宏觀來看，本港發生醫療事故的比率，遠低於世衛報告有關已發展國家或地區的數據：美國爲4%、英國爲11%、澳洲是17%。

2009年初至今共發生10宗大型醫療事故，其中包括：09年1月，病人腎炎入住威爾斯親王醫院，感染肺炎，懷疑因院方延誤醫治，令肺功能永久損害，喪失工作能力；同月，東區尤德夫人那打素醫院殮房遺失嬰兒屍體；2月，老婦在街上暈倒，卻被伊利沙伯醫院急症室打發走，老婦兩日後中風。

09年8月，伊利沙伯醫院護士將未完全稀釋的卡介苗疫苗，爲5名初生嬰兒接種注射。同月，北區醫院護士把嗎啡當普通生理鹽水替病人作靜脈注射，病人7天後死亡。9月，將軍澳醫院爲男嬰注射卡介苗時，錯誤注射治療膀胱癌的免疫治療製劑。同月，衛生署聘用醫療輔助隊，協助全港12萬名幼兒注射肺炎鏈球菌疫苗，運作首天即派錯藥。

醫管局的研究曾發現，因護士派藥出錯的藥物事故佔51%、因醫生處方錯誤爲28%。該局將於2010年起，引入排裝藥代替散裝藥及由藥劑師預備高風險藥物，今年稍後又會在嬰兒及遺體引入射頻鑑別系統，以防調錯嬰兒及送錯屍體。