Appendices

Membership
Task Force on Doctors' Work Hours
Hospital Authority

Chairman:	Mr WU Ting-yuk, GBS, JP	Chairman Hospital Authority
Members:	Mr Peter LO	HA Board Member
	Mrs Yvonne LAW	HA Board Member
	Dr Donald LI, JP	HA Board Member
Secretary:	Ms Karen CHOY	Manager (Boards & Support) Hospital Authority

Membership
Steering Committee on Doctor Work Hour
Hospital Authority

Chairman:	Dr C H LEONG, GBS, JP	Former Chairman Hospital Authority
Members:	Dr Sherene DEVANESEN	Chief Executive Peninsula Health in Victoria, Australia
	Mr Andrew FOSTER, CBE	Chief Executive Wrightington, Wigan and Leigh NHS Trust, The United Kingdom
	Prof T F FOK, SBS, JP	Dean, Faculty of Medicine The Chinese University of Hong Kong
	Prof K N LAI, JP	Chair Professor, Department of Medicine The University of Hong Kong
	Dr C T HUNG	Vice President (Education & Exams) Hong Kong Academy of Medicine
	Dr Lawrence LAI, JP	Chairman Cluster Administration and Specialty Advisory Committee on Doctor Work Hour, Hospital Authority
	Dr W L CHEUNG, JP	Director (Cluster Services) & HA Representative Doctors Staff Group Consultative Committee, Hospital Authority
	Dr Nancy TUNG	Cluster Chief Executive Kowloon West Cluster
Secretary:	Mr Linus FU	Manager (Doctor Work Reform) Hospital Authority

Membership
Cluster Administration and Specialty Advisory Committee on Doctor Work Hour, Hospital Authority

Chairman:	Dr Lawrence LAI, JP	Cluster Chief Executive Hong Kong West Cluster (up to 31.12.2009)
Members:	Dr W L CHEUNG, JP	Director (Cluster Services) Hospital Authority
	Dr Nancy TUNG	Cluster Chief Executive Kowloon West Cluster
	Dr T W LEE	Hospital Chief Executive Pok Oi Hospital
	Dr Susanna LO	Hospital Chief Executive Shatin Hospital & Bradbury Hospice
	Dr K T TOM	Hospital Chief Executive Tseung Kwan O Hospital
	Ms CHAN Yuet-kwai	Cluster General Manager (Nursing) Kowloon East Cluster
	Ms Eva LIU	Cluster General Manager (Nursing) Kowloon Central Cluster
	Central Committees for Clinical & Professional Services Co-Chairs / Representatives:	
	Dr C B CHOW	Hon. Consultant (Paediatrics and Adolescent Medicine) Caritas Medical Centre and Princess Margaret Hospital

Membership
Cluster Administration and Specialty Advisory Committee on Doctor Work Hour, Hospital Authority

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	Dr C H CHUNG	Chief of Service (Accident & Emergency) North District Hospital
	Dr Dawson FONG	Chief of Service (Neurosurgery) New Territories West Cluster
	Dr H S LAM	Cluster Chief of Service (Radiology) Kowloon West Cluster
	Dr S K LI	Chief of Service (Medicine) Pamela Youde Nethersole Eastern Hospital
	Dr Joseph LUI	Consultant (Anaesthesia) Princess Margaret Hospital
	Dr Francis MOK	Chief of Service (Surgery) Caritas Medical Centre
	Dr H K WONG	Cluster Chief of Service (Obstetrics & Gynaecology) Kowloon Central Cluster
	Dr S H YEUNG	Consultant (Orthopaedics & Traumatology) Pamela Youde Nethersole Eastern Hospital
Secretary:	Mr Linus FU	Manager (Doctor Work Reform) Hospital Authority

Membership
Doctors Staff Group Consultative Committee
Hospital Authority

Chairman:	Mr Shane SOLOMON	Chief Executive Hospital Authority
	Dr LAU Ka-hin	Associate Consultant (Psychiatry) Queen Mary Hospital
HA Representative:	Dr W L CHEUNG, JP	Director (Cluster Services) Hospital Authority
Members:	**Hong Kong Public Doctors' Association**	
	Dr CHAN Chi-wing, Timmy	Associate Consultant (Anaesthesiology) Queen Mary Hospital
	Dr TAM Kin-ming	Senior Medical Officer (Medicine) Yan Chai Hospital
	Public Consultant Doctor's Group	
	Dr Vincent YEUNG	Chief of Service (Medicine & Geriatrics) Our Lady of Maryknoll Hospital
	Directly Elected Representatives	
	Dr AU YEUNG Kwok-leung	Medical Officer (Team B1) Castle Peak Hospital
	Dr CHAN Tin-sang, Augustine	Associate Consultant (Radiology) Pamela Youde Nethersole Eastern Hospital
	Dr CHAN Wai-lam	Associate Consultant (Orthopaedics & Traumatology) Kwong Wah Hospital

Membership
Doctors Staff Group Consultative Committee
Hospital Authority

	Dr CHOO Kah-lin	Senior Medical Officer (Medicine) North District Hospital
	Dr HO Hung-Kwan, Michael	Medical Officer (GOPC) Queen Elizabeth Hospital
	Dr HO Sheng-sheng	Senior Medical Officer (Medicine) Alice Ho Miu Ling Nethersole Hospital
	Dr IU Ying-fung, Felix	Resident (Obstetrics & Gynaecology) Tuen Mun Hospital
	Dr LO Chi-fung, Ernie	Resident (Eye) Tseung Kwan O Hospital
	Dr NG Yin-ming	Consultant (Paediatrics) Queen Elizabeth Hospital
	Dr TSE Yiu-cheong	Resident (Oncology) Princess Margaret Hospital
	Dr WONG Cheung	Resident (Accident & Emergency) United Christian Hospital
	Dr WONG Mong-sze, Marcus	Associate Consultant (GOPC) Violet Peel GOPC, Pamela Youde Nethersole Eastern Hospital
Secretary:	Mrs Jessie SZE	Manager (Staff Consultation) Hospital Authority

Membership
Emergency Operating Theatre Task Group
Hospital Authority

Convenor:	Dr Anne KWAN	Chief of Service (Anaesthesiology and Pain Medicine) United Christian Hospital
Members:	Dr P P CHEN	Chief of Service (Anaesthesia) Alice Ho Miu Ling Nethersole Hospital and North District Hospital
	Dr C K KONG	Consultant (Surgery) Yan Chai Hospital
	Dr P Y LAU	Chief of Service (Orthopaedics & Traumatology) United Christian Hospital
	Dr H T LEONG	Chief of Service (Surgery) Alice Ho Miu Ling Nethersole Hospital and North District Hospital
	Dr Joseph LUI	Consultant (Anaesthesia) Princess Margaret Hospital
Secretary:	Ms Elissa TAM	Executive Assistant (Doctor Work Reform) Hospital Authority

Membership
Emergency Medicine Ward Task Group
Hospital Authority

Convenor:	Dr C C LAU	Clinical Service Coordinator (Accident & Emergency) Hong Kong East Cluster
Members:	Dr Jimmy CHAN	Cluster Service Coordinator (Accident & Emergency) New Territories East Cluster
	Dr N K CHEUNG	Consultant (Accident & Emergency) Prince of Wales Hospital
	Dr H T FUNG	Consultant (Accident & Emergency) Tuen Mun Hospital
	Dr H F HO	Cluster Chief of Service (Accident & Emergency) Kowloon Central Cluster
	Dr S K LI	Cluster Service Coordinator (Medicine) Hong Kong East Cluster
	Dr Albert LIT	Chief of Service (Accident & Emergency) Princess Margaret Hospital and Yan Chai Hospital
	Dr F NG	Chief of Service (Accident & Emergency) Caritas Medical Centre
	Dr K L ONG	Consultant (Accident & Emergency) Pok Oi Hospital and Tuen Mun Hospital
	Prof T H RAINER	Hon Chief of Service (Accident & Emergency) Prince of Wales Hospital
Secretary:	Ms Elissa TAM	Executive Assistant (Doctor Work Reform) Hospital Authority

Membership
Technical Services Assistant (Clinical Assistant) Task Group
Hospital Authority

Convenor:	Dr K H CHAN	Associate Consultant (Medicine) Yan Chai Hospital
Members:	Ms K L CHIU	Department Operations Manager (Specialist Out-patient Clinic) Alice Ho Miu Ling Nethersole Hospital
	Mr Alex LEUNG	Senior Manager (Staffing and Non-clinical Grade Management) Hospital Authority
	Ms S H LI	Senior Nursing Officer (Central Nursing Division) Yan Chai Hospital
	Ms May WONG	Department Operations Manager (Specialist Out-patient Clinic) Princess Margaret Hospital
	Ms S H YEUNG	Department Operations Manager (Medicine) Pamela Youde Nethersole Eastern Hospital
	Ms Rhoda CHAN	Ward Manager (Orthopaedics & Traumatology) Caritas Medical Centre
	Ms May Nar TAM	Advanced Practice Nurse (Nursing Services Division) United Christian Hospital
Secretary:	Ms Elissa TAM	Executive Assistant (Doctor Work Reform) Hospital Authority

Key Milestones of Doctor Work Reform
Hospital Authority

Date	Events
2006	
3rd quarter	HA-wide survey on doctors' work hours and doctors' on-call structure
4th quarter	• Set-up of Steering Committee on Doctor Work Hour (04.10.2006) • Set-up of 2 Advisory Committees (04.10.2006): – Cluster Administration and Specialty Advisory Committee on Doctor Work Hour – Doctors Staff Group Consultative Committee • Progress update in: – Cluster Administration and Specialty Advisory Committee (1st – 2nd time) – Doctors Staff Group Consultative Committee (1st – 2nd time) • 1st Meeting of Steering Committee on Doctor Work Hour (13.10.2006) • 2nd Meeting of Steering Committee on Doctor Work Hour (06.12.2006) • 1st round of hospital road show for all clusters
Dec 06 – May 07	1st round of road show to Specialty Coordinating Committee (COC, 16 Specialties)
2007	
1st quarter	• 1st briefing in Hong Kong Academy of Medicine (Education & Exams Committee) • UK visits to 2 champion hospitals (1 Teaching and 1 DGH), deaneries and Royal Colleges (29.01.2007–02.02.2007) • Doctors' on-call activities survey in 3 HA hospitals • Doctor Work Reform Strategic Planning Workshop (23.03.2007) • Progress update in: – Doctors Staff Group Consultative Committee (3rd time) – Nursing Forums (Management and staff representatives) – 3rd Meeting of Steering Committee on Doctor Work Hour (23.03.2007) • 2nd round of hospital road show for all clusters

Date	Events
2nd quarter	• 1st meeting of Task Force on Doctors' Work Hours • 1st meeting of Hong Kong Academy of Medicine • 2nd–4th briefing in Hong Kong Academy of Medicine (Education & Exams Committee) • Consultation with all HA doctors and Hong Kong Academy of Medicine on Doctor • Progress update in: – Doctors Staff Group Consultative Committee (4th time) – Nursing Forums (Management and staff representatives) • 4th Meeting of Steering Committee on Doctor Work Hour (29.06.2007)
May – Oct 07	2nd round of road show to Specialty Coordinating Committee (COC, 16 Specialties)
3rd quarter	• Progress update in: – Cluster Administration and Specialty Advisory Committee (3rd time) – Doctors Staff Group Consultative Committee (5th time) • Consultation with 2 advisory committees, all cluster/ hospital chiefs and HAHO senior executives of HAHO on Doctor Work Reform (03.09.2007 –23.09.2007)
4th quarter	• Progress update in: – Doctors Staff Group Consultative Committee (6th time) – Nursing Forums (Management and staff representatives) – Medical Services Development Committee (1st time) – Task Force on Doctors' Work Hours (2nd time) – Progress update in Regional Advisory Committee (Hong Kong, Kowloon and New Territories) – 5th Meeting of Steering Committee on Doctor Work Hour (22.10.2007) • Consultation on Doctor Work Reform Recommendation Report with 2 advisory committee members, HKAM, cluster / hospital chiefs and HAHO senior executives • Submission of Doctor Work Reform Recommendation Report to Administrative and Operational Meeting, Hospital Authority (29.11.2007) • 3rd round of hospital road show for all clusters
Oct 07–Apr 08	3rd round of Specialty Coordinating Communication (COC) (16 Specialties)

Date	Events
2008	
1st quarter	• Progress update in: – Cluster Administration and Specialty Advisory Committee (4th time) – Doctors Staff Group Consultative Committee (7th time) – Nursing Forums (Management and staff representatives) – Alliance for Patients' Mutual Help Organizations (1st–2nd time) – Hong Kong Academy of Medicine (2nd time) – 6th Meeting of Steering Committee on Doctor Work Hour (23.01.2008) – Panel on Health Services Meeting, Legislative Council (10.03.2008) • HA's delegate visit to UK hospitals in London and Liverpool on Hospital at Night • Overseas expert visit to HA (Dr Patrick CHU) – Sharing forum on pilot reform programmes and discussion forums in pilot clusters (25.02.2008–27.02.2008)
2nd quarter	• Special Plenary Session on Impact of Work Reform, Hospital Authority Convention 2008 (05.05.2008 – 06.05.2008) • Nursing seminar on enhanced nursing roles by UK experts (Dr Patrick CHU & Mr Gerry Bolger) (07.05.2008) • Progress update in: – Patient groups – Nursing Forums (Management and staff representatives) – Hong Kong Academy of Medicine (3rd time) – 7th Meeting of Steering Committee on Doctor Work Hour (19.06.2008) • Introduction of common ward language in Quality Forums of Kowloon West Cluster (27.05.2008 – 20.06.2008)
Apr – Sep 08	4th round of road show to Specialty Coordinating Committees (16 specialties)
3rd quarter	• Progress update in: – Cluster Administration and Specialty Advisory Committee (5th time) – Doctors Staff Group Consultative Committee (8th time) – Nursing Forums (Management and staff representatives) – Hong Kong Academy of Medicine (4th time) • 4th round of hospital road show for all clusters
4th quarter	• Progress update in: – Doctors Staff Group Consultative Committee (9th time) – Nursing Forums (Management and staff representatives) – 8th Meeting of Steering Committee on Doctor Work Hour (17.11.2008) • Issuance of "Guideline on Doctor Work Hour Monitoring" to all Cluster Chief Executives, Hospital Authority (10.12.2008)
Oct 08 – Apr 09	5th round of road show to Specialty Coordinating Committees (16 specialties)

Date	Events
2009	
1st quarter	• Progress update in: – Doctors Staff Group Consultative Committee (10th time) – Nursing Forums (Management and staff representatives) – Medical Services Development Committee (2nd times) – Task Force on Doctors' Work Hours (3rd time) – Progress update in Regional Advisory Committees (Hong Kong, Kowloon, New Territories) • Consultation on draft Interim Pilot Review Report on Doctor Work Reform with 2 advisory committee members, HKAM, Hospital Chiefs and HAHO senior executives • Submission of Interim Pilot Review Report on Doctor Work Reform to HA Administrative and Operational Meeting (26.02.2009) • 5th round of hospital road show for all clusters
2nd quarter	• Progress update in: – Patient Groups – Nursing Forums (Management and staff representatives) – Panel on Health Services Meeting, Legislative council (11.05.2009) • Sharing Session, Hospital Authority Convention 2009 (05.05.2009)
May – Oct 09	6th round of road show to Specialty Coordinating Committees (16 specialties)
3rd quarter	• Progress update in: – 9th Meeting of Steering Committee on Doctor Work Hour (15.10.2009)
4th quarter	• Progress update in: – Doctors Staff Group Consultative Committee (11th time) • Consultation on draft Final Report on Doctor Work Reform with 2 advisory committee members, HKAM, cluster / hospital chiefs and HAHO senior executives
2010	
1st quarter	Submission of Final Report on Doctor Work Reform to Administrative and Operational Meeting, Hospital Authority (25.2.2010)

Summary of Doctor Work Hour Monitoring Surveys
Hospital Authority

I. Methodology

DWH Survey (September 2006)

- Basis : Self-reporting by doctors
- Sample Size : 536 doctors (weekly work hours) and 747 doctors (continuous work hours)
- Features : Retrospective self-reporting

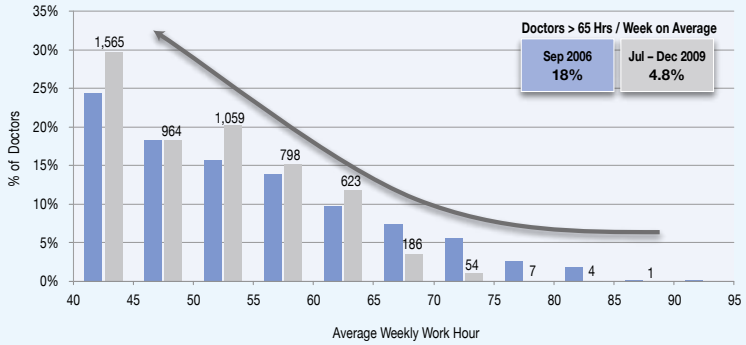
DWH Monitoring (July – December 2009)

- Basis :
  - HA-wide consultation and Steering Committee's recommended work hour formula
  - Doctor Work Hour Calculator developed for all clinical departments
- Sample Size : 5,261 doctors of 222 clinical departments in all HA hospitals
- Features :
  - Prospective counting based on clinical departments' monthly call roster
  - Broad-brush approach
  - Flexibility allowed for new duty pattern
  - Recognition of off-site call duty, travel time for called-back and endorsed unrostered work due to clinical emergency

II. Key Results

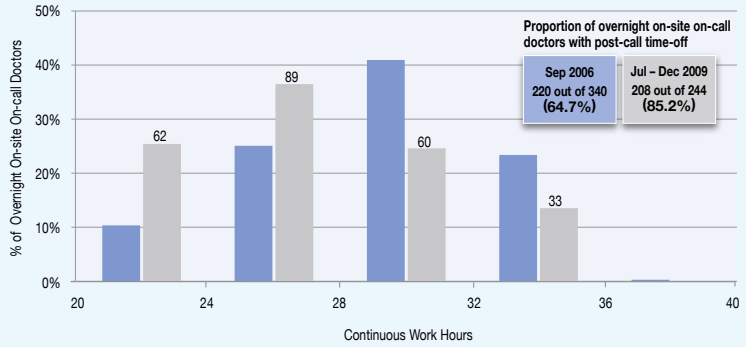
	September 2006	July – December 2009
Doctors working for > 65 hrs / wk on average	18%	4.8%
Overnight on-site on-call doctors with post-call time-off	65%	85.2% (Holiday) 82.4% (Weekday)

Doctors' Average Weekly Work Hour (Sep 2006 Vs Jul – Dec 2009)



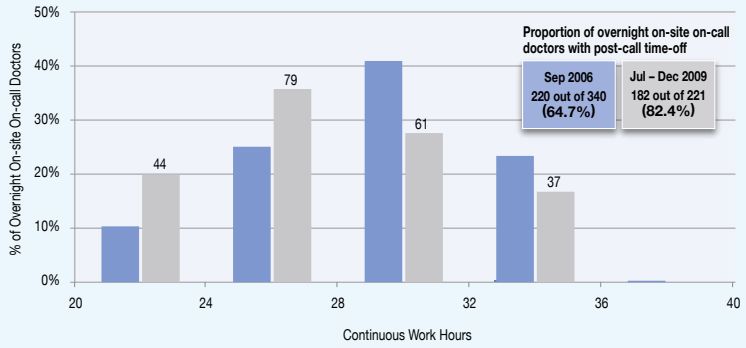
Methodology: Sep 2006 – self-reporting, Jul – Dec 2009 – duty roster based + self-reporting of called-back duties

Continuous Work Hours of Overnight On-site On-call Doctors (Holiday)



Methodology: Sep 2006 – self-reporting, Jul – Dec 2009 - duty roster based + self-reporting of called-back duties

Continuous Work Hours of Overnight On-site On-call Doctors (Weekday)



Methodology: Sep 2006 – self-reporting, Jul – Dec 2009 - duty roster based + self-reporting of called-back duties

1. Average Weekly Work Hours (T) > 65

Specialty	September 2006		July – December 2009				
	Mean T	All T > 65	Mean T	All T > 65	CON T > 65	SMO/AC T > 65	MO/RES T > 65
HA Overall	**55.0**	**900 (Around 18%)**	**51.9**	**4.8% (252/5,261)**	**0.2% (1/583)**	**0.7% (9/1,229)**	**7.0% (242/3,449)**
Neurosurgery	71.4	73%	57.9	12.5% (12/96)	0%	12% (3/25)	15.3% (9/59)
Surgery	63.5	45%	58.4	18.6% (90/483)	0%	1.8% (2/113)	28.8% (88/306)
Obstetrics & Gynaecology	63.9	40%	59.8	17.9% (39/218)	2.8% (1/36)	7.8% (4/51)	26.0% (34/131)
Paediatrics	60.9	40%	56.3	7.0% (23/329)	0%	0%	11.0% (23/209)
Orthopaedics & Traumatology	60.1	29%	57.9	(15.6%) (51/327)	0%	0%	23.7% (51/215)
Oncology	59.7	26%	52.9	0%	0%	0%	0%
Cardiothoracic Surgery	58.3	22%	54.6	5.6% (2/36)	0%	0%	10.0% (2/20)
Internal Medicine	58.0	21%	53.4	1.5% (19/1,241)	0%	0%	2.2% (19/883)
Ear, Nose, Throat	50.7	16%	50.8	4.9% (4/82)	0%	0%	7.7% (4/52)
Ophthalmology	52.8	13%	50.5	6.7% (10/149)	0%	0%	10.2% (10/98)
Psychiatry	53.2	12%	47.6	0%	0%	0%	0%
Intensive Care Unit	53.2	4%	53.3	1.5% (2/131)	0%	0%	2.4% (2/84)
Anaesthesiology	52.2	0%	51.1	0%	0%	0%	0%
Radiology	46.8	0%	47.2	0%	0%	0%	0%
Accident & Emergency	46.3	0%	43.7	0%	0%	0%	0%
Pathology	46.2	0%	46.9	0%	0%	0%	0%
Family Medicine	45.2	0%	44.4	0%	0%	0%	0%
Community Medicine	–	–	47.5	0%	–	0%	0%

* *Methodology: 2006 – retrospective self-reporting*
2009 – prospective & duty-roster based + self-reporting of called-back duties

2. Continuous Work Hours

Proportion of Overnight On-site On-call Doctors with Immediate Post-call Time-off

Specialty	September 2006	July – December 2009 (Holiday)	July – December 2009 (Weekday)
HA Overall	**64.7%**	**85.2% (208/244)**	**82.4% (182/221)**
Cardiothoracic Surgery	0%	33.3% (1/3)	33.3% (1/3)
Ophthalmology	0%	80% (4/5)	80% (4/5)
Radiology	0%	50% (1/2)	100% (2/2)
Surgery	29%	67.7% (21/31)	56.3% (18/32)
Psychiatry	42%	63.6% (7/11)	66.7% (6/9)
Orthopaedics & Traumatology	45%	70.8% (17/24)	76.9% (20/26)
Ear, Nose, Throat	50%	66.7% (2/3)	50% (1/2)
Obstetrics & Gynaecology	67%	81.5% (22/27)	78.6% (22/28)
Internal Medicine	76%	97.6% (41/42)	95.7% (45/47)
Paediatrics	80%	94.3% (33/35)	94.1% (32/34)
Oncology	83%	100% (5/5)	100% (4/4)
Neurosurgery	86%	71.4% (5/7)	71.4% (5/7)
Anaesthesiology	88%	100% (28 / 28)	100% (3 / 3)
Accident & Emergency	100%	100% (1 / 1)	100% (1 / 1)
Family Medicine	100%	100% (4 / 4)	100% (4 / 4)
Intensive Care Unit	100%	100% (16 / 16)	100% (14 / 14)
Community Medicine	–	0%	0%

** Methodology: 2006 – retrospective self-reporting; 2009 – prospective & duty-roster based*

Consolidated Feedback on Doctor Work Reform
Hospital Authority (2007/08 – 2009/10)

Doctors' Work Hours

A. Weekly Work Hours

- Some doctors are concerned that unless extra resources are given, long working hour will remain persistent; some believe that in order to develop a successful programme, more detailed reporting and calculation instructions are needed to replace the ambiguous mechanism such that the submitted data only reflect actual working hours. Some suggest that there should be a full count of travel time and structured training, but partial count of off-site hours and non-structured training. Whereas self-arranged overseas conferences and study courses should not be counted.
- There have been arguments that the reform model is tremendous but may be too modest and lack long-term targets, while capping average weekly work hours (AWWH) at 65 is too much, unfair, destructive to doctors' life and family, and unethical. The lack of written protocols, in addition to conflicts between Steering Committee's beliefs and the corporate policies in the Human Resources Policies Manual also cast uncertainty over the execution.
- The reform, according to some doctors, is only applicable to some hospitals, and should never make doctors working < 65 hours / week worse off.

B. Continuous Work Hours

- The current on-call system, 28 CWH plus a short 4-hour break, dehumanises, robs enthusiasm at work, affects service quality and may result in callosity in patient treatment; a longer sleep time is welcomed.
- Some prefer capping continuous work at in-patient setting (e.g. 12–16 hours) and specialist outpatient setting (e.g. 8 hours), while some believe that the time-honoured on-call system should be maintained and kept at 24 continuous work hours.

Managing Workload at Macro Level

C. Reducing Avoidable Admissions

- Some criticise HA management's unfamiliarity with front line operations for overlooking the importance of GOPC, who can be the first gatekeepers; however, some are skeptical of the gatekeeper role of Accident & Emergency Department (A&E) in reducing avoidable admissions.
- Some have suggested a few ideas for improvement, such as setting up short stay trolleys and beds, as well as units like VTE, to allow better initial diagnosis and to relieve pressure off A&E cubicles. In a similar token, setting up specialist geriatric assessment units run by senior, specialist geriatricians supported by good community care can often avoid admissions altogether.
- Assigning a single Telephone Nursing Consultation Service centre to concentrate experience and expertise in operating telephone consultations for all patients may help reduce avoidable admissions, but more scientific evidences supporting the theory are required.

D. Emergency Medicine / Admission Wards

- In general, frontline doctors are concerned about the outcomes of diverting emergency cases to a certain hospitals and the impact on their work, because only a few selected patient groups may benefit. Cautious monitoring and further pilot work are needed to analyze EMW progress. Some even suggest that establishing night admission wards is a more effective solution.
- Given the shortage of doctor / nursing manpower to run EMW, there is anticipated resistance from staff against further manpower savings. Frontline staff of admission wards may have difficulty in caring for patients of other specialties.

E. Enhancing Public-private Interface

- Staff generally agrees to public-private interface, but believes a more flexible employment scheme towards private practitioners and a greater facilitation of patient referral service to the private sector, such as the Electronic Patient Record System, are needed for greater continuity of care. Similarly, hiring early-retired senior specialists (until they are 65) is also plausible.
- Some are less optimistic about the effectiveness of bringing in private practitioners because of their already heavy workload. Moreover, HA's compensation scheme is not generous enough. HA should instead take in more FM trainees and provide better incentive for them to stay.

<u>Optimising Night Activities in All Hospitals</u>

F. Extended Day Model

- Results in extended day service are positive, but additional resources to hire locums for evening and weekend services are still needed.
- Manpower shortage puts more pressure on middle-ranking clinicians, and makes it even more difficult to handle extended day duties. Some suggest capping day-time activities and strengthening non-medical staff's support.

G. Restricting Emergency Operating Theatre (EOT) Sessions after 22:00 Hours

- The re-engineering of EOT may indirectly shift workload to tertiary acute hospitals, when operations such as acute trauma and obstetric services at these hospitals are unavoidable and mostly accounted for OT sessions at night; more resources are hence needed.
- HA should expand the restricted list of emergency operations at night to include open wounds management and operation on threatened neurological functions of limbs. And since EOT can also reduce cost and length of stay by cutting complication, re-admission and infection rates, it should be further extended to other hospitals for evaluation for workload redistribution effects.
- Some are worried that restricting EOT sessions may lengthen patient waiting time, hence putting patients lives at risk.

H. Extended Roles of Non-medical Staff

- Generally, doctors do agree that additional CTS staff running on 24 hours can free doctors up from doing tedious tasks at night time; some also believe that enhanced pharmacy support for A&E, and extra manpower to community and/ or rehabilitation hospitals will be helpful, but these non-medical staff may not be well-equipped to take up more responsibilities.
- Given the current fragmented nursing skills, some doctors agree that it would be very helpful for nurses to have clinical skill enhancement, but their enhanced roles should never replace a doctor's position.
- Some remain skeptical of CTS' level of contribution, and believe that shorter on-call time should be adopted to relieve the work of frontline doctors. Some argue that CTS's extended role would deprive doctors' training opportunities.

I. Reinforcing Support System and Efficiency

- System protocols must be meticulous but kept flexible in patient management; some agree to protocol-driven 24-hr computer tomography (CT) and magnetic resonance imaging (MRI) service so long as they are supervised by clinicians.
- Some sub-specialty services are technology dependent and need enhancing disease coding system as well as patient and blood identification.

<u>Change in Existing Doctors' Work Pattern</u>

J. Core-competency Call Team

- Elective rotation opportunities are sometimes insufficient and unfair.
- While some smaller hospitals may have difficulty adopting the new concept and should merge with other call teams to ensure unnecessary complication when transferring patients, the modified on-call system also raises concerns over the level of expertise, experience, extra workload and accountability; senior physicians are suggested to provide back-up support.
- Some believe that call team is more appropriate for surgical staff than for medical and should avoid including specialists, unless necessary.

K. Shift System Replacing On-call Duties

- In general, shift system raises concerns over the continuity of care, deterioration of patient conditions, manpower implication and impact on doctors' professional training exposure.
- Some believe that calls on holidays can be demoralising and argue that shift duty is more feasible. However, some residing in remote islands prefer longer work hours. Another suggestion is to make use of SHS to create flexibility in on-call duties.
- Other suggestions:
  - Fewer calls but longer continuous work hours with short breaks in between and a full-day rest after a long working day (e.g. 24 hours).
  - A structured and consistent call pattern (e.g. 6 night shifts in 4 weeks, subject to 65 hours per week and 24 hours of continuous shift) in same specialties across hospitals that is backed by regular rotations.

L. Handover System

- HA must tackle the inadequacy in the current system and develop a standardised toolkit and procedure for more effective handovers. Although a handover system is more applicable to hyper-acute and emergency situations, surgeons' tight schedule will make a good system useless.

Training

M. Training

- Many physicians would like to receive protected training time while some believe there's a need to reinforce clinical supervision of enhanced training. However, the proposed shift system and prolong core competency training have also raised some concerns in providing trainees hands-on experience.
- HA should continue to evaluate nursing leadership training and create a more economical and efficient solution to send nurses for overseas training.

Targeted Deployment of Resources

N. Targeted Deployment of Resources

- Deployment of resources will affect the manpower of a certain pressurised areas, and it should not compromise the training and first hand experience of trainees. HA should look beyond hours of work, collaborate with Academy of Medicine, better define pressurised areas and combine surgical trainees in different specialties to help relieve frontline doctors' workload. Appropriate protocols and guidelines must also be included.
- A few issues – the small amount of budget planned for deployment of resources, financial recognition in lieu of work more than 44 hours, effect of new employment of doctors – need to be addressed in later stages.
- The small increase in number of doctors coupled with an uneven distribution of interns is braved by increases in workload, expectation and turnover rate.

Revamped Honorarium System

O. Remuneration

- Doctors' main concern is fairness: some support more pay for more work, and argue that an across-the-board honorarium system is unfair and open to abuse while their counterparts believe the former policy will polarise payrolls, and have voted for a department-unified compensation scheme.
- FM trainees believe HA should impose a mixed system for promotion to allow more transparency in the selection process.
- A few who commented on the low remuneration rate said honorarium should be equitable to sound attractive to doctors; some wish that excessive long working hours and work at unsocial hours can be addressed more justifiably.

Others

P. Workload Issues

- HA should look into operational needs, work intensity and quality expectation of different specialties, clinical admission and call-patterns.

Q. Monitoring Mechanisms

- Instead of monitoring work hour in compliance with sophisticated formulas, HA should look at patient safety / condition, training opportunity, resident fatigue and team morale. These are all intertwined with doctors' workload.

R. Reform Model and Measures

- Many doctors agree with the reform's initiatives but question about long-run feasibility and improvement targets; they argue that the reform lack a concrete game plan and assertive measures.
- HA should consider enhancing the flexibility of the reform due to the lack of a controlled model, some programmes may not be as effective as previously had predicted. Programme like common ward language is proven unpopular among medical staff. Moreover, some have pointed out that percentage should be used in statistics to allow readers to understand the improvements.

S. Staff Morale Issues

- Some doctors believe cultural change is important among seniors; their occasional on-call duties can help establish leadership and trust between management and frontline staff.
- Low morale of lower / middle tier doctors has been persistent and is partly due to the lack of promotional prospect as well as unequal pay scale. Better employment and remuneration packages should be imposed, while more promotional opportunities should be created based heavily on clinical competency.

Summary of Consultation Feedback on Draft Final Report on Doctor Work Reform (23 Nov – 19 Dec 2009)

From:	Prof Raymond LIANG President of the Hong Kong Academy of Medicine	#1

Thank you for your letter inviting the Academy to comment on the Final Report on DWR.

The Academy understands that the decrease in doctors work hour, being a world trend, is difficult to resist. As mentioned in our responses to you in 2007, limiting the weekly working hours to 65 hours should not have any major impact on training for the time being. The Academy has tried but found it difficult to have quantitative measurement on the impact of DWR on training, given that there are various limitations and confounding factors. However, the Academy accepts in principle that there are long-term impacts of DWR, especially if further reduction of working hours beyond 65 hours per week is required.

To move forward, the Academy would focus far more attention on training than in the past, and take a more comprehensive approach to enhance the quality of postgraduate medical education. The long-term strategy for the Academy with regards to the issue of DWR is to modernise postgraduate medical education and closely monitor the process such that the quality of training would not be affected. While the Academy would try to enlist long-term commitment from Colleges to ensure that quality of training will not be affected by the work hour limitation, we would need support from HA.

Following a workshop conducted in June, a position paper has been drafted, which is being discussed by Education Committee and Colleges of the Academy. The paper serves to highlight the proposed key reforms to postgraduate medical education that are required to modernise the Fellowship training system such that the Academy will produce Fellows meeting the needs of the society in a sustainable manner, under limited time and resources available. In the paper, there is a recommendation that “Colleges should be encouraged to build more skill/simulation laboratories and develop simulator based training. Doctors-in-training should have adequate exposure to simulators. In the longer term, some parts of simulator training should be mandatory and be made widely available so that it can precede practicing on the patient. Simulators should be developed for assessment purposes.”

Simulations would play a more important role in future training, as it provides safe and effective opportunities for learners at all levels to acquire practical skills that are required for quality and safe patient care. We have not yet come up with details about using simulators for training, but expect that it would require resources/support from, and collaboration with, HA.

The Academy will keep HA informed of the development.

From:	Doctors Staff Group Consultative Committee, Hospital Authority (Extract of Minutes of 61st DSGCC Meeting held on 14 Dec 2009)	#2

1. SM(DWR) informed members that the Steering Committee on Doctor Work Hour had compiled the draft Final Report on Doctor Work Reform, a copy of which was sent to members for comments. The draft report was under consultation with major stakeholders until 19.12.09. The draft report would then be submitted to the HA Board in 1Q10.

2. SM(DWR) gave a presentation covering the comparison of the Steering Committee's recommendations between the interim pilot review report and the draft final report; the pilot work reform programmes and outcomes; the issues of concerns and the Steering Committee's proposed recommendations for rollout of the reform strategies in other public hospitals.

3. Responding to a member's enquiries on the mixed outcomes on admission reduction of Emergency Medicine (EM) wards among the 3 pilot hospitals, SM(DWR) explained that CMC was a secondary acute hospital with admission of relatively less critical patients. Hence, admission reduction was more obvious. In PMH and PYNEH, admission reduction was less obvious because PMH was situated at the hilltop and it admitted many categories 1 and 2 patients via ambulances. As for PYNEH, the Observation wards were already in operation before the pilot scheme. Extra beds were added and the wards were renamed for running of the pilot scheme.

4. A member said the doctor work reform had commenced for 2 years but frontline doctors could not feel any reduction in work hours or improvement in working conditions. There were also allegations that data on work hours of doctors could be manipulated by COS and administrative staff. He suggested conducting a survey among doctors on whether they felt any improvement since the doctor work reform. A member commented that the number of work hours could be misleading and the on-call rosters were still poorly arranged. A member suggested that the survey should include all doctors covering all aspects affecting their morale.

5. CE said in light of the skepticism expressed on the number of work hours reported, the Doctor Work Reform team would consider the best way to obtain direct feedback from frontline doctors supposedly to have been benefited.

6. A member suggested HA to include blood culture and cross matching in the scope of round-the-clock Care Technicians' service with a view to reducing the workload of junior doctors. SM(DWR) responded that the 3 pilot hospitals had already piloted Care Technicians to do blood culture with positive preliminary results. For cross matching, further consideration and discussion among doctors and nurses would be needed on this mode of operation. There were also some issues and concerns on responsibility and liability. D(CS) said the suggestion could be further explored in the relevant Work Group under HR.

   [Post-meeting note from HRM(T&D): The next central workgroup meeting of Corporate TSA(Clinical Assistant) Training will be held on 4 February 2010.]

From: A Hospital Chief Executive #3

I write to convey my comments to the captioned draft.
I appreciate the background, share the development direction, support the strategies and pilot programmes, and understand the implementation difficulties detailed in the document.

Rollout of Reform Programmes
Para 023

Training versus service for medical doctors

A. Deployment of Doctors to Pressurised Areas

a) Hospitals
With regard to deploying additional doctors to the pressurised specialties, I would like to highlight the existing unsatisfactory situation. HA, as an organization, is responsible for service provision (employing medical doctors) as well as facilitation of post-graduate clinical specialist training. Many a time, these two objectives do not complement each other.

For example, during night time, although medically trained residents (under the Dept of Medicine) could manage patient problems under the care of other surgical Departments, surgically trained residents under the Orthopaedic & Traumatology Department might not be “able” to look after patients with medical problems (under the care of other non-surgical Departments within the same Hospital).

Medical Officers (service) / Basic trainees (training) should be generic for the first three years of their basic specialist training. However, their respective specialty Colleges might not agree to this proposal.

Work over-lap between GOPC and SOPC

b) GOPC
GOPCs have to serve different purposes at different times. During “peace” time, GOPC colleagues are looking after patients with chronic illnesses. Some of these could have been seen by private doctors. Some of these might have also been followed up by Specialist OPD at the same time.

During “war” time, the limited workforce had to be deployed for other purposes (eg melamine-tainted milk, swine flu).

Family Medicine Physician training is geared towards quality patient care which needs more time. The training is conducted in GOPCs which are set up to meet service demand. Another example of conflict between service and training.

From: A Hospital Chief Executive (Continued)	#3

Enhancement of ambulatory care

c) Many clinical problems do not have to be sorted out in the Hospital. Likewise, many old cases of SOPC do not have to be followed up [that frequently / and be seen by doctors each time / at all].

Para 024

B. Re-engineering of Emergency Operating Theatre ("EOT") Services

Semi-emergency or elective operations can be scheduled in other Cluster Hospitals without Accident & Emergency Department.

Para 025

C. Establishment of Emergency Medicine Wards ("EMWs")

Worthwhile and effective practices by EMWs should be benchmarked and promulgated across HA Hospitals.

Audit and monitoring should be carried out to align variations in EMWs practices (e.g. patients could have just been managed in the EMWs during night time and be admitted to the Hospital admission wards the following day after the cut off hour when total number of patient admissions for the preceding day would be captured)

Para 027

Role of nurses should be better delineated instead of being proliferated in all directions. (eg Nurse consultants vs nurse educators vs nurse specialists)

The Way Forward

Para 030

a) If HA continues to keep pace with forever increasing public demand, existing unstable workforce might not be sustainable. One fine day, the organization had to define certain limits to its scope and depth of services.

b) Some work done by medical doctors could be shared out by other healthcare professionals.

c) Community health care centres, able to mobilise resources from affiliated Hospitals, can divert patient flux away from hospitals. (eg ambulatory care centres)

d) Avoid overlap of work done by GOPC and SOPC

Comparison of Steering Committee's Recommendations in Interim Pilot Review Report (2008/09) and Final Report on Doctor Work Reform (2009/10), Hospital Authority

Recommendations in Interim Pilot Review Report (2008/09)	Recommendations in Final Report (2009/10)
I. Deployment of Doctors to Pressurised Areas	
1. HA to consider reviewing the effectiveness of deploying additional doctors in reducing doctor work hour at different pilot reform sites and pressurised clinical specialties. [Para 420 a]	1. Recommendation kept. Besides, HA was recommended to plan its workforce with reference to the competing service demands, supply of medical graduates, trainee admissions in different specialty colleges, manpower wastage, doctors' working conditions and service sustainability for the entire organization. [Para 217 a]
2. HA to consider continually exploring further means of collaboration with the private sector, like employment of part-time private practitioners through the Flexible Employment Strategy to help out the General Outpatient Departments, dovetailing with redeployment of newly employed doctors to pressurised clinical specialties via the established resource allocation mechanisms. [Para 420 b]	2. Recommendation kept. However, HA was also recommended to develop Family Medicine Specialist Clinics instead of employing private practitioners to help out General Outpatient Departments. [Para 217 b]
3. HA to consider continually reviewing its manpower level, work arrangements and call patterns. [Para 420 c]	3. Recommendation kept. Besides, HA was recommended to continue rationalising its hospital services, streamlining work procedures and fostering multi-disciplinary collaboration in care delivery. [Para 217 c]

Recommendations in Interim Pilot Review Report (2008/09)	Recommendations in Final Report (2009/10)
II. Re-engineering of Emergency Operating Theatre ("EOT") Services	
1. HA to consider re-engineering the EOT services in all acute hospitals with 24-hour emergency services. Different modes of operating theatre services could be introduced after 22:00 hrs to support the night emergency operations. Additional funding, if any, could first be allocated to acute secondary hospitals to expand their operating theatre capacity in the extended day. [Para 528 a]	1. Recommendation kept. [Para 319 a]
2. HA to consider addressing the issues of inadequate day-time operating theatre capacity. [Para 528 b]	2. Recommendation kept. [Para 319 b]
3. HA to consider reviewing the work practice and instilling a cultural change in the surgical stream specialties. [Para 528 c]	3. Recommendation kept. [Para 319 c]
4. HA to consider delineating the roles and service scopes of different hospitals, exploring further room for service re-arrangements, formulating acute trauma and neurosurgical diversion mechanisms and developing protocol-based escort medicine service in all hospital clusters. [Para 528 d]	4. Recommendation kept. [Para 319 d]
5. HA to consider continuing to collaborate with the Hong Kong Academy of Medicine and its Specialty Colleges in enhancing the core competency training of frontline doctors on emergency care. [Para 528 e]	5. Recommendation kept under doctors' training. [Para 638 g]

Recommendations in Interim Pilot Review Report (2008/09)	Recommendations in Final Report (2009/10)
6. HA to explore the feasibility of providing general resident call coverage for patients who were physiologically unstable in the surgical stream specialties with reference to the global trend and the practice in the private healthcare market. [Para 528 f]	6. Recommendation kept. [Para 319 e]
III. Establishment of Emergency Medicine Wards ("EMWs")	
1. HA to consider exploring different models of emergency care for acutely admitted patients and address various limiting factors, like availability of hospital beds, training for a competent workforce, system support and a gradual change for closer cross-specialty collaboration, which were vital to the success of the EMW initiative. [Para 635 a]	1. Recommendation kept. Besides, HA was recommended to (i) adopt appropriate modes of emergency care for acutely admitted patients in accordance with the local situations and the pre-existing set-ups of different Accident and Emergency Departments; and (ii) expand the scope of community care to further reduce avoidable admissions. [Para 422 a – c]
2. For those acute hospitals that had already set up an EMW, HA to consider continuing to refine the service model. [Para 635 b]	2. Recommendation kept. [Para 422 a]
3. In view of the evolving mode of EMW service and the lead time required for addressing the aforementioned limiting factors, HA to consider reviewing the pilot EMW initiative for a longer period and analyzing more performance and outcome data before determining the detailed rollout plan for EMW service. [Para 635 c]	3. Review completed.

Recommendations in Interim Pilot Review Report (2008/09)	Recommendations in Final Report (2009/10)
4. HA to consider enhancing the core competencies of doctors through structured training and staff rotations among hospital clusters and clinical specialties. [Para 634 d]	4. Recommendation kept under doctors' training. [Para 638 g]
IV. Introduction of Care Technician Service	
1. HA to consider extending round-the-clock care technician service to all acute hospitals. Regular review of care technicians' scope of service, coupled with periodic safety monitoring and competency-based refresher training, were also recommended. [Para 726]	1. Recommendation kept. [Para 513]
V. Enhancing Senior Nurse Coverage during Out-of-hours	
1. HA to consider piloting in phases and evaluating the effectiveness of enhancing the clinical, professional and leadership roles of experienced nurses in providing protocol-driven, competency-based and after-hour coverage across clinical specialties in selected acute hospitals. [Para 820 a]	1. Pilot completed. HA was recommended (i) to enhance the senior nurse coverage for clinical departments in all acute hospitals at night, (ii) to clear with relevant professional bodies on the core competency of healthcare workers in different disciplines and develop a framework to facilitate enhancing their scope of professional duties and (c) to extend the roles of other allied health professionals where appropriate to relieve the workload of doctors. [Para 638 a/b/e]
2. HA to consider continuing to organise commissioned clinical skills enhancement training for nurses in acute settings and develop the local training resource to improve the core competency of nurses in acute patient care. [Para 820 b]	2. Recommendation kept. HA was recommended to enhance the professional and core competency of all nurses in acute care coordination, patient assessment, responsiveness and emergency stabilization through development of clinical protocols and regular training. [Para 638 a]

Recommendations in Interim Pilot Review Report (2008/09)	Recommendations in Final Report (2009/10)
VI. Introducing Common Ward Language & Protocol-driven Patient Care	
1. HA to consider extending the common ward language to other public hospitals as appropriate and establishing a uniform approach in multi-disciplinary communication. [Para 905 a]	1. Recommendation kept. Besides, HA was recommended to set up a sound track-and-trigger system with regular compliance audits and user reviews to ensure that deteriorating and potentially critical patient conditions could receive timely specialist intervention. [Para 638 c]
2. HA to consider continuing to formulate, update and promulgate both intra- and inter-departmental clinical management protocols involving multi-disciplinary professionals. [Para 1004 a]	2. Recommendation kept. [Para 638 d]
VII. Piloting an Electronic Handover System	
1. HA to consider piloting and evaluating the effectiveness of the newly developed electronic handover system in order to facilitate structured and comprehensive handover between shifts for critically ill and unstable patients, ensure continuity and safety of patient care and enhance after-hour clinical supervision. [Para 1108 a]	1. Pilot completed. HA was recommended to integrate the electronic handover platform into the upcoming Clinical Management System (Version III) and extend its application to all clinical specialties and hospital clusters. A designated team should be identified to coordinate the system development and rollout arrangement after Doctor Work Reform came to a close in 2009/10. [Para 638 f]
VIII. Strengthening the Core Competency of Health Carers	
1. HA to consider continuing to encourage and facilitate doctors' training and set in different supportive measures and modes of training. [Para 1411 a]	1. Recommendation kept. [Para 638 g]

Recommendations in Interim Pilot Review Report (2008/09)	Recommendations in Final Report (2009/10)
2. HA to consider enhancing the core competency of junior doctors in acute clinical care management by organising refresher training courses in collaboration with different Specialty Colleges. [Para 1411 b]	2. The clinical core competency course was now a mandatory module of specialist training for all basic surgical trainees in HA hospitals. [Para 630]
3. HA to consider continuing to collaborate with the Hong Kong Academy of Medicine in evaluating the impacts of work reform on the standard of doctors' training in the post-pilot period. [Para 1411 c]	3. Recommendation kept. [Para 638 g]
IX. Attaining Quality Hours for Service and Training	
1. HA to consider monitoring the work hours of public hospital doctors in a broad-brush approach and on the principle of prospective counting of rostered work in all situations, except their called-back duties during an off-site call and endorsed unrostered work. [Para 1226 a]	1. Recommendation kept. [Para 735 a]
2. HA to consider putting in place a mechanism to recognise unrostered work beyond the rostered duty hours in unforeseen circumstances and justified by demonstrable clinical needs. [Para 1226 b]	2. Done in both cycles of doctor work hour reporting in 2009. [Para 708]

Recommendations in Interim Pilot Review Report (2008/09)	Recommendations in Final Report (2009/10)
3. HA to consider monitoring the work hours of frontline doctors at regular and appropriate time points – For clinical specialties that were unable to meet the corporate target of reducing doctors' average weekly work hours to not exceeding 65 by the end of 2009, HA to consider reviewing their manpower level, work arrangement and duty patterns at half-yearly intervals. [Para 1226 c]	3. HA was recommended (i) to develop a long-term doctor work hour monitoring mechanism, (ii) to incorporate the reported doctor work hour as a key consideration in its workforce planning, (iii) to review outlier departments' doctor work hour at half-year intervals and other departments at 3-year intervals, (iv) to review outlying departments' manpower arrangement instead of recompensing with time-off for work done in excess of 65 hours per week on average, and (v) to set up a designated team to coordinate the work hour monitoring exercise after Doctor Work Reform came to a close in 2009/10. [Para 735 a/c]
4. HA to consider continuing to explore new ways of operation and work out viable solutions to change doctors' existing work pattern with the ultimate aims of enhancing their work-life balance and morale without compromising the quality of care and patient safety. [Para 1317 a]	4. Recommendation kept. Besides, stakeholder engagement was recommended to formulate viable solutions, balancing the need for granting day-offs for on-call duties against the need for up-keeping patient safety in public hospitals, and ensuring that public money was properly used at all times. [Para 735 b/c]
5. HA to consider gradually implementing a modified on-call system in order to reduce their continuous work hours towards the long-term target of 16 on weekdays and 24 at weekends as well as public and statutory holidays. [Para 1317 b]	5. Recommendation kept. [Para 735 b]

Recommendations in Interim Pilot Review Report (2008/09)	Recommendations in Final Report (2009/10)
6. In the interim, HA to consider attaining 100% compliance with post-call half-day time-off granted to all doctors on overnight on-site call and arranging mutual-cover sleep time for 4 consecutive hours for those who were on overnight on-site duty exceeding 24 hours, subject to adequate workforce, operational practicability and service sustainability. [Para 1317 c]	6. Recommendation kept. [Para 735 b]
X. Targeted Deployment of Resources	
1. HA to consider prudently utilising the healthcare resources in reconfiguring its hospital services, enhancing the service quality and improving the morale of healthcare personnel, while taking into account equity, right incentives and service sustainability in the long term. [Para 1511 a]	1. Recommendation kept and HA was recommended to prudently deploy its limited resources to pressurised areas. [Para 810 a]
2. Realising the financial stringency under the current financial turmoil, HA to consider appropriate resource injection and manpower deployment in the light of the need and the scale of launching various work reform strategies in different public hospitals. [Para 1511 b]	2. HA was recommended to prioritise use of its healthcare budget for those programmes that had a greater potential for increasing the system efficiency, optimising workload, enhancing the quality of care and patient safety as well as improving staff morale. [Para 810 a]
3. HA to consider continuing to explore a sound and appropriate enhanced honorarium system in a broad-brush and nominal approach and deter over-rostering of doctors and self-generating overwork – This could be supplemented by the established special honorarium system to recognise frontline doctors' contribution to ad hoc clinical activities. [Para 1511 c]	3. Recommendation kept and HA was recommended to use doctors' average weekly work hours to differentiate bandings of doctors in different call tiers, specialties and hospital settings. [Para 810 b]

Doctors' Headcount in Various Specialties
Hospital Authority

Specialty	July 2007	July 2008	July 2009
Accident & Emergency	408	435	439
Anaesthesiology	336	349	353
Cardiothoracic Surgery	30	30	29
Clinical Oncology	117	121	130
Dental	0	0	0
Ear, Nose and Throat	74	79	82
Family Medicine, OPD & Staff Clinics	500	510	492
Intensive Care Unit	88	94	114
Medicine (inc HSP, Reh, Inf, CGAT)	1,100	1,121	1,125
Neurosurgery	77	88	90
Obstetrics & Gynaecology	203	207	217
Ophthalmology	138	139	150
Orthopaedics & Traumatology	290	295	303
Paediatrics (inc MH in CMC)	302	306	318
Pathology	176	180	185
Psychiatry (inc MH, except CMC)	280	295	314
Radiology	227	235	246
Surgery	441	454	482
Others	13	15	22
Total	**4,799**	**4,952**	**5,088**

All data on full time equivalent (FTE) basis, rounded to the nearest integers and excluding Interns / Externs / Dental Officers

Source: Workforce Planning Section, Strategy and Planning Division, Hospital Authority

Allocation of Resident Trainees for Doctor Work Reform Purposes

Specialty	2008/09	2009/10
Surgery	13	6
Accident & Emergency	10	4
Paediatrics & Adolescent Medicine	7	5
Obstetrics and Gynaecology	6	1
Anaesthesiology	5	1
Orthopaedics & Traumatology	3	1
Medicine	2	–
Intensive Care Unit	1	1
Neurosurgery	–	2
Ophthalmology	–	1
Radiology	–	1
Total	**47**	**23**

47 out of 350 (i.e. 13.4%) and 23 out of 386 (i.e. 6.0%) new Resident Trainee posts allocated for DWR purposes in 2008/09 and 2009/10 respectively

Source: Medical Grade Department, Cluster Services Division, Hospital Authority

Summary of Turnover Rate of Doctors in Different Clinical Specialties, Hospital Authority

Specialty	2007-2008	2008-2009	2009-2010 (Projected)
Accident & Emergency	5.0%	4.9%	4.0%
Anaesthesiology	7.6%	3.8%	4.8%
Cardiothoracic Surgery	0%	3.3%	6.2%
Clinical Oncology	2.6%	5.0%	2.5%
Ear, Nose and Throat	13.9%	3.9%	4.6%
Family Medicine OPD & Staff Clinics	10.4%	6.8%	7.5%
Intensive Care Unit	0%	4.3%	2.3%
Medicine (include HSP, Reh, Inf, CGAT)	3.7%	4.8%	3.9%
Neurosurgery	1.3%	3.5%	1.5%
Obstetrics & Gynaecology	8.7%	6.0%	6.6%
Ophthalmology	5.9%	6.5%	5.5%
Orthopaedics & Traumatology	2.4%	6.2%	4.2%
Paediatrics	5.8%	6.6%	5.8%
Pathology	5.2%	1.1%	3.1%
Psychiatry	4.7%	4.1%	2.9%
Radiology	6.3%	5.6%	4.0%
Surgery	8.4%	4.3%	7.1%
Total	**5.8%**	**5.0%**	**4.8%**

$$\text{Turnover rate} = \frac{\text{Total no. of staff leaving in respective staff group in financial year (excluding temporary staff)}}{\text{Average strength of respective staff group in the same period (excluding temporary staff)}}$$

Source: Workforce Planning Section, Strategy and Planning Division, Hospital Authority

Intake and Turnover Rate of Nurses
Hospital Authority

	Intake	Turnover ^	Turnover Rate ^
2007–08	671	844	4.5%
2008–09	874	877	4.7%
2009–10 (up to Jun 2009)	78*	110*	4.1%^^

Remark

^ Included HAHO, Gen and Psy streams, voluntary early retirement and retirement

* Apr–Jun 09 intake, turnover

^^ Rolling 12-month turnover rate

Source: Workforce Planning Section, Strategy and Planning Division, Hospital Authority

Acknowledgement

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- Dr John COAKLEY, Medical Director, Homerton University Hospital
- Dr Simon ECCLES, Consultant (Emergency), Homerton University Hospital
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- Homerton University Hospital
- London Deanery
- Royal Colleges of Nursing (London)
- Royal Colleges of Physicians (London)
- Royal Colleges of Surgeons (London)
- Royal Liverpool & Broadgreen University Hospitals

Local Organisations and Participating Units

- Cluster / Hospital Chiefs, General Managers, Clinical Heads and Frontline Doctors
- Cluster Human Resources Division and Information Technology Department
- Hong Kong Academy of Medicine and its Member Colleges
- Hong Kong Public Doctors' Association and other Doctor's Associations
- Hospital Authority Delegates in the Visit to the United Kingdom
- Hospital Authority Emergency Medicine Ward Task Group
- Hospital Authority Emergency Operating Theatre Task Group
- Hospital Authority Specialty Coordinating Committees
- Hospital Authority Task Force on Doctors' Work Hours
- Hospital Authority Technical Services Assistant (Clinical Assistant) Task Group
- Participants in HA's Doctor Work Reform Strategic Planning Workshop
- Respondents in the HA-wide consultation on Doctor Work Reform

Collaborative Departments in Hospital Authority Head Office

- Corporate Communication Department
- Enterprise Resource Planning Project Team
- Finance Division
- Human Resources Division
- Network Management Department
- Nursing Services Department
- Statistics, Workforce Planning and Knowledge Management Department

Glossary

Acronym	Full Description
AHNH	Alice Ho Miu Ling Nethersole Hospital
APN	Advanced Practice Nurse
CMC	Caritas Medical Centre
CMS	Clinical Management System
CMU	Clinical Management Unit
EMW	Emergency Medicine Ward
EOT	Emergency Operating Theatre
Final Report	Final Report on Doctor Work Reform
HA	Hospital Authority
HKAM	Hong Kong Academy of Medicine
ICU	Intensive Care Unit
LegCo	Legislative Council
MEWS	Modified Early Warning Score
NDH	North District Hospital
PMH	Princess Margaret Hospital
PYNEH	Pamela Youde Nethersole Eastern Hospital
QMH	Queen Mary Hospital
SBAR	Situation, Background, Assessment and Recommendation
SOPD	Specialist Outpatient Department
Steering Committee	Steering Committee on Doctor Work Hour
TSA(CA)	Technical Services Assistant (Care Assistant)
UCH	United Christian Hospital
YCH	Yan Chai Hospital