Witness Statement

Name: Dr Behny Samadi

Occupation: Intensive Care Specialist

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 staff specialist within the Intensive Care Unit (**ICU**) at St George Hospital and have been in this role since January 2022.
4. I am also a Councillor at the Australian Salaried Medical Officers' Federation (**ASMOF**). I have been in this role since April 2024.

B. Background

5. I graduated from university in 2010 and undertook my internship year in 2011. From 2012 to 2018 I completed my training in the specialty of Intensive Care Medicine at the Royal Prince Alfred and St Vincent's Hospitals.
6. After finishing my training, I completed a fellowship in Vancouver from mid-2018 to mid-2019.
7. From October 2019, I worked at Nepean Hospital as an Intensive Care Specialist for approximately 1.5 years before I resigned, commenced employment at St George Hospital 10 months later.
8. At St George Hospital, around 70% of my role is patient-facing clinical work, being tertiary care practice. The other 30% is clinical support work, including my role as the Critical Care Echocardiography and Extracorporeal Membrane Oxygenation (**ECMO**) subspecialist. My non-clinical portfolio also includes the management of the wellbeing and welfare in the unit, primarily regarding the medical staff.

C. Staff Specialists Award

9. In my view, there are significant issues with the *Staff Specialists (State) Award* (**the Award**). The main issue being that staff are not properly paid for the work that they do. The flat salary does not account for overtime, on-call, recall or out-of-hours work arising out of clinical demands. I am paid my salary only in accordance with my official full-time equivalency (**FTE**), rather than the actual hours worked. I find this demoralising and it has obstructed the expansion of services. The service for one of my sub-specialties, ECMO, for example is patchy and depends on whether it is required within normal working hours. If the required staff members are not working on that date, the patient will simply not get access to that service. In that instance, despite having the capacity in-house to undertake these procedures, a patient must be transferred. We don't always have the staff available, because we do not pay the staff for extra hours.
10. I learnt early on in my career that I cannot undertake additional work, or I risk burning out. This is more apparent for staff specialists. As a JMO by contrast, you are paid for overtime and receive penalty rates, and accrue leave for extra work. That, in my view, is a fairer system that what is available to staff specialists.
11. Furthermore, the Award does not specify whether time accounted for should be clinical or patient-facing and there is a mismatch between what the hospital needs from staff and the Award. Essential non-clinical work, such as quality control, governance, and wellbeing, is not accounted for in the Award.
12. The Award also provides no mechanism to recognise additional qualifications. I am currently undertaking a Master of Business Administration (**MBA**) and when I finish this qualification, I will receive no promotion, wage increase or career opportunity. This disincentivises staff from obtaining higher qualifications.
13. There is similarly no recognition of, or reward for, subspecialty training and expertise that ultimately benefits the public system. To the contrary, because subspecialty training is often undertaken overseas and can last for long periods of time, staff who choose to pursue

subspecialisation frequently lose all their accrued entitlements due to their break in service. When they return, they may also be paid less than another staff specialist who does not have subspecialty training but has more years of service.

14. There are also limited entitlements in the Award which reinforce fatigue management and safety culture. In my view, there should be entitlements which provide staff with a safe method of travelling home after a night shift, for example taxi vouchers or on-site accommodation. There should also be an expectation of secure parking close to the hospital for shifts finishing late at night. I am aware that some JMOs have reported being followed to their cars when leaving their night shifts.

15. I have observed more staff specialists moving towards visiting medical officer (**VMO**) contracts, either as they arise or by specifically seeking them out in order to address issues of pay. Staff specialists have an arbitrary limit set on the "appropriate" amount of on-call work we can do. As an intensivist, I am on-call much more frequently than a dermatologist for example. By contrast, as a VMO, you can claim all of that time.

16. In my view, the hospital administration does not appear to understand the difference in work between locums, VMOs and staff specialists. Staff specialists undertake a lot of clinical support work. We are invested in the improvement of the hospital. A VMO by comparison is an independent contractor who may have multiple contracts with different hospitals. They are employed and rostered on for clinical work, and it would be very unusual for a VMO to be paid for non-clinical work. Therefore, VMOs largely do not undertake teaching or provide training or support. This represents a huge loss of expertise and training that could be brought back into the public system. The high attrition rate of staff specialists means that you cannot properly train juniors and juniors do not want to become staff specialists either. This creates a self-perpetuating downward cycle.

17. Due to the issues with remuneration under the Award, many staff specialists look for private work to supplement their income. Within my speciality of intensive care medicine, there are

limited private opportunities and the private work which does exist is hoarded by long-term specialists. Opportunities to privately bill patients in public hospitals, termed the Rights of Private Practice (ROPP) system are also dependent on the location of the hospital and its local demographics. There is a perceived inequality between those intensive care specialists who are primarily remunerated by the public system and those who are able to obtain additional income through private work or a hospital with a higher proportion of private billing patients. The ROPP system therefore creates a system where remuneration of the specilaits is dependent on external factors unrelated to expertise, competence or experience and hence breeds discontent and conflict within the specialty.

18. In my view, there needs to be a process of award reform which addresses the wages in the Award, as well as pay structure, to produce a system of remuneration which better reflects the training, qualifications, workload and seniority of staff.

19. To attract staff specialists to work in rural and remote areas, the Award should also provide special loadings for staff in those areas, as well as incentives relating to subsidised accommodation and transport. A retention bonus would also be effective to encourage staff to stay in rural and remote areas in the longer term.

D. Maldistribution of the Workforce

20. Outside of the Award, there may be an alternate mechanism for distributing the workforce into rural and regional areas; for example, a model by which large (and often desirable) hospital facilities in the Sydney metropolitan area offer doctors a substantive role on terms which also require the employee to work a fixed number of days per month in a rural or regional facility.

21. In my view, it would be better for a model targeting maldistribution of the workforce to make regional and rural employment more available to people who want to do it, rather than mandating it. This is because when high-achieving people are stripped of their autonomy, they will always find a way to regain control, which may include working at a different hospital or refusing the regional aspect of the contract altogether. There would also be a proportion of

people who would be excluded from consideration for this type of role due to caring or family responsibilities. Whilst it may work for younger doctors, or those without families or caring responsibilities, the longevity of this type of role is likely to be limited. It would be more effective to encourage people to want to work in rural and regional locations and remove barriers to completing that type of work.

22. There may be instead a role for the colleges to play in this type of distribution exercise. The College of Intensive Care Medicine requires that students complete six months of rural placement as part of their training. During that placement, JMOs have subsidised accommodation and go up one pay scale. If more colleges implemented a mandatory rural placement system, this may assist in alleviating shortages in rural and regional areas in the short-term. To attract those specialists to work regionally in the long-term, those placements would likely need to be extended to up to one year, to allow sufficient time for the staff member to become enmeshed in the community.

E. Burnout

23. I understand, based on my research, my experience as a councillor at ASMOF, my own experience as a specialist, and my interactions with colleagues, that staff burnout is a large problem within the health sector.

24. Furthermore, the FTE model is not a suitable metric. The number of FTE funded in a Local Health District is not reflected in how many staff are actually required to treat patients and complete non patient-facing work on top of this. While a hospital may fund new beds they often do not fund the staffing required to properly care for the additional patients. This contributes to burnout and, in my experience, apathy to trainees and other workplace culture, also reducing the effectiveness for training.

25. In my view, NSW Health leverages and exploits staff members' sense of responsibility to their patients and colleagues and relies on them to do more than they are paid to do when departments are understaffed. As a result, staff do not call in sick or take their leave

entitlements, which causes burnout. In my experience, even when staff are willing to take some of their leave entitlements, for instance to attend a union meeting or training course, they are told they cannot due to having insufficient staff cover.

F. Wellbeing and welfare portfolio

26. As mentioned, one of my portfolios within the hospital is as a welfare advocate. This role is borne out of historical issues. The ICU at the hospital lost its accreditation five years ago due to bullying by the Director of Unit and other senior staff. I have instituted several initiatives in this role to address some of these issues. There has been notable improvement in recruitment and retention of junior and senior staff since I have taken these steps. Most recently, our ICU won the South Eastern Sydney Local Health District award under the People and Culture category, and we have consequently also been nominated for the NSW health award .
27. I am currently undertaking an MBA and through the course of this study have learnt that there is a lot of literature around workforce retention and recruitment, both in the private and public sectors. Properly remunerated and valued staff work better in a team together. I have used the skills I have learned in my MBA to help improve the culture at St George Hospital. One of the steps I have taken is conducting “market research” by canvassing the demographic of the ICU to understand the needs and wants of the team. This process of information gathering helped the team to be heard.
28. After some trial and error, we realised that the best way to receive honest feedback was to create peer-hosted forums. For example, we found that a junior medical officer (**JMO**) forum hosted by a JMO team member prevented a power imbalance within the room. Other methods we tried did not appear to result in honest feedback due to fear from hierarchical structures. In our experience, an anonymised survey also did not produce honest feedback.
29. The data we were able to collect from our survey was very useful in relation to the recruitment of the JMO workforce in particular. I am aware through discussions with the JMO recruitment director that for many years the ICU could not recruit to the required FTE for JMOs. This has

been the first year that we have been able to do that. Anecdotally, in interviews, JMOs have told that they've noticed St George ICU's emphasis on wellbeing. One webpage on the ICU's website is dedicated to wellbeing.

30. We have also regained accreditation by showing positive cultural change in the ICU since April 2022. There was a follow-up visit from the College of Intensive Care Medicine around 18 months after this time and once again, no bullying issues were found.

31. Another positive measure of success has been the proportion of JMOs that are in college accredited positions. In most ICUs the number of trainees in accredited roles is not 100%. The staff required to properly support the unit is more than the level of intensivists supported by the colleges. In my experience, it is normally around 50% of JMOs that are in accredited roles. When I started, only 10% of our juniors were college trainees, whereas in 2024 it is 60%.

32. Furthermore, when I commenced at St George, our registrar pool of around 12 JMOs did not include any female senior registrars. Now, they make up 40-45% of the pool. We currently have two fellows, a junior training fellow, and three senior registered medical officers, two of whom are women. While this cannot be attributed completely to our initiatives, I believe that these have helped.

33. I note that there are some issues that remain difficult to obtain evidence of through our survey results. There is no data on absenteeism for example. Sick calls are more common after the COVID-19 pandemic and in the flu season, but we do not know more than this.

G. Methods of improvement

34. The ICU and the hospital more broadly have taken a number of steps to achieve these positive results.

a) Creating a culture of speaking out

35. One influential principle we identified in our research was that it was useful to flatten the hierarchy and empower staff in day-to-day interactions by creating a common understanding in the leadership group that allowed juniors to speak up. There is a prevalent fear of

admonition in medical culture as JMOs are scared to criticise or appear to be critical. My recommendation to the Director, and their recommendation to other senior team members and staff specialists was not to be offended by respectful questioning by junior staff.

b) Leave entitlements

36. We found that staff were fearful of taking their entitlements to avoid creating the perception that they were slacking off. We now encourage staff to take their leave entitlements and have educated the people responsible for approving those entitlements on these rights. In my experience, few staff read the relevant NSW Health award regarding leave matters, so we have worked to inform staff at all levels about these entitlements. Senior staff are educated at staff specialist meetings. For example, in one meeting I attended, I summarised the NSW Health Award on leave matters. I have also created a one-page written summary which was circulated to both JMOs and staff specialists.

37. I want to ensure there are no conscious or unconscious punitive measures are taken against staff exercising their rights. We have encouraged colleagues to take parental leave and am pleased to say that we have had several fathers take full parental leave in our team last year. This has been beneficial for destigmatising this type of leave.

c) Female role models

38. Similarly, we are aware that there are huge attrition rates of women at senior levels, particularly in the ICU. In an attempt to break down these issues, we have hosted an International Women's Day panel for the past three years. We get several female leaders from our organisation (both medical and non-medical) to speak on a panel in the ICU.

d) Staff burnout

39. To address issues around length of shifts and burnout, we have altered the way shifts are rostered within the unit. A standard ICU shift for a JMO is 12 hours. A junior will have a run of shifts and then a week off. In our varied roster, junior registrars will do three daytime shifts and then nights for the rest of the week. This gives them an extra 12 hours to rest in between

shifts. We have also moved their on-call shifts to fall together, so that they have four weeks in a row in which they are not on-call.

40. A fatigue management system was also created for senior medical staff, using the existing post-graduate fellow roster and outreach roles as sick-on-call, negating the need for further on-call requirements, which would be unpaid under the current Staff Specialist Award.

41. There are also a number of hospital-wide initiatives to improve rates of burnout. There is an initiative to avoid paging JMOs while they are on their lunch breaks to ensure that they actually benefit from this allocated breaktime. There is a hospital-wide Wellbeing Committee chaired by the Director of Medical Services (**DMS**) and Deputy-DMS. This top-down approach is important to staff as it confirms that welfare is an important issue in the eyes of the medical leadership.

e) Facilitating discussion

42. We have worked to facilitate better open discussion and communication within the team. One method of improvement has been to condense emails to JMOs into a weekly update. JMOs were previously bombarded with constant emails. All the emails now go through our secretary who combines important memorandums, events, and meetings into a single email update.

43. We have also created a WhatsApp group with the JMOs that gets updated every rotation. This connects the JMOs to each other and to me as the consultant. I have found that they feel comfortable approaching me about any issues as they have my number and can contact me privately. There have been complaints about sexual harassment or bullying from JMOs that I have been able to personally support the junior through after they contacted me by this means. In those instances, I will ask them whether they would prefer to keep these discussions confidential or would like me to escalate the situation to the Director or Deputy-Director of ICU. Depending on the seriousness, they might escalate this to the DMS or People and Culture who will advise on performance management or other processes (such as mediation/discussion) for people involved.

44. Another communication-related strategy that we have implemented is the anonymous compliment initiative. This is borne out of the theory that positive behaviours need to be positively reinforced. The healthcare system tends to have a punitive response to mistakes but does not provide positive reinforcement for good behaviours and jobs well done. We have created QR codes, located around the unit and included in the weekly update email, which link to a Microsoft form with brief questions to nominate a colleague who has done well and allowing staff to submit an anonymous compliment. All nominees go into the running for Staff Member of the Month for the unit. The winner is awarded a prize, such as a $50 scrubs voucher.
45. Finally, we have also created the role of a Registrar Liaison. One of the senior JMOs acts in this role as a bridge between the JMOs and SMOs. If the JMOs feel uncomfortable approaching me, because of my seniority, they can approach a fellow JMO instead who can bring the issue to my attention. We maintain constant communication and discuss a whole range of issues, from a colleague having a bad break up and needing regular check ins to potential rostering issues.

H. System-wide change

46. In addition to Award reform, and the measures discussed above in Section 'G', I consider that a key strategy in improving staff wellbeing across NSW moving forward is the implementation of a staff recognition program. Whilst there are some LHD-based award programs currently in place, in my view, these are very tokenistic and come across to staff as box ticking because they do not offer staff any real rewards for their accomplishments. The health system is very good at pointing out mistakes, but there are limited to no systems in place to recognise good work.
47. There is also a need to improve communication lines between clinicians and management and improve the leadership capabilities of staff with managerial roles. Part of the problem I see in many departments is the lack of training received by staff specialists outside the realm of patient care. The role of a staff specialist is much broader than just clinical care and includes offering training, writing business cases, and becoming a default leadership group to junior

staff. However, there is no particular training given in leadership and management. This type of training for staff specialists, and other staff with managerial or leadership roles, is essential for producing managers and leaders who can create a common vision for the unit, effectively recognise good work and manage conflict.

48. Finally, there is a need to streamline and simplify administrative processes within NSW Health. In order to complete simple tasks such as applying for leave or applying to be remunerated college fees from a number two account, there are several layers of paperwork, approvals and bureaucracy that staff must navigate. The organisational bureaucracy is a stress that leads to frustration in the workplace and to burnout.

49. The same complicated and bureaucratic administrative processes also make it difficult to obtain essential equipment for patient care. For example, essential ultrasound equipment in the ICU at St George Hospital is currently failing. The financial plan for this financial year was submitted in April, and because this machine was not accounted for in that plan, the LHD will not provide money to replace the end of life equipment. The staff are having to resort to trying to get donations to pay for the new machine and it feels like the organisation is working against us.

Signature: 

Name: Dr Behny Samadi

Date: 30/09/2024