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Preamble and Evolution of Doctor Work Reform

Localised reform with stakeholder engagement for
better care, patient safety, quality hours and improved morale

Doctor Work Reform

INTRODUCTION

101 In its long history of providing quality healthcare services for the general public in Hong Kong, the Hospital Authority ("HA") always took pride in its highly dedicated and professional workforce. In order to cater for the evolving needs and rising community expectations, HA had made strenuous efforts in the past two decades to enhance the quality of care and maintain a competent and highly vigilant workforce of health carers in public hospitals. Improving the work-life balance of frontline staff, in particular doctors who used to work for prolonged hours, always sat among the top agenda items under HA's "People First Strategy". In September 2006, HA conducted a doctor work hour survey which suggested that around 18% of public hospital doctors (i.e. about 900) worked for more than 65 hours per week on average while 35% of the overnight on-site on-call doctors (i.e. about 120) did not have immediate post-call time-off. Figures 1.1 and 1.2 below showed the survey results on doctors' average weekly and continuous work hours in 2006 respectively.

Fig. 1.1 – Average Weekly Work Hours of HA Doctors (Sep 2006)

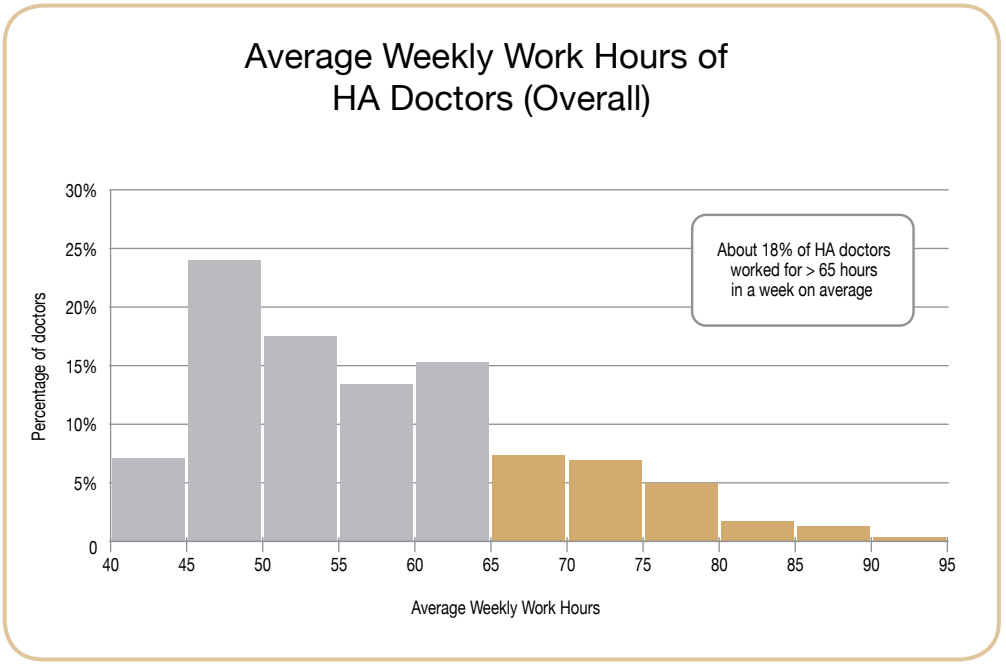
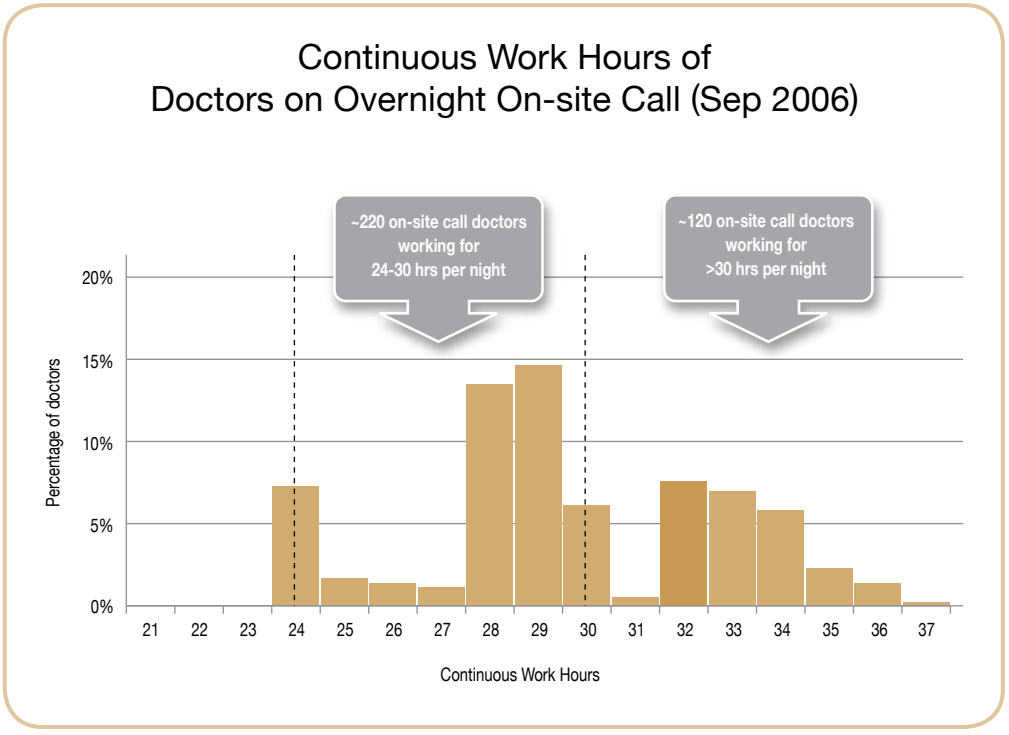


Fig. 1.2 – Continuous Work Hours of Doctors on Overnight On-site Call (Sep 2006)



102 To address the issues of doctors' prolonged work hours, highly intense activities and low morale, HA established the Steering Committee on Doctor Work Hour ("Steering Committee") under the lead of Dr C H LEONG, GBS, JP, Former Chairman of HA, in October 2006. Two overseas experts, namely, Dr Sherene Devanesen from Australia and Mr Andrew Foster from the United Kingdom[1], were invited to join the Steering Committee for experience sharing and wisdom tapping on implementing the work reform strategies. Representatives from the Hong Kong Academy of Medicine ("HKAM") and local medical training universities were also enlisted. Two advisory committees were also set up to collate feedback from the hospital cluster administration, clinical specialties as well as the frontline doctors on any work reform related issues. The memberships of the Steering Committee and the two advisory committees could be found in Appendices II to IV.

103 The Steering Committee was delegated to strategise for and oversee the work reform implementation in HA hospitals with a view to achieving the corporate targets of reducing all doctors' average weekly work hours to not exceeding 65 hours by the end of 2009 while ensuring the quality and safety of patient care. Regular reports would be made to the HA management for attention and deliberation.

[1] Dr Sherene Devanesen was the Chief Executive of Peninsula Health in Victoria, Australia while Mr Andrew Foster was the Chief Executive of Wrightington, Wigan and Leigh NHS Trust in the United Kingdom.

BELIEFS, DIRECTIONS AND OBJECTIVES OF REFORM

104 The Steering Committee believed that Doctor Work Reform could not be taken along without improving staff morale. Five major reform directions were thus outlined to address issues related to doctors' excess work and boost staff morale:

a) The weekly work hours of doctors should not exceed 65 in general while those currently working for fewer than 65 hours should also be benefited from the reform.

b) Doctors should not work continuously for more than 16 – 24 hours.

c) Overtime work of doctors exceeding their conditioned hours should be recognised financially.

d) Manpower should be rationally increased in certain clinical specialties on a need basis.

e) Promotion of doctors should be encouraged in HA, taking into consideration their competency, qualifications and years of service.

105 HA's Doctor Work Reform carried the three-fold objectives of quality patient care through teamwork, risk management for enhanced patient safety as well as quality doctor hours for service and training. It sought to maintain the work-life balance of doctors and provide better and more efficient patient care through enhanced teamwork and explicit sharing of responsibilities. Yet, while it was the attempt to rationalise doctor work hour that triggered Doctor Work Reform, it was never meant to be a pure number's game, nor should it be perceived to nourish a clock-watching culture in clinical practice. The reform entailed a cultural change in the conventional mode of practice and modernising the roles of health carers; and should be deemed the business of everyone in HA instead of the medical profession only.

CONSULTATION AND COMMUNICATION – A LOCALISED REFORM MODEL

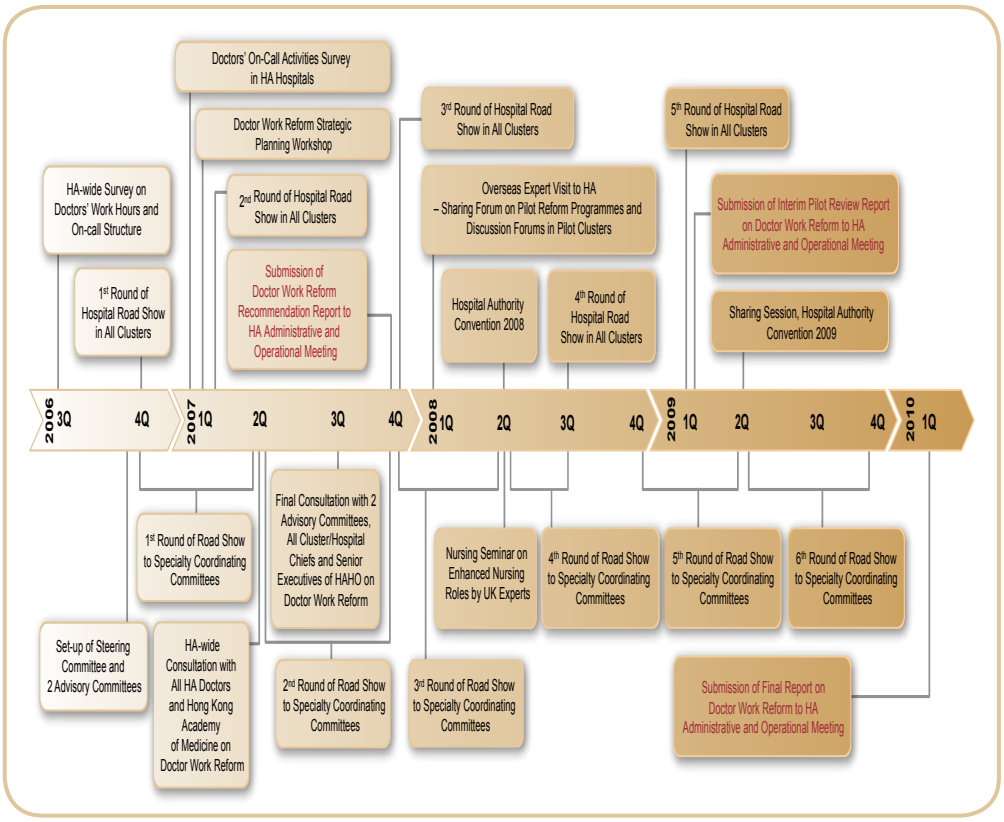
106 Realising the novelty of Doctor Work Reform and with a view to formulating a localised, pragmatic yet sustainable model of service transformation, the Steering Committee kicked off the reform process with an extensive consultation which delivered a consensual selection of leading work reform strategies. Numerous consultative and communication forums were conducted in the past years. The Strategy Planning Workshop held in March 2007, involving more than forty frontline staff and nine clinical specialties, served a head start for the corporate reform. The HA-wide consultations in May 2007, inviting feedback from the HKAM and each and every doctor in HA, as well as the ensuing consultations with the hospital chiefs, clinical specialties, senior executives and the frontline doctor representatives, furnished a reservoir of constructive views and erudite wisdom to enable the Steering Committee to strategise for the corporate reform. Yet, the valuable experiences of the overseas counterparts were never neglected, for they provided great references for implementation of the local work reform in the organization. In particular, the Hospital at Night programme of the United Kingdom had provided the inspirations for certain work reform strategies. Study visits and bespoke sharing by overseas experts were also organised for all concerned stakeholders to exchange views and learn the experiences in work reform implementation.

107 Since 2007, HA had conducted 262 communication sessions, entailing cluster and specialty-based road shows, sharing forums, healthcare conventions and management meetings, with a cumulative attendance of over 5,660 staff members. Close liaison and collaboration were also maintained with patient groups, community leaders as well as the HKAM in order to keep links on the work reform strategies and implementation progress, and collate their feedback on the work reform impacts on patient safety and doctors' specialist training in public hospitals. Around 200 feedbacks had been received from staff in various disciplines; and these had been considered and addressed by the Steering Committee in formulating its reform and implementation strategies. The Steering Committee first submitted its

Doctor Work Reform Recommendation Report to the HA Board in November 2007 and made an Interim Pilot Review Report on Doctor Work Reform to the HA Board for deliberation again in February 2009. The HA Board welcomed the work reform strategies and supported the direction of reform in general. Meanwhile, progress reports were made to the Health Services Panel of the Legislative Council ("LegCo") in March and July 2008 as well as May 2009.

108 Figure 1.3 below gave a brief timeline of HA's consultation and communication process, which had laid a solid foundation for the corporate Doctor Work Reform. This Final Report on Doctor Work Reform was also circulated to members of the two advisory committees[2], cluster and hospital chiefs, senior executives of the HA Head Office as well as the Hong Kong Academy of Medicine for comment before publication; and their feedbacks were deliberated by the Steering Committee in refining its recommendations for HA's consideration.

Fig. 1.3 – Milestones of Consultation and Communication on Doctor Work Reform

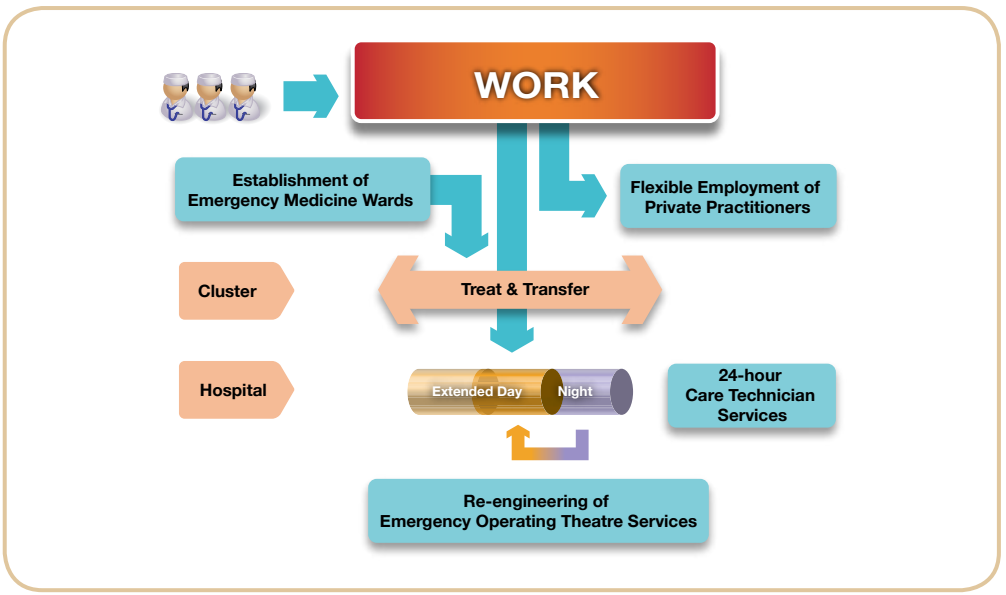


[2] The two advisory committees were the Cluster Administration and Specialty Advisory Committee on Doctor Work Hour as well as the Doctors Staff Group Consultative Committee. All feedbacks received on the draft Final Report on Doctor Work Reform could be found in Appendices X and XI.

PILOT DOCTOR WORK REFORM STRATEGIES

109 Doctor Work Reform encompassed multi-stranded transformation strategies that were aimed to optimise doctors' workload and ensure patient safety through process re-engineering, multi-disciplinary teamwork, engagement with stakeholders and standardization of clinical practice. Since the fourth quarter of 2007, HA had piloted four major work reform strategies, namely, deployment of doctors to pressurised areas, re-engineering of emergency operating theatre services, establishment of Emergency Medicine Wards as well as introduction of care technician services, in order to verify their effectiveness in attaining the stated objectives in selected acute public hospitals. These strategies were complemented with other supportive work reform programmes, like enhancing the senior nurse coverage during out-of-hours, introducing a common ward language, piloting an electronic handover system and strengthening the core competency of healthcare professionals in the pilot hospitals. Each of these work reform strategies had provided a measurable contribution to easing the workload of doctors; and these would be discussed in greater details in the following chapters.

Fig. 1.4 – Pilot Doctor Work Reform Strategies



110 As illustrated in Figure 1.4 above, the vertical dimension portrayed the optimization of total workload while the horizontal dimension depicted the rationalization of night activities in public hospitals. Along the vertical dimension, by establishing Emergency Medicine Wards as a gate-keeper for the public hospital system and employing part-time private practitioners to alleviate the workload in specialist outpatient consultations, it was anticipated that the vast workload block would be trimmed down to a reasonable level that was to be borne by the serving HA staff.

111 On the other hand, along the horizontal dimension at the cluster level, selected emergency cases were diverted to certain hospitals while defined highly complex cases were proposed to be concentrated in a few centres across hospital clusters. This would enhance the efficiency of resource allocation and improve patient access to the scarce medical expertise. Besides, by augmenting the extended day capacity of emergency operating theatres, a certain portion of backlog operations could be cleared while patients would be able to undergo earlier and safer operations conducted by more vigilant doctors. Moreover, a pool of care technicians would be trained up with the extended roles of providing round-the-clock blood-taking, electrocardiogram and intravenous cannulation services. This would enable the frontline doctors to refocus their time on core clinical duties and create room for reducing the number of overnight on-site on-call doctors, hence improving their working conditions.

112 The Steering Committee was cognizant that no one model would fit all and there was no fast-track solution to tackle all issues related to Doctor Work Reform. HA had thus delegated the Steering Committee to oversee the work reform implementation, report progress at regular intervals and recommend the final rollout strategies for those effective work reform programmes to other public hospitals.