醫院管理局
HOSPITAL AUTHORITY

Consolidated Feedback on Doctor Work Reform Consultation Hospital Authority

(As at 22 October 2007)

The Steering Committee aims to develop a local reform model on the basis of wide consultation. Apart from the various road shows and HA-wide communication sessions, a consultation letter was also sent to every doctor of HA and the Hong Kong Academy of Medicine to solicit their concerns and suggestions on the proposed reform strategies. This paper provides a summary of feedback received from doctors of different specialties through the feedback form on the designated homepage of Doctor Work Reform on HA's intranet, facsimile or mail to HA's Doctor Work Reform Team. The other feedbacks, including those from the Hong Kong Academy of Medicine, Specialty Colleges, Specialty Coordinating Committees as well as the doctors' associations, are contained separately in other appendices of the recommendation report.

Doctors' Work Hours

A. Weekly Work Hours

- Report should explain why and how 65 hours / week are arrived.
- Some objection to capping the average doctor work hours at 65 / week: too much, unfair, unethical, too dangerous, destructive to doctors' life and family, doctors treated as low-tech labour
- Tremendous work remodeling but modest and short-term target creates uncertainty - a more focused approach was suggested to handle the work hours of those doctors working for more than 65 hrs per week only and work with the concerned team heads to review their call system. Head office scrutiny and additional resources might be required.
- Concerns about change in conditioned hours: very unreasonable and a threat to those now working < 65 hours / week
- Reform should demonstrate benefits for those working < 65 hrs/week and must not make them worse off
- No doctor should work more than 65 hours per week in a year
- What to count?
  a. Full count of travel time and structured training
  b. Partial count of off-site hours and non-structured training
- Self-arranged overseas conferences and study courses should not be counted as work hours
- How to count?
  a. Varied views as to the "average" span of time in calculating 65 hrs
  b. Unsound to base on current work pattern instead of employment terms

- Conflict between beliefs of Steering Committee and the corporate polices in HA's Human Resources Policies Manual on doctors' overtime pay entitlement
- Currently no written protocol on doctor work hours and HA lacks further plan to reduce doctor work hours
- Need solid feasibility data on expected reduction in work hours through reform

B. Continuous Work Hours

- Long continuous work dehumanizes, robs enthusiasm at work, affects service quality and may result in callosity in patient treatment
- Some prefer capping continuous work at in-patient setting (e.g. 12 - 16 hours) and specialist outpatient setting (e.g. 8 hours)
- The time-honoured on-call system should be maintained and continuous work hour be capped at 24
- Long hours of work should include sleep time
- Standard of care will be jeopardized if we just focus on work hours

Managing Workload at Macro Level

C. Reducing Avoidable Admissions

- Sceptical of the gatekeeper role of Accident & Emergency Department in reducing avoidable admissions
- More scientific evidence required to prove the efficacy of telephone nursing consultation service in reducing avoidable admissions
- HA may consider assigning a single Telephone Nursing Consultation Service centre to concentrate experience and expertise in operating telephone consultations for all patients

D. Emergency Medicine / Admission Wards

- Anticipated resistance from nursing staff against manpower savings by introducing Emergency Medicine / Admission Wards
- Shortage of doctor / nursing manpower to run Emergency Medicine Ward in Accident & Emergency Departments
- Better to establish night admission wards than to set up Emergency Medicine Wards Need clinical guideline or instructions to run Emergency Medicine / Admission Wards
- Nurses and other staff of admission wards may have difficulty in caring for patients of other specialties, not to mention protocol-based care and varied practices among different specialties

E Enhancing Public-private Interface

- Generally agrees to public-private interface
- Some support hiring part-time doctors to relieve workload in specialist outpatient clinics
- Needs greater promulgation and facilitation of patient referral service to the private sector, e.g. by enhanced information technology support (e.g. the Electronic Patient Record System) for greater continuity of care
- Some are less optimistic of private specialist participation in reducing workload

Optimizing Night Activities in All Hospitals

F. Extended Day Model

- Pressure on middle-ranking clinicians
- Heavy outpatient workload makes it difficult to handle extended day duties
- Concerns over manpower shortage to man extra operating theatre sessions in the evening
- Suggest capping day-time activities
- Need strengthening of non-medical staff's support
- Suggest hiring of locums to supplement evening / weekend services

G Restricting Emergency Operating Theatre Sessions after 22:00 Hours

- Closing night time emergency wards puts lives at risk
- Concerns over patient care and deterioration of patient conditions due to cancellation of night time non-emergency operating theatres
- Restricting emergency operating theatre sessions lengthens patient waiting time
- Daytime protected emergency operating theatre sessions for Paediatrics
- Need for more resources for evening operating theatre sessions
- Need further studies to prove effectiveness of strategy towards workload reduction
- Suggest to extend the restrict list of emergency operations at night to include open wounds management and operation on threatened neurological functions of limbs

H. Extended Roles of Non-medical Staff

- Anticipated resistance from nursing staff against taking up non-clinical duties of doctors
- Fragmented nurse skills need re-engineering and training
- Suggestion of remuneration incentives for nurses
- Care technician service running on 24 hours is crucial to relieve doctors' workload especially at night time
- Primary healthcare staff not equipped to take up more responsibilities
- Extending roles of others would deprive doctors' training opportunities
- Enhanced pharmacy support for A&E and medical admission ward requested

I. Reinforcing Support System and Efficiency

- Some agrees to protocol-driven 24-hr computer tomography (CT) and magnetic resonance imaging (MRI) service, subject to:
  a. Injection of contrast be supervised by clinicians rather than radiologist
  b. Availability of RIS at home and facilitation of tele-radiology
- Some sub-specialty services are technology dependent e.g. Computer Assisted Orthopaedic Surgery
- Needs enhancing disease coding system as well as patient and blood identification

Change in Existing Doctors' Work Pattern

J. Core-competency Call Team

- Concerns over level of expertise, experience and accountability of call team and cross-specialty coverage after midnight (especially for secondary hospitals)
- Call team is more appropriate for surgical field colleagues than for medical counterparts
- Call team can reduce 1st level call but increase 2nd level or senior call - Purpose of call team may be defeated if specialists frequently called in for back-up support
- Need for reallocating Senior Medical Officers' duty to provide back-up support
- Suggest more involvement of on-site Consultants for greater expertise
- Large specialties have their own night call team, but for small surgical specialties, they may combine to form one night call team
- Emergency Medicine ward, admission ward and core-competency call team could be integrated into one team to provide core service for all acute hospitals in the long term.

K. Shift System Replacing On-call Duties

- Concerns over continuity of care, clinical deterioration of patient conditions, more frequent PM / night calls, manpower implication and impact on doctors' professional training.
- Conditioned hours should be defined for doctors as pre-condition for running a shift system
- 13 / 16-hour shift renders inadequate training exposure
- Some residing at remote sites (e.g. outlying islands) have to take 3 - 4 hours traveling and prefer working extra hours instead of shift
- Some supported mandatory granting of post-call half-day to boost staff morale
- Other suggestions:
    a. Fewer calls but longer continuous work hours
    b. 6 night shifts in 4 weeks, subject to 65 hours per week and 24 hours of continuous shift
    c. Structured on-site and off-site calls with call frequency and consecutive on-site shifts capped
    d. Designated work within shift (e.g. in-patient, out-patient and operating theatre sessions) with regular rotations
    e. Doctors completing a long extended day call should not be assigned off-site call on the same night
    f. A full-day rest to be granted after long duty hours (e.g. 24-shift)
    g. Flexible shift system with introduction of certain short breaks / protected sleep time in a 24-hour shift
    h. Compensation for off-site calls required, especially for hours returning to hospital
    i. Mandate from Specialty Coordinating Committees to ensure consistent call pattern in the same specialties across hospitals

L. Handover System

- More applicable to hyper-acute setting and emergency situations with focus on numerical life parameters rather than patient care
- Surgeons have practical difficulties in attending handover due to operations and patients scattering at many sites would make handover within limited time difficult
- HA is suggested to develop a standardized toolkit and operational procedures for effective handover of clinical information

Training

M. Training

- Concerns about impact of shift on professional training of doctors
- Some suggest protected time for training
- To reinforce clinical supervision for enhanced training, esp. for surgical operations / interventional therapy

Targeted Deployment of Resources

N. Targeted Deployment of Resources

- Injection or redeployment of resources required to implement reform initiatives, esp. for smaller hospitals with stretched manpower / specialties without Intern provision
- Financial recognition or time-off in lieu for work > 44 hours
- Employment of more new doctors to relieve workload - need solid feasibility data
- Need to address uneven distribution of Interns in different hospitals / specialties and increasing staff turnover in HA

Revamped Honorarium System

O. Remuneration

- Some suggest more pay for more work (including on-call duties)
- Some suggest granting honorarium according to frequency of night shift
- Incentive at pre-determined rates is required to differentiate work at unsocial hours and excessive long working hours
- Work at unsocial hours and work beyond 44 hours / week should be capped
- Compensation rate should be higher than the normal hourly pay rate
- All on-call duties and doctors on 2nd call returning to hospital for clinical duties should be compensated
- Across-the-board honorarium system is unfair & open to abuse
- Some object to more pay for more work - why?
    a. Create specialty discrimination among doctors
    b. Difficult to quantify work in different specialties
    c. Augment pay differentials between contract and permanent doctors
    d. Concern over fair assessment of impact factors for off-site duties recognized as on-site work hours

Others

P Workload Issues

- Reform should take into account operational needs and work intensity of different specialties
- Some suggest to conduct a fair and open assessment of workload across hospitals with reference to number of clinical admissions, complexity of cases, work intensity, hospital stratification, quality expectation, on and off-site calls and other non-clinical duties
- The recommended measures seem to have minimal impact on work hour improvement for O&G and Paediatrics Departments where 40% of frontline staff work more than 65 hours per week

Q Staff Morale Issues

- Need for strong leadership and trust between the management and the frontline to attain success in reform
- Low morale of lower / middle tier doctors due to poor promotional prospect, unequal pay scale for doctors in the same tier and restriction in taking up locum jobs
- Increased intake of medical students in coming years will adversely affects the career prospect of doctor
- HA should improve work conditions, employment and remuneration packages (especially the salary rate for those employed after April 2000) and career progression based on competence to retain doctors
- Clinical competency should come before administrative capability in doctors' promotion

R Applicability of UK Model

- Not a good reference for Hong Kong
- The United Kingdom also faces big issues of training

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