Opinions of Overseas Experts on Doctor Work Reform, Hospital Authority

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I think this is a very well presented, well-argued and well thought-out document, full of information with both local and overseas data. Your Hong Kong data look particularly strong. Your well-documented process of engagement with stakeholders such as the academics, colleges, universities and frontline doctors are admirable.

Your team needs to be congratulated on producing such a paper, which really addresses all the issues. In effect, your paper is proposing a whole system approach in this Doctor Work Reform project where every issue, both strategic and operational, is thoroughly considered.

There are some areas which are particularly strong, such as the strategic issues of targeted allocation of resources, training, remuneration, admission avoidance and nurse-led telephone service. Key operational issues are also addressed, such as admission ward, multi-disciplinary team work, handover, treat and transfer, extended theatre time, training of extended roles of technical staff and the concept of core competency.

On the issue of core-competency call team, I see that you face some strong reservations from professional bodies, hospital management as well as the frontline doctors. My views are that this opposition is mainly applicable to very specialized and complicated services. In my view, most of the work needing the attention of the medical staff is primarily at secondary care level involving mainly cardio-respiratory and gastroenterological cases. In fact, in my hospital, up to 80% of admissions to the medical unit on a daily basis are related to these, so you may wish to argue that the core-competency call team is for dealing with common clinical problems faced by any secondary care hospital rather then dealing with complicated specialist areas.

Your pilot will start later this year in the Kowloon West Cluster and in Paragraph 912 you mention that there needs to be a system of continual performance indicators. I think this is very important and you may wish to include in these indicators the usage rate of the extended theatre time. In the UK we did not monitor this aspect as we did not put in resources on this very important issue. The other monitoring indicator that you may wish to include is the effect on doctors' training assessed through interview, log book or appraisal. When I was doing this in the UK, I appraised all the junior doctors in my hospital myself and I was heartened to find that they did not feel their training compromised (there is a confusion and misunderstanding of the current feeling in the UK, that the training of junior doctors is compromised. The point to note here is that this is mainly due to the new Modernization

Medical Career and the run-through training programme and it has nothing to do with the Hospital at Night Project when the workweek is shortened to 56 hours. However this in my view is a problem with the 2009 target of 48 hours per week). This will not apply to HK, as your aim here is 65 hours per week, which in the UK will be regarded as an ideal working week for training and learning. All these indicators can then be part of an audit tool for the pilot site in assessing any teething problems and see if patient safety is compromised.

You may also wish to include the use of such indicators in page 9 of your executive summary under the already existing heading 'pilot implementation', as this may reassure the HA that there is a properly thought-through process of on-going assessment of the Doctor Work Reform pilot.

The other comment I like to make is that there seems to be little engagement with the nursing profession as stakeholders. May be this is because of the fact that there is a shortage of nurses as well. Doctors and nurses almost always deliver the frontline care and if team and multi-disciplinary team working are emphasized, then the role of nurses in this may need to be considered, in addition to the technicians.

Once again, I feel privileged to be asked to pass comments. The above are my honest and humble views which I hope you will find helpful.

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(Date : 24 September 2007)

Firstly I congratulate you and your team on this major piece of work.

I have very few comments to make having scrutinized the entire document.

One of the solutions that might be worth considering, which I could not find mentioned in detail, is the possibility of integrating primary and community care more closely into the system. There seems to be a lot of pressure on the acute sector and specialist doctors, and from my conversations I understand that quite a lot of this work would be allocated to primary care in the UK. This requires that primary care acts as a 'gatekeeper' and that access to the hospital sector is controlled by primary care. Of course the British model has built up over many decades, and I understand that it may not be compatible with the medical culture in Hong Kong, but I thought it worth mentioning. Some of your telephone advice models seem to be moving in this direction.

Chapters 1 to 3: I have no specific comments.

Chapter 4: This sort of figure for out-of-hours work seems almost universal. I see from the appendix that not all of your hospitals describe the same pattern and that in some specialties the work does not diminish overnight. The other main point (as you consider later on) is that the period 1700 to 2200 cannot be treated the same as the period 2200 to 0800, yet almost the whole world over, we staff hospitals as if they are identical.

Chapter 5: We too have a great diversity in what should be considered as 'work hours'. The current UK situation is that if a doctor is in hospital, they are working irrespective of whether they are asleep or working all night. This seems to me fundamentally unjust, but that is our law (I speak as one who used to be up all night as a junior!).

The off-site duties are a problem. Again, off-site duties are paid the same whether there are frequent calls or only one every few weeks. I would urge you to address this, perhaps by paying an honorarium for those who are called infrequently rather than a fee-per-night; it might also be possible, with respect to resident staff who are not called frequently, to make them non-resident.

I strongly support Para 513 which seeks to limit work hours. I accept your point in 518, that if the shift patterns (particularly at weekends and public holidays) are too short, then doctors end up working many more of them. This is very unpopular in the UK, and you have the opportunity to avoid this by being more flexible about maximum shift length at weekends. We have missed the opportunity to do this.

Para 521 was an interim solution that we also used and proved helpful.

Chapter 6: We have implemented Para 622 some time ago, and the advantage is that all patients admitted as emergencies are gathered in the same location. This makes life easier for the doctors. We used to do this for medical patients only, but as of August 1st 2007 we admit all medical, urology, surgical and orthopaedic emergencies to the same area. I would strongly support your desire to do the same thing. I understand the Australian model is similar.

I support your stance in Para 632. There is a significant potential for abuse, which is not always intentional, but is a side-effect of the system.

Para 640 is generally supported in the UK by the Royal Colleges and most doctors. The aim is to get someone to a specialist as soon as possible. The problem is that this entails reducing the number of centres providing such services – this is not popular with the people in the UK (and I imagine the same would apply in Hong Kong) but our government is pushing through this sort of reform at present. I do not see any other solution, and I agree with our government and Royal Colleges.

In Para 632, as mentioned above, I would strongly support allocation of more doctors to the 'twilight' period up till 2200. This allows 'day' work to be completed before the really antisocial hours.

I strongly support Paras 674 and 678.

Chapter 7: I support the Steering Committee's views here. We need to reduce the requirements for doctors to perform routine tasks and develop other healthcare workers' skills. We must also recognize that most out-of-hours emergencies are of a generic nature and rarely highly specific to the patient's specialty of admission. Thus the skills needed on-site should be generic, with specialized help available within agreed timescales (we use 30 minutes in the UK as a benchmark for how quickly a doctor should be able to get to the hospital).

Chapters 8 to 11: I have no specific comment.

I am very grateful to the Steering Committee for letting me be involved in this work. I wish you good luck in your work in the future, and I am at your disposal for further assistance if you think I can be of help.