20th June 2007

Dr C H Leong
Chairman
Steering Committee on Doctor Work Hour
Hospital Authority
147B Argyle Street
Kowloon.

Dear CH ,

Consultation on Doctor Work Reform (DWR)
Hospital Authority

Thank you for your letter of 9th May 2007 inviting the Academy to comment on the DWR consultation paper. The Council, the Education Committee and the Past Presidents Advisory Committee of the Academy have discussed the paper. The Academy, as the statutory Organization for training and standard of specialist medical practice, would like to offer its views in relation to training, professional standard and medical manpower.

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.

2. The 65 weekly work hours must be maximized for training purposes to compensate for the time reduction. This is especially true for skill-based training such as surgery since acquisition of any particular surgical skill needs time, practice and immersion. It

would seem contradictory if on-call doctors have to take up more "generic" work which will invariably prevent them from learning the specialty-specific skills.

3. Hence, within the 65 hours, there should be protected training time for the trainees.

4. For years, simulator/laboratory type training has been used in our current structured training programs. Reduction of working hours requires that such training methods be further enhanced to compensate for the lost time in patient contact, and in interaction between trainers and trainees. There is also the need to delineate the core competencies that are generic, and those that are specialty-specific. These measures require resources that must be in place before implementing reduction in work hours.

Shift working/Doctors not working continuously for more than 13-16 hours

5. A rigid work hour may not be conducive to training. Operations and emergency care may last beyond 13 or 16 hours. Acute emergency care is one of the important training aspects in most specialties.

6. In shift duties, trainees do not get to see patients "from beginning to end". Such practice of "total care" is very important in learning, and also in building the future independent specialist practice. Flexibility should be allowed in implementing this continuous work hour rule. The system should consider allowing trainees to stay behind just for learning purposes.

7. Shift working requires handing over of patient care. In order to achieve good training and good patient outcome, an effective and efficient handover system must be developed first.

Reducing night activities

8. Moving night activities to daytime will still require the same number of, if not more, doctors. There may be a situation of dilution of training due to increased number of doctors. The need as specified in (4) is reiterated.

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.

Competency-based call team

10. Such a call system requires the doctors to have the "generic" skills on top of their specialty-skills as discussed in (2) above. These skills must be defined so that trainees can learn as well as perform their patient-care effectively.

11. Reducing layers of call and enhancing senior coverage may affect trainers. Their work load and burden will increase resulting in dissatisfaction and leaving the Hospital Authority. It is evident that training will then be affected. The Hospital Authority will need to consider part-time employment of trainers who have gone into private practice.

Reducing duplication of work

12. Limited repetitive work is needed for training especially for skill-based training. This is the cognitive learning theory. Taking history from a patient for a second time may reveal features not apparent at the first history taking.

Extending the roles of non-medical staff

13. A trainee should be able to perform basic skills such as the setting up of intravenous lines which may be mundane but life-saving in certain circumstances. We do not wish to see that doctors are "de-skilled" and be restricted in the scope of care to their patients.

Professional Standard of medical services

Reducing night activities

14. Certain night activities cannot be reduced. They are Obstetrics, neonatology and Pediatrics. Even in other specialties, patients become ill in the middle of the night, or their conditions change to critical. Although the experience in United Kingdom has not shown

any significant change in quality and outcome after implementing the *Hospital at Night* Project for over 3 years, the Academy urges the Hospital Authority to monitor closely the standard of services, the quality and the outcome if this scheme is to be implemented in Hong Kong.

Competency-based call teams

15. Apart for Obstetrics, Neonatology and Pediatrics, there are other complicated or emergency situations in other specialties that require immediate and appropriate medical care. The importance of the competence of such an on-call team is evident. The Hospital Authority has to define clearly and categorically such *competencies* before it can launch the "competency-based call team".

16. In defining the *competencies* for this work reform and on-call team, the Academy wishes to know if the competencies required are expected to be at the specialist level, or otherwise. The standard of medical service may be affected if the extra skill/competency is not set at the specialist level. With limited time for training, it can be easily seen that there is competing priority between training for a specialty and training for health-care service provision.

17. There is a need for clear guidelines for junior doctors to call for assistance, whether from their senior doctors, or from other specialties. A policy on "jump call" allowing senior nurses to call for assistance may also be necessary.

Shift working/Doctors not working continuously for more than 13-16 hours

18. This system can result in problems such as quality and timeliness of patient-care, reduced doctor-patient rapport, failure in communication, just to mention a few. On the other hand, the Academy is aware of the adverse effects of long working hours on doctors. To strike a right balance will mean the building of bigger team of doctors for the shift duty and who know each other's practice well and are working in well defined areas.

19. A clock-watching mentality may develop especially when there is

no flexibility in the continuous working hours. Patient care can be compromised.

20. Handing over between shifts of doctor may be an issue of time and quality particularly in large hospitals with a bigger number of patients. It is suggested that there be fixed teams of doctors so that handing over will almost always be within the same teams as discussed in (18).

21. The consultation paper suggested the setting up of "Centers of Excellence" where critically ill patients will be transferred for treatment. It is suggested that a "Flying Squad" be established for such a purpose so that these ill patients will be transferred under the best care. Doctors and nurses should not be deployed from any unit/hospital for such a function.

Medical Manpower and Resources

22. With this Doctors Work Reform, it is plain that there must be additional manpower for the Reform to fly. The Academy would wish to see that the additional manpower is one that is sustainable, and is one that gives regard to training. In the past years, the Academy has seen the effect of limited resources (deficits) on training, much to the detriment of the development of some specialties. Obstetrics & Gynecology (OG) is one good example, and the Community of Hong Kong as well as the OG units are now suffering.

23. Limited working hours for trainees will mean the need for a more efficient and sophisticated training program such as virtual reality, simulators etc. The resource implication is evident. The Academy understands that the Hospital Authority has training as one of its missions. The Academy hopes that adequate resources will be allocated for this Reform with regard to training.

24. When there is a need for more doctors, the issue of adequate supply from the medical schools, or from abroad, will arise.

Reducing hospital admissions and enhancing outreach services

25. This is a trend worth supporting, but it must not be seen as a possible solution to reduction of number of doctors needed for medical service. Even if a certain percentage of hospital admission is reduced, there is still the need for the skeleton number of doctors.

Enhancing Public-Private Interface (PPI)

26. PPI is a means to facilitate patients in seeking the kind of health-care they wish to have. The Academy understands that there is currently some degree of PPI, and feels that if PPI is to be successful, perhaps the whole PPI picture be clearly defined to the private as well as the public medical sectors.

Concluding Remark

The Academy would wish to suggest that a *Pilot Study* be conducted to see the effect of this Reform, both in training and in service, before embarking on a total scale. The Academy would like to reiterate that under no circumstances can training, and hence the professional standard, be compromised, though it respects the concept of work-life balance.

Some Colleges have made specific comments on this Reform in relation to their Specialty and their letters are enclosed for your reference.

With Best Wishes,

Yours sincerely,

Professor Grace Tang
President

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Mr Elmer Wan
General Secretary
Hong Kong Academy of Medicine

14 June 2007

Dear Mr Wan,

Doctor Work Reform

I refer to your memo of 18 May 2007 inviting colleges to give views to the Academy on the Hospital Authority's Consultation Paper on Doctor Work Reform.

We note that the Paper not only recommends work hours for doctors of Hospital Authority, which is one of the most concerned issues regarding the heavy workload in public hospitals, it also addresses the overall working condition of public hospital services with a view to improving the efficiency and quality of clinical activities.

We consider that the proposed strategies have addressed the very important workload issues in public hospitals which would help to improve clinical quality, occupational health and well being of health care workers, and in turn ensure patient safety. We welcome the recommendations made in this Consultation Paper.

Yours sincerely,

Dr Thomas Chung
Honorary Secretary
Hong Kong College of Community Medicine

THE COLLEGE OF DENTAL SURGEONS OF HONG KONG
香 港 牙 科 醫 學 院
(Incorporated with Limited Liability)
A Constituent College of The Hong Kong Academy of Medicine

6 June 2007

Mr Elmer Wan
General Secretary
Hong Kong Academy of Medicine
(via email : elmer@hkam.org.hk)

Dear Elmer,

Doctor Work Reform (DWR)

Refer to your memo dated 18 May 2007 regarding 170th Council Meeting (Follow-up) for the above.

After discussed in our 141st Council Meeting, we only concerned with those trainees who work less than 44 hours per week, other than that it would not affect the specialist training pathway.

Kind regards,

Yours sincerely,

Dr John Y K Ling
President

Preliminary Feedback on Doctor Work Reform (HA)
From Hong Kong College of Orthopaedic Surgeons

Due to the short consultation period, our College is not able to conduct thorough consultation and discussion among ourselves on this important issue. We would like to submit our preliminary feedback on this project.

We Support the following issues

1) The key directions to address the workload issues and to boost the morale of HA doctors
   - the weekly work hours of doctors should not exceed 65
   - overtime work of doctors should be recognized financially
   - manpower should be rationally increased to provide quality and effective services
   - promotion of doctors should be encouraged
2) The concept of extended day work hours
   - avoid inefficient work in the mid-night
   - not to delay the non life- or limb-saving operations to the midnight which is not fair to everybody and to avoid conflict between the patients and the orthopaedic surgeons
3) Concentrating emergency services into designated hospital, the surplus manpower can be deployed accordingly
4) Provision of 24-hour CT and MRI services for all hospitals with 24 hours emergency admissions
5) Better hand over system
6) Admission ward to take care of patients who do not require urgent attention from the orthopaedic surgeons. However, the manpower in the admission should be additional staffs rather than contribution from the orthopaedic department
7) Concentrating highly sophisticated services into a few centers

   Contemporary orthopaedic surgery is technology dependent; we will soon be marginalized if we do not develop the necessary new technology. Take the example of Computer Assisted Orthopaedic Surgery (CAOS) and Minimally Invasive Surgery (MIS); HK citizens are asking for these services in HA because they have access to these services in China and other Southeast Asia countries. All these advance technology should be provided in selected centers only.

We have reservation on

1) To limit the continuous work hour to 13-16 hours, this will change the traditional work pattern of doctors and they will have to work on shift duty. The compartmentalization of service will scarify the continuation of care to our patients and deprive the training of our trainees in routine patient care

We object to the proposal on

1) Development of nurse clinic and to extend the roles of the paramedics

   Our trainees should not be deprived of the training opportunity on basic patient care and triage of complex cases. A specialist led service will be down graded to a paramedics led service which is obviously undesirable.

2) Subspecialty call duties cover by a competency-based call team

   Cross subspecialty team cover within the same specialty is acceptable with proper backup of the specialist; e.g. general surgery team can cover the urology or plastic team or vice versa. However, cross specialty coverage is not acceptable

Our proposal

1) Provide designated **daily** trauma list to all orthopaedic departments with 24-hour emergency service
2) Recruit more paramedics like radiographers and theater technicians for the extended day operation list
3) HA should inject additional resource for training of surgery related trainees. Reduction of work hours will decrease the exposure of our trainees to emergency procedures. This can be compensated by structured training programme; e.g. computer simulation training, hand-on workshop with cadaveric dissection on various orthopaedic subspecialties
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
25 May 2007

THE UNIVERSITY OF HONG KONG

Professor Yu Lung LAU 劉宇隆教授
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29 May 2007

Our Ref: H:\office\yllau\hkcp\HKAM – admission ward\at

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

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

HONG KONG COLLEGE OF PHYSICIANS
香港內科醫學院

(Incorporated in Hong Kong with limited liability)

30 June 2007

Dr CH Leong
Chairman
Steering Committee on Doctor Work Hour
Hospital Authority
147B Argyle Street
Kowloon

Dear Dr Leong

Consultation on Doctor Work Reform (DWR)
Hospital Authority

Our College has discussed the captioned paper at our Council Meeting and wishes to highlight the following points:

(1) Our College hopes that the Hospital Authority (HA) can provide more opportunities for training for our trainees.

(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
President

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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)

8th June 2007

Professor Grace Tang
President
Hong Kong Academy of Medicine
10/F, Hong Kong Academy of Medicine
Jockey Club Building
99 Wong Chuk Hang Road
Aberdeen, Hong Kong

Dear Professor Tang,

Consultation on Doctor Work Reform
Hospital Authority

The Consultation paper on Hospital Authority Consultation on Doctor Work Reform (DWR) has been distributed to the Colleges through the Academy, for soliciting views and opinion. Our College has sought comments from our Fellows and members and the issue has been discussed in our recent Council Meeting.

Our College would like to submit our concerns on the Doctor Work Reform Consultation Paper as below to the DWR Steering Group via the Hong Kong Academy of Medicine, on the issues relevant to our Specialty.

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.

2. The total number of out of hour CT & MRI examinations would increase -

This may induce inefficiency especially if radiologists or radiographers are called back to the hospital to perform or interpret the findings. On the other hand an extended hour of service would cause displacement of other core services if the manpower supply is inadequate. Importantly, such service requires specialists. As a result, specialists are needed to work frequently in extended hours. Such work pattern for senior staff may be unfavorable for their expanding scope of professional and life style activities. This will worsen our brain drain to the private sector of experienced staff who are the core group involved in training and heading different subspecialty operation.

3. Premature starting of the "doctors work hour project" without adequate radiology manpower support would cause displacement of other core activities & affecting training :

a) **Specialists :**
   - Specialists taking time off in lieu, or working a non-standard day pattern may not be available to participate in some teaching sessions or to supervise trainees during the traditional working hours. This will be particularly problematic if a consultant has a special interest or subspecialty and is not available to cover subspecialty training during any days off in lieu of extended or weekend working.
   - Clinico-radiological meetings may be disrupted. The importance of these meetings for patient management and also for audit and governance cannot be over-emphasized. Multidisciplinary meetings are also now a major part of specialists' workload and these would be very difficult to organize with 7-day / extended day working.
   - The potential loss of the clinical radiologists who are the leads in multi-disciplinary teams during 'core' working days must be assessed.

b) **Trainees :**
   - As the 24 hour protocol driven CT and MR would invariably involve major redeployment of the manpower within the

departments, the present clinical service in other modalities would be compromised. This might have implications on subspecialty training as trainee might not have enough exposure if the whole departments shift to 24 hour CT and MR service. We can foresee that all the subspecialty trainings, let alone emergency radiology would be more deficient following the implementation of the exercise.

4. We are also concerned about inappropriate requests and radiation exposure to the patients. Making appropriate request should be a core value of the competency-based call teams and such decision cannot be relied upon by very junior on call clinical trainees. Radiology request should be regularly 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.

In conclusion,

1. More manpower has to be put into the radiology service if 24 hour MRI is to be practised for extended indications other than acute cord compression.

2. In order not to compromise the delivery of care in the normal working day, an increase in workforce of radiologists and radiographers is necessary. However, in the recent years the rapid drain of radiologists and radiographers already put the service under acute strain. Recruitment & training of new staff and retaining of experienced staff is mandatory. 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.

3. Installation of facility to review images or completed examinations in the home of the on-call clinical radiologist would help, but its contribution has to be further evaluated.

4. Monitoring this proposed "protocol driven" CT/MRI imaging service and auditing of clinical demands on the off-hours radiology service should be well in place.

5. Training of specialists requires long duration and good coordination of resources from the Hospital Authority and our College. We recommend that relevant action and communication should be initiated as soon as possible.

We request that our above views on the Doctor Work Reform Consultation Paper will be forwarded awhole to the DWR Steering Group via The Academy.

Thank you for your attention.

Yours sincerely,

Lilian Leong
President
Hong Kong College of Radiologists

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