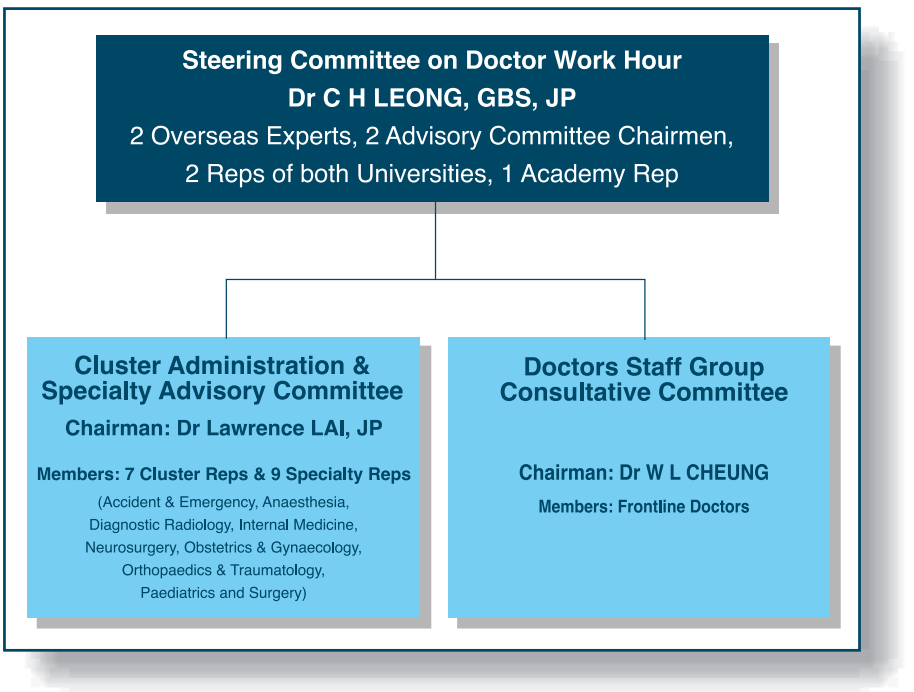
CHAPTER 4 – EVOLUTION OF DOCTOR WORK REFORM

I. Structural Framework

401 The Steering Committee on Doctor Work Hour was set up in October 2006 under the lead of Dr C H LEONG, GBS, JP, Former Chairman of HA. Underpinning the Steering Committee, two Advisory Committees comprising frontline doctors, cluster administration and specialty representatives had also been formed to advise the Steering Committee on formulation of the reform strategies (Figure 4.1). The membership of the Committees is shown in Appendix I.

(Fig. 4.1)



402 The Steering Committee focuses its work on the following 5 areas and would submit a Doctor Work Reform Recommendation Report to the Chief Executive of HA:

a) To steer and develop strategy
b) To analyze and identify the best practice for doctors' work hours
c) To advise how to achieve the 65-hour target and reduce excessive continuous work hours
d) To review feedback and advice from the two Advisory Committees
e) To recommend an implementation plan

II. Local Evidence

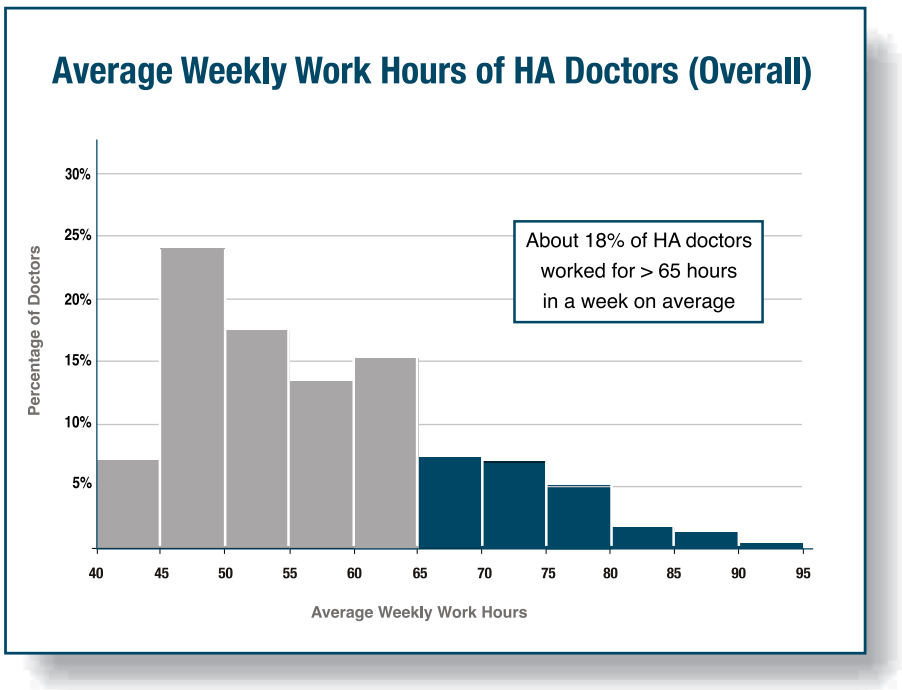
403 Before initiating any change, it is imperative to know where we are and the issues of concern. Accordingly, HA has conducted the following studies and surveys:

A) HA-wide Survey on Doctors' Work Hours

404 This self-reporting survey was conducted in September 2006 to review the average weekly on-site work hours [4.1] and continuous on-site work hours of HA doctors (excluding Interns). 32 hospitals and 21 specialties were involved. Out of a total of 747 samples collected, 536 and 258 useful responses were identified on average weekly and continuous work hours respectively. About 35% of doctors (N=258) in the survey sample were on overnight on-site call with their continuous on-site work hours ranging from 24 to 37.

405 From the survey, it was estimated that about 18% of all HA doctors (excluding Interns), or 24% of doctors at Medical Officer ("MO"), Resident ("R") and Resident Specialist ("RS") ranks, worked for more than 65 hours in a week on average (Figure 4.2).

(Fig. 4.2)

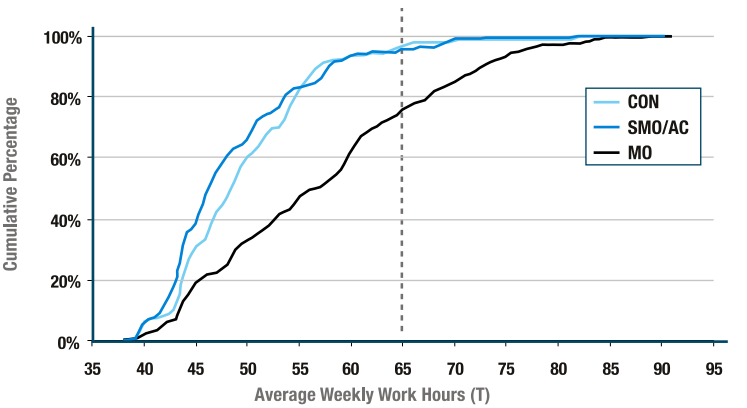


4.1 Including meal but excluding off-site call and off-site telephone consultation

406 The survey revealed that HA doctors' average weekly work hours ranged from 38 to 91. The first-line doctors (MO, R and RS) worked for the longest hours (Figure 4.3).

(Fig. 4.3)

Average Weekly Work Hours of HA Doctors by Rank



Rank	T>55 (%)	T>60 (%)	T>65 (%)
CON	85 (17%)	30 (6%)	15 (3%)
SMO/AC	168 (17%)	69 (7%)	40 (4%)
MO	1,717 (53%)	1,199 (37%)	778 (24%)

407 The five specialties with the longest doctors' average weekly work hours (T) were, in descending order, Neurosurgery, Surgery, Obstetrics & Gynaecology, Paediatrics as well as Orthopaedics and Traumatology. There was no significant statistical difference in the average weekly on-site work hours among doctors in different categories of hospitals (Table 4.1).

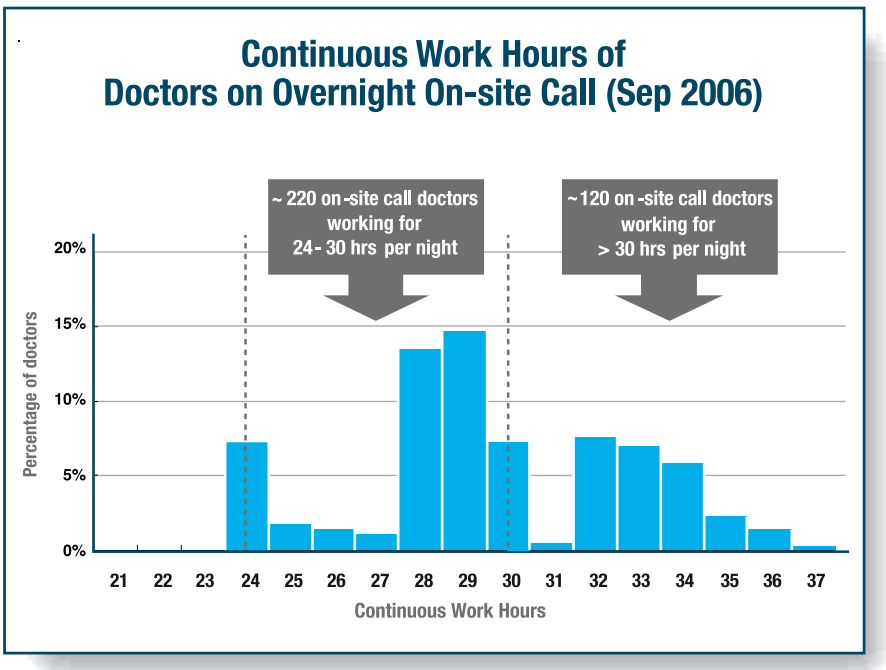
(Tab. 4.1)

Specialty	Count	Min T	Max T	Mean T	T>65*	% all * T>65
Neurosurgery	8	40	83	71.4	6	73%
Surgery	48	43	91	63.5	22	45%
Obstetrics & Gynaecology	22	44	85	63.9	9	40%
Paediatrics	33	42	84	60.9	13	40%
Orthopaedics & Traumatology	32	44	75	60.1	9	29%
Oncology	12	46	77	59.7	3	26%
Cardiothoracic Surgery	5	46	75	58.3	1	22%
Internal Medicine	123	40	82	58.0	26	21%
Ear, Nose & Throat	8	38	85	50.7	1	16%
Opthalmology	16	43	69	52.8	2	13%
Psychiatry	30	40	78	53.2	4	12%
Intensive Care Unit	10	40	66	53.2	0	4%
Anaesthesia	48	43	61	52.2	0	0%
Diagnostic Radiology	25	40	55	46.8	0	0%
Accident & Emergency	43	40	59	46.3	0	0%
Pathology	20	40	57	46.2	0	0%
Family Medicine & Outpatient	53	40	61	45.2	0	0%
Overall	536	38	91	55.0	96	18%

* Weighted figures rounded to the nearest zero.

408 In a local survey conducted in September 2006, everyday there were about 220 and 120 doctors on overnight on-site call who worked continuously for 24 to 30 hours and more than 30 hours respectively (Figure 4.4).

(Fig. 4.4)



409 Doctors of the two teaching hospitals tended to have longer continuous on-site work hours than those in other hospitals ($p<0.001$). There was no significant statistical difference in the continuous on-site work hours among doctors working in different categories of hospitals other than the teaching hospitals.

B) HA-wide Survey on Doctors' On-call Structure

410 This survey aimed to compare the on-call structure (the number of doctors on overnight on-site call) with emergency admissions, emergency operations and the average daily bed occupancy in different specialties. Ten specialties were selected, namely, Ear, Nose & Throat, Internal Medicine, Neurosurgery, Obstetrics & Gynaecology, Oncology, Ophthalmology, Orthopaedics & Traumatology, Paediatrics, Psychiatry and Surgery.

411 It was found that emergency admissions fell significantly after midnight in the Departments of Internal Medicine, Orthopaedics & Traumatology and Surgery.

412 From the survey findings, the Steering Committee concluded that there were different possible ways to reduce doctors' work hours by matching the medical manpower and competence with the patient workload and complexity, such as optimizing the number of on-site call doctors after midnight, arranging doctors' on general call to cover sub-specialty calls in secondary hospitals and cross-specialty call cover in some selected specialties.

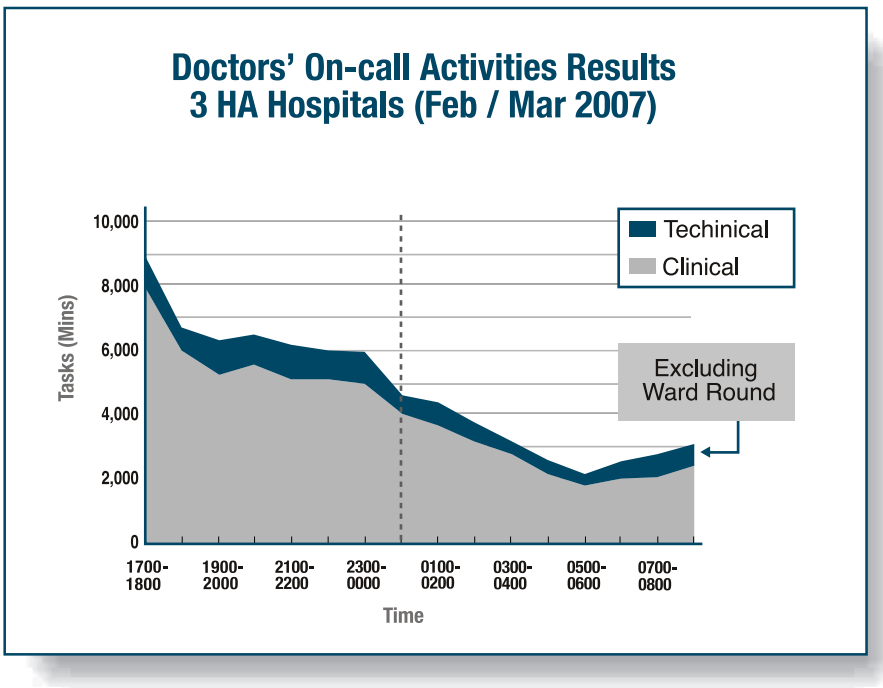
C) Doctors' On-call Activities Survey in 3 HA Hospitals

413 This survey was conducted in 3 HA hospitals with the key aims of delineating the nature and pattern of overnight on-call activities as well as determining the proportion of overnight on-call activities that could be taken up by trained non-medical staff.

414 The survey was conducted in 2 phases. Phase I was carried out on 22 – 27 February 2007 (Thursday to Tuesday) while Phase II was conducted on 15 – 19 March 2007 (Thursday to Tuesday).

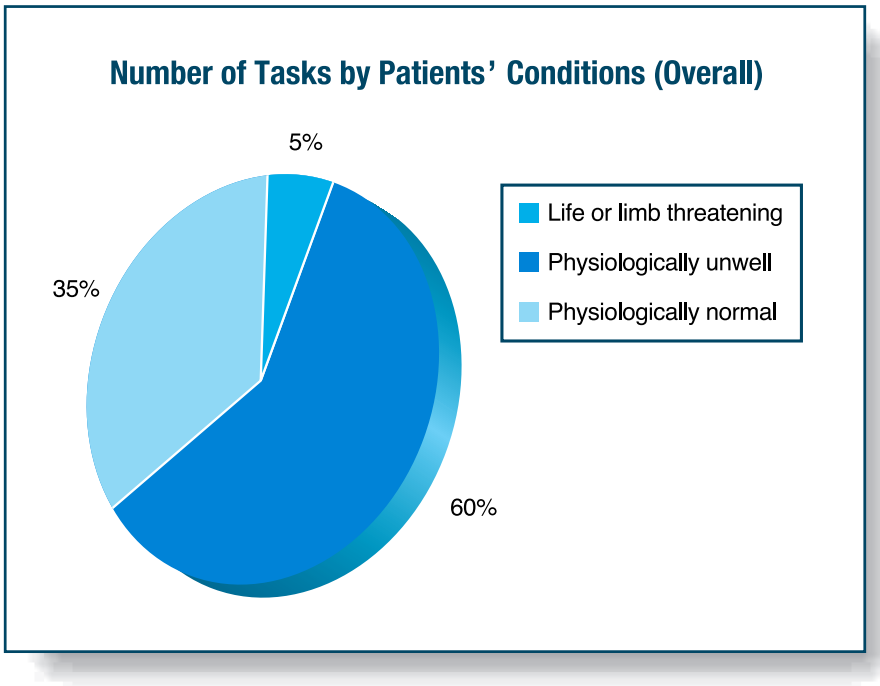
415 According to the survey findings, the overall activities (in terms of task time) dropped after midnight. (Figure 4.5)

(Fig.4.5)



416 It was also found that only 5% of the night activities were related to life-threatening conditions that required immediate doctors' attendance while 60% and 35% were related to physiologically unwell and normal conditions respectively. The pattern of activities was similar to that in the UK public hospitals (Figure 4.6).

(Fig. 4.6)



417 The survey also revealed that 16% of the on-call activities were related to technical tasks which could be taken up by trained non-medical staff (Table 4.2).

(Tab. 4.2)

Doctors' On-call Activities Results

Finding:

- **Similar to UK pattern**

Activities	A	B	C	Overall	UK
Tasks related to life-threatening conditions	4%	5%	6%	5%	7%
Tasks related to normal patient conditions	26%	30%	40%	35%	31%
Tasks that could be taken up by trained non-medical staff	13%	12%	18%	16%	Appro-ximately 20%

III. Overseas Models

418 The Steering Committee recognized that there were major differences between the local and the overseas healthcare systems, such as doctor-to-population ratio, availability and diversity of paramedic support, size of hospitals, roles of Accident and Emergency Department, gate-keeper function of private practitioners as well as cultural expectation of medical treatment.

419 However, this should not preclude Hong Kong from making reference to the pearls of overseas models. The Steering Committee analyzed and learnt from the Hospital at Night Model in the UK and the Safe Hours Project in Australia the pros and cons of different strategies taken in their reforms. Details of the UK and the Australian systems can be found in Appendix III.

IV. Doctor Work Reform Strategic Planning Workshop

420 The Steering Committee held its 3rd meeting and conducted a one-day Strategic Planning Workshop on Doctor Work Reform on 23 March 2007 at Princess Margaret Hospital. Focus group discussions were held on the following topics:

a) Work hours and remuneration
b) Optimizing activities at night and service rationalization
c) Patient safety, quality of care and staff training

421 This was an important milestone of the corporate reform. The Strategic Planning Workshop was attended by over 70 participants, including 41 frontline staff of 9 specialties (viz., Accident & Emergency, Anaesthesia, Diagnostic Radiology, Internal Medicine, Neurosurgery, Obstetrics & Gynaecology, Orthopaedics & Traumatology, Paediatrics and Surgery) and 16 cluster / hospital chiefs. Various reform strategies and options were discussed, and their views and suggestions had formed the discussion framework in the corporate-wide Consultation Paper on Doctor Work Reform which was released on 9 May 2007.

V. Communication and Consultation
Objectives – Stakeholder Engagement, Buy-in and Trust Building

422 Stakeholder engagement, buy-in and trust building between staff and the management were all prerequisites of reform. The Steering Committee believed that the best way to attain positive outcome and ultimate success of reform in the public healthcare sector was to keep on communicating with the stakeholders, reviewing the impacts and effectiveness of various reform strategies and refining the mode of operation so as to continually improve patient services in the long term.

A) Internal Communication

Doctor Work Reform Website

423 A designated Doctor Work Reform website was accessible under the Doctors' Column at HA's intranet homepage. This website contained timely progress updates and archived information about the corporate Doctor Work Reform.

Intranet Feedback

424 The designated website also provided a channel for staff to give their views and feedback related to Doctor Work Reform. So far, about 120 responses had been received via the intranet feedback form. The communication flow on handling intranet feedback is detailed in Appendix VIII.

Road Shows and Communication Sessions

425 Three rounds of road show were organized to communicate with the frontline and the management on the progress of Doctor Work Reform. The road shows and communication sessions recorded an attendance of about 100, 307 and over 1,100 doctors (i.e. about 25% of all HA doctors) in the first, second and third rounds respectively. In addition, three exchange sessions were conducted in the General Managers (Nursing) Forum. The presentation materials were available at the designated Doctor Work Reform website for staff reference.

Publication – Doctor Work Special

426 Ten issues of the newsletter, Doctor Work Special, had been published since kick-off of the Doctor Work Reform project. The newsletter shed lights on the targets, key milestones, consultation logistics and all relevant matters related to the Doctor Work Reform. Electronic version of all issues of the Doctor Work Special was placed at the designated Doctor Work Reform website for staff reference.

B) External Communication

The Hong Kong Academy of Medicine ("Academy")

427 A total of four communication sessions had been held with the Academy. Two briefings were arranged for its Education Committee on 9 January and 8 May 2007 and another briefing was arranged for the Past and Present Presidents of the Academy and the Specialty Colleges on 5 June 2007. Arrangement was also made for the Colleges' representatives to meet the Chairman of the Academy of Medical Royal Colleges of the UK on 13 June 2007 to facilitate better understanding of the background and concepts underlying the work hour reform in the UK.

Public Engagement

428 The Steering Committee strove to keep all stakeholders, including members of the general public and patient groups, informed of the latest development of the Doctor Work Reform. Several media interviews had been arranged since October 2006. Dr C H LEONG, Chairman of the Steering Committee, first promulgated the 5 beliefs of the Steering Committee in the media interview on 23 April 2007. A media briefing on the HA-wide consultation was also held on 9 May 2007. Communication with the community on Doctor Work Reform would continue.

VI. Consultation on Doctor Work Reform

429 The Steering Committee sought to develop a local reform model on the basis of wide consultation targeted at all HA doctors and the Hong Kong Academy of Medicine.

430 An HA-wide consultation commenced on 9 May 2007 with a consultation document sent to every HA doctor and the Academy to present the concept and timeline of Doctor Work Reform and solicit their feedback on the reform. The period of consultation, initially closing on 6 June 2007, was extended to 20 June 2007 at the request of the Academy and the Hong Kong Public Doctors' Association. Over 140 responses had been received through HA's intranet and fax. These responses were considered along with those from the Academy, Specialty Colleges, Specialty Coordinating Committees, Hong Kong Public Doctors' Association, other Doctors' Associations and HA's staff groups.

431 Following release of the consultation document, more then 60 communication sessions (including focus group meetings, departmental meetings, staff forums and hospital management meetings) had been conducted in the third round of communication sessions with different groups of stakeholders, such as the Specialty Coordinating Committees, Cluster and Hospital Chief Executives, General Managers (Nursing) and frontline doctors. These sessions were attended by over 1,350 staff, including more than 1,100 doctors.

432 All stakeholders' views and recommendations had been duly considered in formulating flexible and sustainable solutions to address both doctors' work hours and patient care issues in the long term. Details of all feedback were accessible at http://ha.home/visitor/view_content.asp?content_id=21005.

433 The final round of consultation on the draft Doctor Work Reform Recommendation Report was conducted from 3 to 23 September 2007. Target respondents included members of the Cluster Administration and Specialties Advisory Committee on Doctor Work Hour and HA's Doctors Staff Group Consultative Committee, as well as all Hospital Chief Executives and Senior Executives of the Hospital Authority Head Office. Six feedbacks had been received from individual doctors and the senior management whereas additional comments and responses from the two Advisory Committees, Hong Kong Academy of Medicine, Coordinating Committee (Radiology), Hong Kong Public Doctors' Association, HAHO Nursing Services Department / Cluster General Managers (Nursing)

as well as the UK experts on the Hospital at Night projects could be found in the Appendices. All feedbacks and comments from the respondents had been duly considered and addressed in this Report.

VII. Blueprint for Reform Implementation

434 The Doctor Work Reform Recommendation Report, if accepted by HA, will form the blueprint for implementation of the reform strategies in hospital clusters. The impacts and effectiveness of these strategies in achieving the stated objectives of Doctor Work Reform will be reviewed in due course.