醫院管理局
HOSPITAL AUTHORITY

EXECUTIVE SUMMARY

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

Introduction

001 The Hospital Authority ("HA") is committed to improving the working conditions of public hospital doctors and maintaining a high standard of care for the patients. To promote work-life balance and enhance staff morale, HA continuously strives its best to address the issues related to doctors' long work hours and excess workload.

002 The Steering Committee on Doctor Work Hour ("Steering Committee"), established in October 2006 under the lead of Dr C H LEONG, GBS, JP, former Chairman of HA, is tasked to formulate strategies and implementation plans with a view to **reducing, within 3 years, the work hours of doctors to not exceeding 65 in a week and their continuous work hours to a reasonable level.** Underpinning the Steering Committee, two Advisory Committees have also been formed to solicit feedback from frontline doctors, clinical specialties and cluster administration on the impacts of work reform strategies on doctors' work, training and ultimately patient care services.

Doctors' Work – Issues and Recommendations

003 Based on the findings from local surveys on doctors' work hours, on-call structure, duty roster and corporate-wide communication and consultation exercises, the Steering Committee has identified a number of issues of concern with corresponding recommendations for improvement as follows:

a) Long weekly work hours

According to a local survey on doctors' work hours conducted in September 2006, about 900 HA doctors (i.e. 18%) worked for more than 65 hours in a week. The long work hours were attributable to the voluminous workload and frequent overnight on-site calls shouldered

by a relatively small pool of doctors on rotation. HA is recommended to identify measures to optimize the night activities in all hospitals and reduce the number of overnight on-site doctors required in each hospital while ensuring quality patient care and safety.

b) High intensity activities
It was a general phenomenon that a significant portion of doctors' work hours in most clinical specialties were spent on performing mundane and repetitive technical tasks rather than core patient services. HA is recommended to find ways to reduce avoidable workload, concentrate activities into a few centres and pool doctors to work in specialties / hospitals with highly intensive activities in order to achieve the ultimate goal of delivering quality patient care.

c) Long continuous work hours
Prolonged continuous work hours would jeopardize doctors' clinical decision making and put patients at risk. HA is recommended to work further to shorten doctors' continuous work hours by improving their work pattern, such as replacing overnight on-call duties with a partial shift system and reinforced training.

d) Low staff morale
The low staff morale of doctors could be attributed to pay disparity, unequal work and slow career progression. This was partly reflected in the hastened brain drain of HA doctors to the private sector in recent years. Apart from the two HA-wide doctor-related initiatives, namely, New Career and Pay Structure for Doctors as well as Flexible Employment, HA is recommended to formulate a broad-brush nominal system to recognize doctors' excess work hours and retain well-qualified staff in the organization.

Beliefs and Directions

004 The Steering Committee believes that Doctor Work Reform cannot be taken along without improving staff morale. Corporate reform in the following directions can address the issues related to doctors' excess work hours and boost the morale of HA doctors:

a) The weekly work hours of doctors should not exceed 65 in general while those currently working for fewer than 65 hours should also be benefited from the reform.
b) Doctors should not work continuously for more than 16 – 24 hours.
c) Overtime work of doctors exceeding their conditioned hours should be recognized financially.
d) Manpower should be rationally increased in certain clinical specialties on a need basis.
e) Promotion of doctors should be encouraged in HA, taking into consideration their competency, qualifications and years of service.

005 On the other hand, the intrinsic nature of the medical profession entails round-the-clock service and inevitable work at unsocial hours. There is no exception for HA doctors. The Steering Committee fully appreciates the dedication of the frontline doctors in taking on calls out-of-hours and is cognizant of their request to reduce not only their work hours, but their frequency of on-site call during the

unsocial hours as well. Yet, the Steering Committee also believes that HA doctors, as respectable professionals, should pursue medical professionalism and quality patient care rather than meticulous counting of work hours. Their excess work hours should be nominally recognized in a broad-brush approach rather than on an hour-to-hour compensation basis, given the inherent differences in work intensity not only among specialties, but also within the same specialties in different hospital settings. Furthermore, the efficacy of Doctor Work Reform in managing workload and hence doctors' working conditions would need to be verified through various pilot programmes in the organization. Continuous communication and genuine exchanges with stakeholders at all levels on Doctor Work Reform are of paramount importance to taking the leap forward and attaining ultimate success in the long term.

Reform Objectives

006 The key objectives of Doctor Work Reform are as follows:

a) Quality patient care through team work
b) Risk management for enhanced patient safety
c) Quality doctor hours for service and training

Local Reform Model Founded on Wide Consultation

007 The Steering Committee is mindful to formulate a rational reform model to cater for local needs by way of wide consultation and engagement of stakeholders and professional organizations. A Strategic Planning Workshop involving more than 40 frontline staff and 9 specialties was held on 23 March 2007. Views of the participants had been incorporated to form the discussion framework in the consultation paper, which was sent to every HA doctor and the Hong Kong Academy of Medicine on 9 May 2007. The final round of consultation with the two Advisory Committees on Doctor Work Hour, all cluster and hospital chiefs and senior executives of the HA Head Office started on 3 September 2007 and all feedback received has been incorporated or addressed in this Recommendation Report.

The Steering Committee's Recommendations

008 **I. Work Hours – What & How? (Chapter 5)**

a) The Steering Committee recommends that all HA doctors should not work for more than 65 hours in a week on average. HA may consider counting the weekly work hours of doctors as an average over a period of 26 consecutive working weeks. Should doctors' average weekly work hours exceed 65 hours, HA is recommended to look into the work arrangements and identify ways to rectify the situation. [See Para 522 items (a), (e) & (h)]

b) HA may consider fully counting doctors' time involved in rostered on-site clinical care, administrative duties, intervening meals and commuting as well as urgent called-back on-site clinical duties during an off-site call as work hours. [See Para 522 items (b) & (d)]

c) HA may consider counting official release and paid study leave as work for the purpose of assessing doctors' average weekly work hours. For simplicity and consistency in calculation, a broad-brush approach is recommended to count the duty hours. [See Para 522 items (c)]

d) HA may consider counting doctors' time involved in an off-site call from home as one equivalent on-site work hour. Out-of-hour commuting time taken by doctors for each called-back on-site duty may also be counted as one equivalent on-site work hour. [See Para 522 items (b) & (d)]

e) HA may consider gradually reducing the continuous work hours of doctors towards the **target of 16 on weekdays and 24 at weekends and holidays** in the long term. HA is recommended to arrange no more than 5 consecutive night shifts for doctors under the new work hour arrangements. [See Para 528, 529 & 732 item (a)]

[For interim recommendations on continuous work hours and time-off arrangements, please refer to Para 013 item B2.2 below for details.]

II. Reform Strategies

A. Optimizing Total Workload (Chapter 6)

009 Strategy A1 - Managing Workload at Macro Level

A1.1 HA may consider establishing **Emergency Medicine Wards** in selected acute hospitals with 24-hour Accident and Emergency services as a gatekeeper to reduce avoidable hospital admissions, curtail duplication of work and optimize night activities in clinical departments. [See Para 623 item (a)]

A1.2 HA may consider employing **part-time private practitioners** through a contemporaneous Flexible Employment strategy to partially relieve the workload of doctors in certain overstretched departments. [See Para 634]

A1.3 HA may consider exploring the extension of **Telephone Nursing Consultation Service** to all hospital clusters to further reduce avoidable admissions. [See Para 623 item (b)]

010 Strategy A2 - Treat-and-transfer among Hospitals

A2.1 HA may consider delineating the roles and scope of services of different hospitals in each cluster and **concentrating selected emergency admissions into tertiary hospitals** in order to optimize patient access to emergency services currently provided by a limited number of HA doctors. [See Para 653 item (a)]

A2.2 HA may consider establishing **Escort Medicine Teams** in different clusters by phases, with all necessary care protocols and transfer guidelines, to support inter-hospital treat-and-transfer of stabilized critically-ill patients. [See Para 653 item (b)]

A2.3 HA may consider forming **service networks** for certain clinical sub-specialties across clusters and setting up task forces to formulate a clear timetable for service networking. [See Para 653 item (c)]

011 Strategy A3 - Optimizing Night Activities in All Hospitals

A3.1 HA may consider **restricting emergency operations after 22:00 hours** to patients with life, limb or sight-threatening conditions only and expanding the operating theatre capacity in the extended day on weekdays in all hospital clusters. [See Para 674]

A3.2 HA may consider enhancing the professional role of nurses in the patient care process and planning for provision of **24-hour care technician service** to carry out blood-taking, intravenous cannulation, electrocardiogram recording and / or other activities as appropriate, so as to allow on-site doctors to re-focus their time and work on core clinical decision making and communication with patients and their relatives. [See Para 682 item (a)]

A3.3 HA may consider the role of **admission wards** and explore their potentials for concentrating resources and staffing to handle emergency admissions as per the prevailing conditions in different hospitals. [See Para 687]

A3.4 HA may consider reinforcing the overall clinical diagnostic system support and plan for **expanding computerized tomography service to the extended day** in selected acute hospitals, subject to manpower availability. [See Para 698 item (a)]

B. Change in Existing Doctors' Work Pattern (Chapter 7)

012 Strategy B1 - Building Core-competency Call Teams

B1.1 HA may consider working out **a system** to design, update and promulgate both **intra- and inter-departmental clinical protocols** involving multi-disciplinary professionals in order to ensure seamless and quality patient care through teamwork. [See Para 717 item (a) & 819 item (c)]

B1.2 HA may consider optimizing the number of overnight on-call doctors required in hospitals by extending **doctors on general call to cover sub-specialty calls in their respective departments.** [See Para 717 item (b)]

B1.3 HA may consider exploring further the option of competency-based patient care after 22:00 hours on weekdays and throughout weekends and holidays, complemented by subsequent ward rounds by specialists, to ensure quality care and patient safety. If the introduction of **core-competency call teams** is agreed, the teams can be phased in after staff training on core skills and competencies within the local departments. [See Para 717 item (c)]

013 Strategy B2 - Shift System Replacing Overnight On-call Duties

B2.1 HA may consider gradually implementing a **shift system** to replace overnight on-call duties to address the issue of long continuous work hours of doctors. HA is recommended to attain the target of reducing doctors' **continuous work hours towards 16 on weekdays and 24 at weekends as well as public and statutory holidays** in the long term. [See Para 528 & 732 item (a)]

B2.2 HA may consider, in the interim, attaining **100% compliance with post-call half-day time-off** granted to doctors on overnight on-site call. [See Para 531 & 732 item (b)]

B2.3 HA may consider arranging **mutual-cover sleep time for 4 consecutive hours**, recommended to be counted as work hours, for doctors on overnight on-site call duties exceeding 24 hours, subject to service sustainability and regular monitoring. [See Para 531 & 732 items (b)]

014 Strategy B3 - Structured and Comprehensive Multi-disciplinary Handover

B3.1 HA may consider putting in place a **structured and comprehensive multi-disciplinary handover system** for critically ill and unstable patients to ensure patient safety and continuity of care. [See Para 740 item (b) & 819 item (b)]

015 C. Training under the New Work Hour Arrangements (Chapter 8)

C1 HA may consider following the prevailing study leave policy and administrative procedures to facilitate and encourage doctors' training, subject to service requirements, operational practicability and resource availability. [See Para 819 item (a)]

C2 HA may consider making more use of **simulation and scenario-based training sessions** to supplement the contemporaneous training framework for doctors. [See Para 819 item (d)]

C3 HA may consider exploring with the Hong Kong Academy of Medicine to introduce **cluster-based training programmes** with rotation of trainees among hospitals. [See Para 819 item (e)]

C4 HA may consider creating **part-time doctor service posts** for consistently overstretched specialties to concentrate resources for enhanced doctors' training. [See Para 819 item (f)]

C5 HA may consider adopting a **common ward language** (e.g. MEWS – Modified Early Warning Score) among non-medical staff to facilitate identification of critical patient conditions for timely specialist intervention. [See Para 819 item (g)]

016 D. Targeted Deployment of Resources (Chapter 9)

HA may consider strategically deploying resources to the following areas in order to protect the safety and health of both doctors and patients:

D1 Enhancing operating theatre capacity, setting up Emergency Medicine wards, deploying care technicians with extended roles and enhancing diagnostic imaging support for patient care

D2 Employing more doctors for selected specialties without pre-empting implementation of other re-engineering and reform initiatives

017 E. Enhanced Honorarium System (Chapter 10)

E1 HA may consider exploring a sound and appropriate enhanced honorarium system to recognize the excess work hours of doctors in a **broad-brush and nominal approach** to deter over-rostering of doctors and self-generating overwork. [See Para 1024]

Pilot Implementation

018 HA may consider pilot implementing selected strategies of Doctor Work Reform in the hospital clusters and allocate resources strategically. Moreover, HA may consider providing incentives for clusters to roll out pilot projects of proven benefits, such as employing care technicians, employing part-time doctors to help out in specialist outpatient clinics, opening extra operating theatre sessions and training of core-competency call teams. Besides, HA may consider putting in place a monitoring system to ensure that the reform programmes are implemented for the intended outcome.

The Way Forward

019 Doctor Work Reform is the business of everyone in HA rather than just the pilot sites. To make the reform a success, the Steering Committee recommends HA to **continually communicate with all stakeholders** and implement changes gradually and strategically. HA may consider conducting qualitative and quantitative assessments in order to show that Doctor Work Reform is beneficial to both doctors and patients. Though additional funding is required for certain reform initiatives, HA is recommended to continually strive for further process re-engineering and lead changes within the bound of available resources.

Steering Committee on Doctor Work Hour
Hospital Authority
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