Consultation Feedback from Specialty Coordinating Committees, Hospital Authority

(As at 22 October 2007)

1. Consultation Schedule

Month / Year	Coordinating Committee (COC)
Dec 2006	Ear, Nose & Throat
Jan 2007	Surgery , Ophthalmology, Neurosurgery, Radiology
Feb 2007	Accident & Emergency, Internal Medicine, Paediatrics, Pathology, Orthopaedics, General Manager (Nursing) Forum
Mar 2007	Intensive Care Unit, Anaesthesia, Clinical Oncology & Psychiatry
Apr - May 2007	Obstetrics & Gynaecology, Family Medicine

2. Feedback from Coordinating Committees on Doctor Work Hour

a) Anaesthesia (19/03/2007)

Regarding HA survey on weekly work hour, members noted the survey was encompassing doctors at all grades in the Ana specialty. Though the overall findings revealed the weekly work hour was within 65, staff at the senior level were actually working in relatively long hours than the junior staff in catering for patients' needs. Also, the proposed shift of night activities to day had its limitation due to emergency situation whereby overnight calls would be unavoidable. The restructuring of call roster also implied the possible need for additional resources. Dr. M Y CHENG suggested that if COC perceived the requirement of additional resources for those pressure areas, they should be delineated and justified in form of a program to facilitate the necessary deliberation.

b) Ear, Nose & Throat (22/12/2006)

In regard to the possible arrangement for night time calls, there was a list of ENT process indicators available that described the service standard. Dr. F M TONG would kindly help identify the indicators in order for Dr. D YEUNG to further deliberate in light of patient safety and service quality consideration.

c) Internal Medicine (06/02/2007)

1. The proposal of the Steering Committee on Doctor Work Hour to reduce long weekly work hours and continuous work hours for the medical staff is supported.

2. The "Hospital at Night" should not be rigidly implemented across all clinical departments in all HA hospitals.

3. Doctors working in medical departments within the Hospital Authority are already extremely stretched in coping with the heavy workload. Most departments have already implemented measures to tailor manpower deployment in accordance to the service volume during different times of the day. There is already very little idle time for the on-call staff with high work intensity.

4. As background information, approximately 80% of medical in-patients are admitted as emergency. The patients are mostly frail elderly with multiple co-morbidities and require considerable care from the medical and nursing staff. There are also very heavy clinic and specialty services during office hours. There is very little spare capacity for internal deployment if doctors have to be exempted from ward rounds and clinic duties following on call work.

5. Continuity of care is an important aspect of internal medicine service, for better understanding of the patients*underlying medical and psychosocial problems and efficiency of patient turnover. This cannot be replaced by simple handover of cases in between shifts.

6. Medical departments within the Hospital Authority should not have great difficulty in capping the weekly work hours at 65 hours with some additional manpower. There should be some flexibility in applying the principle in allowing slightly more hours for certain weeks and less for others to facilitate duty rostering.

7. Most medical departments would find it difficult to decrease the duration of continuous work hours to 13 - 16 hours without significant additional medical manpower. The alternative of increasing call frequencies and duty allocation at unsociable hours would lead to tremendous resistance and grievances from the frontline medical staff.

8. There should be a mechanism for addressing the off-site on-call work for specialists in providing consultation service to back up the residents who are undertaking call duties on site.

9. The nurses working in medical departments are also extremely stretched in coping with the large number of emergency patients, especially during peak seasons. They will require support in terms of additional health care assistants to relieve them of low-complexity patient care procedures as well as training and development opportunities to develop expertise as nurse practitioners in internal medicine.

d) Neurosurgery (24/01/2007)

1. It would be imperative to instill the concept to on-call MOs that the need to address emergency calls should take top priority over other works, including the duties inside OT.

2. Currently the cluster management had overriding authority in deciding the practice of call pattern, such as cross surgical calls, according to local operational needs, despite that the arrangement might not be in line with the overall policy. COC would need to voice out to ensure that the agreed policy was to be carried out properly across the board.

3. The Neurosurgery call in QMH was separated from the General Surgery call. The objective was to ensure better patient management and service quality.

4. The first call MO should have a minimum number of 5 people to allow a strict 65-hour week and the Saturday/Sunday compensatory leaves compliance.

5. By allowing combined on-calls, this will put pressure on the second on-calls (usually the specialist neurosurgeons level).

6. The number of junior MO should be made adequate (n= three to five), not just for the on-call and emergency, but for the regular duty during the day for the acute and convalescence / rehab beds. Acute beds include general neurosurgical patients and High Dependency Unit beds. Convalescence and rehab beds are neurosurgical patients transferred early to a different wing prior to discharge.

7. The biggest obstacle for the 65-hour working week is the shortage of BST and service MO in the non-specialists component of the neurosurgical service. Because of this, the specialist staff is overloaded with general medical and preparatory work for surgery, post-op care and discharge.

e) Ophthalmology (11/01/2007)

Members were encouraged to contact Dr. YEUNG if they had any feedback on the proposed strategies for cutting doctors' hours to 65 hours a week. Regarding a new night-duty system, Dr C C CHI would work out the quality services of Ophthalmology (including provision of on-site doctors) in the HA.

f) Orthopaedics & Traumatology (26/02/2007)

1. Reservation on the general call to cover sub-specialty call.
2. Concern about possible cross-specialty call coverage in secondary hospitals, i.e. other specialists to look after the O&T patients after midnight.
3. Additional doctors to be required according to individual hospitals' workforce.
4. Incorrect number of on-site doctors found in the TKO's call structure survey.

g) Paediatrics (12/02/2007)

Dr C B CHOW opined that safety and quality of patient service were two importance elements on work hour issue.

h) Radiology (Part I - 29/01/2007)

1. The members of the Radiology COC had read the consultation paper "Doctors Work Reform" and would like to express our concerns.

2. The article stated that "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". Our views are as follows:

3. Protocols:

   i. In drafting of the protocols which requires radiology support, radiologists should be involved.

   ii. Protocols not only involve technical details in performing the examination, but should also involve the degree of radiologists involvement in the exam, such as reporting.

   iii. We have the view that all the urgent CT and MRIs performed in extended hours should be reported by radiologists.

   iv. For suspected surgical emergencies, urgent CT and MRI should be done only if the clinicians think that they would operate the patient at night when the radiology findings concur with their suspected clinical findings. Otherwise the examination should be deferred to the next day.

4. Workload increase and its consequences:

   i. In the present situation, the work force of radiologists and radiographers are under strain. There has been a rapid drain of radiographers and radiologists from HA in the recent years. Recruitment & training of new staff and retaining of experienced staff are mandatory. But even after such action, it needs time for the situation to become stabilized.

   ii. Both the total number of CT & MRI & the total number of out of hour CT & MRI would increase. This would add to the already overstretched work force of radiologists and radiographers. In order to cope with the increase in workload after normal work hour, either more frequent on call or extended work hour of radiologists is necessary. The on call system induces inefficiency because of the addition of traveling time. Extended work hour is also not a solution, since it will cause displacement of other core services if the manpower supply is inadequate. Moreover, if specialists are needed to work frequently in extended hours which

is socially unfavourable, there will be increasing brain drain of experienced staff to the private sector.

iii. Core activities and training will be affected if there is premature starting of the "doctors work hour project" without adequate radiology manpower support. Besides clinical sessions, specialists participate in clinical radiological meetings, participates in multidisciplinary teams, and training sessions for general and subspecialty radiology. These would be disrupted with compensated leaves of specialists. Deployment of manpower geared for 24 hour CT & MRI would also affect training opportunities of trainee for specialty branches in Radiology other than emergency CT & MRI.

iv. The implementation of the "doctors work hour project" should be gradual, awaiting the number of radiologists and radiographers to be refilled to the required number.

5. Timely replacement of CT & MRI in HA hospitals are necessary. Backup CT & MRI should also be present in hospitals with emergency service. The key role of CT & MRI for supporting decision making cannot be over emphasized.

6. Night team competency and consultation:

   Inappropriate requests not only increase in workload of radiologists, but would also give unnecessary radiation to the patients. The paper "Findings and recommendations from the Hospital at Night project" (www.modern.nhs.uk/hospitalatnight) recommended that there should be strong medical leadership at night, from doctors, at middle grade level or above. The night team should consist of staff competent in making appropriate radiology request as their day staff. One of the team member should be capable of interpreting CT brain. Consultation to the radiologists should be the same rank. The calling in of one consultant should be at the direct request of another consultant, and not by his or her junior staff, the same is for the AC rank. There should be regular audit for inappropriate requests.

7. The consultation paper also touched upon the development of teleradiology system. The installation of such system to allow the on-call radiologist to review images at home or other hospitals would help, but its contribution has to be further evaluated.

Radiology (Part II - 21/09/2007)

1. The Coordinating Committee of Radiology [COC(Rad)] supports the Doctor Work Reform to reduce long weekly work hours and continuous work hours for medical staff. Nevertheless, COC(Rad) expresses much reservation in introducing the extended-day model before manpower shortage in Radiology could be addressed. The concerns are depicted below:

Acute Manpower Shortage

2. With high turnover rate, recruitment and retention difficulties, the whole Radiology service has been facing acute manpower shortage. The workforce of both radiologists and radiographers are under strain. The adverse situation has already imposed much pressure at the current service provision. With no new intake, the extended hour service will further stretch on the existing under-strength workforce, which will, in turn, put the quality of the service at risk. In the Recommendation Report, in order to uphold our service standard and expedite patient management, senior radiologists are proposed to support the extended hour imaging service. With an overall lack of senior radiologists in HA, the commitment to support the extended hour will further adversely affect staff morale and aggravate the brain drain to the private sector. This would have tremendous repercussion on our overall radiology service provision

3. The "radiologists to clinicians ratio" is one of the useful indicators to reflect the manpower requirement to sustain radiology support for clinicians. Based on the Medical Manpower Indicator Report on the HA Statistics & Research Home Site, the radiologist to clinician ratio (excluding Anaesthesia & Pathology) in HA was 1:16.5 in 2001 and 1:17.9 in 2006; whereas, the usual historical quoted reference in the previous COC meeting was 1:10. The wide deviation reflects the critical manpower deficiency in radiology notwithstanding the increasing demand arising from technology advancement and changing clinical practice, both in terms of diagnostic imaging requests and patient treatment by interventional radiology.

Overall System and Clinical Support

4. COC(Rad) agrees that "the extended-day model cannot stand on its own". In order to optimize night activities, ensure patient safety and reduce doctors' out-of-hour workload, the overall system and clinical support should be reinforced for its efficient operation. To support the on-site clinicians during extended work hours, demand on diagnostic imaging and interventional procedures are expected to increase, coupled with increased off-site consultations after the extended hour. To realize and sustain the

initiative, it is necessary to instill corresponding manpower support, particularly under such stringent manpower situation, where further stretching is not possible.

5. The Recommendation Report discussed in its paragraphs 907-910 (pages 99-101) about resources deployment for targeted areas. The Steering Committee estimated the annual resources required to be deployed for "enhancing diagnostic imaging support" would be at a range of $12-22 Mn. COC Radiology recommends that each center should have a team comprising of 1 AC, 2 radiographers and 1 RN to support the extended hour CT imaging, the additional interventional procedures and operating room radiography. The quoted amount of $22M is deemed not sufficient to cover the acute hospitals in HA.

Requests by Specialists

6. To enhance the efficiency in providing radiology support and to safeguard the appropriateness of radiological requests, all requests should be initiated by specialists. It is always desirable to have direct communications with the attending specialists. It is particularly essential during off-site support.

Tele-Radiology & Off-site Call for On-site Work

7. COC opines that feasibility of introducing tele-radiology for off-site radiologists could be explored to enhance system efficiency. Nevertheless, tele-radiology means that the off-site radiologist is, in fact, performing on-site work. The efforts and time involved include not only the consultation, but also the image downloading, image review and reporting, which is, in fact the same as on-site work and time spent should be counted accordingly.

Representation of the Pilot Hospitals

8. COC welcomes pilot to put the model on trial. Nevertheless, the pilot should involve a large tertiary center, with all relevant clinical departments operating in the extended hour model. Under such circumstances, the impact on radiology service during the extended hour and after midnight can be more realistically reflected.

9. The extended-day model cannot stand on its own. While the issue of acute shortage in radiology service has called for HA's urgent attention, sufficient workforce for clinical support should be in place to complement with clinical services to realize this new model. Rapid and thorough expansion of PACS and other IT support would assist in optimizing radiologist efficiency. To facilitate off-site diagnostic support and radiological consultations, technological advancement is needed, and efforts of staff in providing such "off-site work" should be recognized.

i) Surgery (09 / 01 / 2007)

1. COC members' comments / suggestions:

   i. Although admission might be reduced after midnight and OT would be avoided after midnight as far as possible, the patients in ward still required reassessment and hence the actual workload after midnight was not much reduced.

   ii. The benchmark from UK might not be a good reference locally. As a matter of fact, the UK system was then facing big issues on training.

   iii. It would be useful to assess impact of the proposed change on service quality as that would be a major public concern.

   iv. Instead of having the strategies applied across the board, appropriate stratification of hospitals should be looked at.

   v. The measures might have possible impact of 'compressing' considerable specialties onto a single person. The compatibility and magnitude of this generic person would also be a concern.

   vi. HA needed to deliberate on whether we aimed at having more senior people to do the job or by pooling of manpower. If the job requirement demanded experienced staff, then there would be a price to pay for.

   vii. The component of remuneration that was commensurate with workload could be considered as a measure conducive to retaining experienced staff and addressing the equity issue across specialties on salary payment.

   viii. The current scenario might have the tendency of shifting night time workload to day. The situation would actually put much pressure on those middle-ranked staff. It might be helpful to set a capacity limit for day-time activities.

   ix. The issue of continuous work hour was a concerned part as this would put pressure on doctors. It was noted that post-call compensation was currently not rendered by some hospitals which would be a major concern.

x. The compressed work hours would likely have impact on experience and training. The introduction of service MOs might be a useful means to enhance flexibility and help address service needs at the basic level.

xi. On surgical manpower requirement, there was a need to strike a balance between availability of training materials and manpower that sometimes posed difficulties in making accurate estimates. The recent exodus had further aggravated the situation.

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 remuneration and employment of service MOs etc were all worthwhile to be further contemplated upon. It was also reckoned that practically speaking, the UK experience might not be directly applicable to our local situation.

3. As far as COC(S) was concerned, the meeting agreed the first priority should be set on the reduction of continuous work hour. All junior doctors should be given at least 1/2 day compensation after overnight call. This was considered an overwhelming concern as it involved patient safety and occupational health issues. COSs(S) were invited to set this as their prime target. The issue would be reviewed again alongside further development.

j) Remarks

There was no particular feedback on Doctor Work Reform from the following specialties:

- Accident and Emergency
- Clinical Oncology
- Family Medicine
- Intensive Care Unit
- Obstetrics & Gynaecology
- Pathology
- Psychiatry