香港公共醫療醫生協會
Hong Kong Public Doctors' Association
Secretariat: c/o Geriatric Day Hospital, 4/F Yaumatei Specialist Clinic Extension, 143 Battery Street, Kowloon.
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June 6, 2007

Dr. C.H. Leong,
Chairman,
Steering Committee on Doctor Work Hour,
Hospital Authority.

Dear Dr. Leong,

Joint Position Statements on Doctor Work Reform

With reference to your Consultation Document dated May 2007, we would like to submit comments on the highlighted **key directions** of the Document as follow:

Overtime work of doctors exceeding their conditioned hours should be recognized financially

1. "Conditioned hours" is defined in section B2.2.1 of the Hospital Authority Human Resources Policy Manual as "*the official hours of duty applicable to individual employees. It forms the basis for the calculation of basic salary, cash allowance and other benefits as appropriate.*" In the corresponding section of the Administration Manual, it is stipulated that "*The conditioned hours for most ranks and grades [including doctors] are 44 hours gross per week.*"

2. It is known in common law that, even if "conditioned hours" is defined in the employment contract, whether overtime attracts compensation shall depend on the contractual agreement. The dispute between doctors and the Authority will be decided by Court later this year.

3. Whatever the outcome, ***the defined "conditioned hours" should be expressly re-recognised***, so that the Authority should morally (though may not be legally) avoid requiring doctors to work excessively beyond "conditioned hours".

4. If the Authority is to financially recognise doctors' overtime works, the principle in section E4.2.3 of Human Resources Policy Manual should be followed:

> "*Overtime work should normally be recompensed by time-off in lieu. Where this is operationally impracticable within a reasonable period from the date on which the overtime is worked, an overtime allowance may be paid to eligible employees. An employee who qualifies for an Overtime Allowance may, instead of being paid the Overtime Allowance, opt to take time-off in lieu at a later date mutually convenient to the employee and the management.*"

That is to say:

a. The Authority is entitled to compensate its staff with time-off, so as to meet the fluctuating service demand without additional resources.

b. ***It is up to the Authority to offer any financial reward in exchange for the time-off.***

c. ***However the staff is entitled to opt for time-off if he chooses to do so.***

5. Regardless if overtime work is eligible for compensation or not, the maximum weekly work hours shall be limited as excessive long working hours is unsafe and endangering patient care.

The weekly work hours of doctors should not exceed 65 in general while those currently working for less than 65 hours should also benefit from the reform

6. If 65 are to be taken as the "maximum" weekly work hours in general, then ***the actual weekly work hours should only be allowed to exceed 65 in a small percentage of occasions***. Since 65 are quite demanding on staff, 5% is a reasonable upper limit.

7. In the Consultation Document, it is proposed to count weekly work hours as an "average over a period of 10 weeks" (§17). Such method actually gives rise to "average" weekly work hours, so that the actual weekly work hours may exceed 65 in 50% of occasions. It is too frequent and unacceptable.

The doctors should not work continuously for more than 13 – 16 hours

8. Currently the "contractual" weekly working hours are 8 hours for 5 day and 4 hours for 1 day. Colleagues are required to stay behind and continue to work (i.e. on-call) once every 3 to 6 days, such that colleagues are actually working for more than 30 hours once every 3 to 6 days.

9. Colleagues in general feel that "continuous" work hours should be reduced to 13 hours. However if in return colleagues are to be required to attend such "extended duty" more frequently (e.g. once every 1.5 to 3 days), the overall effect will be even more devastating to social life.

10. Hence ***the frequency of "extended duty" must not be increased to more than the original "on call" frequency (i.e. number of calls per month)***.

Manpower should be rationally increased for certain clinical specialties on a need basis

11. ***A set of formulae to calculate manpower based on service demand should be established***. For examples

    a. If 80 patients are to be seen in clinic, and each patient is to occupy 15 minutes of consultation time, then 20 doctor-hours are required (i.e. a 4-hours clinic would require 5 doctors).

    b. If 10 colonoscopies are to be performed in a session, then 8 doctor-hours are needed (i.e. a 4-hours session would require 2 doctors)

Promotion of doctors should be encouraged in HA taking into consideration doctors' competency, qualification and years of services

12. "Promotion taking into consideration competency, qualification and years of services" has all along been the Government policy for decades. "Annual increments", "omitted points", "increments for higher qualification" and "increments for years of experience" have long been established in the pay scale of Civil Service Professionals.

13. In the year 2000, the Government reduced the starting salaries of newly recruited Professionals by 5 points, but left the increments, omitted points and the pay scale unchanged.

14. However the Authority, in addition to reduce the starting salary, had aggressively cancelled all the omitted points, increments and reduced the overall pay scale of doctors. The subsequent poor staff morale and legal confrontation spoke for itself.

15. Now the Government proposes to increase the starting salaries of newly recruited Professionals back to the pre-2000 level. In connection with Hospital Authority, the Government proposes:

> "*... noting that the subventions to some organisations had been reduced in connection with the downward revision of starting salaries for the civil service in April 2000, the Government will consider adjusting, where necessary, their subventions in the context of the present exercise, having regard to factors including the terms of individual subvention agreements and the amount of reductions made in the 2000 exercise. Discussion will be held with bureaux/departments concerned on what adjustments, if any, should be made to the subventions of different organisations in accordance with this broad approach.*"

16. Hence ***the Authority should simply restore the pay scale (with various types of increments and omitted points) of doctors back to the pre-2000 structure***.

17. For colleagues recruited after April 2000, the Government proposed to increase their pay point according to an old recommendation of the Standing Commission. The recommendation read as follow:

> *"We believe, however, that in certain circumstances, the rules as they stand display an excessive concern for the preservation of relative seniority within a scale, particularly since pay and seniority are not necessarily related. We recommend, therefore, that new rules should be drawn up which should provide that no civil servant shall lose on conversion but the extent to which he benefits on conversion should not normally exceed one increment.*
>
> *Any revised rules for converting salaries should not restrict us from recommending special conversion arrangements where we consider such arrangement to be necessary or appropriate."*

18. The recommendation therefore does not preclude special conversion arrangement if it is necessary and appropriate. In the provision of medical services, experience and qualification always associated with seniority; therefore it should be reflected in the pay point. Hence, for operational reason, and there had been such a practice, ***incremental credits for relevant previous experience and qualification should be given to colleagues recruited after April 2000***.

This is a Joint Position Statements from:

Hong Kong Public Doctors' Association
Frontline Doctors' Union
Alice Ho Miu Ling Nethersole Hospital Doctors' Association
Caritas Medical Centre Doctors' Association
Castle Peak Hospital Doctors' Association
Kwai Chung Hospital Doctors' Association
Tung Wah Group of Hospitals Doctors' Association
North District Hospital Doctors' Association
Prince of Wales Hospital Doctors' Association
Pamela Youde Nethersole Eastern Hospital Doctors' Association
Queen Elizabeth Hospital Doctors' Association
Queen Mary Hospital Doctors' Association
Tuen Mun Hospital Doctors' Association
United Christian Hospital Doctors' Association
Yan Chai Hospital Doctors' Association

Thank you for your attention

Shea Tat Ming
President

c.c. Mr Anthony Wu, Chairman of Hospital Authority
Mr. Shane Solomon, CE of Hospital Authority

This Statement was jointly submitted by the HKPDA, FDU,
13 Hospital Doctors' Associations and 1,027 doctors working in Hospital Authority.

香港公共醫療醫生協會
Hong Kong Public Doctors' Association

19th October 2007

Dr. the Hon C H Leong
Chairman,
Steering committee on Doctor Work Hour
Hospital Authority
HAHO

Dear the Hon Dr Leong,

RE: Doctor Work Reform Recommendation Report

The hard work of compiling this detailed report was greatly appreciated. We expect the positive far-reaching influences of the report will help to uphold the standard of medical care in Hong Kong. However, there are recommendations or suggestions far from satisfactory or fair to the medical doctors, according to the international standards. Our comments were summarized in the attached power-point presentations.

The recognition of the extra-hour work with financial compensation is welcomed. However, we want to reiterate the right to opt for time off if we choose to do so by surrendering the financial reward.

Concerns about lengthening of training period after limiting the on-call hours of the junior specialist trainees have been raised by the Academy and several Colleges. However, service work without the supervision of senior specialist of the middle grade or above, especially at night, is not counted as proper training in most Western countries currently. Moreover, professional & legal accountability will be questionable if the off-site call of the supervising senior was not considered “full time normal work” as stated in the report. Indeed, the senior on call has borne folds of responsibility and stresses because after-office hours is the most risky period when there is the thinnest manpower and support of all kinds in the most unsocial time. Besides, the senior off-site call cannot and should not leave the Hong Kong territory and has to be even within minutes of reach from the corresponding hospital compounds once his or her name appears on the call list. We once again stress that doctors are professionals

and not just hand-on laborers in an assembly line of a “medical” factory. Therefore, off-site on call should be counted as full contribution to the teamwork in the on-call unit.

We wish the committee will respond to our comments positively and we are more than happy to detail them in case of any queries.

Sincerely,

Dr Duncan H K Ho

President, the Hong Kong Public Doctors’ Association

Receivved on 20 Oct 2007 at 01:38hr

醫院管理局
HOSPITAL AUTHORITY

EXECUTIVE SUMMARY

Doctor Work Reform Recommendation Report
by
Steering Committee on Doctor Work Hour
Hospital Authority

Something that concern HKPDA
HIGHLIGHTS

Manpower (Mar2006)	
Consultant	501
AC/SMO	979
MO/Resident with FHKAM	858
MO/Residents without FHKAM	2250
Intern	~280
% of all interns working >65/wk	No data
% of all doctors (except intern) working >65/wk #	18% (>900)
% of MO/resident working >65/wk #	24%
No. of doctors on-site call every day #	340
No of doctors off-site call every day	No data
No of doctors off-site call every day called-back	No data

#Sept/Oct 2006 surveys

Rest requirement

EWTD Rest Requirements European Working Time Directive

- Minimum of 11 hours continuous rest in every 24 hour period.
- Minimum rest break of 20 continuous minutes after every six hours worked.
- Minimum period of 24 hours continuous rest in each 7 day period (or 48 hours in a 14 day period).
- Minimum of 4 weeks paid annual leave.
- Maximum 8 hours work in each 24 hours for night workers.

II. The British Model

These are employees' rights
http://business.guardian.co.uk/print/0,,5022999-108725,00.html

- Days off per fortnight

I. The Australian Model

1. 3.5 days in each 2 week period
2. 2 days must be consecutive
3. Remainder must be 1.5 consecutive or 3.5 off (4 hours = 0.5 day)
4. Minimum 10 hours between rostered shifts

Rest requirement

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NO chapter on REST – no need to learn from Australian/British models?
Status quote – post-call ½ day plus 1 rest day per week (13:00 Sat to 13:00 Sun consider acceptable?) AND only need to be 100% compliance by June 2008! (para 732)

You may sleep for 4 hours after working continuously for 24 hours (para 730) if
There is mutual cover &
There is no urgent matters
REST requirement is
•NOT a practice code
•NOT a quality indicator

Weekly work hour

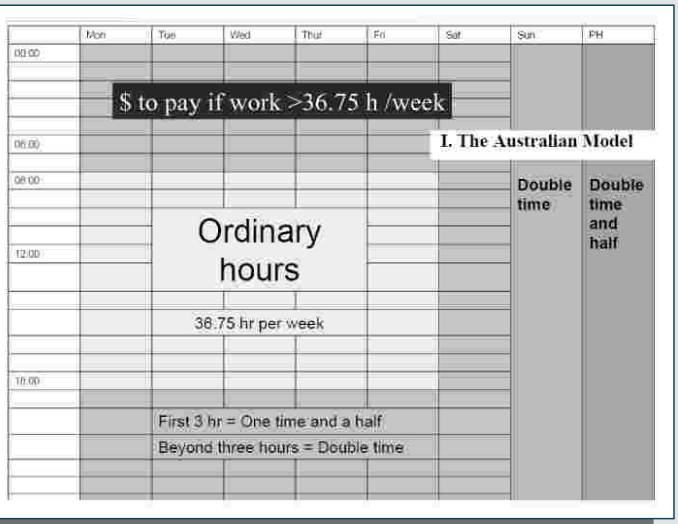
Safe Hour Roster Design

Australian Medical Association's National Code of Practice-hours of work

- For Interns / Residents – 38 hours per week averaged over four weeks (Lower risk category)
- For Registrars – 43 hours per week averaged over four weeks including 5 hours of training time free from service (higher risk category)
- Meal breaks – 30 minutes minimum and counted as time worked
- 28 day roster (at least) must be promulgated 14 days before commencing
- Doctor may request specific shift at least 1 week prior to roster promulgation
- 7 days notice to change roster unless emergency exists
- Doctors must **not** work:

1. > 75 hours in 7 consecutive days
2. > 140 hours in 14 consecutive days
3. > 280 hours in 28 consecutive days

Unless Doctor gives written consent to waive this entitlement or medical emergency or disaster situation



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1. Not more than 65h average over 26 weeks
   - Thus 75 h/wk for 13 wk + 55 h/wk for 13 wk would be considered target-compliant
2. No benchmarks for consecutive 7, 14 and 28 days
3. No suggestion on "training time free from service"
4. One off-site call = counted as 1 hour of work (para 523)
5. Work hours for those currently working <65h /wk will INCREASE (para 511)

Para 503-512

What does it mean?

monitored and audited. We would like to refer to the paper "Findings and recommendations from the Hospital at Night project" (www.modern.nhs.uk/hospitalatnight) which recommended that there should be strong medical leadership at night, from doctors, at middle grade level or above.

Are we behind?

I. The Australian Model

The Australian Medical Association (AMA)'s *National Code of Practice - Hours of Work, Shiftwork and Rostering for Hospital Doctors* was developed through a consultative process , involving all Australian hospitals, state health administrations, medical and regulatory organisations, doctors, and a range of other bodies and individuals.

The Code was adopted by the Federal Council of the Australian Medical Association in March 1999 and was implemented in 2000. Two nationwide surveys on doctors' work hour were done in 2001 and 2006 after the implementation.

European Working Time Directive

Agreement was reached in May 2000 between the European Parliament and the Council of Ministers on the arrangements and timetable for doctors in training to be included in the EWTD.

II. The British Model

- August 2004 – Interim limit of an average 58 hour maximum working week and EWTD rest requirements.
- August 2007 – Interim limit of an average 56 hour maximum working week.
- August 2009 – Deadline for the average 48-hour maximum working week – this could be extended by another 3 years with an interim limit of an average 52 hours maximum

Here is the benchmark

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"It is the Steering Committee's aim that HA doctors will not work for more than 65 hours per week on average by the end of 2009" (para 1017)

Long-term goal after 2009? } lacking
65h/wk is final? What about interns? }

65h/wk is ultimate?

2. The Chairman summarized that we were then in the process of identifying ways to strike a balance between work hour, training as well as the service aspects. In targeting for the ultimate goal of 65 work hours, each department could adopt different strategies in coping with issues related to service capacity and availability of experienced staff. The options of flexible

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Time-off in lieu and No call request

Furthermore, we have recently conducted a **Questionnaire on Flexible Employment and Working Hours for Doctors, soliciting views of both male and female public doctors**. We have just completed the collection of the questionnaires and so far we have collected about 250 questionnaires from our respondents. The Committee is now doing further analysis of the data. Hopefully we will have the final results available at the end of July. However, preliminary analysis has already showed some useful comments from our colleagues working in the public sector :

Hong Kong Women Doctors Association

1. Disregard training requirement, preliminary data showed that the majority of our respondents agreed to have the option to decide the amount of on-call duty at work, and the option to decide not working overnight or on public holidays.

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June 6, 2007

b. ***It is up to the Authority to offer any financial reward in exchange for the time-off.***

c. ***However the staff is entitled to opt for time-off if he chooses to do so.***

These views were individually supported by >1200 HA doctors

A firm NEGATIVE reply

1008 The Steering Committee respectfully declines the suggestion of the HKPDA and other Doctors' Associations that staff may opt for time-off in lieu, since this is neither operationally feasible nor sustainable to ensure quality patient care and safety. Staff should continue to follow the prevailing HA human resources policies.

NOT feasible now nor in the future?

Potential impact on training – selected items

Appendix IXa

Training

Weekly work hours of doctors not exceeding 65 in general

1. We see at this moment that the suggestion to limit the weekly working hours to 65 may not have major impact on training. It is envisaged that further reduction of working hours beyond 65 per week can cause training problems.

9. While trainees are having reduced night activities, they still need their trainers for supervision as well as for training. The total number of doctors working at night may not be substantially reduced. This is discussed later under "Manpower" as well.

O&T

4) After careful assessment of the quality and quantity of our trainees under the revised working environment, our College will not exclude the possibility of "extension" of training period

Prepared by Dr Ngai Wai Kit
Hong Kong College of Orthopaedic Surgeons

Dr CT Hung
Chairman
Doctor's Work Hour Working Group
c/o Hong Kong Academy of Medicine
99 Wong Chuk Hang Road
Aberdeen, Hong Kong

Paediatrics

Dear Dr Hung,

On behalf of the Council of the Hong Kong College of Paediatricians, I would like to respond on the matter of "Work Hours/Admission Ward" according to our 108th Council Meeting on 11 May 2007 that no children should be admitted to the new generic "Admission Ward", they should be directly admitted to paediatric ward for specialist care.

Thank you very much for your kind attention.

Yours sincerely,

YL Lau

c.c. Professor Louis Low, President, HKCP

HONG KONG COLLEGE OF PHYSICIANS
香港內科醫學院
(Incorporated in Hong Kong with limited liability)

(2) At present many Fellows and trainees are working continuously while on call for more than 24 hours at one time, mostly from 28-32 hours. Moreover, due to the growing number of elderlies and those with chronic diseases, work intensity in acute medical wards is always high in general but more so when a small numbers of doctors are on call at night for large departments. These long intensive working hours are very unhealthy among healthcare workers. Our College urges HA to appropriately add resources to medicine departments, to ensure our College Fellows and trainees need only work continuously for not more than 16-24 hours at one time. This will certainly be beneficial to care quality and patient safety, and ensure staff health and life balance.

Thank you.

Yours sincerely

Prof KN Lai

RECEIVED 13 JUN 2007

HONG KONG COLLEGE OF RADIOLOGISTS
香港放射科醫學院
Founder College of the Hong Kong Academy of Medicine
(Incorporated in Hong Kong with limited liability)

The article states, "To support the extended day and optimized night model, protocol-driven 24-hour CT and MRI for critical patients with therapeutic implications will be advocated." We have elaborated on the implications affecting our service and training on the above proposal:

1. The total number of CT & MRI examination would increase - This would add to the already overstretched work force of radiologists and radiographers.

The $X honorarium

	New honorarium proposed according to status & speciality (weighted mean week work hour)			
	AED	Psy	Med	Sur
Basic trainee	43.1-48.3h/wk ($1x)	54.6-57.2h/wk ($2x)	62.3-62.5 h/wk ($4x)	64.7-73.5 h/wk ($4x)
Higher trainee				
RS			56 h/wk ($3x)	
AC/SMO		45.8-47.8 h/wk ($1x)	50.8-51.9 h/wk ($2x)	55.4 h/wk ($3x)
Consultant				51.5 h/wk ($2x)

Projected yearly spend = ???
Under the existing honorarium, HA spend about HK$140 million yearly

#Sept/Oct 2006 surveys

Table 1. Summary of DWR Recommendation report for issues raised in Joint position statements signed and submitted by the HKPDA, FDU, 13 hospital doctors associations and 1027 HA doctors.

Joint position statements on DWR dated 6 June 2007	Response in DWR recommendation report Nov 2007	Comments
Para #1 to 5		
We requested the defined "conditioned hours" be expressed re-recognised.	Para 1005 and 1008. Our suggestion was acknowledged but ignored.	
In accordance with the principle in section E4.2.3 of Human Resources Policy Manual, we requested the HA to honor doctors' entitlement to opt for time-off if he chooses to do so.	Para 1005 and 1008. Our suggestion was acknowledged but rejected.	
We believes "those currently working for less than 65 hours should also benefit from the reform"	Work hours for some doctors currently working <65h /wk will INCREASE (para 511)	
To safeguard the already poor social life of dedicated doctors, we believes that "the frequency of "extended duty" must not be increased to more than the original on-call frequency (i.e. number of calls per month)	Regrettably, our suggestion was explicitly rejected. "*…the Steering Committee would not prescribe such a rule on shift pattern or on-call frequency for doctors*." (Para 520)	
Para #11		
To increase accountability and rationalization of manpower resources, we suggest "a set of formulae to calculate manpower based on service demand"	Regrettably, this suggestion was ignored. It is regrettable that the principles and recommendation in para 904-913 do not seem to be driven by workload data and figures.	
Para #6 to 7		
To better safeguard patient safety, we requested "the actual weekly work hours should only be allowed to exceed 65 in a small percentage of occasions"	Para 507-8. Our suggestion was rejected. Instead of using a "People First" and patient-centre approach, a management-oriented formula (para 512e) is recommended.	With regret, the insistence on average over 26 weeks will inevitably endanger patient safety because the actual weekly work hours may exceed 65 in 50% of occasions.
Para #8 to 10		
For the safe of staff health, we believe that doctors should not work continuously for more than 13-16 hours.	Regrettably, this is only a "may consider" recommendation "in the long term" and our suggestion was explicitly rejected for weekends and holidays, during which doctors will be required to work continuously for 24 hours. (Para 518, 519) "..the Steering Committee believes that it is **not realistic nor feasible to adopt** the shift pattern of **13-16 hours as a short-term target**."	**In the short term, this means that the public will need to accept the well-documented dangers inherent with having doctors to work excessive long continuous hour.**