Witness Statement

Name: Dr Fred Betros

Occupation: 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 and have practised as a consultant in the Western Sydney Local Health District (**WSLHD**) since 2006. I currently work as a Visiting Medical Officer (**VMO**) at the Blacktown / Mount Druitt and Hawkesbury Hospitals. Previously, I was the Head of Department of General Surgery at Blacktown Hospital for a period of approximately six years, concluding in late 2018. I have a half day list each fortnight at Mt Druitt, I have three lists at Blacktown a month (I recently had one taken from me and allocated to another surgeon), I have 2 half days lists at Hawkesbury a fortnight.
4. I also work in private practice at Norwest Private Hospital and Lakeview Private Hospital at Bella Vista, the latter of which I part own. I have three lists a fortnight in the private hospital system.
5. In addition, I participate in the on-call rosters at Blacktown / Mt Druitt and Hawkesbury Hospitals.
6. On days when I am not operating, I consult from rooms at Norwest, Blacktown and Richmond (approximately 2 – 2.5 days a week).
7. I am currently the Vice President of the Australian Medical Association (NSW) (**AMA (NSW)**), and an examiner for the Royal Australasian College of Surgeons.

B. Engagement as a VMO

8. I have worked as a VMO throughout my career within the WSLHD. During the period 2016 to 2021, I was Head of Department for General Surgery at Blacktown Hospital. Prior to that I

had acted in the role at various times from 2014 to 2016. Under the VMO Fee-for-Service Contract there is provision for VMOs to be paid at the sessional hourly rate for matters such as teaching, committees and meetings. I claimed and was paid for four hours per week at a sessional rate for my administrative work as Head of Department. While Heads of Department are more often Staff Specialists who get more dedicated time for work of this nature, and administrative support, there are VMOs who accept these roles. A VMO as head of department is more probably more common in regional areas because most consultants are engaged as VMOs and there are fewer Staff Specialists.

9. The General Surgery team at Blacktown / Mount Druitt Hospital is largely made up of VMOs. There are nine VMOs and three Staff Specialists. Blacktown remains a Fee-for-Service hospital despite its size and role as a teaching hospital. I believe this may remain the case as it is harder to attract staff to Blacktown than Westmead.
10. It is my preference to be engaged as a VMO rather than as a staff specialist because of the flexibility that comes with this allowing me to work across the public and private systems.
11. Staff specialists who are salaried have time for training Doctors-in-Training built into their remuneration. As a VMO and Staff Specialist a lot of training in undertaken in the operating theatre (and for Staff Specialists, in clinics), however, there are many hours over and above this spent teaching. There is provision in the VMO Determinations for VMOs to be paid but frequently Local Health Districts decline to pay VMOs, and this work is unpaid and is done out of goodwill. I do see the public hospital system as a mentorship model of which a key feature is training the next generation of consultants.
12. There are VMOs who are no longer taking on training roles such as supervisor of training roles due to the refusal of Local Health Districts to pay for this work and the ever-increasing demands on consultants in the public hospital system. There is a risk that the responsibility for training will increasingly fall on staff specialists. This additional responsibility may impact on the wellbeing of staff specialists from an employment standpoint, and I believe may also

create a wedge between staff (particularly between staff specialists and VMOs).

C. Private Patients in Public Hospitals

13. In public hospitals, patients may elect to be treated as private patients. There are many instances in my experience, and the experience of my colleagues, where at the time I see a patient and operate, all documentation available reflects that the patient is a public patient. However, some weeks or months later when the claim for payment is processed in VMoney (the electronic claiming system for VMOs), the claim for payment is rejected on the basis the patient is a private patient.
14. It is not uncommon for patients to say they do not know if they are public or private.
15. The VMO contract is a contract for the provision of services to public patients.
16. The failure to contemporaneously notify the VMO (or Staff Specialist as the case may be) that a patient wishes to be treated as a private patient are as follows:
    a. The VMO is deprived of the opportunity to accept the patient under his or her care;
    b. The VMO is deprived of the opportunity to provide the patient with informed financial consent (which can have consequences as to whether the VMO is paid and / or insurance (see below);
    c. If a patient is private, medico-legal responsibility rests with the VMO's medical indemnity insurance as TMF does not extend to private patients save for an option for VMOs to accept an extension of cover in regional and rural areas);
    d. In the public hospital system, VMOs will supervise Registrars operating on public patients. If the VMO subsequently finds out the patient was private, this leaves the VMO open to complaint by the patient who expected the VMO to personally perform the surgery and leaves the VMO vulnerable if there is a claim.

17. When a patient elects to be a private patient the contract for the provision of the service is between the VMO and the patient not the VMO and Local Health District. VMOs are not, but should be, involved in the decision to accept a patient as a private patient.
18. Given recent increases in medical indemnity premiums, it is more important than before that VMOs make an informed decision about whether they accept a private patient.
19. Approximately 95% of private patients I treat in the public system are emergency patients. In contrast, approximately 5% of my private patients in the public system are elective patients.
20. I understand that the Local Health District offers to pay the excess for patients who elect to be treated privately.

D. The treatment of public patients in private hospitals

21. Public patients may be treated in private hospitals under local agreements, and during the COVID-19 Pandemic this happened on a larger scale under government agreements with private hospital operators. A lot of practitioners agreed to undertake public elective surgeries in a private setting to help reduce the backlog of surgeries. This, however, raises issues of operational safety.
22. For example, patients in the public health system overall are more chronically ill with more co-morbidities. By taking on a public patient, a private practitioner also takes on extra work to assess whether any new health issues have arisen for a patient while on the often-lengthy public waiting lists. The public systems simply sends across the recommendation for admission form and little else.
23. In the private hospitals I work at, we are not provided with a funding package that covers this additional cost of assessment. Instead, private hospitals have to negotiate to be sent any pre-clinic admission information in relation to those patients. There is also an element of risk as private hospitals will not always have an ICU or psychiatry unit for example, which may be

needed to support these patients' complex needs. Furthermore, it is not always made clear to treating practitioners if they are covered under the Treasury Managed Fund when treating these patients.

24. Treating public patients in private hospitals also results in a loss of training opportunity for junior doctors in the public hospital system. It is often the case that the doctors-in-training do not follow the work when it is sent out to the private system. This can mean is takes longer for doctors-in-training to reach the required competencies to practise as a consultant.

Signature:

Name: Dr Fred Betros

Date: 12 July 2024