Witness Statement

Name: Dr Shehnarz Salindera

Occupation: Specialist Breast and General Surgeon

1. This statement sets out the evidence that I am prepared to give to the Special Commission of Inquiry into Healthcare Funding as a witness.
2. This statement is true to the best of my knowledge and belief.

A. Role

3. I am a General Surgeon in Coffs Harbour, with subspecialisations in breast surgery and surgical oncology. I work at Coffs Harbour Hospital in the as a Visiting Medical Officer (**VMO**) and have been in this role since 2017. I provide outpatient consultations from the Coffs Harbour Breast Clinic.
4. I also work in private practice, performing surgery at the Baringa Private Hospital.
5. I am currently the supervisor of General Surgery training for Coffs Harbour Hospital and the course coordinator for the University of Sydney Masters in Surgery Leadership Program.
6. I am also currently a member of the Mid North Coast Local Health District (**MNCLHD**) Board. I have been a Board member since December 2022.

B. Public/private work

7. In addition to my work at Coffs Harbour Hospital, I also work in private practice. Most weeks I spend about two to three days per week in surgery. Approximately half of that time in a public hospital and the other half in private hospitals.
8. I also spend approximately two days per week in clinic. My clinic operates out of my private rooms in Coffs Harbour. Most of my clinic patients are public cancer patients who are having follow up appointments for their breast cancer treatment. Around 90% of my clinic time is spent with public patients.
9. Operating a clinic in a public hospital is expensive, because it requires a large number of staff, including multiple clinicians, and systems with strong administrative support. This is

not easily established outside of metropolitan areas where it is harder to attract and retain staff. There also needs to be efficient documentation and recall systems for follow up of cancer patients.

10. In my opinion a clinic can be run more efficiently in a private setting. For example, in my rooms, I have a one staff member who is both the practice manager and deals with all of administrative work such as appointments and patient recalls. I am away from my rooms two or three days a week conducting surgery, which gives my practice manager time to carry out the administrative work, including the large amount of paperwork involved. I can run this clinic relatively cheaply, about 30% of my billings go to practice administration costs. I do not receive any allowance or other payment from the public system for providing this service from my private rooms and so charge a consultation fee.
11. I triage my own patients daily so that urgent cancer patients are seen within the week and important diagnosis are not missed. I check every referral including the imaging to ensure no delays or missed diagnosis.

C. Scope of on-call practice and issues with retrievals

12. Although I am a specialist breast surgeon, I undertake on-call work in general surgery at Coffs Harbour Hospital. This can include work in paediatrics, neurotrauma and appendicitis, among other areas.
13. Coffs Harbour Hospital is not a tertiary hospital, and emergency surgical patients often require transfer to a tertiary hospital. Often the retrieval service is unable to attend, either due to weather, or the unavailability of an aircraft or retrieval team. The retrieval service is inadequate for our needs and places a great amount of pressure on surgeons who are on-call making on-call stressful and increases clinical risk to patients.
14. Patients are most commonly transferred from Coffs Harbour Hospital to John Hunter Hospital and in some circumstances the Gold Coast University Hospital in Queensland. These are the two closest tertiary retrieval hospitals to Coffs Harbour.

15. Although NSW Health recently rebuilt the Tweed Valley Hospital, they did not make it a tertiary centre for retrieval. Had this been done, Tamworth, Coffs Harbour and Port Macquarie could have sent retrievals to Tweed Valley rather than John Hunter Hospital.
16. The helicopter that generally service the Coffs Harbour area is based at John Hunter Hospital. Sometimes if a retrieval is required, a helicopter may come from Lismore, but this leaves that area without cover for the period of use.
17. If patients cannot be transported to an appropriate tertiary hospital, we are left trying to look after the sickest and most clinically complicated children. This impacts recruitment in rural areas as doctors from metropolitan locations are hesitant to take on this burden.

D. Remuneration for on-call work

18. I work at Coffs Harbour Hospital as a VMO on a fee-for-service basis. This causes issues in relation to the payment of on-call work. I do not get paid for being on-call generally or for the provision of advice over the phone. Unless a clinician goes in and performs an operation, we do not get paid. If I spend five hours looking after a critically ill patient, stabilising them, taking numerous phone calls to a retrieval team in a helicopter for example, but do not ultimately operate on them, I do not get paid. When I do get paid for operating, it does not include what may be hours spent in preparing a patient for surgery such as resuscitation, insertion of chest drains or other lines.
19. A clinician must lodge a VMoney claim for every patient that we see, however, the amount that can be claimed does not come close to a regular consult fee. For example, a hospital initial consult is paid around $100 as per medical schedule fee MBS item 104 but in rooms fee that would be charged would be $310. It is also unclear from the VMoney transcript what proportion of the MBS number is paid.
20. Often there is also a delay in being paid for VMoney claims. There are claims I have had approved in mid-May 2024 that have not been paid by July 2024. This is due to the hospital

implementing a checking system which in my case rarely results in a claim being rejected but delays payment by weeks.

E. On-call safety issues

21. The general surgery on-call roster for consultants is currently 1 in 8 this year only previously 1 in 6 (i.e. the total on-call roster was shared equally between 8 consultant clinicians). Generally, a consultant is rostered to be on-call for a week at a time (24hrs x 7days).
22. On average, I work 60 to 70 hour per week. If I am on-call, I am expected to always be within 20 minutes of the hospital and will often be called in two or three times per week. I am also still expected to see my normal patients during the day daytime. As a surgeon who treats cancer, this type of work cannot wait. I might be up until 3am on-call and then come in at 8am for my normal operating list or clinic.
23. When I commenced working at Coffs Harbour Hospital, the on-call roster for general surgery was 1 in 7, which fell to 1 in 5 when two consultant surgeons retired and were not replaced. It remained at that frequency during the COVID-19 pandemic until eventually another surgeon was retained in 2022 making it 1 in 6.
24. The department had asked for a total of eight consultants in order to decrease the frequency of on-call rostering so that it was 1 in 8, instead of 1 in 6. We were promised that number in 2022 by the then Director of Medical Services (DMS) and the General Manager. This, however, did not come to fruition because Administration believe that more surgeons would result in more patients being added to the waitlist and that they did not have any more operating time to offer. Despite explaining that we were prepared to share the existing operating time amongst the group our request was refused by the DMS and GM of CNN MNCLHD. It is a commonly held belief that more surgeons increases a waitlist but there is no basis for this. More surgeons only improves patient access to care with the wait time to being seen being shorter. In November 2023, the department came together again and

indicated that unless the hospital could provide extra consultants, we would have to fill the gaps with locums.

25. I am aware of excellent candidates who have wanted to work in Coffs Harbour, but the hospital refused to employ them because of a belief that if there are more doctors available to see patients, the waiting lists will grow. This view has been expressed to me on a number of occasions by administrative staff and the DMS and General Manager. This is not reflective of reality. I see patients who are urgent, such as with cancer within a week, but the rest of my patients have a three to four month wait. If we retain more consultants, patients will not have to wait as long to receive care. While there is increased activity, the result is that patients are seen in a more clinically appropriate timeframe. Myself and the other members of the department were willing to divide lists so some relief from on call. This proposal was accepted.
26. The hospital agreed to retain two locums, which is expensive. There are however other issues with locums. If a patient is seen by a locum, the locum does not carry out the follow up work. Instead, this is added to the list of one of the permanent members of the department. With eight consultants, including the two locums, we are at our full capacity. One of my colleagues had a heart attack on the job and we did not have any extra capacity in rostering, so the rest of us just had to pick up his shifts ourselves and share the load.
27. My colleagues in metropolitan areas largely do not face the same on-call issues. Breast surgeons in cities would not often do on-call surgery, because it is hard to maintain the skills there needed to be on-call. When I worked at Royal North Shore Hospital (**RNSH**) as a fellow in 2018, I was on a 1 in 12 on-call roster for emergency general surgery/Acute Surgical Unit (**ASU**) and I as the fellow was first on-call, not the consultant. This year, the fellow we have employed at Coffs Harbour Hospital only works during the day. They run the ASU and operate in hours on emergency admissions such as appendicitis or cholecystitis under our

consultant supervision. This was to allow the consultants more time to continue clinics and elective surgery and facilitate faster access to emergency surgery for emergency patients.

28. It is my view that the only way to manage on-call hours safely is to ensure sufficient staffing levels to alleviate the burden on individual clinicians. If a unit is asking for more staff, this should not be unreasonably refused. In some areas of the state, surgeons lose income if a hospital employs more staff as they each receive less elective work. That is not the case in Coffs Harbour as there is sufficient work and our patients do not want to go to other cities to receive treatment.

F. Accredited training positions

29. One of the main methods to build staffing numbers to safe levels is to retain additional trainees. As mentioned, I am currently the supervisor for trainees in general surgery for Coffs Harbour Hospital. I also supervise unaccredited registrars who are not in the training program, but who are acting in a registrar capacity. Currently, there are four accredited and three unaccredited trainees that come under my supervision.

30. For many years, there were only four trainee general surgeons in Coffs Harbour Hospital. My colleagues and I recently sought to expand upon the training posts available within Coffs Harbour Hospital. The Royal Australasian College of Surgeons (**RACS**) said that it was not sustainable to undertake 1 in 4 on-call rostering and 72-hour weekends for trainees due to burnout and risk of patient harm. I personally observed trainees experiencing burnout. In a 72hr weekend on-call it is very possible to be so busy that you may get less than 8yrs sleep across three days with the expectation you return to work Monday morning for a regular weeks work. I recall this being the case even when I was a trainee and it is unsafe.

31. In acknowledgement of the understaffing, the LHD increased the funding to five training positions. My colleagues and I pushed for six positions last year, but we fell outside the RACS accreditation window to obtain accreditation for additional training positions. This year, the

RNSH had a spare trainee who grew up in Port Macquarie, so when we asked for an additional person, they agreed to move up here.

32. Although three of the seven trainees I supervise are not in accredited roles, the job is essentially a stepping stone for them as they will likely move onto the accredited training program after this time with us. Positions such as this should be accredited and funded because they help alleviate the rural workforce shortage.

G. Rural training positions

33. In my view, RACS has done a lot to improve support for rural and regional training.

34. In 2020 RACS created a Rural Health Equity Strategic Action Plan **(RCS.0001.0063.0001)**, which focuses on four main areas: entry and access to training, selection criteria, training itself, and recruitment and retention. Under this program, students from rural backgrounds are given more points, and once they are in a training program, there is increased coordination between rural training posts.

35. There has also been a move to accredit more rural training posts, however, in my view there should be more collaboration between the hospitals and colleges to achieve this. The general surgery training program has so many trainees that it is taking longer to complete the training program as there are key competencies that must be signed off by supervisors. Instead of the standard four to five years, it is now taking some trainees longer to complete the program. Therefore, this year RACS did not take on any trainees in an effort to manage those already in the system. NSW Health became aware that there were to be no new general surgical trainees, so from December 2023 began approaching each hospital asking if there was scope for additional training posts to be established.

36. RACS has recognised this and is attempting to roll out more training positions across Australia and New Zealand, but the accreditation process takes time. I have met with the current president of RACS, Associate Professor Kerin Fielding, who is from Wagga Wagga and

so has a personal perspective of work in rural and regional areas. She has been able to keep pushing for this change.

H. Funding and support for trainees and funding and support for Fellows

37. In my specialty of breast surgery, you must move to the city to become a specialist. Currently, there are no accredited training positions for breast surgery in Australia outside of a metropolitan area. While there are training positions at Tweed Heads and Bendigo in Victoria, these are not RACS accredited positions.

38. I have made an application to train a specialist in breast surgery here in Coffs Harbour which was refused because the Specialist Training Program (**STP**) funding program does not cover fellowship training. This is unfortunate as we needed to fund rural surgical training across the whole training pipeline if we want to solve the rural workforce shortage.

39. One of the main issues I have encountered in trying to facilitate a training position for breast surgery is that the hospital is not willing to pay for the trainee. The hospital takes the view that they pay me, so queries why they should continue to do so if it is a fellow undertaking a lot of the work. The Hospital does not want to pay two people for one procedure.

40. Therefore, if we receive accreditation for a breast surgery training post, I will have to fund the trainee to come through other means. I have applied for STP funding from the Federal Government but have been put on a waiting list and it will not be until 2026 that we might receive it.

41. A lot of fellowship positions are not funded. When I was a trainee breast surgeon at RNSH, I had an honorary scholarship from The Friends of the Mater Foundation, because they wanted to train someone with a rural background. I am therefore now looking for grants and saving money to fund the position myself, as I recognise that the hospital will not pay for the trainee. This would require me to pay the fellow from my own pocket for their work in a public hospital. The fellow could also assist in private breast surgery cases to help support their income.

42. As mentioned above, there are currently four accredited trainees in general surgery at Coffs Harbour Hospital. Three of these positions are paid for by the hospital and one is covered by STP funding. The unaccredited trainees are paid for by the hospital. I have applied for STP funding for those trainees if they become accredited.
43. My understanding is that the hospital is willing to pay for general surgical trainees, but not advanced trainees such as fellowship positions unless the VMO do not bill which is not possible in my sub-specialty, because they cannot see the benefit in funding me to do the work and a fellow in breast surgery.
44. A fellow in general surgery is supervised during the daytime, but the supervisor does not bill for this time. We do, however, assume the risk. When surgery is performed by a trainee under my supervision, I do not get paid for this time. The money the hospital saves on supervising surgeons, it uses to pay the trainees. In that way, I am essentially taking a pay cut so that I can have a fellow on-site during the day, as I am foregoing the pay I could be receiving by conducting the surgery myself in order to allow a trainee to perform the surgery, for which I am not paid. Any complications that may arise from these procedures become my responsibility and I see these patients for free for follow up in my rooms for some extra relief to the system because there is no public clinic to see the follow up patients that the fellow has operated on under our supervision
45. My supervisee is very junior, having only completed their exams in 2023. It is their first time working on their own. Therefore, they are quite dependent and consult with me on every case. I am aware of every patient that they see and provide assistance with seeing patients if the trainee's workload is too high. I assist with the management of patients and provide care, as well as oversight and supervision.
46. Providing quality training and support relies in part on my ongoing relationships outside the hospital. For example, every month I dial into meetings with Westmead Hospital and RNSH's

melanoma teams to keep up to date with best practice. I do not get paid for this time, but I am lucky to have these relationships, which benefit my own practice and my trainees.

47. In my view, this level of support is not something that a locum can provide. If locums were relied upon as supervisors there would be no continuity for trainees. Furthermore, as clinicians have little control over which locums are utilised, it can affect the quality of training. However, I cannot supervise effectively or provide a good level of support if I am under constant pressure from unreasonable workload. Unfortunately, trainees see the huge workload for rural and regional doctors. If I cannot present a good experience to them, they are less likely to return as they perceive positions in the city to be better supported.

I. Role of VMOs

48. In my view, there is a lack of understanding within the public health system of the role of VMOs. There is a false perception that VMOs just come in to work and leave, without contributing to the administration or functioning of the hospital.

49. I have spent my time on the MNCLHD Board trying to explain to my colleagues that VMOs are not just independent contractors. The Board did not originally understand that VMOs undertake the same work as staff specialists but are just paid in a different manner.

50. In my experience, VMOs regularly undertake extra work such as teaching trainees or training nurses. None of this, however, is paid. Further, I am aware through conversations with VMO colleagues that when they are not in the hospital, they are in their rooms essentially running public clinics by bulk billing all their patients for outpatient consultations to help see and look after their patients.

51. There is currently one staff specialist general surgeon in our general surgery team at Coffs Harbour Hospital, and the rest of the team are VMOs. My staff specialist colleague spent the first six months in this role without a public oncology clinic, despite his desire to establish one. Now he has cut his 1 FTE down to 0.5 FTE and also runs private rooms.

J. Supporting rural and regional doctors

52. In my view, more must be done to support rural and regional doctors. I will often see 30 patients in an afternoon with only one nurse and one administrative staff member as support. My colleagues at Westmead Hospital have 20 administrative staff members, five doctors and two consultants in their afternoon clinic. We perform the same work in regional areas, but with far less resources.
53. Furthermore, there is little to no support when staff wish to take leave.
54. The last real holiday I had was two years ago. I took 2 and a half weeks of leave for my wedding, however, the hospital refused to fund a locum to cover this period. Instead, my public lists were cancelled. Two urgent patients had to go to Sydney and one to Lismore. The others had to wait 30 days to be treated.
55. Last year when I presented at a conference for breast surgery in London, I found my own locum and paid them myself by billing their work as fee-for-service and passing this onto them. This required me to use a separate contract which the AMA helped me with, and the locum worked in my clinic and in the public hospital. My office did the billing for them and they were paid 70:30 based on the fee-for-service model so that 30% covered the operating costs of the clinic. There have also been times when I could not find a locum who agree to this arrangement and wanted a flat fee which I paid myself to the effect of $10,000 for 5 days cover when I got married in 2022.
56. I did this to ensure that my patients were looked after.
57. I am the Chair of the RACS Younger Fellows Committee. In this role I have seen that younger surgical fellows are not willing to take the risk and move to rural or regional areas.
58. Most colleagues in my year of practice that I have spoken to prefer to remain underemployed in Sydney than work regionally with low levels of support. In instances where I have called colleagues in metropolitan areas for assistance, they have declined to do so, even for a week or so.

59. In my view, this is exacerbated by the funding cycles set by NSW Health. In the District we have had a shortage of staff, particularly in nursing, so last year embarked on an overseas recruitment campaign. This year, the State health budget has been cut and there will be staffing cuts across the public hospital system.

60. I have sat in three MNCLHD Board meetings in which we have discussed cutting FTE after having only just spent time and money retaining these overseas nurses. It is so difficult to find staff in regional areas, and yet when they come, they are not given job security. This is affecting the pipeline for nursing and medical staff alike.

Signature: 

Name: Dr Shehnarz Salindera

Date: 8/8/24