

**Special Commission of Inquiry
into Healthcare Funding**

**Before: The Commissioner,
Mr Richard Beasley SC**

**At Level 2, 121 Macquarie Street,
Sydney, New South Wales**

Thursday, 14 November 2024 at 10.00am

(Day 059)

Mr Ed Muston SC	(Senior Counsel Assisting)
Mr Ross Glover	(Counsel Assisting)
Dr Tamsin Waterhouse	(Counsel Assisting)
Mr Ian Fraser	(Counsel Assisting)
Mr Daniel Fuller	(Counsel Assisting)

Also present:

Mr Hilbert Chiu SC with Ms Joanna Davidson for NSW Health

1 THE COMMISSIONER: Good morning. Go ahead, Dr Waterhouse.

2

3 DR WATERHOUSE: Thank you, Commissioner.

4

5 Over the next two days you will be hearing evidence
6 from clinicians in a panel format similar to what happened
7 with the recent workforce solutions hearings. I'm going to
8 keep my opening brief because you have a number of
9 witnesses who will be giving evidence and I think it's more
10 important that you hear from them.

11

12 The witnesses giving evidence met with you and members
13 of the Inquiry team during visits to the local health
14 districts when meetings were arranged for clinicians to
15 tell you about their experience working in the New South
16 Wales health system. Attendees at the meetings were
17 encouraged to speak freely and this led to valuable
18 discussions and thought-provoking views being shared.

19

20 Together with the site visits, these meetings have
21 proved valuable for obtaining a complex perspective on
22 matters that are relevant to the Inquiry's terms of
23 reference.

24

25 Unfortunately, it's not possible to take evidence on
26 every topic raised in those meetings or to call everyone
27 who contributed to give evidence.

28

29 THE COMMISSIONER: At least not take evidence in this
30 forum. Yes.

31

32 DR WATERHOUSE: So the approach adopted for these two
33 hearings has been to distil three themes from those
34 discussions and identify the witnesses who are well placed
35 to give evidence on those themes.

36

37 I note some of the clinicians on the panels are wholly
38 occupied with delivering patient care. Some have moved
39 from clinical roles into positions with leadership or
40 management responsibilities, and some combine their
41 involvement in patient care with leadership or management
42 roles.

43

44 In general terms, the three themes that will be
45 covered in the panels today and tomorrow are as follows:
46 the first panel will look at sustainability of the public
47 health system and what it can be expected to provide; the

1 second panel will examine concerns about inadequate and
2 inequitable funding in outer metropolitan local health
3 district; and the third panel will look at the impact of
4 patients waiting for long periods in hospital for
5 a residential aged care place or an NDIS plan.
6

7 Moving to the first panel to talk about sustainability
8 of the public health system, this topic will examine the
9 notion that there should be a ranges of services that the
10 community can expect from the public health system and,
11 conversely, whether there is a limit beyond which
12 expectations of the public health system may not be
13 reasonable. Inevitably, this involves contemplating, at
14 a high level, how decisions should be made and where that
15 line should be drawn and by whom.
16

17 We will also look at what options there are to manage
18 expectations and to divert funding from low-value,
19 high-cost interventions and treatments, particularly when
20 these are unlikely to improve the patient's quality of life
21 or life expectancy.
22

23 For the first panel we have three doctors from the Mid
24 North Coast Local Health District giving evidence, two of
25 them are in court today, Dr Bruce Hodge, on the left, is
26 the director of surgery at Port Macquarie Base Hospital,
27 and Dr Steve Begbie is a medical oncologist and executive
28 clinical director of Hastings Macleay Clinical Network.
29

30 In addition, online we have Dr Rob Hislop, who is the
31 acting director of medical services for Hastings Macleay
32 Clinical Network, joining us via AVL, and he is also an
33 intensive care specialist. I understand Drs Hodge and
34 Begbie will be giving an oath and, Dr Hislop, if I can
35 check whether you plan to give an oath or an affirmation
36 this morning?
37

38 DR HISLOP: An oath, thank you.
39

40 DR WATERHOUSE: Would it be easiest for the oath to be
41 read out and then each witness to say --
42

43 THE COMMISSIONER: I think it would. Just before we do
44 that, though, in my haste to start my computer up,
45 I accidentally, but somewhat rudely, didn't offer the
46 representatives of health to announce their appearance so
47 perhaps I'll just invite to you do that now. I do know who

1 you are, but for the record.

2

3 MR CHIU: Commissioner, for the record, Chiu, appearing
4 with my learned friend Ms Davidson, for the record.

5

6 THE COMMISSIONER: Yes, we can read the oath once and each
7 witness can then acknowledge it.

8

9 <BRUCE HODGE, sworn [10.05am]

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11 <ROBERT GORDON HISLOP, sworn

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13 <STEPHEN DONALD BEGBIE, sworn

14

15 <EXAMINATION BY DR WATERHOUSE:

16

17 DR WATERHOUSE: Dr Hodge, if I could start with you, could
18 you give your full name for the record, please.

19

20 DR HODGE: Bruce Hodge.

21

22 DR WATERHOUSE: And you're the director of surgery at --

23

24 DR HODGE: I'm the director of surgery for the Hastings
25 Macleay Network at the Mid North Coast and I'm also the
26 deputy director of medical services at Kempsey District
27 Hospital.

28

29 DR WATERHOUSE: And you are a general surgeon?

30

31 DR HODGE: I'm a general surgeon.

32

33 DR WATERHOUSE: Specialising in breast and colorectal
34 surgery?

35

36 DR HODGE: Mainly breast and colorectal surgery, yes.

37

38 DR WATERHOUSE: Can you tell me what the Hastings Macleay
39 Clinical Network covers in terms of area?

40

41 DR HODGE: Our service really focuses on the local areas
42 of Port Macquarie and Kempsey. The hospitals we provide
43 service through are Port Macquarie, Wauchope and Kempsey,
44 with a range of services varying at each of those sites.
45 We have far more high-level services, mainly level 5
46 services, in most sub-specialties at Port Macquarie, and
47 level 3, some level 4 services at the remaining two sites,

1 covering the broad range of medicine and surgery,
2 rehabilitation and high-level cancer services, which
3 Steve's involved in with the oncology unit and
4 radiotherapy.
5
6 DR WATERHOUSE: I might move now to Dr Begbie. Can you
7 state your full name, please, for the record.
8
9 DR BEGBIE: Yes, Stephen Donald Begbie.
10
11 DR WATERHOUSE: And you are a medical oncologist and
12 cancer researcher?
13
14 DR BEGBIE: General physician, for my sins, as well.
15
16 DR WATERHOUSE: And also the executive clinical director
17 for the same network that we just discussed?
18
19 DR BEGBIE: Yes, Hastings Macleay, yes.
20
21 DR WATERHOUSE: Dr Hislop, could you please give your
22 full name for the record.
23
24 DR HISLOP: Robert Gordon Hislop.
25
26 DR WATERHOUSE: And you are an intensive care specialist
27 and the acting of director of medical services for the same
28 network, Hastings Macleay?
29
30 DR HISLOP: A small point of correction. At the time when
31 the Commissioner came to visit us in Port Macquarie I was
32 briefly the acting director of medical services. We now
33 have a full-time appointee to that role so I no longer act
34 in that role. I'm an intensive care specialist. I work as
35 a general physician at Port Macquarie Base Hospital and I'm
36 the chair of the medical staff council for the last
37 12 months.
38
39 THE COMMISSIONER: Just pausing there, how is everyone
40 going for hearing that?
41
42 DR BEGBIE: It is a bit soft.
43
44 THE COMMISSIONER: Dr Hislop, I think we got the gist of
45 what you said, but moving forward, we might just have to
46 keep an eye or an ear on how clearly we can hear you.
47

1 DR HISLOP: I'll speak up a little bit, if that helps,
2 Commissioner.

3
4 THE COMMISSIONER: That would be great, if you did that.
5 We'll see how we go.

6
7 DR WATERHOUSE: Now, as I understand it, none of you have
8 prepared statements, but you were all participating in the
9 meeting with the Commissioner in Port Macquarie; is that
10 correct?

11
12 DR HODGE: Yes.

13
14 DR HISLOP: Yes

15
16 DR BEGBIE: Yes.

17
18 DR WATERHOUSE: I'll be exploring some of the aspects of
19 what you talked about in that meeting and I suppose if
20 I might just start with you, Dr Hislop, we often talk in
21 terms of there being resource constraints. Do you see
22 a lack of funding as being the primary issue or is it more
23 about how the available funding is allocated?

24
25 DR HISLOP: Look, I think it's - I think I would have to
26 say it's about how the funding is allocated. So as I said
27 to the Commissioner when he came to visit us some months
28 ago, we live in a rich country in Australia and we spend
29 a very significant proportion of our rich GDP on our health
30 care.

31
32 I may be incorrect but I believe the figures are
33 something like - I think we may have increased our GDP
34 expenditure on health from something in the realm of
35 5 per cent to something in the realm of 10 per cent in the
36 last 20 years. So we have an ever-increasing slice of the
37 GDP pile in a rich country, yet for those of us on the
38 ground floor working in health, we do experience a resource
39 constrained system and one that is increasingly resource
40 constrained.

41
42 To me, it doesn't make sense that we can expect to
43 continue to spend an every-increasing slice of that GDP
44 pie. There are other necessities government has to be
45 spending its resources on, including health - sorry,
46 including education and other very important matters. So
47 if we are spending a generous proportion of our rich

1 nation's production on health care, but we're experiencing
2 extreme constraint, I think there has to be an answer which
3 lies in how we utilise those resources, how we distribute
4 those resources.

5
6 In my experience to date, there really is no framework
7 for appropriately sending those resources to the places
8 where value is the highest. It's relatively random, in my
9 experience, where resources are spent, and I think
10 randomness is a recipe for ever-increasing problems in the
11 way that we've experienced in the last 20 years and I think
12 things will only get worse without a better plan.

13
14 DR WATERHOUSE: Thank you.

15
16 Dr Begbie, can I turn to you, do you have anything
17 that you'd like to add to that or do you agree with
18 Dr Hislop?

19
20 DR BEGBIE: Yes, I do. Compared to some countries, we do
21 have the advantage of being able to spend our health
22 resources on the whole population, which I think is a great
23 part of our system, but I think our system has barriers and
24 I think the federal/state health systems not being as
25 efficiently working together as they should and could is
26 a major part of that, and so I would say that efficient use
27 of budget is a really important part of what we should be
28 discussing. So yes, system improvements I think are still
29 something we should be working towards.

30
31 DR WATERHOUSE: Dr Hodge --

32
33 THE COMMISSIONER: What do you mean by "efficient"?

34
35 DR BEGBIE: I did like the idea of a single health system
36 for Australians a number of years ago, which never really
37 came to fruition, and in some ways, it does appear as if
38 the state and federal health systems rather than working in
39 unison are often working in competition, each trying to
40 avoid to take responsibility for certain parts on the
41 border, and I think if we got that sorted out -
42 unfortunately not something that a New South Wales inquiry
43 can necessarily, by itself, solve, but I think we would
44 save a significant proportion of the amount of money that
45 we spend on health care.

46
47 DR WATERHOUSE: Dr Hodge, what are your thoughts on this

1 issue?

2

3 DR HODGE: I think that we are slightly under-resourced in
4 comparison - the regional areas are under-resourced often
5 in comparison to some of the city centres, where we can
6 provide service to help save other components, because
7 we've got a lot of historical funding that is related.
8 I think in my 30 years of involvement in that degree of
9 local planning, you have always heard about the equity
10 level of money that is spent per person, et cetera, and
11 I think we're behind there.

12

13 On the other hand, the point of how we allocate that
14 resource is very, very important, and I think the other
15 thing that we actually have is the difficulty of aligning
16 the best way to spend that resource, which is determined by
17 forces outside of a lot of clinical control, and I don't
18 believe that the systems that we have in place to allocate
19 or provide that resource moving forward are actually
20 significantly robust.

21

22 While we can't be overly prescriptive in everything
23 that we do, we are introducing many guidelines for
24 processes, and some of the thought processes that we need
25 to be thinking about when we even put some of the patients
26 in is do they - are they defined adequately, do we have
27 a good reason for doing things?

28

29 If you look on a surgical perspective, which is again
30 a high-cost component in hospital services, that we are
31 individual contractor-based decision-makers, that doesn't
32 necessarily lead to an efficient, sustainable thing,
33 because it's my decision as to why I'm doing something,
34 which may or may not actually meet the standard of care.

35

36 At the back end, we've got reasons for doing things,
37 and the MBS has changed various things, and they went
38 through that process over the last seven or eight years -
39 for instance, even in colonoscopy, it's a great example -
40 where you had to define things. That's actually been
41 a complete failure, because what they thought would be the
42 outcome actually hasn't been the outcome because nobody can
43 control that, because it's all done by individual outside
44 contractors.

45

46 As our system, the question is, should we be doing
47 something about that? How do you regulate that process

1 where you determine the usefulness of the procedure; is it
2 right to keep doing it? Contractor-based processes aren't
3 necessarily the best way of doing it if you don't regulate
4 the contractors.

5
6 DR WATERHOUSE: So is it fair to say --

7
8 THE COMMISSIONER: Just pausing there, so I understand, in
9 part of your answer there you said:
10 *Even in colonoscopy it's a great example*
11 *where you had defined things, that's*
12 *actually been a complete failure because*
13 *what they thought would be the outcome*
14 *hasn't been the outcome , , .*

15
16 I don't know what - I don't mean this disrespectfully, but
17 I'm not sure I know what any of that means.

18
19 DR HODGE: Okay. So every reason for doing a colonoscopy
20 has its MBS number. What was expected to control the
21 reason --

22
23 THE COMMISSIONER: So it might be a symptom?

24
25 DR HODGE: Yes, for why everybody is coming in. The data
26 is completely manipulated, you just find a number to make
27 it fit. And where the planning was so that all the reasons
28 for people would actually fit into the boxes, that hasn't
29 occurred.

30
31 THE COMMISSIONER: I see.

32
33 DR HODGE: So you just change the number to do what you
34 want to do.

35
36 THE COMMISSIONER: I see.

37
38 DR HODGE: And the reality is, at the back end, there is
39 no method of actually controlling it.

40
41 Now, the problem is, you can use that, the MBS says
42 "You are out of that number", so you give them a new number
43 to get paid.

44
45 As a controller or - is this a good method of
46 gatekeeping? But you have to actually regulate that
47 process to get the information, the data, to do reasons for

1 doing that.

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So we have a method of controlling what we're doing, how we're accessing our system there, but we we're not using it, and in many reasons of "Why are you doing" something, how is our system actually controlling that, and we have poor information systems on the reason for doing something and then, at the back end, of understanding why it was done.

There's actually no great correlation, because you actually sit down and get medical record people to code, but they just code out of the notes. We haven't got a prospective reason. So we're also spending vast amounts of money on people looking backwards as to what has happened instead of looking forward on what we're actually going to be doing and we base our funding on that backward view. It is not a great way of running a business.

THE COMMISSIONER: Yes.

DR WATERHOUSE: So would it be fair to say that there is not really an incentive for surgeons, in the case of the example you are giving more generally - there is not really incentives for clinicians to be delivering value to the system when you have a system that is actually encouraging them to do procedures, or what have you?

DR HODGE: That has been a driver that you can actually - that people can do things to make money. That's worldwide and that's one of the issues that's raised worldwide about how contractors or other people are actually paid on this process. If the question is, are we delivering those things at high quality, that's a different question, and the quality is probably fine. So that any procedure done is actually done quite safely and is of good quality and outcome. But the question is: should it have been done in the first place? So you can do things well but the question that's comes back is: should it have been done at all?

THE COMMISSIONER: That's a difference between quality and value.

DR HODGE: Yeah, that's correct, and that's the hard part of doing it. It was done safely, fantastic. But should it have been done?

1
2 DR WATERHOUSE: Dr Begbie, do you see this tension in your
3 practice, medical oncology and general physician work
4 generally - the tension between delivering what a patient
5 might benefit from, from delivering what is value to the
6 system?

7
8 DR BEGBIE: Yes. I will give you an oncology - well, it's
9 a medical example and that's the PBS. So I equate it to
10 a family that has a whole set of rules on the fridge but
11 never actually disciplines anyone for breaking those rules.
12 So the PBS has a wonderful set of indications for expensive
13 new drugs, but very rarely does it actually audit whether
14 the patients that were prescribed the drug actually matched
15 the indication. And so to please patients - because there
16 is no financial benefit generally in prescribing an
17 expensive drug as a physician, but you are keeping your
18 patients happy that you are giving them the best possible
19 care. And so my concern about a lot of our systems is we
20 spend a lot of money on therapies; we don't do as much
21 review of the appropriateness of that prescribing and, you
22 know, we have these great systems, but I don't think enough
23 system review.

24
25 When it comes to inpatients, where physicians spend
26 most of their time, again, you know, it comes down to
27 generally patients will turn up at the emergency
28 department, they'll be admitted under your care. There
29 aren't the same perverse incentives to keep people in a
30 hospital bed for longer, but again, physicians are often
31 people pleasers, a lot of doctors are, and that's, in many
32 ways, a great thing, but when you have a population that
33 expects more and more and more from the system, a system
34 that is filled with people pleasers who want to please the
35 patients and the relatives who have higher and higher
36 levels of expectations will often say, "You want to stay in
37 another day, another week? You want to have this done and
38 that done?" It's easier to say "Yes", and just organise
39 what the community or the family expect, rather than push
40 back and say, "No, that's not necessary, and in fact, you
41 are going home today."

42
43 That anxiety that, you know, those push-backs build in
44 a clinical workforce, particularly when maybe the nurses
45 and the allied health people are saying, "How dare the
46 doctor send you home today when you didn't want that",
47 those caring professions are becoming more and more

1 expensive because we have a community that, I think at
2 times, takes the care our hospital system provides for
3 granted.
4

5 DR WATERHOUSE: I'm going to come back to that in a little
6 bit more detail.
7

8 Dr Hislop, can I just go to you. I understand you
9 made a comment in the meeting or to the effect that a large
10 part of healthcare expenditure occurs in the last six
11 months of life, which ties in to something we're talking
12 about in terms of value. Do you want to expand on that?
13 I apologise if I've paraphrased you incorrectly but maybe
14 talk through that.
15

16 DR HISLOP: I think that's a fair summary. Again,
17 I apologise for not being aware of the exact figures, but
18 I think it's the same in most healthcare systems, in that
19 a very significant amount of per capita expenditure is
20 expended in the last few months of somebody's life.
21

22 Now, that makes sense, because most people - unless
23 you suffer a very sudden and unexpected illness where you
24 die very suddenly, of course, there's going to be expenses
25 related to an illness you get, you get treatment for, that
26 goes badly and you end up dying from.
27

28 So there's some - to some degree, that's an "of
29 course" statement, it's always going to happen. But I do
30 also believe that we find ourselves increasingly
31 implementing higher and higher level care and interventions
32 to try desperately to prolong the life of dying patients,
33 very frail patients, very co-morbid patients, and in many
34 instances, I think we're not very successful in doing much
35 other than prolonging death rather than providing a quality
36 of life, and that can happen at great expense.
37

38 It's a very difficult problem to fix, though, I think,
39 because what patients and families seek from doctors most
40 of the time, in terms of information and decision-making
41 and what to do in the future - patients are often really
42 seeking absolutes from us. "If we do this, this will
43 happen", "If we do that, that won't happen", but largely
44 we're dealing with probabilities and likelihoods and that
45 gets very difficult for families, to be able to make
46 decisions with.
47

1 When people struggle to make decisions, we often find
2 ourselves doing more rather than less - not always but very
3 often - and often that more is very costly. So the
4 challenge remains how to communicate with patients and
5 their families when we think someone's time is nearly up or
6 is coming, and how is the best way forward to deal with
7 that. And not always does that mean an intensive care
8 admission as things start to go very badly.

9
10 DR WATERHOUSE: So in an intensive care setting, do you
11 find that sometimes there is pressure from families or
12 potentially patients to go above and beyond and provide
13 every possible investigation and treatment?

14
15 DR HISLOP: Very commonly, yes.

16
17 DR WATERHOUSE: And do you get that pressure from your
18 fellow clinicians? As a doctor do you find nurses and
19 allied health staff apply that sort of thinking as well?

20
21 DR HISLOP: Very commonly, yes.

22
23 DR WATERHOUSE: Dr Begbie, do --

24
25 THE COMMISSIONER: Just pausing there, so I understand
26 this, let's say that there is - probably because there is -
27 a limit to how much the state can allocate to the health
28 budget because of the reasons that have already been
29 mentioned, that we also have to fund public education and
30 police and roads, even toll roads, et cetera, et cetera,
31 and if there is a limit to how much money can be allocated
32 to NSW Health, then you do have decisions to be made about
33 how much money you spend on expensive interventions near
34 the end of the patient's life versus money that might be
35 spent on early paediatric interventions that might have
36 a lifetime of benefits.

37
38 That is difficult - I get that. But can you give me
39 some examples of the kinds of - I think it's well settled
40 that you are right, that in the last six months of people's
41 lives, that's where most of the expenditure is in the
42 public health system, but can you give me some examples,
43 specific examples, of the kinds of things - this is for all
44 three of you, by the way - of what we're talking about here
45 or what you are talking about here?

46
47 DR HISLOP: Well, in terms of intensive care admissions

1 towards the end of people's lives, before giving specific
2 examples I'd like to say that my career in health has
3 spanned nearly 30 years and in that time I have seen the
4 kinds of patients who mostly would never be referred to
5 even be considered for an intensive care admission, are
6 routinely referred, and with an expectation that the answer
7 will be "Yes", and those patients will be admitted to
8 intensive care for life supportive therapy.

9
10 I'm talking about patients who might have end-stage
11 obstructive lung disease from a lifetime of smoking, who
12 are dependent on home oxygen, who are very frail, have
13 almost no exercise capacity, can't really walk very far at
14 all, and come down with a respiratory illness, be it a
15 respiratory infection, and they're referred to us to
16 support them through because this respiratory infection is
17 potentially reversible.

18
19 Now, that's true, but what isn't reversible is the
20 fact that they have end-stage obstructive lung disease and
21 are already chronically severely debilitated from their
22 disease and the best you can hope for is to get them back
23 to a very debilitated state that they were in prior, with
24 a very shortened life expectancy.

25
26 So these are the kinds of patients we find ourselves
27 under increasing pressure over recent decades to admit and
28 to care for, and sometimes those patients do survive their
29 ICU admission; sometimes they don't. Sometimes, they go on
30 to have very prolonged stays in hospital. They may well
31 survive to be discharged, often to re-present multiple
32 times in the next few months with similar illnesses.

33
34 Often, then, you know, only to succumb within
35 12 months after several more intensive care admissions and
36 acute hospital admissions, and you know, I think you do
37 have to wonder about the value of that kind of care.

38
39 Now, these kinds of conversations are extremely
40 confronting.

41
42 THE COMMISSIONER: Yes.

43
44 DR HISLOP: I think it's because these conversations are
45 extremely confronting that, as a profession, we haven't
46 really gone there and governments have chosen not to go
47 there either, up until now, and really, people still have

1 chosen not to go there up until now, but here we are.

2
3 The problem with not - so I can understand why people
4 struggle with these conversations, because in a way, it's
5 sort of almost - it turns life into a commodity and equates
6 life with dollars and things like that.

7
8 However, we do have a public healthcare system and
9 we're all - the medical fraternity, clinicians, are all
10 responsible for how that precious public purse is spent,
11 and in the absence of considering the value that we get for
12 the dollars we spend, we get randomness, and wherever we
13 spend a dollar in health of public funds is somewhere else
14 we didn't spend it. So I think we have to consider these
15 outcomes.

16
17 THE COMMISSIONER: Yes. I think - sorry, have you
18 finished? Please go on.

19
20 DR HISLOP: I guess I could just go on to some other
21 specifics. It doesn't necessarily have to relate to
22 intensive care itself, but, you know, I'm seeing
23 increasingly over time - again, at the start of my career
24 a patient with end-stage renal failure had to be of
25 a certain general robust state of health, despite their
26 kidney failure, to be referred for long-term dialysis, but
27 these days I'm seeing some clinicians who will dialyse, who
28 will offer chronic long-term dialysis to anybody that wants
29 it with the view that, "It's not up to me to decide who
30 should or shouldn't get long-term dialysis."

31
32 So these are some of the examples. We're seeing
33 patients with very complex head and neck cancers, who might
34 be very elderly, might already be suffering from dementia,
35 might be reasonably dependent on their loved ones for the
36 activities of daily living, who are going and having
37 high-end invasive head and neck surgeries, to then be
38 followed up by radiotherapy, all of which is very expensive
39 care for someone who is already frail and towards the end
40 of their life. These are just several examples and these
41 kinds of examples exist throughout the healthcare system.

42
43 THE COMMISSIONER: Just before I ask Dr Begbie and
44 Dr Hodge whether they've got anything further on this
45 topic, can I throw another topic on that's related for your
46 views? It's related to what we're talking about, at least
47 a little bit.

1
2 In the last few site visits we have had to some of our
3 public hospitals, we've been - we haven't actually been
4 shown, but part of the discussion has been some
5 cutting-edge surgical techniques. One is laser into the
6 brain to treat epilepsy, which seems to be having some
7 fantastic results for people that are having multiple fits
8 per day. The laser goes in, deals with the scar tissue and
9 completely seems to resolve the epilepsy that can't be
10 dealt with by medication.

11
12 Another surgical technique we've been shown is -
13 I will mispronounce this - pelvic exenteration surgery,
14 which - well, you would know more than I, but the removal
15 of a whole heap of cancerous tissue in the pelvis, all of
16 the organs, and 16 hours of surgery, et cetera, et cetera.
17 Now, no-one should think that - I'm raising these as
18 hypotheticals and no-one should think that I don't think
19 that the public system shouldn't be offering these kinds of
20 surgical treatments. The laser surgery for the epilepsy
21 seems like something we very much should be doing.

22
23 Again, with the exenteration surgery, I'm not
24 suggesting that the public system shouldn't be doing it,
25 (a) because it can extend people's lives; and (b) it's no
26 doubt very fulfilling for the clinicians that work in the
27 public system to be able to do that kind of surgery.

28
29 But that's an example of something that's incredibly
30 expensive in the public system, and it might be right at
31 the edge - this is not me making a finding, this is me
32 throwing something up for debate - it might be right at the
33 edge of what the public system should offer in terms of
34 free public health care, because it's so labour intensive,
35 it requires so many clinicians involved, it takes so much
36 time, it's so expensive and, as I said, there are other
37 things that health has to spend its money on, like
38 prevention, paediatric interventions, the things
39 I mentioned before.

40
41 Is that part of the discussion too, as well as perhaps
42 offering low-value care for someone that's got so many
43 comorbidities, their life expectancy is very short but the
44 family's putting pressure on them to do something
45 incredibly expensive?

46
47 DR BEGBIE: So both the operations you have talked about

1 are appropriate if you have selected the right person.
2 I mean, six months of immune therapy is probably around
3 about the cost of a pelvic exenteration, and we do that
4 every day of the week.

5
6 It's about making sure that you are doing it on
7 someone - such a big operation, with its morbidity --

8
9 THE COMMISSIONER: You want the odds to be that this
10 is --

11
12 DR BEGBIE: -- that it has a reasonable chance of life --

13
14 THE COMMISSIONER: -- another five-plus years of life --

15
16 DR BEGBIE: -- buying them years.

17
18 THE COMMISSIONER: Not another five months of life.

19
20 DR BEGBIE: Yes, and so we've got these really good
21 systems of looking at quality of life years gained, and we
22 say that we make the judgments in our health system based
23 on those principles, but so often we don't.

24
25 I mean, one of the things I've been thinking - I, in
26 my oncology role I deal with death all the time, and in
27 30 years of practising oncology, there has been an D
28 existential change in our culture, that from a time when
29 people would talk as families about the prospect of death,
30 accept it as an inevitable part of life and, more often
31 than not, accept that when we have run out of options, that
32 was an acceptable pathway for them to follow with good
33 palliative care, to an environment where it's not part of
34 the public discourse and people will go kicking and
35 screaming much more frequently to death than they used to,
36 particularly the sort of generations that are coming
37 through.

38
39 So I think that's an existential problem we have to
40 face, and doctors themselves can't solve that. That's
41 a whole of culture, whole of society discussion, coming
42 back to an acceptance that it's okay to die and it's not
43 necessary to flog yourself for the final six months of your
44 life.

45
46 So those discussions are, you know, really important,
47 because when it comes down to it, each individual decision

1 I think needs to be bigger than one individual making
2 a choice. If you've been trained in one of these high-tech
3 procedures, you've spent your entire life working towards
4 doing lots of them, and you've got the toys at your
5 disposal to do the procedure, and you're funded to do it
6 whenever you want to, then as a clinician, you're going to
7 do as many of them as you can, if people want them and they
8 consent to it.

9
10 But if, as a culture, we say, "You know, there are
11 fences around who should get these PBS items and these MBS
12 items, it's not just all-comers, it's not just people who
13 are fearful, it's people who are actually going to obtain
14 evidence-based benefit from those things that, as
15 a culture, we have agreed we can afford", that's our way
16 forward.

17
18 And I think we've probably got the systems and the
19 toys but we haven't worked out how to police those systems
20 and toys as they expand more and more quickly, and I think
21 one of the areas that we've saved money is on review and
22 audit of our systems, and if we did more of that and then
23 not, you know, threatening people, but educating people
24 about, "Well, look, you know, we've looked at your
25 prescribing, we've looked at your decisions around surgery.
26 We kind of think - no, we see, because we've looked at the
27 evidence - that there are areas where you're prescribing
28 outside of the true indication, or you're operating outside
29 what we consider to be best practice. We need you to
30 change those habits and we'll have another look in a year
31 or two's time and see how you are going", that would be
32 a helpful use of resources, and if senior clinicians with
33 experience were part of that process, rather than, with all
34 due respect, bureaucrats who just see the words and don't
35 see them in the operation report, then I think we could
36 achieve quite a bit in terms of re-educating people to make
37 wiser decisions about how they use resources

38
39 DR WATERHOUSE: If I can Just --

40
41 THE COMMISSIONER: Sorry, I should just say, if, in the
42 course of one of your answers, anyone wants to add, please
43 put your hand up and say so.

44
45 DR HODGE: Just following on your comment on pelvic
46 exenteration, the issue is, on cost - I agree, they should
47 actually be done, and the one thing about that particular

1 thing is they're actually only done in really one centre
2 and the scrutiny of the process is actually quite robust.

3
4 THE COMMISSIONER: Yes.

5
6 DR HODGE: The interesting part is that actually the
7 operation is not the expensive bit, it's the after care.
8 All those people have tens of thousands of dollars spent on
9 them every year to actually keep them going. The cost of
10 stoma care, et cetera, is hideously expensive. The actual
11 operation after a short period of time is nothing. It's
12 the quality of life component and the support services and
13 the mental health issues that actually consume the dollars.

14
15 THE COMMISSIONER: Yes.

16
17 DR HODGE: Now, again, it's not a discussion - it's not to
18 say you should or shouldn't do it in those circumstances.
19 Providing you do good case selection, you actually get, for
20 that individual, length of life. The question, of course,
21 is - and these are judgmental decisions, aren't they - does
22 that equate to quality of life, et cetera.

23
24 I have several patients who have been through it, and
25 the first year or two of this afterwards is just the most
26 miserable period for these poor people, and then a few
27 years later they have actually now recovered from the
28 onslaught, they are still well, they are coping with
29 everything and they have resumed normal activities, and
30 that's the issue there, you will actually seeing them down
31 the track, and you go, "Yes, it actually was worth it."
32 The ongoing expense of those is small in comparison to lots
33 of other things that we actually do.

34
35 The issue you could argue is sometimes how we do other
36 things. The person who has quite end stage dementia falls
37 out of bed in the nursing home, they fracture their hip,
38 they come in for a pain relief operation and hip
39 replacement, they go back to the nursing home and they die
40 a week later.

41
42 Now, that's a frequent problem. And they are more
43 issues of process that one needs to consider, because
44 that's high cost. Now, they may not go to the intensive
45 care unit, they go to the ward, they create enormous
46 processes in the context of resource allocation while they
47 are in there, but then they quickly go back to the nursing

1 home and they get no value out of the damn thing, they
2 don't even know though they've had it. The problem is,
3 we're doing it for pain relief and we're doing it to
4 palliate the patient.

5

6 THE COMMISSIONER: The transcript won't show you are using
7 inverted commas for "pain relief".

8

9 DR HODGE: That's right.

10

11 THE COMMISSIONER: I'm not sure - what should I take you
12 to understand by "pain relief"?

13

14 DR HODGE: Yeah, because we're just using it as analgesia.
15 Instead of giving some morphine, I do an operation so
16 they're out of pain now.

17

18 THE COMMISSIONER: Is that because morphine sounds to look
19 a lot like palliative care or --

20

21 DR HODGE: No, it's not. It's how you palliate somebody
22 in that context, and that's the issue. If you look at the
23 surgical audit of mortality, the CHASM data, if you
24 actually look at that, we have a very robust system of
25 planned procedures going well. There are very few people
26 who come in and for a planned operation and unexpectedly
27 die. It does happen but it is really, really uncommon.

28

29 Of all those that die post surgery, they're almost all
30 emergent cases, and in the majority of them that have
31 actually died, the question only is: "Why did you do it in
32 the first place?" Because when you review the cases, which
33 we - you know, I review a lot of them too when they just
34 sent out to you as a reviewer. You actually just wonder
35 why in the world we did this in the first place.

36

37 They have consumed vast resources, and the question
38 comes down to, again, how the clinicians in the beginning
39 have responded to that thought process, because you just
40 read, you know - and they all write, "What was the
41 expectation of death at the beginning of the procedure",
42 and they almost all write, "Expected", so if I expect them
43 to die, why have I done it? Not, "Oh, the expectation was
44 minimal death" - you can argue that's a great concept, yes,
45 a bit unfortunate if something happened and they died. But
46 if they die and I expected them to die, we actually have
47 a problem, and we have spent \$100,000 in doing so. And

1 what that resource has meant, just as you said, if I look
2 surgically, that can be 20 hernia operations. I can get
3 20 people back to work in their building site or whatever
4 they are doing in their daily life for that one episode of
5 care.
6

7 Those are the issues that we have to actually
8 confront, because we do have a constrained resource.
9 Should we have a constrained resource? The answer is, of
10 course: "Yes, we should have a constrained resource
11 because everything is finite." But the question is how do
12 we control or how do you educate people into that concept
13 of finance and be involved in resource allocation?
14

15 The comment that Steve made about data and feedback
16 actually is really, really important, because if you
17 actually analyse people's processes and feed that data back
18 to them in comparative session, we are all incredibly
19 competitive individuals. But when you have an outlier, you
20 have to show that outlier how they are outlying and what -
21 how they need to improve to get back into the fold and not
22 be on the fringes of care, be it length of stay, type of
23 patients being admitted, procedures performed, et cetera,
24 out of all of that. We have to be better at our data
25 feedback to people to make comparative individual
26 processes.
27

28 When I first started, Medicare used to send us data
29 every year of how many blood tests we ordered, how many
30 x-rays I had done, and gave us - gave me the feedback as
31 a segment of my peer group, where did I fit into it. So
32 was I an outlier? Did I order too many blood tests through
33 the system? They've stopped doing that because --
34

35 THE COMMISSIONER: Why?
36

37 DR HODGE: I have no idea. It was the most useful piece
38 of yearly information I got that said that I was well
39 within the norm. Nobody was going to come and look at me
40 because I was doing - or I was at the bottom of --
41

42 THE COMMISSIONER: Probably why they stopped giving it to
43 you, because it was useful, that's Canberra.
44

45 DR HODGE: That's right, but this type of feedback
46 actually is vitally important and we need to invest in
47 those systems to actually institute change.

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DR WATERHOUSE: Commissioner, I'm mindful that Dr Hislop wanted to add something.

THE COMMISSIONER: Of course, yes.

DR HISLOP: So Commissioner, I just wanted to say, you are correct, I think, in that it's not simply a question of where can we find places where we're spending enormous amounts of money for very low value. That does exist, but also there is a more nuanced question which is just where do we spend best our resources?

So there are places where we spend high amounts of money for what seem like amazing outcomes, but those amazing outcomes are for few individuals and they are exceptionally costly.

An example of that is I have a friend who is a haematologist who was telling me about a patient of his, who is in his 80s with acute myeloid leukaemia, who has ended up on a medication that's costing \$36,000 a month. That is keeping the patient alive and keeping him in remission, but that's an exceptionally expensive intervention.

Now, I'm not here to say that that treatment shouldn't happen, but what that demonstrates is the challenge we have in modern medicine. At the moment, we have enormous amounts of - well, a very high rate of newly developed drugs coming onto the market. Many of these drugs are extremely effective but many of them are also exceptionally costly, and the challenge is: how do we use them best; how do we cope with what is this voracious appetite for these treatments, with resources that are struggling to match?

As Dr Hodge said, of course we have a finite resource and we all understand that. What we also have is really an infinite appetite as a healthcare system to use that resource.

As humans, it's only human nature that we all want to be healthy and it's only human nature that most of us really want to live forever. Trying to marry those two things together is exceptionally problematic and it keeps coming back to resource allocation, which really, ultimately, is an ethical conversation.

1
2 These conversations are extremely difficult, and these
3 conversations also often start to broach into even
4 religious views, because, for most of us, it's very
5 difficult to separate our ethical and religious views, and
6 people of different ethical and religious backgrounds can
7 have entirely different ethical understanding and
8 approaches to this sort of question, which can make it
9 entirely thorny in a very multicultural, multi-ethnic,
10 multi-religious society.

11
12 So these are some of the challenges we find ourselves
13 facing. And I don't necessarily have - I definitely don't
14 have all the answers. I absolutely don't. I know I have
15 a lot of questions. But what answer I do have is that
16 I think whatever approach we try and take to this very
17 thorny question, and a question of growing importance,
18 however we tackle it, it will be an imperfect response, but
19 an imperfect response and one attempted with the right
20 intentions of doing the best with that resource for the
21 most is one that will have a better outcome than no
22 approach at all.

23
24 DR WATERHOUSE: Dr Begbie, did you want to add something
25 to that?

26
27 DR BEGBIE: No, thank you.

28
29 DR WATERHOUSE: If I can go to what you were talking about
30 before about the pressure that clinicians feel to provide
31 particular treatments and so on, and that can be from
32 different quarters, it can be from patients, families,
33 other staff, et cetera, what mechanisms do you have
34 currently, such as in medical oncology, to be able to take
35 a stand against that or take a different position, as
36 a doctor?

37
38 DR BEGBIE: I struggle less, and I think it's about
39 experience and communication skills. You know, and I too
40 remember getting that feedback from Medicare, and I think
41 feedback is something that's sorely missing in our system.
42 Groups of clinicians being able to sit around with data
43 and, you know, compare and contrast and try and learn from
44 one another. I think that there will be hard core patients
45 and hard core families that no matter how gifted you are at
46 explaining the pros and cons of a treatment, still opt for
47 the low-value option, if they're entitled to it within our

1 system as it stands and, you know, you may proceed with it.

2
3 But then there's a group of patients in our community,
4 particularly in a sort of region like ours, who just don't
5 know enough to make decisions, and if you spend enough time
6 with them talking through pros and cons and honestly answer
7 "Doctor, if it was you or your mother, what would you do in
8 this situation", it helps to bring the humanity into the
9 discussion, and oftentimes, you know, a shared
10 decision-making model is not about us making the decisions
11 for them but leading them into making a decision that is
12 around quality of life and value, because a large
13 proportion of our culture, if they understood that the
14 choices they were making were going to impact on the health
15 of their grandchildren or their neighbours, would
16 incorporate that into their decision-making matrix.

17
18 But we often rush, we don't give them enough time and
19 clear enough indication - clear enough explanation for them
20 to make the wisest decision. For some clinicians, they're
21 also excited about using the treatment, they maybe haven't
22 done it enough, and so there can be vicarious, you know,
23 reasons behind it, which have their subtleties. You
24 couldn't look at them and say the person has made the wrong
25 choice unless you dug pretty deep, but, yes, when our
26 system is based on "Here are your drugs. We encourage you
27 to use them and we're funding them. Here are your
28 operations, we encourage you to proceed with those
29 operations on appropriate patients" - I often wonder -
30 again, this is partly a federal issue - if we expanded our
31 thinking with systems that are already in place like the
32 PBS and MBS and said, "These operations should be done if
33 the patient's expected survival is X months or X years;
34 these drugs should be reconsidered in patients with
35 a certain number of comorbidities", or however we decide to
36 do that, because at the moment, the 80-year old with acute
37 myeloid leukaemia is treated the same as the 26 year old
38 with acute myeloid leukaemia. There is no sense in which
39 a prescriber or a surgeon, except through their own
40 judgment, is encouraged or discouraged from treating those
41 two individuals differently. Oftentimes, it is a bald
42 decision based on tumour type and a set of clinical
43 criteria.

44
45 DR WATERHOUSE: So is it fair to say that the system, as
46 it currently is configured, tells you everything that is
47 available and possible but doesn't give guidance as to

1 what's appropriate?

2

3 DR BEGBIE: No, and we've got good systems in some areas,
4 such as multidisciplinary team meetings and peer group
5 discussion forums, but not everyone makes use of that. You
6 know, one of the issues that we face is that there are
7 people in solo practice out in the community making
8 decisions without much oversight, overview or group
9 discussion, who are being held to account currently much
10 less than people who are in big, you know, organisations
11 with multidisciplinary teams and vocal advocates for
12 different positions.

13

14 It's healthy for us to debate and discuss, and the MDT
15 system is a great one. But some MDTs work better than
16 others, and so, yes, prospective assessment of whether
17 something is appropriate is important, but I think there
18 needs to be more retrospective analysis of the choices that
19 clinicians are making, and not in a punitive way, as
20 I said, but in a forum for education and improving
21 practice.

22

23 DR WATERHOUSE: Dr Hodge, do you find in those
24 multidisciplinary team meeting settings or the audits that
25 you spoke of previously, most clinicians are willing to
26 come on board and reflect on their practice, or do you have
27 some that tend to stand their ground and say, "My patients
28 are different, that's why I'm an outlier"?

29

30 DR HODGE: In an MDT, it's a much more - a system where
31 everybody will agree and I don't think the arguments are
32 there, mainly because we're dealing with just an individual
33 patient. Totality of care is the retrospective audit
34 process and, yes, I mean, people say, "I've got the right
35 to do this. This is what I'm doing". I think it's how you
36 bring people back, is the issue, or even, to a degree,
37 having good data to actually support your concept of
38 change.

39

40 We are, in the world of massive data, data poor,
41 because our systems don't provide a lot of that feedback
42 and information which would actually be quite useful. As
43 I said, we are responders, certainly in the surgical sense,
44 of having people just pop things in and deciding to do what
45 they want and the system will have to respond to their
46 individual decisions, and a system that may or may not
47 provide the resource that matches any one individual

1 demand, and how you massage that across various competing
2 specialties or clinicians to give other patients access at
3 one point, where some people may have a waiting list of
4 100 people and somebody has a waiting list of 10 - do you
5 move that resource around? Do you make these people with
6 the 100 wait to the end and this person's going to wait two
7 months and these people are going to wait two years?

8
9 How do you do that within our defined limited resource
10 at one point in time, knowing how people's lives are
11 structured, et cetera, and what rules are we going to play
12 by that actually allow that to be done in a reasonable
13 fashion and to keep engagement? The problem we have is
14 when we inflict other changes, we disengage people as well,
15 and we need the people to be engaged to provide the service
16 to talk to to actually institute change. We are masters of
17 not doing that.

18
19 DR WATERHOUSE: When you say "inflict other changes", what
20 do you mean by that?

21
22 DR HODGE: If we have to alter how we're going to provide
23 the care and do our system, we have to be able to talk in a
24 fashion that says, "We need to do something different
25 here." Or, if I want to actually allocate more time to
26 this other person, because we've got to cancel this
27 person's cases or list, it never goes down well and you
28 disengage those people. That is because each of our
29 systems is finite and each of them is constrained, so I've
30 only got so many lists per week to give out to all the
31 surgeons, and it is well short of demand.

32
33 That is, if the demand is the number of people on the
34 waiting list, irrespective of whether they should be there
35 or not because we're not talking about that, we're talking
36 about just numbers of things that are there and how we
37 allocate that resource into that space across the competing
38 processes of planned surgery and emergent surgery.

39
40 DR WATERHOUSE: Sorry, just to clarify, by "emergent
41 surgery", you mean emergency surgery?

42
43 DR HODGE: Emergency, yes.

44
45 DR WATERHOUSE: Is it your view that the system
46 effectively - and going back to the point about everyone
47 being time poor as well as resource constrained in a

1 financial sense, is it that the system incentivises people
2 just to put patients on the list and keep operating, rather
3 than having those difficult conversations with them as to
4 whether they really need that operation or if it's the best
5 for them?
6

7 DR HODGE: In many cases our system will encourage that
8 because of waiting times. So people will say, "You
9 probably don't need your operation now but you will
10 probably need it in a year's time. Here is the form and
11 you can wait all this time and by the time you get there,
12 maybe you will need it."
13

14 The policy is that you should only be put on the
15 waiting list if you need the operation tomorrow. I will
16 actually tell you that if I went out and offered everybody
17 an operation tomorrow or next week I would probably half
18 decimate the waiting list, because a lot of people don't
19 want their operation tomorrow; they've been put on with the
20 expectation that there may be a year's wait.
21

22 But we don't have the resource to actually offer them
23 tomorrow, because many patients do get better and
24 particularly in some orthopaedic patients where they have
25 a sore shoulder today, they have symptoms, but we know it
26 will take a year to get better with physio, et cetera.
27

28 But they won't all get better, and we know that too,
29 so the question is a lot of them get put on, and that's the
30 reason why 40 per cent of them, by the time they get to the
31 end, we've thrown the form away. But we're reacting to
32 these long lists that create an issue for us in how we're
33 managing demand and allocating resource.
34

35 DR WATERHOUSE: Dr Begbie, I think you wanted to say
36 something there.
37

38 DR BEGBIE: Just an example of perverse incentive in our
39 system. In our region we've got some fantastic GPs who
40 I guess partly get tired of complex conversations about
41 difficult cases and decide that it would be much easier
42 joining a skin cancer clinic, and given that we live in a
43 sunburnt country, you can spend your entire day seeing
44 elderly people with multiple skin lesions and excising
45 them --
46

47 THE COMMISSIONER: Not necessarily completely elderly

1 people either.

2

3 DR BEGBIE: No. But the quality control might go as far
4 as to determining what proportion of the lesions you remove
5 come back with significant pathology if you're sending them
6 for pathology. But in an environment where we desperately
7 need GPs out there, so we can get our patients out of the
8 New South Wales hospital system to see their GPs, so many
9 of them are in these little, you know, spaces where all
10 they do all day is treat skin lesions, and the question
11 would be: do you really need to take all the skin lesions
12 off this 88-year-old fellow, or could he be left alone,
13 given his comorbidities? And yet the system makes it more
14 attractive to be a GP that does minor surgery than a GP who
15 looks after the needs of generally unwell people in the
16 culture, in the system.

17

18 DR WATERHOUSE: Dr Hislop, did you have anything to add
19 about that? I want to ask you something else in a moment,
20 but did you have anything to add in relation to that point?

21

22 DR HISLOP: Yes, I would agree with that. It's almost an
23 endless sea of skin lesions that we could be taking off
24 elderly patients, and you do have to wonder what really it
25 achieves in terms of long-term outcome for those very
26 elderly patients on whom it is being done. Some of these
27 people, it's almost impossible on to spot the normal skin
28 for the lesions. So I would agree with that.

29

30 Look, we have a system that - I think it's
31 Charlie Munger, who said, "You show me the incentive,
32 I will show you the outcome", and however you incentivise
33 doctors, there is a chance for incentivising perverse
34 outcomes.

35

36 With fee for service, unfortunately, you incentivise
37 for procedures and services to be done that are not
38 necessarily required or not necessarily of the best
39 benefit, and potentially and almost certainly not
40 necessarily the most cost beneficial in terms of their
41 outcome.

42

43 But, you know, if you incentivise doctors on salaries,
44 you potentially can pay them to be relatively unproductive.
45 So it is difficult, how to remunerate doctors so that you
46 get the best outcome and certainly the best use of scarce
47 and precious healthcare resources. That's a challenge.

1
2 There are all sorts of things in our system that work
3 against us in terms of allocating those resources as best
4 we can. I remember as a medical student I was taught that,
5 from an ethical perspective, I had a duty to only one
6 thing, and that was the patient in front of me at the time.
7 I always found that a little bit hard to understand, given
8 that, for many of those patients, we are treating them on
9 a public budget.

10
11 So for me, I believe that yes, I have an absolute
12 concrete duty of care to the patient in front of me, and
13 I absolutely want to do my best for those patients at all
14 times, but there is a more abstract duty that does exist
15 regardless of whether we want to believe that it does or
16 not, and that is a more abstract duty to the whole of
17 society who also are responsible for those resources being
18 available and will also be responsible for demand for those
19 resources elsewhere.

20
21 The challenge is how to marry that very concrete duty
22 with the abstract and more nebulous duty, and that's very
23 difficult to do as a single clinician at the bedside.
24 I think, you know, it's advisable that there are certain
25 bodies set up at various different levels throughout the
26 healthcare system to be able to assist in taking that load
27 off clinicians at the bedside.

28
29 DR WATERHOUSE: Just on that subject, what sorts of bodies
30 do you have in mind when you refer to that process?

31
32 DR HISLOP: Before there's a body, I think you need to
33 have a public discourse about this notion. I think that
34 public discourse needs to be had at a national and a state
35 level. Such a discourse needs to be one that has
36 bipartisan support. If you start playing party politics
37 with an issue like this, it will go nowhere, and it is too
38 important an issue to play party politics with, I believe.

39
40 After such conversations and discussions are generally
41 had with the community, which will struggle to hear it,
42 then I think you need federal bodies, state bodies, LHD
43 bodies and even hospital bodies - and, in a way, I'm
44 talking sort of committees that are set up with a view to
45 enable ethical decision-making and sensible decision-making
46 around resource allocation in health care when it comes to
47 public spending.

1
2 Now, I don't have much more in terms of concrete ideas
3 than that, but that's an idea that I have. Like I said,
4 I have a lot of the questions; I don't have a lot of the
5 solutions.

6
7 DR WATERHOUSE: That's okay.

8
9 Dr Begbie, do you have a view on that in terms of what
10 sorts of bodies you might consider to try and resolve some
11 of these tensions?

12
13 DR BEGBIE: Well, I've already modified the PBS and the
14 MBS to have more criteria, so that will be a big piece of
15 work. And I think that would be a really good starting
16 point, because we've already got these bodies in place with
17 people who are charged with making decisions based on
18 quality of life years gained. I think we just need to have
19 a bit more detail in that and, secondly, I've - I'm putting
20 some resources into audit of use of PBS and MBS items so
21 that people can get feedback about how they can improve
22 things.

23
24 Whether you call it a low-value care committee - you
25 know, senior clinicians, appropriately funded, time to sit
26 down and review cases - not even cases that are raised,
27 but, you know, cases that come up in medical record review
28 as worthy of discussion so that feedback can then be given
29 about, you know, "We seem to be doing a lot of this
30 procedure in the hospital; we seem to have poor outcomes
31 getting" - whether it's the orthopaedic surgeons or the
32 department of medicine or ICU - "together and saying,
33 'Look, can we do better with this type of patient in the
34 future. We've reviewed, you know, 20 sets of notes, these
35 are our conclusions. We think it would probably be better
36 if the next 10 of these patients that came through, we
37 received a summary of the case and were able to help you
38 decide, you know, how to proceed with that particular case,
39 because we think there is an issue in this space.'"

40
41 DR WATERHOUSE: If I clarify there, so this sort of
42 committee, what you are talking about with this is not
43 saying particular procedures should not be done or
44 particular therapeutics should not be given but, rather,
45 it's about patient selection; it's looking at the procedure
46 or the drug but it's also looking at the person, not just
47 their age but their comorbidities and other factors, to

1 marry it together to say, "Is this a good use of resource
2 in this context"; is that correct?
3

4 DR BEGBIE: Yes. So using the emergency fractured neck of
5 femur example that Dr Hodge raised, the option of sitting
6 down and saying, "We cannot approve anymore funding for
7 anything because the LHD is 50 million in the red. Did you
8 realise that 5 million of that is due to this procedure and
9 only 50 per cent of those patients are surviving beyond
10 a month? Is there some way that that's something we could
11 do differently into the future?"
12

13 If we find multiple examples of that that impact on -
14 you know, again carrots have got to be part of this. If
15 you want to do pelvic exenterations or you want to do that
16 laser operation to prevent epilepsy, you have to find
17 low-value procedures in your department that you might
18 otherwise choose not to do, because our budget can't do
19 both the thing you've always been doing for low value and
20 the thing you believe is of higher value.
21

22 So, yes, the more we can turn this into a process
23 where, you know, good clinical practice is incentivised,
24 but as we've all said, the community has to see the benefit
25 to them and conversations need to be had about, "We can't
26 treat those of you who have a debilitating problem that
27 keeps you from work, keeps you spending time with your
28 families over the 20 or 30 years that you're going to
29 continue to live and yet, in our system, we're doing all
30 these other things, maybe to your parents or your
31 grandparents" - we need to have a discussion about value
32 and benefit to everyone and, you know, "Will you come on
33 this journey with us, because we can't do it as clinicians
34 without you?"
35

36 DR WATERHOUSE: Dr Hodge, is part of the issue - and you
37 gave the example before about a fractured neck of femur
38 being replaced in order to provide pain relief, is part of
39 the challenge that there's not always an evidence base that
40 says whether or not this person is better off with
41 analgesia medication or having their hip pinned? Is that
42 part of the issue, that there isn't always that evidence
43 base?
44

45 DR HODGE: Ultimately all of those decisions are
46 individual clinical decisions, who whoever is on will make
47 that decision for that particular patient. So it will be

1 a day of the week decision. Again, you can't change that
2 under our current system. I think, looking back on what we
3 do, you know, we have - I was just making a note here. We
4 spend a lot of time reviewing morbidity and mortality,
5 which is important, because they're defined bad outcomes.
6 The question is we never actually spend much time talking
7 about what we've done right or how we've analysed our
8 performance, which is probably actually more important,
9 because the bad outcomes are actually uncommon in our
10 system.

11
12 What we do right and with good clinical outcome is
13 actually good, and where we actually technically do it, the
14 question that we're still raising is should we have done
15 some of it to start with, not that we got a good outcome
16 for a operation or a procedure or some other process.

17
18 The question of what we need to be able to do is to
19 perhaps spend some of our time being provided the resource
20 in analysis in our system. I would think, though, this has
21 to all be done at a local level. You can't actually
22 institute this as a whole of government process. All of
23 these are departmental discussions: how does each
24 department be supported within the LHD or their networked
25 hospital system as analysis of their performance, and how
26 does that fit in, because that's the type of information
27 that we actually need to actually drive change.

28
29 We're talking about here how we're going to alter our
30 system in order to have money. Health, I think, is very
31 good at talking about change; society is great at talking
32 about, "We've got to change." The only thing I would
33 observe in health is we never change. There are more
34 change managers out there than you can poke a stick at but
35 nothing changes.

36
37 DR WATERHOUSE: If I can just go back, though, to the
38 question, it might have been my framing of it, I understand
39 that the actual administration of care is of very high
40 quality. I'm not suggesting that the pinning of the hip or
41 the replacement of the hip is not a high-quality operation.
42 But in terms of the value, both to the individual and to
43 society generally, is there often a lack of evidence that
44 says which is the better option, or is the evidence always
45 there to say, "This person with a fractured hip is better
46 off having medication not having a hip --"
47

1 DR HODGE: It's often whatever's most convenient.
2
3 DR WATERHOUSE: I understand how the decision is made.
4
5 DR HODGE: No, but that's how the decision is made:
6 whatever is convenient.
7
8 DR WATERHOUSE: So is there a lack of evidence?
9
10 DR BEGBIE: No, the data is there.
11
12 DR HODGE: The data is there, that's right.
13
14 DR BEGBIE: Not all clinicians read the data and the data
15 is based on an analysis somewhere else of 80 patients over
16 a five-year period that was 10 years ago, and, you know,
17 we're always able to side-step those kinds of decisions by
18 saying, "In my care, things are different", or "This
19 patient is different", or "The family are making me and
20 I have no choice."
21
22 DR WATERHOUSE: So whether or not the evidence is there,
23 that's not the basis for the decision-making?
24
25 DR BEGBIE: No.
26
27 DR WATERHOUSE: I might go to Dr Hislop, who has his hand
28 raised.
29
30 DR HISLOP: I was going to say that the fractured neck of
31 femur, I think we're using that as an example because it's
32 the case for us - it's a bit different to just a broken
33 bone. So over the years, really, fractured neck of femur
34 is a presentation that tends to go with a degree of frailty
35 and often has been a highly morbid condition.
36
37 A lot of the time, you know, the survival after
38 a fractured neck of femur historically in years gone by was
39 quite low, because it wasn't so much the fact that the
40 patient had a broken hip, it was that they broke their hip
41 because it was a reflection of their frailty. So that's
42 why this is an example that is used.
43
44 So when Dr Hodge is talking about operating and fixing
45 the hip versus giving analgesia, what he's really meaning
46 is operating and fixing the hip as a means to relieving the
47 pain of an unstable fracture or giving morphine as a means

1 of treating that pain, with an expectation that that is
2 palliating the patient and the patient is expected to die.

3
4 Now, I think the literature does - I mean, I'm not
5 a hip surgeon, so I'm speaking with perhaps not the best
6 and most relevant knowledge, but we do know if we don't fix
7 that hip the patient will die. So I think there is the
8 belief that if you fix the hip, if they die anyway, well,
9 it was good palliation. If you fix the hip and they
10 recover from it and do a bit better for a little while,
11 then it probably wasn't a bad thing to do.

12
13 In a way that potentially might for some be the easier
14 decision to make. But I think also it's a good case to
15 highlight that, for many doctors, what becomes the path of
16 least resistance is to do something. It is often much more
17 complex to do less. It requires conversations that are
18 often nuanced and difficult for families to understand or
19 patients to understand and appreciate as to why it is that
20 we are not doing something. "We're going to give you pain
21 relief but we're not going to operate."

22
23 It can be very difficult for patients and families to
24 hear, "We're not going to do something", because mostly,
25 people are desperate for you to do something. Even if it's
26 not all that likely to provide much more benefit, it's
27 usually a much more easy conversation to sit down and say,
28 "This is what we're going to do." So I think
29 unfortunately, that's the reality, there's a perverse
30 incentive to having an easier conversation about all the
31 things you can do rather than what we should or shouldn't
32 do, and particularly what we should not do. They're much
33 harder conversations to have.

34
35 And I think as doctors, we're not well enough
36 protected, with some of these difficult situations that can
37 arise. With the best of intentions, the HCCC has been set
38 up to look after patients and families but the consequence
39 of organisations like that is that doctors can often find
40 themselves encumbered with complaints which may arise out
41 of difficult conversations had with the best of intentions,
42 which end up with complaints that need formal responses to,
43 and these things can all get very challenging for
44 clinicians with busy lives, and they can also be incredibly
45 confronting from a professional point of view.

46
47 I think if you were to look at, you know, how do most

1 doctors conduct their business, very commonly, most doctors
2 will conduct their business to stay out of trouble as best
3 they can so they will often take the path of least
4 resistance, and very often that path of least resistance is
5 to do more not less.

6
7 DR WATERHOUSE: You've mentioned the word "confronting"
8 a few times in the context of these conversations, which is
9 understandable. Do you think too much time during training
10 is spent teaching young medical students and then through
11 to young doctors all the things that are possible and not
12 necessarily spending time educating them about how to look
13 at this more objectively and say, "Just because it's
14 possible, doesn't mean it's a good idea"?

15
16 DR HISLOP: Yes, I think it is a fair statement. I think
17 also, doctors, no matter how good they are at having these
18 difficult conversations about what it's best not to do,
19 these conversations are the most difficult and often are
20 the ones avoided.

21
22 DR WATERHOUSE: And obviously part of this comes from
23 experience, and we've talked about inexperienced clinicians
24 being put in this situation sometimes.

25
26 DR HISLOP: Yes.

27
28 DR WATERHOUSE: Is there a role for mentorship by more
29 senior doctors who have been through this to be able to
30 provide guidance to junior doctors working in these types
31 of roles?

32
33 DR HISLOP: Yes, absolutely. I mean, I have regular
34 meetings with families and patients myself in my clinical
35 role, and I will usually take along my junior doctor or
36 doctors who are working with me at the time and they can
37 join me in those conversations and watch me navigate my way
38 through those - navigate a difficult course sometimes,
39 absolutely.

40
41 But it doesn't necessarily mean those conversations
42 get any easier. I mean, I've been having these
43 conversations for years. I still find myself in very
44 difficult conversations and very difficult situations.
45 Some of us are better at handling them than others, but
46 also there's an incredibly - there's an incredible
47 disparate view amongst the medical profession of what our

1 role is in terms of having these conversations and resource
2 allocation. But you're right, often we find the most
3 junior doctors are the ones having these conversations, or
4 relatively junior doctors are having these conversations.

5
6 I will often find that I am rung up in the middle of
7 the night, as the intensivist on call, about a patient who
8 has presented in some degree of extremis or some degree of
9 illness that may well require intensive care admission,
10 however, they may be debilitated with multiple severe
11 chronic medical comorbidities, their level of function may
12 be already very poor, their quality of life may already be
13 very poor. Even prior to this acute hospital admission,
14 their life expectancy may well have been very short, and
15 someone, who's not really well prepared or experienced to
16 go and have these difficult conversations, will go and ask
17 the patient what do they want, and they will come out with
18 a shopping list that ticks the box that they're for
19 everything - they're for intensive care admission, they're
20 for ventilation, they're for dialysis, they're for
21 inotropes and they're for CPR, and I will get a phone call
22 saying, "This is the patient who has presented and, by the
23 way, they're for everything, so can you please take them to
24 intensive care?"

25
26 Now, I would often wish that that sort of conversation
27 hadn't been had yet might have been left until I can get
28 there and indulge the family and patient in a more nuanced
29 conversation around what is or isn't likely to be
30 achievable, how noxious the support may or may not be, and
31 try and bring a reality focus together with the situation
32 of their background and their current illness to come up
33 with a more appropriate plan.

34
35 It is very difficult to replan a plan once it has been
36 made, and so I find myself at times feeling cornered to
37 bring patients into intensive care when I really don't
38 think it's in their interests. This is not necessarily
39 just about the greater good of the resource but in terms of
40 the good for the patient, yet a conversation has been and
41 addressed and begun in such a way that really the outcome
42 was going to be that they're for intensive care admission.
43 "Hi there, Mr So-and-so, you're really sick at the moment.
44 Do you want us to do everything or not?" Those are the
45 sorts of sometimes very naive ways these conversations are
46 introduced and mostly, of course, those patients are going
47 to say, "Yes, what do you mean? I mean, why would you want

1 me not to - why ever would I want you not to do everything
2 for me?"

3
4 So, yes, often we do find that it's the people who are
5 not really equipped to be having the conversations who find
6 themselves in them, and that's to be avoided.

7
8 Some of this, I think, is the unforeseen consequence
9 of what is an increasing push to engage in advanced care
10 conversations with families and patients as they present to
11 an emergency department.

12
13 Now, I actually have a view that really, unless - that
14 many doctors are really not qualified to be having those
15 conversations. They don't really know what they're talking
16 about when they're talking about the therapies that we are
17 "offering" or "not offering". They don't really have an
18 understanding of the patient's prior status and what's
19 likely to be achieved or not be achieved if these life
20 supportive cares are instituted and implemented. So
21 I think there has been this feeling in the community that
22 if only we engage in advanced care planning more quickly,
23 more readily and more often with our patients out there,
24 that we will make a lot of this problem go away.

25
26 In my experience, unfortunately, we can embark on
27 those conversations, and if we are not well prepared and
28 well schooled and with the appropriate background to have
29 those conversations, we perversely end up with the reverse
30 outcome that those entering into those conversations really
31 intended.

32
33 DR WATERHOUSE: I might go to Dr Begbie. I think you
34 wanted to add something to that?

35
36 DR BEGBIE: Yes, look, I think we've focused on things
37 that are difficult to solve, but there is another sphere
38 that I think we can probably all get on board with and that
39 is if someone has a four-week admission after their pelvic
40 exenteration, the decision about what blood tests to order,
41 what drugs to continue, how many cannulas to put in, how
42 many disposables to use in different situations is
43 I think a - those sort of decisions about wise use of the
44 small resources, I think is something that the whole health
45 system should be getting behind tomorrow.

46
47 Now, we've got a very enthusiastic GP turned emergency

1 department doctor in Coffs Harbour who is on the
2 sustainability bandwagon and most doctors, most healthcare
3 professionals have a sense of the importance of sustainably
4 living and making choices and reducing landfill and
5 reducing the number of tests that we organise. So, yes,
6 there'll be these important decisions around should we
7 operate or shouldn't we, but the education piece around do
8 we need to do a blood test every day, do we need to do
9 a chest x-ray every day, do we need to do arterial blood
10 gases every four hours - those are discussions that we're
11 having in our hospitals, and hopefully are happening around
12 the whole state, and yes, we could save money on do we
13 operate or not, but I think there's enormous amounts of
14 savings to be had in supporting and educating our junior
15 medical officers and our registrars and even our
16 consultants about what is going to make a difference during
17 an admission and what isn't going to make a difference.

18
19 So yes, if we're looking at solutions, yes, all of
20 these committees and subcommittees, that's going to be
21 important, but in terms of low-value care, if a full blood
22 count and a biochemical profile at admission are normal and
23 the patient is sitting there for five days being treated
24 for pneumonia, do they really need those tests repeated
25 every day, and what are the things that we could mainly
26 stop on their regular medication chart that we don't need
27 to continue?

28
29 There's a bunch of things that I think we could be
30 training our workforce to make the small wins that
31 ultimately can add up to the big wins that we're talking
32 about here, and those are not difficult conversations. We
33 do not seek the consent of a family when we choose to order
34 a full blood count or a chest x-ray. We just get on and do
35 it. And historically, we've got into the habit of doing
36 that more often than we need to. Part of that is defensive
37 medicine but a lot of it is lazy medicine, just not
38 thinking, just wanting to please the consultant by having
39 the latest result on the tip of your tongue, and a lot of
40 that can be fixed with better education and better
41 communication.

42
43 DR WATERHOUSE: It can be difficult to embed changes of
44 that nature, and we talked before about nothing ever
45 changes. Is one option to have evidence-based clinical
46 guidelines by which patients are managed after particular
47 procedures and so on, so that they can be expected to have

1 blood tests on particular days not every day, or whatever,
2 depending upon the clinical need?

3
4 DR BEGBIE: Yes, but just as, for example, cancer
5 diagnosis is a really good motivation to stop smoking,
6 a warming planet is a very good motivation for young
7 people, who are the future of our health system, to change
8 practice, if they see the choices that they're making every
9 day that are not dependent on the consultants, making
10 a difference to the world that they will inherit.

11
12 I think one of the bits of advice I would give to
13 government, as we exercise our minds about this Inquiry, is
14 we've actually got another imperative that we can actually
15 use as a motivator for some of this change, both for
16 considerate community members, you know, things have got to
17 change, but certainly for the professions that look after
18 the health system. So I would encourage that to be part of
19 the conversation, because we - you know, it's not just
20 about money, it's about what the money represents and the
21 waste of small amounts of money and, you know, large
22 amounts of waste, physical waste as well as general waste,
23 that we can, I think, argue with one another is a good
24 thing to make change in.

25
26 And, sorry, even simple things like which waste
27 company NSW Health chooses to do business with and in the
28 tender process, the way that they are going to illustrate
29 to us their use of the waste once it leaves the hospital
30 system, their encouragement of us to have various recycling
31 modules all over the hospital - that will go to places
32 where they will actually be used not stored and then burnt
33 later on. These kinds of things at a government
34 procurement basis could make a really significant
35 difference, without some of the angst that these other
36 discussions are raising.

37
38 DR WATERHOUSE: Commissioner, I'm mindful of the time.

39
40 THE COMMISSIONER: Yes. We'll have a break now until
41 11.50. We'll adjourn until then.

42
43 **SHORT ADJOURNMENT**

44
45 THE COMMISSIONER: When you're ready. Go ahead.

46
47 DR WATERHOUSE: Just before the break, Dr Begbie, you

1 mentioned that old chestnut, "defensive practice", and
2 I was just wondering if you could tell us your thoughts
3 about whether or not anxiety or defensiveness, in terms of
4 practice, is part of the driver for going along with what
5 people ask for, in terms of low-value treatments?
6

7 DR BEGBIE: Yes. I mean, it's interesting, as I reflect
8 on it personally, I probably felt it more before the
9 medicolegal reforms 15, 20 years ago, than I do now, but
10 that might partly be because of experience and capacity to
11 navigate things a bit better.
12

13 So yes, I think there is an element that's defensive,
14 but, you know, the treasury managed fund in support of, you
15 know, cover of hospital-based clinicians for both private
16 and public admission I think provides a level of comfort
17 that shouldn't mean that we lose sight of making the right
18 decisions. So I think there is a significant element where
19 better education about value in those small decisions with
20 our junior medical staff - a lot of it, I think, is
21 inexperience. So yes, there's an element of defensiveness,
22 but as we've talked about, some of that's just in
23 relationship.
24

25 Rob mentioned the HCCC. For most people, what you get
26 out of an HCCC complaint is just heartburn and grief and
27 disappointment that your quality and ability is being
28 questioned. It rarely leads to someone losing rights to
29 practise; it rarely leads to it moving on to a medicolegal
30 thing, but it often makes you feel really bad for quite
31 a significant period of time, and medical staff, caring
32 professions, don't like feeling bad. They like to think
33 that they're doing the right thing by the people that they
34 see every day. So, yes, I think they want to impress, they
35 want to do the right thing, and we need to wean people off
36 the sense that doing more tests than is required, using
37 more disposables than is required, is good medicine, and
38 persuade everyone that it is actually lazy medicine.
39

40 So maybe they're defending against their senior -
41 their bosses, as much as, you know - I think it's probably
42 maybe more that, than fear of lawsuits, these days.
43

44 DR WATERHOUSE: So in terms of talking about being
45 defensive or having anxiety about that, would it be fair to
46 say that it's not just litigation, and maybe litigation is
47 the smallest, it's about reputational harm or the stress of

1 going through a complaint process, things like that; that
2 it's a much more multifactorial experience?
3

4 DR BEGBIE: There is a lot of people pleasers in medicine
5 and people don't want to be a disappointment, they don't
6 want to be criticised, they want people to think the best
7 of them, and that's probably most of us at one level. But
8 in a sense we need to be making sure that everyone
9 understands that there are a variety of imperatives and we
10 need to be meeting all of our imperatives and the
11 sustainability of the health system is as important as your
12 feelings on a particular day. Yes.
13

14 DR WATERHOUSE: To your point about climate change and
15 perhaps that being a motivator for younger generations to
16 look after the planet, do you think that there's a tension
17 between that and also their career prospects and wanting to
18 make sure that they do know exactly what the latest
19 haemoglobin is for the consultant they're working for?
20

21 DR BEGBIE: No, no, I actually think - and I raised that
22 because I think the government, I see, has an opportunity
23 to both save money and reduce waste and use the level of
24 concern in the community about the sustainable planet to
25 achieve the same purposes. So, yes, I just think that's
26 a good trigger that we've got at the moment that we
27 wouldn't have had 20 years ago - we probably should have
28 had 20 years ago but we didn't have 20 years ago - and that
29 can be used, I think, as it is being used in our LHD
30 through the work of individuals, but I think we should be
31 encouraging people to be raised up in each of our LHDs,
32 each of our networks, to do that work, to say, you know,
33 "There's a range of good reasons why you should be
34 organising fewer investigations."
35

36 And look, quality can actually be impaired by people
37 that have too many tests that they've organised in a day
38 and don't chase up the results and miss the things that
39 were really important by close of business. So, yes,
40 I think there's a lot to be gained with those small wins
41 and something to be gained with the other big wins we've
42 been discussing.
43

44 DR WATERHOUSE: Dr Hodge, can I ask what your views are
45 about whether or not that defensiveness or anxiety in its
46 broadest sense, not specifically a medicolegal claim - does
47 that play out in surgery, in your experience?

1
2 DR HODGE: I think it does. I think people always quote
3 that as - give it as a reason for doing something. I tend
4 to think, though, that good clinical medicine is always
5 defensible. I just think we always throw, "Oh, let's do
6 this because I'll be criticised if it's not done" - if you
7 do the right thing, you're actually perfectly fine by doing
8 or not doing a test. You've just got to adequately examine
9 the patient and know what you're doing.

10
11 Technology is just wonderful because it's given us so
12 much more information than we used to have, and has allowed
13 us to do a myriad of things that we could never, ever do
14 before. But we need to work out what's the wise
15 application of that technology rather than worrying about
16 whether we're going to be sued if we don't do it.

17
18 DR WATERHOUSE: Does some of it come down to communication
19 and not so much what's possible but how we communicate
20 those things to the patient?

21
22 DR HODGE: No, because I don't think necessarily the
23 patient is involved in most of those initial discussions or
24 decisions. Stuff is just done because people come in with
25 something and then they go and get this x-ray or that x-ray
26 or this blood test, and sometimes they don't need it,
27 because our system is slow. One of the - in how certainly
28 hospitals which are big consumers of money work, there is
29 sort of the 50 per cent distribution that comes in through
30 the front door of the ED and then there are those that come
31 through a planned process for surgery.

32
33 So we've actually - and really, they are the two
34 processes we run our acute hospital systems on to a large
35 part. You're looking at different people with different
36 drivers in both of those places, to say what's going to be
37 done and how we are going to manage certain conditions, and
38 then how other people who may look after those people are
39 going to respond in a timely fashion.

40
41 There is a trend, and certainly something that I do
42 when somebody comes in with some rectal bleeding now, that
43 they go off and have a CT angiogram. Now, that's a very
44 expensive test. It is actually moderately completely
45 useless unless you are going to use it for a specific
46 reason to do a specific intervention, mostly which is never
47 ever going to be done. But trying to stop that process of

1 that very expensive and potentially dangerous test is
2 actually very, very hard.

3
4 DR WATERHOUSE: Why?

5
6 DR HODGE: Because it has crept into clinical practice by
7 a group of people who aren't actually acting on that
8 process, and how you've got to change that - and that's not
9 defensive medicine, they're not doing it to defend
10 themselves, they're actually just doing it because somehow
11 that's become the clinical norm.

12
13 DR WATERHOUSE: Just talking through that example, then,
14 how is it that it's become the clinical norm?

15
16 DR HODGE: I haven't the faintest idea. To be honest,
17 I actually ask that same question. I don't know, because -
18 and when we creep it into the next layer down of our
19 registrars, because I was actually reading something
20 yesterday on a patient complaint about this very problem,
21 and then they write that, you know, "If they get another
22 bit of bleeding we're going to do this test" or do an
23 angiogram. And I'm going, "You'll never do that test
24 because you don't need to do that at that level because
25 you're not going to act on it or need that information, and
26 it's only going to really apply in really specific
27 circumstances that that test is ever going to give you any
28 information that's of value."
29

30 Unfortunately that's an age-related thing of having to
31 see something over a long period of time to understand the
32 condition. So we've - there is knowledge out there that
33 has been inappropriately applied. You can't change that,
34 because that's just general knowledge and an expediency
35 process as well. We've created processes that everybody
36 has to be processed quickly, which is very good, but this
37 is the price we've also paid at the other end to get people
38 through a system in a defined short time period, and if we
39 don't meet that KPI, there's another reason to complain,
40 because the patient has to be seen, expedited out in four
41 hours, et cetera - all that type of stuff drives pressure
42 to make decisions, and sometimes, that could be the wrong
43 decision.

44
45 That's the balance the system is making between
46 expediting care, which has great benefits, versus, in a
47 small select group of people, perhaps doesn't provide the

1 same benefit but harms.

2

3 DR WATERHOUSE: So I don't want to labour the particular
4 test that you're talking about, but just so that
5 I understand, is this an example of unwarranted clinical
6 practice variation where some surgeons are requesting that
7 test and others say it's unnecessary, or --

8

9 DR HODGE: I think it is.

10

11 DR WATERHOUSE: Or is there an element that it is more
12 junior doctors that are requesting the test on the
13 assumption that the consultant will want it?

14

15 DR HODGE: That's also true. I think that's the problem
16 with changing processes. People grasp some things, and
17 you've got the combination of some people saying, "Oh this
18 is the latest and greatest, let's do it", and others are
19 just trying to please, or not necessarily trying to please,
20 I think actually applying information in the wrong way,
21 because I would argue that all of us, particularly in our
22 place, think it's all useless and we shouldn't be doing it,
23 but to stop it is actually very, very hard, because we
24 don't - because it all happens before we're even involved,
25 and you say, "Please don't do that", but how do you get
26 that message out?

27

28 I think that is the problem we've got across
29 technology, access, and trying to push people through
30 quickly: unless you have got some robust system of how to
31 actually review all these cases, which is time consuming
32 and laborious, requires support services - because
33 a one-on-one discussion often doesn't change anything
34 because it's a corridor discussion.

35

36 DR WATERHOUSE: So those that are accessing - Dr Begbie
37 I know you want to add to that but if I can just clarify -
38 those that are actually requesting tests are doing so with
39 a view to expediting patient care to meet KPIs?

40

41 DR HODGE: Yes.

42

43 DR WATERHOUSE: Is that fair? But, in fact, those tests
44 requested are not actually useful in determining the
45 treatment they will need downstream?

46

47 DR HODGE: That's correct.

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DR WATERHOUSE: Dr Begbie, can you comment on that?

DR BEGBIE: Yes. So it's no coincidence that the leaders of the sustainability movement in our LHD are emergency medicine physicians, and they are the doctors with the biggest blank cheque in the hospital for investigations. They are struggling at times in our institution to appoint enough senior decision-makers, and so often they've got junior decision-makers having to make decisions before the senior decision-makers come in.

So to have much stricter guidelines of what's appropriate in certain situations, these would be the indications to organise the expensive or dangerous test, and those only, and again, these are the situations - and "Did you realise that that blood test panel that you organised actually costs \$500"?

I think the interesting thing about it is that doctors have this capacity to fill out blank cheques without actually knowing the cost of the cheque that they're writing, and you just put a series of letters on a blank piece of paper and hand it to the phelobotomist, those tests get done, and particularly as a junior doctor, you have absolutely no clue, unless you've been educated, what you have just cost the system, and if you don't know and maybe you didn't get the result back today and you wanted it, you forget, you do it again tomorrow and maybe two days later - you know, there is waste in the system because of these questions of education, but also some level of accountability, and the two are connected.

DR WATERHOUSE: Are you familiar with the tiered systems whereby certain tests can be ordered by any doctor, some tests can only ordered by a registrar or above, and some tests only by a consultant.

DR BEGBIE: Mmm-hmm.

DR WATERHOUSE: Do those work, in your experience?

DR BEGBIE: They can work if they are adhered to but in, you know - we have a ridiculously busy emergency department where, as I said, the senior decision-makers are having to make decisions on the fly, and if someone says, "Here is half the story, shall I organise test X", again, the path

1 of least resistance is to say, "Yes, if you think that's
2 appropriate, order it", and so, you know, we sometimes
3 worry that the salaries in the place are the most expensive
4 thing; if the people on the higher salaries are actually
5 good at what they do, they can potentially save a lot of
6 money in terms of unrequired investigations and other
7 things done.

8
9 DR WATERHOUSE: Dr Hislop, did you want to make a comment
10 on that from an ICU perspective?

11
12 DR HISLOP: If I could, I'd like to make a comment on
13 defensive medicine, which is all part of the - I think
14 that's all part of what we're discussing at the moment.

15
16 DR WATERHOUSE: Sure.

17
18 DR HISLOP: I think I see it differently to my colleagues.
19 I think the practice of defensive medicine is incredibly
20 pervasive and drives practice in a very powerful way, and
21 drives over-investigation and over-treatment in a very
22 large way. I'm aware of it myself on a daily basis.
23 I feel like I'm ordering tests I don't really feel like
24 I need but I feel like I am sort of going to have to do
25 them if I want to practise defensive medicine, and although
26 I don't desperately want to practise defensive medicine,
27 I do want to feel like I am not unduly exposing myself to
28 risk, and to my patients.

29
30 But the practice of defensive medicine is largely
31 about protecting oneself and I feel that I practise that
32 a lot and I think I'm probably more resistant to it than
33 many. So I think it's incredibly pervasive and I think it
34 does explain or it is responsible for waste in the system,
35 absolutely. It can take good value care and make it less
36 value; it can take it poor value care and make it poorer
37 value. So I think it's incredibly pervasive and I think
38 for me it's so pervasive that it's easy for us to actually
39 stop seeing it for what it is, because it's been so
40 pervasive for so long.

41
42 DR WATERHOUSE: When you talk about the risks, if I can
43 just clarify, are you talking then specifically about
44 medicolegal risk or are you talking about reputational
45 harm, complaints and that broader spectrum of what people
46 defend themselves against?

1 DR HISLOP: The much more broad spectrum that you outlined
2 so well. I totally agree with how you outlined the drivers
3 of defensive medicine. I think there are perverse outcomes
4 to - in a way, it's the perverse unintended consequence of
5 increasing attention in the hospital system over the last
6 20 or 30 years to governance quality and safety. But all
7 of us have, or many of us have, just a vague understanding
8 of an ogre in the room, be it medicolegal, be it quality
9 and safety, be it colleagues and M&Ms, like, there's - be
10 it HCCC complaints, be it dissatisfied patients and
11 colleagues - there are a lot of different drivers for
12 practising increasingly defensive medicine, in my view, and
13 there's also --

14
15 DR WATERHOUSE: So you see it as something that's getting
16 worse, do you, or broader, should I say?

17
18 DR HISLOP: I think it's - over my career, it's definitely
19 got worse. I think defensive medicine was probably really
20 beginning around the time I began my career and it's
21 definitely grown over those 30 years. Whether it continues
22 to grow or not, I'm not sure. I think it's probably at -
23 I'm not sure it can grow much more than where it is at, at
24 the minute, it's extreme at the moment, I believe.

25
26 You know, there are similar perverse incentives to
27 things like the Garling report that was handed down some
28 years ago after the unfortunate death of that young patient
29 at the North Shore, and what's happened over time in
30 relation to that is that care for patients on the ward is
31 becoming increasingly risk averse. That risk has been
32 increasingly taken up by admitting lower and lower acuity
33 and lower and lower risk patients into intensive care units
34 and that has consequences as well.

35
36 There are policies being written in hospitals that
37 demand that certain therapies and certain interventions and
38 a certain requirement for observations mean a patient must
39 be cared for in intensive care. The problem with that is
40 it means that sometimes there are patients for whom you
41 might have somewhat more limited expectations for their
42 outcome, as a result of their advanced age, frailty,
43 comorbidities, poor quality of life, et cetera, for whom it
44 may have been deemed that an intensive care admission is
45 not appropriate or not in their interests or not what that
46 patient desires, yet they might suffer a certain -
47 a certain complication in hospital which demands a certain

1 treatment that has been forbidden to be provided on the
2 wards. So then the question is do we then admit that
3 patient to intensive care to provide that treatment or can
4 we try and provide that treatment in less than perfect
5 circumstances, because what we're not offering here is
6 perfect?

7
8 So with the best of intentions, there are policies
9 that have been written in hospitals that are all - that are
10 nearly all being written for the patient for whom we are
11 pulling out all stops. But that doesn't exist for all
12 patients. There are some patients for whom they lie in a
13 more nuanced zone of, "We will do some things, we will do
14 some things that are reasonable, but there is a line beyond
15 which we won't cross", because at that point we cross into
16 lower value care and often we cross into increasing
17 noxiousness of therapy and support for patients.

18
19 There have been many changes that have developed in
20 the healthcare system over the years, many of them with the
21 best of intentions. But often changes with the best of
22 intentions also create unintended perverse consequences.

23
24 DR WATERHOUSE: The policies to which you refer, are they
25 the sorts of documents that come from the ACI that are
26 clinically informed and have gone through a robust evidence
27 process or do they tend to just come down as directives -
28 or through might come from the CEC or whatever, or they're
29 coming down as directives that aren't necessarily informed
30 by the general clinical risk?

31
32 DR HISLOP: They're often local policies and procedures
33 and guidelines. So one example --

34
35 DR WATERHOUSE: And are they clinically informed or --

36
37 DR HISLOP: Well, I'm not sure how well clinically
38 informed they are. I mean, I take - I would have
39 a different opinion with many of them. And look, I think
40 many of these policies need a qualifying statement that
41 leads in. For the patient in whom we are doing everything
42 or have the highest of expectations, this kind of treatment
43 requires intervention in ICU.

44
45 For those for whom ICU admission is deemed not
46 appropriate or not warranted, we can do this on the ward,
47 understanding that there is some increased risk, but we

1 will accept that risk.

2

3

4 I think in hospitals we've started to develop a binary
5 view to risk. By that, I mean we are trying to approach
6 zero risk, particularly on the wards, and anything above
7 and beyond zero or an absolute negligible risk must go to
8 ICU. Now, I think that's unrealistic and increasingly poor
9 value. And I think to some degree, some of this lies in
10 medicine's preoccupation with using the aviation sector as
11 a model for quality governance and safety. I think it is
12 crazy that we do that because they are two such entirely
13 different sectors.

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Of course, when you're flying on an aeroplane that you don't have to get on, when you're choosing to go from Sydney to London on a holiday, you want to be almost 100 per cent guaranteed you're going to get there in one piece. Of course you do, and you don't want someone taking any chances with that. But this is an elective industry. You get to choose the plane that's built, you get to service it exactly when and how you should, you get to mothball that aeroplane when it's beyond its use-by date, and this is not what health represents.

A much more realistic representation of health care is taking out a bunch of World War II vintage fighter planes, making them all take off from a field with some dysfunctional radar, making them all fly around for three hours and then trying to bring them all safely with some old communication equipment. That's much more realistic.

So I think perversely, we try and approach risk in hospitals from a sort of zero perspective, which is unrealistic, given what we're dealing with. I think we need to understand what is reasonable risk and what is reasonable risk and safety when it comes to expected outcomes, particularly for patients who are encumbered with very significant comorbidities on multiple organs and systems.

So I have also come to suspect that over time - that as we increasingly try and approach a zero risk with a lot of patients, we perversely increase risk as well, I think there is probably a U-shaped curve to that. But I do think that an unrealistic approach to risk has led to a problem with how we manage the patients in hospital for whom - for those patients who aren't necessarily young and fit and

1 equate to the elective flight to London; it's more the
2 elderly comorbid patient who has no choice but to try and
3 fly across the Atlantic in a 1940 propeller plane. How are
4 we going to try to improve the chances of that going
5 reasonably well, knowing that, despite whatever we do, it
6 may well not go 100 per cent? I think that's a somewhat
7 confused metaphor, but I'm doing my best.

8
9 DR WATERHOUSE: That's okay. We can run with it. If
10 I can just clarify one thing, so with these local policies
11 or policies generally that require a patient to be treated
12 in intensive care for particular treatments rather than on
13 the ward, because they're trying to eliminate risk, do you
14 believe that there is a place for, again, patient
15 selection, whereby you actually accept a level of risk in
16 certain circumstances, based on the fact that a person with
17 so many comorbidities, et cetera, may not be appropriate to
18 admit to ICU to manage that risk?

19
20 DR HISLOP: Yes, and a classical example would be a drug
21 like intravenous amiodarone. Very commonly, patients in
22 hospital will go into an abnormal heart rhythm called rapid
23 atrial fibrillation, or atrial fibrillation with a rapid
24 ventricular response rate. This is a very common problem
25 in hospitals. It is a very common problem for patients to
26 suffer out in the community.

27
28 Intravenous amiodarone in an acute setting is a very
29 safe drug and I use it all the time in intensive care.
30 Unfortunately, despite being very safe, there are many
31 hospitals which will have policies and protocols and
32 procedures forbidding its usage on the ward.

33
34 Now, the problem is, then for such a patient, you
35 might find yourself having to decide to admit someone to
36 intensive care when it's not really appropriate, or to just
37 forgo and not give them the treatment you want and give
38 them nothing, which also, I think, is inappropriate.

39
40 I think the risk of giving that drug is inflated, but
41 many of these policies will demand that it needs continuous
42 cardiac monitoring, et cetera. Now, I think the risk posed
43 by giving that drug in a ward situation is actually
44 reasonably low. It may not be nil, but I think for those
45 sorts of patients, it's low enough that you accept that
46 there is some risk, but it is better than giving them
47 nothing.

1
2 So this is the perverse situation we find ourselves
3 in: rather than treat that patient in less than perfect
4 circumstances on the ward, you either make that choice to
5 bring them to intensive care, which is not appropriate, or
6 to not provide that treatment at all on the ward, which
7 I would say is also inappropriate.

8
9 So those sorts of policies, in my view, should have
10 a qualifying statement that tries to pick up that nuance.
11 But most of the policies written in hospital are absolutely
12 not nuanced at all and don't leave any wriggle room for
13 sensible clinicians to make sensible decisions which relate
14 to the patient in front of them, their history, their
15 comorbidities and their expected future.

16
17 DR WATERHOUSE: You spoke earlier about the ethical
18 training that you have doing medicine, that basically you
19 had to focus on the patient in front of you and not look at
20 the abstract of other patients.

21
22 DR HISLOP: Yes.

23
24 DR WATERHOUSE: Does it come to a point sometimes when you
25 are effectively looking at two patients and trying to work
26 out who gets the ICU bed?

27
28 DR HISLOP: That can happen, yes. It happened acutely for
29 me at times during the swine flu epidemic in 2009 when
30 I was working at RPA. We had a very stressed intensive
31 care system at the time. We had lots of patients on a
32 particularly high level cardiorespiratory support called
33 ECMO and we found ourselves very capacity constrained in
34 terms of which patients we could admit to the ICU, and
35 absolutely I found myself triaging patients in a way that
36 I hadn't had to triage before. It was almost, in a way,
37 like a wartime triage.

38
39 I must say, since those days and since, in more recent
40 times, finding myself on the Mid North Coast rather than in
41 Sydney, I less often feel that acute pressure and I am much
42 more often able to make decisions just based on what
43 I think is appropriate for that patient in front of me.

44
45 But I would say that I feel like - I do find myself
46 under pressure recurrently to be admitting patients to
47 intensive care when I don't think it's really the right

1 thing to be doing. And I would say if you look at
2 Australian intensive care resources versus somewhere like
3 the United Kingdom, it would seem that the resources we
4 have are much greater, and I think it's probably because we
5 are less discerning with how we use those resources.
6

7 DR WATERHOUSE: That's a slightly different view in terms
8 of the pervasiveness of defensive medicine and looking at
9 those sorts of tensions, being expected to do things. Did
10 you want to make any other comment, either of you, on that?
11

12 DR BEGBIE: I would just say I agree that expectation has
13 increased. I think - I mean, my feeling is the New South
14 Wales Government, in the past, has passed legislation that
15 makes it more about satisfying the patients and their
16 families and dealing with maybe an HCCC complaint, more
17 than facing the wrath of the medicolegal system. I just
18 might have been lucky in that I haven't faced it myself
19 and I've forgotten about it, but, yes, I think there
20 are different ways in which you can look at maybe
21 expectation-driven medicine. That's certainly on the
22 increase. But I think it's community expectations, which
23 can devolve into legal action in certain circumstances.
24

25 DR WATERHOUSE: When there is a complaint, do you feel
26 supported by the system in dealing with that?
27

28 DR BEGBIE: Well, personally, I do. I don't think
29 everyone shares my view, but, I mean, I have a sense that
30 the way that our medical defence system is set up, both
31 within the public system and without, means that we
32 probably don't have to feel stressed in the way that it
33 impacts on our day-to-day decisions, but I think it's the
34 human in front of you, or the group of humans in front of
35 you and their expectations which are well below the level
36 of, you know, threatening a lawsuit, mostly, that are the
37 ones that provide those expectations that increasingly we
38 have to meet.
39

40 I don't think we're that far apart but it may be that
41 Rob's done a lot more of the acting DMS role where he's had
42 to look at the complaints and that's sort of focused his
43 mind more than me, who has, you know, done responsibilities
44 that haven't seen as many of those come across my desk
45

46 DR WATERHOUSE: Dr Hodge, do you have a view on that?
47

1 DR HODGE: I think overall the system does provide
2 support. I think - but the problem is in any process, it's
3 the individual who ultimately takes the feeling of being
4 attacked, and that's the issue that you have in essence of
5 medical litigation, because you're being held accountable
6 for whatever. I think it relates to - is it related to
7 a bad outcome, is it decision based, whatever the driver
8 is, but however you take it, it's a personal affront to
9 yourself, and no matter how much support you actually
10 provide, you can't overcome that emotion, and that emotion
11 can be very soul destroying for individuals. You know, you
12 can have a good supportive system but it doesn't change the
13 emotion, and I think that's the problem with that part of
14 the system.

15
16 I don't know how you can change that, because that's
17 still the bottom line. Nobody's gone to work really to
18 harm; you've gone to work to do your job and if you have
19 had a bad outcome, you're still going to be called to
20 action on that and respond to any complaint, and they are
21 very hard. So I think we are supported, yes, but I don't
22 think it changes much.

23
24 DR WATERHOUSE: Any comment on that, Dr Hislop?

25
26 DR HISLOP: I would agree very much with Dr Hodge.
27 I think the supports are there, but the supports don't
28 change the affective component of being on the end of it,
29 and most doctors will do whatever they can to avoid finding
30 themselves in that situation, and definitely it's a driver
31 of defensive medicine.

32
33 DR WATERHOUSE: What about support to have the difficult
34 conversations and support when you want to maybe put some
35 limits around the care that will be offered. Do you feel
36 that that is something that clinicians are empowered to do
37 in an ICU setting?

38
39 DR HISLOP: We're empowered to have those conversations.
40 Unfortunately, we're not blessed with the power of
41 foresight to know whether they will go well or not,
42 although, you know, as you develop your skills, you can
43 start to - I think you can start to read the room sometimes
44 before you even enter into such discussions, so you can
45 develop ways to dip your toes in the water much more
46 gently. I don't think what's needed is really help in
47 terms of having the discussions, but I think it would be -

1 again, some of these outcomes are somewhat random. Despite
2 what your own clinical assessment is and your assessment of
3 what is the right course of action for this patient, what
4 comes after the conversation, the outcome after the
5 conversation is a blend of what you bring and what the
6 family bring) in terms of a whole bunch of complex inputs,
7 educational back ground, cultural background, religious
8 background, family dynamics. Very often it's one difficult
9 family member who is the one who drives what the outcome is
10 going to be.

11
12 Much easier, I would imagine, if you go to such
13 a meeting and say, "Here's the clinical situation. Here's
14 what we need to do and here's what we should do." You
15 know, I can imagine a situation in which there might be
16 demands for therapies that one might think are futile or
17 offer little benefit. If one could say, "Learned body X
18 has considered that and it's not allowed", that's a much
19 easier answer to give. That might sound a little "Big
20 Brother" and a little challenging, but, you know, often
21 people use the intensivists like that.

22
23 So there are times where I get consults from other
24 teams about a patient of ours, you know, can they be
25 admitted to ICU, and what they're really hoping is that
26 I'll say, "No", so that they can go to the families and
27 say, "Intensive care won't take you", which again is all
28 very difficult. Again, that's not really how the culture
29 goes. Now, 20 or 30 years ago, that's exactly how the
30 culture was. Intensive care would just say "No" and that
31 was it. But, you know, I think we've all - that approach
32 has changed over the years, and I think most of us try to
33 reach a consensus and an understanding with the family
34 and/or the patient so that people are satisfied that the
35 way forward is one that we can appreciate, understand and
36 accept.

37
38 That's an ideal outcome and I don't think any of us -
39 it's very rare that I think these days we would say things
40 like, "No". But sometimes, that's what other attending
41 teams are hoping for, and they can make it - they can blame
42 us rather than have to have the difficult conversations
43 themselves. But I think none of us really feel all that
44 comfortable being the one to just say, "No" either, so we -
45 I think most of us don't do that and we try and enter
46 a more - a more nuanced situation where we can agree on
47 a path forwards, with families and patients.

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DR WATERHOUSE: Dr Begbie, I think you want to add something?

DR BEGBIE: Yes. In their wisdom, if NSW Health instructed each board to have a complex care committee, or whatever it was called, and a clinician took a patient to that committee and the committee made a decision that was supported by the New South Wales Government, and then it becomes the complex care committee's responsibility for the decision that was made, as Rob has said, that would take a lot of pressure off those clinicians so that they're not making a decision as an individual clinician that the 95-year-old mother that's been loved and cherished by the family is not suitable for surgery in this situation; no, it's the complex care committee that's been set up by the state government, you know, and supported in different ways, so that, yes, you're not the subject of criticism when what you were trying to do was to see this as low value care - not that the individual was of low value, but the care was of low value, and that for the high-value individual that you don't want to give low-value care to, you're trying to explain to the family, you know, what they need is comfort at this point, not high-tech medicine, surgery, whatever it might be. That would be, I think, a potential solution.

THE COMMISSIONER: I can see a complex care committee being referred to as a "death squad" in some parts of the media, but --

DR HODGE: Could I make the comment? We tried at our hospital, many years ago, to do one and it was called a "death squad". That's exactly what it was called. You've got patients who you wanted to bring - and, "You're just creating a death squad" --

THE COMMISSIONER: Please don't think I think that's an appropriate term. I can just see that being a term used by - maybe it is too cynical - some parts of the media. But have there been --

DR HODGE: No, it was. It was the doctors who called it the "death squad", because we tried to introduce it and we tried to get a bunch of senior clinicians, and they said "You're taking away my authority as an individual to make a decision and you are just going to be the death squad."

1 So you're quite right, in the general --

2

3 THE COMMISSIONER: My question was: has there been
4 something in the past analogous or equivalent to a complex
5 care committee?

6

7 DR BEGBIE: We just had that illustration. That's why
8 I sort of changed from a low-value care committee to
9 a complex care committee, because there's probably less in
10 the term. We're going to have to make hard decisions one
11 way or another out of this Commission, and anything we do
12 that - well, anything we do like these big decisions - as
13 I've said, the smaller decisions we can probably do more
14 gently and easily - is going to be disliked in certain
15 circumstances, and I think it's the right thing to do. It
16 doesn't really matter what someone whose interests stood in
17 the way of calling it, you know, discussing it in negative
18 terms, shouldn't be a reason not to do it if it's the right
19 thing to do.

20

21 So I was actually thinking it was an active decision
22 that I'm making as a clinician: I think that what the
23 family want is not good for the patient, here's the case,
24 it's not a death squad as far as I'm concerned, I need some
25 help. I've voluntarily filled out the form, sent the case.
26 Whoever is independent of the case has analysed it and
27 given me a response. That's different from a committee
28 that overviews doctor X every surgical procedure he does,
29 and says, "Oh, no, I don't think you should do that one",
30 "Oh, no, I think that's" - no, this is referred by the
31 clinicians for input where the clinician and the family or
32 one member of the family, who might be against the other
33 members - you know, there's conflict and you're putting
34 together a body that provides advice, and it could be
35 a statewide body, because these things don't come up all
36 the time. Anyway. A thought.

37

38 DR WATERHOUSE: Just to that point, you mentioned before
39 possibly a board committee and then you've said a statewide
40 body. Is there a risk that by moving it further and
41 further away from the coalface, it comes to be seen that
42 these are people who are not necessarily in touch with the
43 decisions that you're grappling with?

44

45 DR BEGBIE: I'd prefer an LHD based one. But while we're
46 on the subject of boards, having been on the Mid North
47 Coast one for nine years, I really think it's important, as

1 we're making these crucial decisions, that boards do have
2 representatives on them, or at least advisers at every
3 meeting that provide input as to how challenging it is to
4 work in New South Wales hospitals.

5

6 DR WATERHOUSE: I'm going to come to boards in a moment,
7 if I might.

8

9 DR BEGBIE: I'll look forward to that.

10

11 THE COMMISSIONER: It may be better that it's dealt with
12 at LHD local level, but there is an assisted dying
13 committee, isn't there?

14

15 DR WATERHOUSE: There is a Voluntary Assisted Dying Board.
16 That's true.

17

18 DR BEGBIE: So we have a death squad already.

19

20 DR WATERHOUSE: In any case, if there were a committee of
21 this nature, say at an LHD level, would you see that as
22 being something that a clinician referred to and then was
23 able to say to the family, "I have the support of the XYZ
24 committee, that this is really not in the best interests of
25 your mother", or would it be - or would you see that
26 committee having a decision-making power, to Dr Hislop's
27 point a minute ago, that they used to rely on the ICU
28 saying no, so that a clinician would actually be saying,
29 "No, no, the committee has decided I can't go ahead and
30 offer this to your mother". How do you see it operating?

31

32 DR BEGBIE: I think it should have an audit and review
33 component so that cases are looked at retrospectively and
34 advice comes out of the subcommittee and committee that
35 ends up being advisory and educational, and then really it
36 has to be available on an ad hoc basis for difficult cases,
37 because you can't wait, with the patient on the ward, for
38 three weeks until the next monthly meeting of said
39 committee. It needs to go out to them with a basic set of
40 information, more questions to be asked and, you know,
41 a meeting over Teams to, you know, discuss it and then come
42 back with recommendations, and how much teeth it has
43 I think is very much a question for NSW Health: do they
44 want it to be a body that says, "No, the system's not going
45 to fund that and therefore you cannot do it", or is it
46 a body that is going to say, "The advice of the committee
47 is that you go down this pathway if the senior clinician

1 either has already gone down an alternative pathway because
2 they couldn't wait - there are problems there - but, you
3 know, anything along these lines will need to be thrashed
4 out in detail.

5
6 But, yes, I think it could very well do the job of
7 looking at cases in retrospect and saying, "In future,
8 don't you think we should be doing things differently?"
9 That would be far less confrontational than the actions of,
10 you know, "No, you will not do this." Although there may
11 be cases, and certainly there are cases, that hit the media
12 that go through the courts, where long-term ICU decisions
13 have to be made and the legal system becomes involved.

14
15 So at a lower level than those sorts of cases, where
16 there's time to make a decision, a patient on a waiting
17 list, for example, and whether they're suitable - those
18 kinds of things - much more difficult in the acute sort of
19 emergency situation to get all the information, to get it
20 to a committee before a decision needs to be made
21 prospectively.

22
23 DR WATERHOUSE: Dr Hodge, what are your thoughts on the
24 model that is being described there, or variations thereof?

25
26 DR HODGE: We've instituted a high risk anaesthetic clinic
27 to actually prevent those patients - they come, they're
28 assessed by the anaesthetists first, and that has actually
29 been highly successful, because we've actually sought that
30 other person's input to say, "No, no, the person is going
31 to have a really bad outcome. They're not going to survive
32 the procedure from an anaesthetic perspective." So that
33 has actually been very, very beneficial.

34
35 I think the concept of some sort of recommended
36 process from above would be great because it would
37 institutionalise that process within each of the facilities
38 that are actually having to deal with this and it would put
39 it at the forefront of a process that is a bit haphazard,
40 because we've instituted that and that bit works there
41 locally, when we tried to take it to the next level of an
42 acuteness - so that's actually great for some of those
43 patients coming through who are more borderline. When
44 you're trying to deal with an acute problem, with an
45 emergent issue, it's very much clinician dependent on how
46 that clinician will actually drive that conversation, and,
47 you know, in many respects, it comes down to that person's

1 view of end-of-life processes. I mean, I'm moderately hard
2 in that concept, I would say somebody's not going to do it
3 or if I've got the difficult conversation, I'd say,
4 "I don't believe this is right for this patient. It is
5 really an affront or an assault on that person to do
6 something that we know is not going to work." You know, in
7 essence, they do a laparotomy, they're going to be cut open
8 and they end up dying anyhow.

9
10 That's a horrible way of dying, and it is the reason
11 why the concept of those end-of-life processes are
12 documented so nobody gets the last 10 minutes of their life
13 with somebody jumping on their chest and breaking all their
14 ribs, and we need to proactively treat those individuals
15 with respect as they die.

16
17 Now, I feel strongly about that, so we make sure that
18 that, for my patients, when we know that's going to occur,
19 documentation is there, everything happens - I have that
20 problem with my parents at the moment. They've been in
21 hospital and I very strongly make sure that if there was an
22 adverse event, nobody is to do that to them, because it
23 is - to me, that is just an assault. We are very good at
24 sometimes not being proactive enough, and it's got to be
25 clinician led, unfortunately, and we have to actually
26 I think empower, and the concept of some processes more
27 formalised would be great, because I think it gives power
28 to clinician bodies to set up and actually be more
29 responsible for some of those decisions.

30
31 I think we've done it in steps. We've tried to do it
32 more formally. As I say, we got called a "death squad"
33 when we raised it, and we were just going, "We can't take
34 on the rest of the individuals with that concept", because
35 we were just trying to be supportive, "If you've got
36 a difficult case, we're happy to get a group of senior
37 clinicians to actually help you through that difficult
38 decision-making process", but that person has to be asking
39 for that help.

40
41 Often the ones that don't ask, they don't want it;
42 they're already determining that clinical outcome. Those
43 that would ask are probably already having that
44 conversation, because many times, if you're having that
45 conversation directly with the family or whatever, as we've
46 said before, you're already in that process of diverting or
47 changing the outcome of not operating.

1
2 The problem you have, that we alluded to before, is
3 the first point of contact is often the most junior people,
4 which creates our system, in the sense of it's their
5 experience or their first comments that are held often by
6 the patients or the relatives. Many patients who are
7 elderly, believe it or not, if they know they're going to
8 die - they actually know they're going to die, I have
9 conversations every day with people in their 90s or their
10 late 80s who are frail about doing procedures. They get
11 sent for something and, honestly, you ask them a simple
12 question because they get sent - because maybe something is
13 wrong and somebody thinks they might have cancer, for
14 instance, you ask them, "Now, if we investigated and looked
15 for this and we found it, what would you do", "Well,
16 doctor, I wouldn't do anything, I'm too old". They
17 actually know and they have answered the thing themselves.
18 They are often sent and steered into a course by somebody
19 else, and that happens still when they come and present to
20 the emergency department.

21
22 Our registrars, when they do - if they haven't thought
23 about, in essence, non-operative management, the first
24 thing they talk about is, "I have Mrs Smith who has
25 a problem and she needs" - "needs" is always the greatest
26 word ever brought out. "Needs an operation to do this",
27 and I sit there going, "Really? I don't actually think she
28 needs that at all. What she needs is appropriate care, not
29 an operation."

30
31 But once it's started, once that train has left the
32 station, it's very hard to get it back in, and you have to
33 then, sometimes, go and spend a lot of time pulling it back
34 to actually change that course.

35
36 And so that's part of our system of how we actually -
37 that's very hard to change, because those people are always
38 going to be at the coalface.

39
40 DR WATERHOUSE: So those junior people are telling
41 a patient or a family of a patient what's possible, not
42 what's necessarily appropriate, reasonable, ideal, but what
43 is possible, and then as a consultant, you coming in and
44 trying to explain those other aspects becomes very
45 difficult because it feels like you are taking something
46 away?
47

1 DR HODGE: Much harder, because you've already given
2 something, where if you've got that different view of that
3 futility - "futility" is actually a bad word; we should try
4 to avoid that - the non-beneficial processes to that
5 patient, you then direct the whole course from the
6 beginning into a different way.

7
8 Now, I think that's a - I mean, we're spending a lot
9 of time talking about small areas here. I mean, they are
10 very costly. Most of this just reflects system change on
11 how we need to address and put our thinking into the
12 different layers of education and process. We have a
13 position for a junior fellow, and so they've got their
14 fellowship, they're coming into a role, they've given them
15 a position now as a consultant for a period of time, and
16 they struggle horrendously in their first six months when
17 they have to now take that ultimate responsibility of those
18 decisions.

19
20 They've been now out for, you know, from intern to
21 whatever, 10-plus years, 12 years, or something, in the
22 process of leaving university, and these concepts are very,
23 very difficult to deal with. We're ill-equipped with it at
24 the end of training, and how you then spend a lot of time -
25 the clever ones ring you all the time and you get phone
26 calls all day and all night about, "I've got this difficult
27 problem. How should I deal with this?"

28
29 The clever ones ask because they understand there are
30 issues to deal with. The ones who aren't, unfortunately,
31 as clever just go and do the operations and provide that
32 care that doesn't actually help the people. I can have
33 a discussion and go, "Why did you do that?" It doesn't
34 help the patient, it doesn't help the system, it doesn't
35 help the family because the family is still grieving. It
36 doesn't matter how you do it, if the patient dies, the
37 family is going to grieve. You're just changing the method
38 of grieving, and sometimes I don't believe you have done
39 the patient's end of life a service.

40
41 So they're hard. They're hard. There is no simple
42 answer. But I do think supportive processes that help
43 embed change would be highly, highly useful to us as
44 clinicians, because it would bring it to the forefront at
45 each facility to look at that process better than I know,
46 we're looking at it now. We're afraid often to raise these
47 issues of how that care is looked at and supported for the

1 clinicians, because we're leaving it to individuals.
2

3 In many respects, even when we came back to our first
4 discussion, leaving everything to an individual is perhaps
5 not sometimes the best method of providing care across the
6 system. Because individual decisions, although great, are
7 still individual decisions; they are not necessarily those
8 with the collective wisdom.
9

10 DR WATERHOUSE: Dr Hislop, did you want to comment on that
11 idea of the committee to support clinicians making these
12 types of decisions and some of the other points that have
13 been made?
14

15 DR HISLOP: I don't think I have a lot to add. I think
16 absolutely it could be very helpful, but I also can see how
17 such a committee could be labelled something that's fairly
18 unsavoury, so I'm not too sure that I have much to add to
19 that nuance that's already been brought out.
20

21 DR WATERHOUSE: Are there challenges with such a committee
22 in terms of - I mean, obviously we have talked about
23 potential negative media in some circles. Do you see that
24 there are also perhaps vested interests or people not
25 wanting to change practices that are longstanding?
26

27 DR HISLOP: Yes, and I can see there would be people
28 reticent to refer to such committees and to just go their
29 own way anyway. It might be interesting to find referring
30 to such committees who recommend that you should be more
31 aggressive in your therapies. I mean, that may well happen
32 as well. "This patient, we think they deserve this kind of
33 intervention, because you have overlooked", blah, blah,
34 blah. That would be helpful.
35

36 Sorry, I think I've gone off track a bit there. Can
37 you repeat the question, please?
38

39 DR BEGBIE: No, I think that's all right.
40

41 DR WATERHOUSE: Dr Begbie, sorry?
42

43 DR BEGBIE: I think that's a helpful comment, because most
44 Central American death squads have a fairly sort of
45 100 per cent ratio of fulfilling their purpose. They're
46 not there to decide that someone should, in fact, be
47 allowed to go free and thrive, and if this is a complex

1 case committee or whatever it's called, the decision, the
2 recommendation, may come, "No, do the operation", you know,
3 "There's enough data, there's enough will with the patient
4 and the family. We can see a value in proceeding with the
5 active course in this situation." You know, if every time
6 the committee recommended no active therapy, it may develop
7 that reputation. But it's there for complexity and for
8 advice and for education. It's not there as an excuse for
9 every clinician who wants a patient to go to hospice, that
10 that's the direction they should be going, and it should be
11 set up as such.

12
13 DR WATERHOUSE: I mean, obviously it wouldn't be possible
14 to make something like this mandatory because it's in the
15 eye of the clinician as to whether a case is complex and
16 meets the criteria, but how do you get around that issue of
17 some doctors never bringing forward a case because they're
18 completely comfortable making their own individual decision
19 even if other colleagues don't agree with them, and others
20 perhaps defaulting to bring lots of decisions because they
21 like the security of knowing a committee agrees with them?

22
23 DR BEGBIE: So they get caught up in the retrospectoscope.
24 So in the monthly meeting there's a retrospective analysis
25 of fractured neck of femurs, pelvic exenteration, whatever
26 it might be, and the data is examined and the outcomes are
27 looked at and a process starts. If four out of four pelvic
28 exenterations that one of the surgeons have done have ended
29 up in 30-day mortality, there's a question to be answered
30 there and a review is conducted: is this down to surgical
31 technique or is this down to patient selection?

32
33 So I think you support the people that want your
34 support but then you analyse the data in particular areas.
35 You know, it's happening at a quality board point of view
36 but, quite frankly, quality boards, quality subcommittees
37 have become an exercise in multiple people sending reports
38 that get eyeballed, not enough time for proper analysis,
39 and if you were restricted to sort of analysing, you know,
40 one topic at a time to look at quality in a particular
41 space within your LHD, there could be tremendous benefit in
42 that focus.

43
44 DR WATERHOUSE: Do you see that - sorry, I'll come back to
45 you, Dr Hodge - quality committee role as being perhaps
46 diverted to trying to meet KPIs that have been said and, in
47 fact, not focusing on some of the things that are important

1 to clinicians?

2

3 DR BEGBIE: Oh, look, any subcommittee can be diverted,
4 over time, to become completely useless and there needs to
5 be a regular review of whether it's fulfilling its
6 purposes. So - yes, and I think we should be reviewing all
7 of our board subcommittees for wasting time and resources,
8 as often they do.

9

10 DR WATERHOUSE: You talk about two types of surgical
11 procedures, but I'm mindful that you are a physician.
12 Would this committee also look at things like high-cost
13 drugs, admission to intensive care and non-surgical
14 intervention?

15

16 DR BEGBIE: Yes, absolutely, I'm not trying to divert it
17 on to Bruce's patch. Yes, and you could even set it up in
18 such a way that, you know, one medical and one surgical
19 topic was discussed each time, or, you know - and then
20 occasionally paediatrics and occasionally obstetrics and
21 gynaecology. Yes, there'd be scope to cover the breadth of
22 work that you were doing as a hospital. But yes, that's
23 a potential model that would cover those who are ignoring
24 these difficult decision-making processes.

25

26 DR WATERHOUSE: Dr Hodge, you were going to say something?

27

28 DR HODGE: Yes, I think following the thing we were
29 talking about the complex care and anaesthetic committee,
30 they often allow patients to go through, it's just
31 a complex patient. So what should we do with this complex
32 patient? Do you reckon it is good or do you reckon it's
33 bad? A lot of them go through, because we go, "No, no,
34 we'll actually achieve something useful".

35

36 It's actually seeking further clinical advice and
37 I think this is about clinical advice and support. It's
38 not about not doing something. It's about doing the right
39 thing. And that's, I think - we can't equate - the concept
40 is it's a "no" committee, it's not a "no" committee; we're
41 just taking a complex case and trying to analyse the best
42 use of resource or the best - actually we can even talk
43 about the best outcome for the patient is really what we're
44 after and does this benefit the patient or not and we will
45 say, "Yes, on balance, we all think this is the right thing
46 to do. It's complex, it's difficult, but I think we should
47 go ahead and do this", whatever we're going to do for this

1 patient. And that's just supportive processes for
2 clinicians in difficult circumstances. I think that's what
3 we're after.

4
5 DR WATERHOUSE: And does value-based health care take into
6 account not just what the outcome for the patient is but
7 what's important to that patient in terms of the outcome
8 that they are looking for?

9
10 DR HODGE: Ultimately, yes. In many cases you frame that
11 anyhow within your decision, because many patients you know
12 there are very many risk - you know, again, this is
13 surgically orientated, there are many risk calculators
14 there that say, "These are the outcomes, these are the
15 things to expect, you've got these co-morbidities, and on
16 average when you do this procedure, this is what happens to
17 this cohort of patients." And you say, you know, "You've
18 got a 40 per cent chance that the best outcome is going to
19 be, apart from death, you are going to sit in a nursing
20 home in a chair - that's it." And they go, "I don't want
21 to do that. I'm not prepared to take a 40 per cent risk of
22 being in a chair in a nursing home."

23
24 There are many similar processes that you can use to
25 document those outcomes. It's well known. There are vast
26 data banks now on those processes, and patients will adapt
27 to those things as well, because you are providing
28 information, which is all we need to do.

29
30 DR WATERHOUSE: I'm mindful of the time, Commissioner, but
31 I do have a few things I wanted to finish off on.

32
33 THE COMMISSIONER: Yes. All right.

34
35 DR WATERHOUSE: If we go briefly to talk about the board,
36 I understand that you have been on the board for nine years
37 or were you on - are you currently on the board?

38
39 DR BEGBIE: No.

40
41 DR WATERHOUSE: In what capacity were you on the board?

42
43 DR BEGBIE: I was a member of the board when it was first
44 constituted. So when the LHDs first constituted, I put in
45 an expression of interest and was invited to the board and
46 served eight or nine years. And, you know, I think in that
47 initial board in our particular region, there was

1 a hospital-based clinician from the north and myself from
2 the south, and it provided insights for the non-medical
3 members of the board as to what was actually going on.
4

5 Now, it's a balance. I mean, it's clear that you
6 don't want boards overwhelmed by vocal doctors running the
7 show, but my experience is, with the sort of people that
8 were selected for boards, that was not going to happen.
9 But I guess my reflection over the last few years since
10 I have left the board is that there hasn't always been
11 a voice to the board about what is actually happening on
12 the coalface. The voice comes from executive, who - it
13 comes through their own lens.
14

15 But there are alternatives. I mean, there would be
16 the possibility of making sure that there was an advisory
17 role for hospital-based clinicians, so they didn't
18 necessarily have a vote on the key decisions, but they were
19 there to advise every board meeting about the things that
20 were going on, and that could be selected from medical
21 staff councils or from executive medical and clinical
22 directors - a range of people, DMSs, et cetera, so that,
23 yes, the boards were being well advised.
24

25 Some of the complex things that will come out of this
26 Commission, boards will find difficult to get their heads
27 around unless they've got good advice from clinicians.
28 I think that's a feedback from my time in the role, but
29 also seeing the impact of relatively less coalface advice
30 to the board since I have no longer been there.
31

32 DR WATERHOUSE: One of the requirements under the Health
33 Services Act is that the board must invite the chair of the
34 medical staff executive council, or medical staff council
35 if there is no medical staff executive council, to every
36 board meeting. So does that happen in your district?
37

38 DR BEGBIE: It used to in a haphazard fashion when I was
39 on the board. Rob would be able to tell you how often he's
40 been invited in the last year. But because our board has
41 multiple sites to go round, it might be in Port Macquarie
42 twice a year and in Coffs Harbour twice a year, so the
43 presence of a, you know, large hospital clinician might be
44 once or twice a year, which may or may not be adequate for
45 the purposes of getting advice to the board.
46

47 DR WATERHOUSE: So is it also a case that one particular

1 person may come from one of those sites and is not
2 necessarily able to represent the breadth of what's going
3 on across the different facilities and different sizes of
4 institutions, et cetera?

5
6 DR BEGBIE: That could be the case except I take the view
7 that if you're a board member, it's your responsibility to
8 consult widely, and if you are an adviser to the board,
9 again, it's important that you're taking that
10 responsibility seriously.

11
12 One of the advantages of it being a DMS or a member of
13 the medical staff council or executive clinical director is
14 they are often present at all of the hospital-based
15 meetings and are hearing what the issues are. And they are
16 often the sort of interested, talkative people that get
17 around and work out what's really important to clinicians.

18
19 DR WATERHOUSE: Does it need to be senior doctors only or
20 could it be senior nurses, allied health practitioners?

21
22 DR BEGBIE: No. I mean, the board has, as well, had
23 hospital-based senior nurses. I can't remember senior
24 allied health. But it's whoever within the key clinical
25 sites is going to be a voice for clinicians. It doesn't
26 matter what their basic degree or initial training is.
27 They just have to speak up and, you know, it's that - you
28 know, the reality is doctors are often imbued with the
29 confidence to be a voice to power, and that's not always
30 the case in other craft groups, but it can be if you pick
31 the right person.

32
33 DR WATERHOUSE: Dr Hodge, noting that there is a seat at
34 the board, what's your perspective on how it should be
35 different to the current sort of rules that are in place
36 about having somebody there? How should it be different
37 from the medical staff executive council chair, or
38 whatever.

39
40 DR HODGE: To represent at the board meetings?

41
42 DR WATERHOUSE: Yes.

43
44 DR HODGE: The problem we've got is that if you just
45 appoint one person, they're just going to be a board member
46 by default, almost, because they're just going to be there
47 all the time. I suppose - in my time when I was on the

1 board prior to Steve, you provided some degree of clinical
2 input yourself on to decision-making processes.

3
4 I think the trouble is, as I said, it rotates around
5 a lot, certainly in our area, I'm not sure again what's
6 happening here in Sydney. I think we've never really had
7 a connection on that role. I mean, that's probably been
8 the problem. I don't know if Rob has been - I was chair of
9 the medical staff council and never got invited to a board
10 meeting, ever.

11
12 DR WATERHOUSE: How should it look different from your
13 point of view to that arrangement? What would you like to
14 see different?

15
16 DR HODGE: To be honest, I think the most important part
17 for clinicians is to be involved in some processes that
18 actually provide feedback. Does it have to be through the
19 board? I don't know. I think it needs to be done through
20 the executive. I think clinicians need some degree of
21 involvement in the decision-making processes that relate to
22 their facilities. You know, we're heavily hospital based
23 in that context, but across the component we have areas
24 that we interact with community-based services and
25 hospital-based serviced, but we're not involved in any
26 decision-making processes or actually provide input into
27 that.

28
29 Now, you're not going to be the ultimate
30 decision-maker, that actually doesn't matter, but you can
31 provide advice about what's going on at the front and
32 actually how you can direct adequate use of resource.

33
34 I think there are many committees, there are many
35 individuals providing lots of data out there, but we're not
36 really involved unless you're in certain circumstances.
37 I have my roles. There is lots of information that even
38 relates to my sub-specialty I don't get access to. You're
39 not invited to meetings in relation to surgery. That just
40 happens over there, and you sit there going, "Well, we're
41 the deliverer on the coalface of who is going to get what,
42 why and when, and somebody else who was commenting on the
43 decision that you made, they don't report to you."

44
45 We have a broken system in the sense of communication
46 and processes where the process of reporting and delivery
47 don't actually meet.

1
2 DR WATERHOUSE: To be clear, it could actually be
3 a connection in with the executive, not just with the
4 board, it's not a specifically board issue; is that
5 correct.
6

7 DR HODGE: I think, to be honest, the day-to-day running
8 of processes is all to do with the executive. The board
9 has its other financial roles and all the other bits and
10 pieces, and I think some intermittent things, that may be
11 useful, but service is still delivered by the executive and
12 on the ground, and I think that's where us as clinicians
13 are going to have greater input into that on-the-ground
14 process and how we interact with the executive to make the
15 on-the-ground decisions which are going to be reflected
16 back to the board through those proper channels and
17 governance that already exists.
18

19 DR WATERHOUSE: I would like to go to Dr Hislop because
20 I'm mindful of the time, we need to sort of wrap this up.
21 Did you have anything you would like to add in terms of the
22 role of clinicians either at board or executive level in
23 decision-making?
24

25 DR HISLOP: Yes, I do. I hold these views very strongly,
26 actually, and I think we should have better avenues of
27 input both to the executive and to the board.
28

29 Hospitals are a very different organisation, and
30 although hospital structure reflects a corporate structure
31 with an executive and a board, doctors at hospitals
32 represent a very different kind of employee to most
33 employees in the private sector, in private organisations.
34

35 We are particularly blessed with an ability to see
36 what is actually going on with the patients and with the
37 service and what is required, and I believe, over the last
38 several decades, the medical fraternity has found itself
39 increasingly sidelined from management of hospitals and
40 where they are going and where they are headed.
41

42 I do think it's difficult to find the right clinician,
43 because, you know, many senior clinicians are relatively
44 siloed and struggle to represent anything beyond - above
45 and beyond their own department, but I do think there are
46 the right individuals in hospitals who can represent
47 appropriately to the executive and to the board about

1 what's going on on a global scale in terms of health care
2 delivery in our hospitals.

3
4 So I think that it's very clear that in New South
5 Wales in recent years, medical staff have gradually been
6 being weeded out of the boards. I can tell you that across
7 the statewide medical staff council chair meetings that are
8 had on a regular basis, there is great dissatisfaction with
9 the fact that really across the state the medical staff
10 have been weeded out of those boards and I do think it's
11 incredibly important that the right person or people have
12 some input at board level.

13
14 Now, I don't think they necessarily need to be board
15 members but I do think they should be invited to board
16 meetings. Who is the right person? I think the right
17 person is, as you have suggested, the medical staff council
18 chair or the medical staff executive council chair. They
19 are selected as the right person to represent the body of
20 the senior medical staff.

21
22 I also think they should have appropriate input with
23 the local executive in particular the chief executive.
24 That hasn't been happening in our district for some time.
25 I think there have been certain individuals who have had
26 access to the chief executive. Now, we have just lost our
27 14-year standing chief executive, so it may well be that
28 things will be different into the future. But I don't
29 think there have been appropriate structures and
30 appropriate input from senior clinicians with a broad view
31 in our network to be able to feed back to the executive,
32 nor to the board.

33
34 The problem I think you have, when you exclude medical
35 staff from being able to take part and engage in these
36 conversations and discussions and actively engage in how to
37 bring services forward, you actually encourage not just
38 disengagement but you can actually encourage interference.

39
40 So absolutely I think there is a very big problem with
41 a lack of bringing in appropriate medical staff who have an
42 appropriate holistic view to be able to guide and advise
43 executive and board. And I think it needs to be at both
44 levels. The problem you have if it's just at executive
45 level is that there can absolutely be a sanitation of the
46 message that's delivered when that message is delivered to
47 the board through the executive. So I think both levels

1 are required.

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I can say that since the Commission came and visited us in the Mid North Coast some months ago, that I've had one very brief conversation with the chair of our board who has suggested that we should start to arrange regular meetings, which I welcome but has yet to happen.

DR WATERHOUSE: And just to clarify, I mean, the medical staff council structure was set up, as I understand it, to try and provide that conduit with management. You are the chair of the medical staff council. Is it your view that that can't work or it just is not working in your present context? Is that an option?

DR HISLOP: The medical staff council - our medical staff council works in a very cooperative, collaborative and healthy way with our local executive, ie, the network executive. But I would say we are entirely estranged from the LHD executive and from the board, really. And so I think that's a problem.

I think we're very lucky with the culture we have locally and the engagement we have locally, and we've worked very hard to foster that engagement, but there has been no avenue for engagement at LHD level, nor at board level, and I think that's a very big - I think that's a massive deficiency in our LHD that could be addressed easily and made so much better.

DR WATERHOUSE: Dr Begbie?

DR BEGBIE: I just want to clarify for the Commissioner that the chairman of the medical staff council is elected by the senior clinicians to be their representative. He is kind of like the shop steward. I did that role many years ago and so did Bruce. The executive clinical director, which is the job I do, is the Garling role, which is supposed to be the bridge between senior clinicians and the executive, and therefore I've had more interaction with senior executive, and it would be completely ridiculous if I didn't, because that's my job. But both the representative of senior clinicians and the executive clinical director, by rights, should be regularly meeting with the executive and sometimes that happens and sometimes it doesn't. It should be mandatory.

1 DR WATERHOUSE: Is there a doctor on the executive of the
2 district?
3

4 DR BEGBIE: No, no, not the first couple of tiers of the
5 LHD.
6

7 DR WATERHOUSE: No executive director of medical services
8 or anything?
9

10 DR BEGBIE: Sorry, so we just for the first time appointed
11 a district director of medical services, and under the
12 district director are network DMSs and deputy DMSs. So,
13 yes, there are doctors within the executive, and they are
14 very busy with all of the nuts and bolts stuff, rather than
15 as much of the high-end advisory role that these kind of
16 positions could provide.
17

18 DR WATERHOUSE: Commissioner, I have no further questions.
19

20 THE COMMISSIONER: Can I just ask the three of you, is
21 there anything important that you don't feel you have had
22 the opportunity to say?
23

24 DR HODGE: Could I just make one comment? This is
25 a separate issue on funding and on the method of funding,
26 and clearly there has been a focus of government on meeting
27 triple zero targets, particularly in surgery, and that's
28 all fine and, you know, that's getting everybody treated in
29 those clinically important times.
30

31 The problem is that the funding comes in spits and
32 spurts and we achieve a goal and then we withdraw the
33 funding and then we talk about giving some more funding
34 and - the problem with this on and off process is the
35 creation of more disengagement and more frustration. Given
36 the fact that we are talking about sustainability, it is
37 not sustainable to keep treating people in such a poor
38 fashion. And we have to actually remove ourselves from
39 that temptation. We need to be looking at how we actually
40 sustainably fund ourselves.
41

42 The unfortunate thing is in the post-COVID world, the
43 amount of money that was wasted in this desire both from
44 the Commonwealth and the state is absolutely just
45 astronomical, and although we achieve processes, from our
46 end here, you know, we send people down to Sydney for
47 a simple operation, flew them down with their partner, got

1 them a car transport to a private hospital in Sydney for an
2 operation that, in all honesty, could have been done
3 locally except the decision-making was we couldn't do it
4 and pay the price at our local institution, pay the doctor
5 50 bucks above whatever they were getting, but we would
6 spend \$5,000 on a process to send them down here.

7
8 That's just one small example but it happened many
9 times, and the outsourcing and the other processes of
10 patients - since June our waiting list locally has gone
11 from zero overdues to now 220, I think it is up again this
12 month, another 10 per cent, and, you know the question
13 is --

14
15 THE COMMISSIONER: Why has that happened?

16
17 DR HODGE: Because there is inadequate baseline funding to
18 meet the demand. Now, we could argue the toss back again
19 as to whether those patients should or shouldn't be there.
20 That's a separate question. But given the fact that they
21 are there and this is the system we are considering is
22 appropriate, the - we're just getting to the point where
23 we're going to have to do our next surge, and the problem
24 is that the number of people that we put that in relates to
25 very high-expense operations that take a lot of time,
26 because we can actually - the simple, quick ones, you can
27 push through to keep the numbers nice, and that's what you
28 do over time, you cherry-pick a system to make the numbers
29 look as good as you can. And we're left with this cohort
30 of patients who need more time and a bucket load of extra
31 money and then we disengage a very important cohort, and
32 most of this then relates to orthopaedics because of the
33 nature of them.

34
35 The same individuals, certainly in our institution,
36 and it would be fair across most acute public hospitals,
37 are responsible for about 50 per cent of all acute surgery
38 that is being done, and probably 65 per cent of the acute
39 time that is required, and we disengage them in this
40 process.

41
42 So what we need is the concept of sustainability and
43 assurance of processes of funding that's going to meet that
44 and an ability to negotiate with the system to work out how
45 we can best utilise that resource within our allocation.

46
47 Probably that's our biggest - from a surgical

1 perspective, that's our biggest thing that we're actually
2 facing at the moment, is how to keep that process of
3 engagement and sustainability going, because of the process
4 of funding.

5
6 We've got our budget coming up finally for the year.
7 It doesn't really matter to a degree, because you know
8 money is going to arrive. So everybody's getting paid.
9 But it's how we continue across our system to marry budget
10 demand, expectations, and none of those can actually - they
11 all have a different dollar value.

12
13 That's the difficulty that we have on the ground of
14 keeping our system going at the moment, from a surgical
15 perspective. It's because we are reliant on that flow,
16 regardless of sort of some of the discussions we've been
17 having already about the value of processes and the wastage
18 of money elsewhere.

19
20 The other issue is we constantly talk about savings in
21 the system, and at the moment, we can't spend to save, so
22 the right person in the right place is not considered
23 anything to be done because that may involve an FTE and we
24 don't like FTEs again. We're in that mantra again from
25 many years ago.

26
27 One of the other most important components is really
28 the avoidance of wastage, because if you don't waste, you
29 don't need to save, and our greatest saving is being
30 careful on systems and how we institute those changes.
31 That's behavioural. Again, which relates to engagement.

32
33 The problem we're having at the moment is to keep that
34 engagement because of what the healthcare system has been
35 through over the last couple of years, and it's very
36 difficult, and we send mixed messages. The messaging
37 component again of several years ago is we're all putting
38 gloves on to do everything and now we've got a gloves off
39 campaign. It's very difficult when we keep changing
40 direction.

41
42 Again, probably the first direction was slightly
43 wrong, done in good faith but wrong. And we're doing this
44 across our system all the time, when we just react to an
45 acute problem rather than plan for the future. That's
46 about all I need to say but that's the biggest thing that
47 I can see from my perspective.

1
2 DR BEGBIE: And I'll segue straight on. I agree with all
3 of that, but the other thing is that if we want to be an
4 innovative health system, we do need to escape from the sea
5 of red ink to the point where, if some innovation, many of
6 which have been demonstrated in research to save money, is
7 logical, we're now in a situation where that innovation is
8 not actioned because the system doesn't believe it can
9 afford the up-front cost in place of the saving that will
10 come later and, yes, we're --

11
12 THE COMMISSIONER: Can you give me an example of that?
13

14 DR BEGBIE: Oh, look, when you demonstrate that putting on
15 an allied health practitioner on the weekend is going to
16 get six people home, saving you \$6,000, when the physio
17 might have cost you 400, 500 dollars, you need to spend the
18 money to save the money, and that's the kind of thing that
19 finance are forbidden from doing. Anything new or
20 innovative is verboten and we need to move past that and
21 see, you know, that's a value intervention and we must
22 spend money on things that are going to save us money.
23

24 THE COMMISSIONER: That sounds closer to commonsense than
25 innovation, but --
26

27 DR BEGBIE: Yes, but in a health department that is
28 obsessed by FTE and red ink, it's very difficult for them
29 to seek and receive permission to do any of those
30 cost-saving efforts. Then, you know, when there are
31 organisations within the instrument of NSW Health like
32 pathology New South Wales and NH&MRC, whose goal should be
33 to innovate and encourage clinical research, who it almost
34 seems are actively sitting on their hands not encouraging
35 such important work, you know, those are organisations that
36 need internal review and improvement so that we, as
37 clinicians, can see them as partners in research and
38 innovation rather than hurdles that we need to jump over.
39

40 I could give you more detail but I think we're running
41 out of time but it's something perhaps to pursue into the
42 remains of the Commission.
43

44 THE COMMISSIONER: Okay. We will do that.
45

46 Dr Hislop, is there any final observations from you?
47

1 DR HISLOP: Thanks, Commissioner. I just very quickly
2 wanted to clarify my last comments around board and
3 executives. Just very quickly, I did want to say that our
4 new chief executive has also reached out and touched base
5 with me, so I am hopeful that I may have a more engaging
6 relationship with the new chief executive that we have into
7 the future, so I'm looking forward to that.

8
9 And just to acknowledge that, yes, in the last
10 12 months, in our district, we have had appointed
11 a district director of medical services and his appointment
12 has been unbelievably good for our network. His work has
13 been amazing and much appreciated, his contributions, they
14 have been huge and he has done wonders for the care of our
15 patients and the morale in the hospitals and the work of
16 the doctors. So it is not all without hope and some of it
17 has been very good.

18
19 THE COMMISSIONER: Thank you.

20
21 Mr Chiu, is there anything that you would like to ask?

22
23 MR CHIU: I have no questions, thank you.

24
25 THE COMMISSIONER: To the three of you, thank you very
26 much for your time. We know how busy you are and we're
27 very grateful. So thank you again.

28
29 We will adjourn until - I will make it 2.15.

30
31 <THE WITNESSES WITHDREW

32
33 LUNCHEON ADJOURNMENT

34
35 THE COMMISSIONER: Yes, Dr Waterhouse.

36
37 DR WATERHOUSE: Commissioner, as I flagged earlier,
38 members of the second clinical panel today will be giving
39 evidence about funding concerns in an outer metropolitan
40 area. That area is Nepean Blue Mountains Local Health
41 District.

42
43 During visits to regional, rural and metropolitan
44 districts, the Inquiry team has heard about various funding
45 challenges. In the visit to Nepean it was apparent that,
46 although this is regarded as a metropolitan LHD, some of
47 the issues in that district that were identified appear to

1 align with some of the regional issues that we've also
2 heard about.

3
4 Concerns were raised about funding allocations to this
5 district being inadequate and also inequitable compared to
6 other districts, and in particular, to meet the needs of
7 the community that faces significant disadvantage. So we
8 have four clinicians on this panel. The three doctors are
9 here in the court. They are Associate Professor James
10 Mallows; Dr Stavros Prineas; and Dr Nardeen Habashy; and
11 online we have Mr Darryn Egan, who is a registered nurse
12 and team leader with the Penrith community mental health
13 team.

14
15 I'm told that Drs Mallows and Prineas will be giving
16 evidence by way of affirmation and that Dr Habashy and
17 Mr Egan will take an oath.

18
19 <JAMES LESLIE MALLOWS, affirmed [2.17pm]

20
21 <STAVROS PRINEAS, affirmed

22
23 <NARDEEN HABASHY, sworn

24
25 <DARRYN GERARD EGAN, sworn

26
27 <EXAMINATION BY DR WATERHOUSE:

28
29 DR WATERHOUSE: Dr Mallows, if I can start by getting you
30 to state your full name for the record, please?

31
32 ASSOCIATE PROF MALLOWS: James Leslie Mallows.

33
34 DR WATERHOUSE: And you are the chair of the Nepean
35 Hospital medical staff council?

36
37 ASSOCIATE PROF MALLOWS: Yes.

38
39 DR WATERHOUSE: And the chair of the medical staff
40 executive council for the district?

41
42 ASSOCIATE PROF MALLOWS: Yes.

43
44 DR WATERHOUSE: I understand you are also an emergency
45 medicine physician.

46
47 ASSOCIATE PROF MALLOWS: Yes.

1
2 DR WATERHOUSE: And director of emergency medicine
3 research for Nepean Hospital?
4
5 ASSOCIATE PROF MALLOWS: Yes.
6
7 DR WATERHOUSE: And you are a clinical associate professor
8 at the Nepean Clinical School; is that correct?
9
10 ASSOCIATE PROF MALLOWS: Yes, Sydney University.
11
12 DR WATERHOUSE: Dr Prineas, could you please state your
13 full name for the record.
14
15 DR PRINEAS: It is Dr Stavros Prineas.
16
17 DR WATERHOUSE: You are the chair of medical staff council
18 for Blue Mountains district hospital.
19
20 DR PRINEAS: Yes, I am.
21
22 DR WATERHOUSE: You are the head of anaesthetics at Blue
23 Mountains and Springwood hospitals; is that correct?.
24
25 DR PRINEAS: That's correct.
26
27 DR WATERHOUSE: And I understand you also run a patient
28 safety consultancy firm by the name of ErroMed.
29
30 DR PRINEAS: That is correct.
31
32 DR WATERHOUSE: Dr Habashy, could I get you to please
33 state your full name for the record?
34
35 DR HABASHY: Nardeen Habashy.
36
37 DR WATERHOUSE: You are an advanced trainee in
38 endocrinology at the Nepean Hospital?
39
40 DR HABASHY: Yes, that's correct.
41
42 DR WATERHOUSE: Have you done all of your training at
43 Nepean Hospital?
44
45 DR HABASHY: Yes, save for three months as a secondment at
46 Ryde Hospital, but yes, otherwise yes.
47

1 DR WATERHOUSE: If we turn to you, Mr Egan, can you hear
2 me clearly?
3
4 MR EGAN: Yes.
5
6 DR WATERHOUSE: Could you please state your full name.
7
8 MR EGAN: Darren Gerard Egan.
9
10 DR WATERHOUSE: You are the team leader, as I mentioned,
11 at Penrith community mental health team.
12
13 MR EGAN: That's right.
14
15 DR WATERHOUSE: And you are a registered nurse by
16 background?
17
18 MR EGAN: Yes.
19
20 DR WATERHOUSE: I understand that you were previously
21 a nurse unit manager in an inpatient setting; is that
22 correct?
23
24 MR EGAN: Yes, so for the old Pialla unit and the
25 high-dependency unit so at Nepean hospital, yes.
26
27 DR WATERHOUSE: At Nepean Hospital?
28
29 MR EGAN: Yes, yes.
30
31 DR WATERHOUSE: I might start by just referring to
32 Dr Mallows' submission that you made on 1 November 2023.
33 I understand that the other witnesses giving evidence were
34 part of the meeting with the Commissioner and the Inquiry
35 team on 21 October, but they haven't made separate
36 submissions or statements.
37
38 Have you had a chance to review your statement -
39 sorry, your submission, Dr Mallows?
40
41 ASSOCIATE PROF MALLOWES: I skimmed over it earlier in the
42 week.
43
44 DR WATERHOUSE: And through that process, have you been
45 able to confirm that it is true and correct to the best of
46 your knowledge?
47

1 ASSOCIATE PROF MALLOWS: I'm comfortable with the contents
2 of the submission.
3
4 DR WATERHOUSE: Commissioner, I would like to tender that
5 document, if I may. I'll just read the number for the
6 transcript. It's SCI.0011.0536.0001.
7
8 THE COMMISSIONER: I now have three copies.
9
10 DR WATERHOUSE: Excellent. I don't propose putting that
11 up on the screen at all. It does, however, contain some
12 helpful graphs that might be of interest going forward.
13
14 THE COMMISSIONER: Yes.
15
16 DR WATERHOUSE: If I can just talk about the content of
17 that submission a little bit, you refer on the first
18 page to the emergency department at Nepean Hospital being
19 routinely completely overwhelmed.
20
21 ASSOCIATE PROF MALLOWS: Mmm-hmm.
22
23 DR WATERHOUSE: You say there are more patients or the
24 presentations are increasing, the patients are sicker and
25 there is a lack of inpatient beds that you can move them
26 into; is that correct?
27
28 ASSOCIATE PROF MALLOWS: Yes.
29
30 DR WATERHOUSE: You also talk on that page about staff
31 being very committed to trying to do the right thing by
32 patients --
33
34 ASSOCIATE PROF MALLOWS: Yes.
35
36 DR WATERHOUSE: -- but some staff burning out in the
37 process of going through the work that they do.
38
39 ASSOCIATE PROF MALLOWS: Yes.
40
41 DR WATERHOUSE: Can you just perhaps expand on that and,
42 in particular, outline the period over which you have seen
43 that situation develop?
44
45 ASSOCIATE PROF MALLOWS: Okay. First of all before we
46 start, is it possible for me to get a copy of the
47 submission to refer to? I didn't bring a copy. Sorry

1 about that.

2

3 I may not need to refer to it but we will see how we
4 go.

5

6 Could you just repeat the question, please?

7

8 DR WATERHOUSE: My question is: if you could just tell us
9 over what period that situation has evolved and perhaps
10 expand on it, to the extent that you wish to, in terms of
11 how you would describe the situation.

12

13 ASSOCIATE PROF MALLOWS: Okay. So basically - I mean,
14 the trouble is I've been in an emergency physician for,
15 like, 20 years and there are periods where it's been like
16 that over that time.

17

18 I'm going to focus more in the last two or three
19 years, but certainly the problem is longstanding and it's
20 been longstanding because of the lack of inpatient beds.
21 A lack of inpatient beds then leads on to very poor
22 emergency department flow of admitted patients and then,
23 you know, it's like plumbing, you get the blockage on the
24 wards, then the blockage in the ED, and that contributes to
25 ambulance ramping and contributes to patient wait times.

26

27 More specifically about the burnout, the staff
28 burnout, I think what we're starting to talk about is moral
29 harms. You know, we're trying to do the best for our
30 patients but in relatively substandard conditions.
31 I wouldn't mind talking to those conditions at some point,
32 but the reality is, you know, we are hampered by the
33 conditions.

34

35 In a perfect world a patient would have an adequate
36 and thorough assessment in an actual hospital bed. Now, it
37 turns out that, you know, because of the overwhelming
38 number of patients and the lack of flow and the lack of ED
39 beds, first of all, we've changed our model of care so
40 that, you know, we can do some of our assessments and
41 patient management in examination couches or in comfy
42 chairs. We do start the ball rolling on patients on
43 ambulance stretchers when we have significant access block.
44 But that will, you know, decrease the quality of care and
45 it's not good for the patients.

46

47 So when you get back to staff burnout, there is a lot

1 of moral harm when it comes to staff looking after these
2 patients, knowing that you're not doing the best job that
3 you can for these patients, outside of, you know,
4 conditions of your control.

5
6 Even, you know, managing very, very sick patients on
7 an ambulance stretcher while we're trying to create
8 a resuscitation bed, you know, that creates a lot of angst
9 because the patient needs a resus bed but we just have to
10 wait for it, and then a lot of stress about, well, how are
11 we going to create that bed because we're full elsewhere?
12 See what I mean? So what we're seeing now, the burnout,
13 we're really talking about moral harm and the stress that
14 comes with that. Not only that --

15
16 DR WATERHOUSE: Could I stop you there? Could you define
17 for the court what you mean by "moral harm"?

18
19 ASSOCIATE PROF MALLOWS: It's a very subjective term,
20 obviously, but it gets back to what are we there for?
21 We're there to give the best care we can for the patient,
22 and that - you know, we are morally obliged to do that
23 outside of any sort of professionalism that comes with the
24 job, and so it is a very ill-defined term, but when people
25 are morally and making deliberate decisions to give
26 substandard care, that's the kind of harm that we're
27 talking about.

28
29 That obviously has psychological ramifications in
30 terms of, you know, how people approach their job, whether
31 they look forward to their job. You know, because that's
32 part of the burnout is when you stop looking forward to
33 coming to work. And then when you're at work, you know,
34 it's just a nightmare of, you know, substandard care
35 patient after patient, and then when you go home, how well
36 can you actually cope with that? Then it obviously has
37 ramifications on psychological health and psychological
38 safety, if you see what I mean, and all the ramifications
39 that come with that.

40
41 THE COMMISSIONER: Just pausing there for a moment, one of
42 the things you said in your answer was:

43
44 *We're trying to do the best for our*
45 *patients but in relatively substandard*
46 *conditions.*

47

1 ASSOCIATE PROF MALLOWS: Yes.

2

3 THE COMMISSIONER: Then you told me you wanted to say
4 something about that.

5

6 ASSOCIATE PROF MALLOWS: Yes.

7

8 THE COMMISSIONER: What do you want me to understand by
9 "relatively substandard conditions"?

10

11 ASSOCIATE PROF MALLOWS: So we have patients that have the
12 majority of their care in a chair, when in best practice --

13

14 THE COMMISSIONER: These are ED patients coming in?

15

16 ASSOCIATE PROF MALLOWS: ED patients. Best practice, they
17 would be in a bed. And we have patients in a chair
18 waiting, perhaps overnight, for a bed on the ward because
19 they are an admitted patient, and there are patients
20 presenting with conditions such as chest pain, cardiac
21 conditions, respiratory conditions, the list goes on, that
22 would be better managed in a bed, more appropriately
23 managed in a bed, but they sit in a chair and they get some
24 of their medical assessment and nursing care in an
25 examination couch.

26

27 But we have patients in chairs receiving intravenous
28 therapy, intravenous antibiotics and intravenous fluids.
29 There are patients that when they arrive to triage, we have
30 to make a decision in terms of how badly do we want this
31 patient on cardiac monitoring? It's not do they need it,
32 because often they do, and in a perfect world they would,
33 but we have to - that may not be available, because of the
34 situation we're in.

35

36 So we have to make decisions about where are we going
37 to put these patients, because in a perfect world they need
38 cardiac monitoring, they're not going to get it, and
39 obviously they need to be in a situation where we can
40 monitor them a bit more closely. That again begets moral
41 harm because you're making a decision about a patient that,
42 you know, very rarely may actually have a life-threatening
43 cardiac arrhythmia and they're sitting in a chair.

44

45 THE COMMISSIONER: But the conditions you're describing,
46 should I assume these are daily, not intermittent?

47

1 ASSOCIATE PROF MALLOWS: Hourly.

2

3 THE COMMISSIONER: Okay. So that means every day?

4

5 ASSOCIATE PROF MALLOWS: Yes.

6

7 DR WATERHOUSE: Just going to your references then to
8 a "perfect world" and to "best practice", is it your
9 understanding that Nepean is an outlier in this regard and
10 that there are not patients being treated in a similar
11 fashion - in chairs, et cetera - in other local health
12 districts?

13

14 ASSOCIATE PROF MALLOWS: Look, it's going to be difficult
15 for me to answer that accurately, but I suspect - and there
16 are patients that are best managed in a chair as well,
17 don't get me wrong. I feel as if, at Nepean, there's more
18 of a balance towards, you know, sicker patients being in
19 chairs. But beyond that, I can't really comment on other
20 EDs, but I suspect that - I mean, I have anecdotes which
21 are not really evidence, where, you know, patients get much
22 better flow, much better conditions in other bigger
23 departments with a lot more staff, nursing staff, medical
24 staff.

25

26 DR WATERHOUSE: Is this something that you --

27

28 THE COMMISSIONER: Sorry to interrupt, but just so
29 I understand this, is it a lack of available beds on wards,
30 a lack of beds in the ED or some combination of both?

31

32 ASSOCIATE PROF MALLOWS: It's going to be a combination.
33 So to cover the first point, we may have 30 admitted
34 patients waiting for a ward bed at 8am. That's especially
35 bad, you know, Monday, Tuesday. It has been up to 50, but
36 I think, over the last 12 to 18 months, I think we've got
37 on top of that partly because we've really taken the plunge
38 and opened extra beds on the ward.

39

40 Now, reality is when you look at those 30 patients
41 waiting for a bed at 8am, that's in the context of maybe
42 having 26 bed spaces and a lot more, maybe 12, 18,
43 examination couches and two internal waiting rooms. So
44 obviously when you put 30 patients waiting for a bed on the
45 ward into a 26-bed emergency department plus chairs, we're
46 going to be quite full. So that's the first point.

47

1 Then emergency departments get routinely overwhelmed,
2 but Nepean it's almost a daily occurrence because we're
3 getting 240, 250 patients a day now in a department that
4 may have been designed for 210.

5
6 I feel as if if there were no ward patients in the
7 ED - and we had an empty Ed - I think we would absolutely
8 do a lot better. But there may be cases that we would
9 still get overwhelmed just because patients do not present
10 throughout the day, they present - there's a bi-modal peak,
11 there's a peak at about 11am and a peak at 7pm, so when the
12 bus comes in, so to speak, we will get overwhelmed but with
13 a well-functioning department we can usually get over those
14 humps.

15
16 THE COMMISSIONER: When you use the term "overwhelmed",
17 should I understand that to be, at least in terms of how an
18 ED should operate, something like, "We're not able to move
19 patients that need to be admitted from the ED to a ward in
20 a clinically appropriate time"; is that --

21
22 ASSOCIATE PROF MALLOWS: Yes. Yeah, I think --

23
24 THE COMMISSIONER: My memory is, when we had our
25 roundtable out at Nepean, there was a concern expressed -
26 it may be more broadly than elderly patients, but a concern
27 expressed that elderly patients were spending an amount of
28 time in ED that was clinically significant, in the sense
29 that it had been likely to result in either an adverse
30 outcome or was certainly not the best provision of care
31 required; is that --

32
33 ASSOCIATE PROF MALLOWS: Yes. Can I also make a point,
34 when I use the term "overwhelmed", part of it is we have
35 a sick patient, can we put them somewhere appropriate? And
36 so we might get two or three all at once and we have no
37 place to put them in a timely fashion. So that's one
38 aspect.

39
40 And as you point out, yes, the elderly - you know,
41 they don't - it's not overwhelmed in a time point, so to
42 speak, but they just accumulate, and we may have six or
43 eight of those patients who have been waiting more than
44 24 hours for a ward bed, and that causes harm for that
45 particular group of patients. In fact, I've just had some
46 research published looking at Nepean's model of care and
47 how we offload ambulances, and it's pretty clear that the

1 patients that we can't offload from ambulances are the
2 elderly patients that have very poor morbidity, poor
3 mobility and largely, you know, waiting hours and hours and
4 hours for a bed on the ward.

5
6 DR WATERHOUSE: I just want to ask one more question
7 before I give a chance to the other witnesses to make
8 a comment. You talk about burnout of staff and you say
9 that that means not wanting to come to work. How does it
10 play out? In other words, how are you aware that staff are
11 burnt out?

12
13 ASSOCIATE PROF MALLOWS: Look, we talk, basically. You
14 can see it on the floor. You know, there are some nursing
15 and medical staff I have worked with for more than a decade
16 and you can tell when someone's not right.

17
18 THE COMMISSIONER: We've had the discussion of the word
19 "burnout" several times in the Inquiry, and what tends to
20 be - it shouldn't be what I think. What I'm told is that
21 it's not a reference to normal fatigue --

22
23 ASSOCIATE PROF MALLOWS: No.

24
25 THE COMMISSIONER: -- of being involved in provision of
26 healthcare services, it's something far more significant,
27 including one of the things you have said, not wanting to
28 go to work; it's disengagement.

29
30 ASSOCIATE PROF MALLOWS: Yes.

31
32 THE COMMISSIONER: A much deeper level of psychological
33 type harm.

34
35 ASSOCIATE PROF MALLOWS: Mmm.

36
37 THE COMMISSIONER: Is that what you mean?

38
39 ASSOCIATE PROF MALLOWS: Exactly. Yes.

40
41 DR WATERHOUSE: Does it play out in terms of an increase
42 in turnover of staff?

43
44 ASSOCIATE PROF MALLOWS: Difficult to say, because of
45 shortages and the fact that we have - you know, we have
46 a high turnover because nursing staff get a job and then
47 they get something somewhere else, so it's difficult.

1
2 There is definitely a type of person that enjoys and
3 thrives in emergency medicine, whereas there are other
4 people who do not, and that's just the nature of the piece
5 and that's totally fine.
6

7 But also importantly, I think, you look at sick leave,
8 and the example I'll raise is when you look at the JMO
9 cohort coming through, the PGY1s and 2s, the interns and
10 residents, they will have far higher rates of sick leave in
11 the ED compared to the wards. And there's a number of
12 factors that relate to that, but part of that is going to
13 be the shiftwork and the hard work and the 10-hour shifts
14 and the potential, you know, burnout towards the end of the
15 term.
16

17 DR WATERHOUSE: Dr Habashy, if I can just go to you,
18 you're, obviously, a doctor on the wards at Nepean Hospital
19 and you're taking patients from the emergency department to
20 be cared for on the ward; is that correct?
21

22 DR HABASHY: Yes.
23

24 DR WATERHOUSE: Would it be fair to say that what has been
25 described is consistent with your experience of visiting
26 the emergency department?
27

28 DR HABASHY: Definitely. I think I can - I've seen a lot
29 of what Dr Mallows is talking about. We've had multiple
30 instances of going down to ED to see our patients who have
31 said, "I have been here all night. I've been trying to
32 sleep in this chair. Can I just go home because I don't
33 want to wait anymore?" It happens all the time.
34

35 I was recently on the ward and we had two people who
36 were sitting in ED for - in a short-stay bed, in a bed, for
37 about four days because there was just no spot on the ward.
38 These were people who needed to stay in, they needed
39 investigations, they needed scans, they weren't people who
40 were appropriate to send home, so it definitely happens all
41 the time.
42

43 I think just to the point of burnout, from my
44 perspective - you know, as we've said I've been at Nepean
45 Hospital for a number of years now - I definitely think
46 I've seen it more. At the moment, I believe the resident
47 medical officers, so the junior medical cohort, the

1 residents are about 30 short at the moment, and those
2 vacancies - they are trying to employ people but the
3 remaining doctors are just having to pick up all the slack
4 and those doctors are very openly saying that they are
5 burnt out, that they're having to really pick up that extra
6 workload, and I agree, they're calling in sick because they
7 just - it's difficult to keep at the same momentum all the
8 time.

9
10 DR WATERHOUSE: And of those 30 --

11
12 THE COMMISSIONER: Sorry, can I just ask, the patients
13 that you talked about that were in short-stay beds for up
14 to four days, is that an outlier or are people routinely in
15 the ED that need to be admitted beyond, say, 24 hours?
16

17 Any one of you can answer this, by the way.

18
19 DR HABASHY: I mean, I wouldn't say it's a daily
20 occurrence or anything like that, but it has happened -
21 I couldn't quantify it for you, sorry, but it does happen
22 quite frequently. I can say at least people staying
23 overnight in the ED, that's a few times a week, I would
24 say, maybe two times a week at least. That's what we're
25 hearing from the patients. Then we're trying to give them
26 a plan to get them home as soon as possible so that they
27 can leave the hospital instead of being stuck.
28

29 MR EGAN: Can I just contribute to that based on
30 experience from yesterday? The nurses strike was on
31 yesterday. I usually work in the community, I was
32 redeployed up to do mental health assessments up in the ED
33 and up the TAC unit at Nepean.
34

35 We had two clients who were basically the previous
36 night really quite troubled and were agitated and
37 aggressive. Anyhow, I walked into an area, went and saw
38 the clinical NUM. She redirected me to an area that was
39 probably - it's an open area probably three times the size
40 of my office here. They probably had 15 people in this
41 area on chairs, with two clients - mental health clients
42 from the night before with security there watching them.
43 There was absolutely no dignity in that at all and you
44 couldn't even walk past - to actually get to the mental
45 health client, you were actually having to basically dodge
46 chairs and people and IV drips, et cetera, to get there.
47 It was - I have basically worked up at Nepean ED, when was

1 it, probably 15 years ago, for five years, I've never seen
2 it like that ever. Now, it may have been one day but it
3 backs up exactly what they're saying.
4

5 THE COMMISSIONER: All right. And, sorry, this wasn't
6 a problem caused by - a temporary problem caused by the
7 strike?
8

9 MR EGAN: No, no, this was basically - apparently from
10 what I was hearing, this was something that's quite common,
11 that you've got people in these - just on normal chairs,
12 just in an area that's - obviously you can't see my office
13 and I can't tell you how many metres it was, but I just
14 thought it was absolutely poor, like, absolutely no
15 dignity, no privacy at all, especially with someone who was
16 highly distressed the night before.
17

18 THE COMMISSIONER: Yes.
19

20 DR WATERHOUSE: Just going on from that, does that have
21 a flow-on effect in terms of the impact on those mental
22 health patients who have presented in a state of distress
23 and are now in a fairly stressful environment? Does that
24 have flow-on effects to them?
25

26 MR EGAN: Absolutely, especially - I'll probably talk
27 about this later, but probably 70 per cent, 80 per cent of
28 the guys we look after have major trauma backgrounds and
29 they're going into a situation where they've got people
30 with trauma sitting right next to them. There's no area
31 that's quiet, or basically we can deescalate or, as
32 Dr Mallows said, like a bed, you know what I mean, where
33 they can have a bit of privacy. There was none of that at
34 all.
35

36 DR WATERHOUSE: Sorry, I'll come to you Associate
37 Professor Prineas. Dr Habashy, just going back to what
38 you were saying about coming down to the emergency
39 department, seeing a patient there, do you find that you're
40 under a lot of pressure working on the wards to be
41 discharging patients where you might feel that they are not
42 quite ready or there are other perhaps limiting factors,
43 but you're under pressure to discharge to free beds for the
44 emergency department?
45

46 DR HABASHY: I think yes. I would say that there is
47 definitely a push to get people out of the hospital,

1 definitely, but at the same time, there's also a lot of -
2 there's a lot of hurdles, I feel, for a lot of patients to
3 actually get them out of the hospital. So I think at the
4 last roundtable discussion, I don't know if I mentioned
5 this but on our ward that we were working on there were
6 20 out of the 28 beds that we just couldn't - we couldn't
7 shift these people out to a sub-acute facility or home
8 because of various reasons, waiting for NDIS funding,
9 waiting for ACAT services, waiting for just various things
10 that were sort of outside of our control.

11
12 While there is a lot of a push to get people who can
13 go out of the hospital, and we're very happy to facilitate
14 that because we also want people to go out and be
15 functioning back into society, at the same time, there's
16 a lot of roadblocks to that and there's a lot of just, you
17 know, "What can we do? We're stuck."

18
19 I think a lot of the times our hands are tied and
20 we're going to different avenues, talking to the social
21 workers, talking to the occupational therapists, the NUM,
22 the discharge planner and everyone is shrugging their
23 shoulders saying, "Well, we have to wait for X, Y, Z."
24 Yes, for the moment, there's a green light, there's
25 definitely a big rush to get someone out of the hospital.
26 Yes, I think there are lots of fronts of blockages that we
27 need to face.

28
29 DR WATERHOUSE: Dr Prineas, what's the experience like at
30 Blue Mountains and Springwood and do you have other
31 comments to make more broadly?

32
33 DR PRINEAS: Thank you for asking. I think this is a very
34 interesting discussion. I'd like to make two points.
35 First of all, I would like to drill down on this concept of
36 burnout and drill into the psychology of it and why it's
37 simply more than just fatigue.

38
39 It's been described to me as being like acquiring
40 a sense of pointlessness, a sense of futility, a lack of
41 feeling valued, not being able to take pride - not feeling
42 like one can take pride in the work that one does, and
43 consequently, you just don't feel like going the extra
44 mile.

45
46 Now, that, not going the extra mile, is actually
47 really, really dangerous for any public healthcare system.

1 The minute clinicians perceive that they're going to just
2 work to rule or they're not going to go the extra mile when
3 it's required, when there's a patient in front of them,
4 there's no public healthcare system that can survive
5 sustainably without that goodwill.
6

7 So it's a very legitimate question, I believe - and
8 a very legitimate issue - that any healthcare system must
9 address. They must be able to make provision for being
10 able to preserve, nurture and support clinician goodwill.
11 It adds value - it doesn't just add value to the system, it
12 lubricates that system and it allows that system to
13 function. So that's the first point I wanted to make about
14 that.
15

16 The second point I wanted to make is a very practical
17 thing that's happening right now at Blue Mountains. Right
18 now we're having somewhat robust discussions between Nepean
19 and Blue Mountains about being able - Nepean being able to
20 send patients to Blue Mountains in order to redress their
21 elective list backlog, and we're receiving some push-back.
22 They want to be able to book patients as much as possible,
23 and if theatre lists overrun, at Nepean, they've got
24 a level 6 intensive care unit, they've got staff
25 everywhere, they have critical care backup. So if a list
26 overruns or if a patient has a complication, they can
27 accommodate it very well.
28

29 But those very same executives are actually pushing
30 for us to do patients up at Katoomba, and they're wondering
31 why we can't overrun. We have to say to them that we have
32 a very, very small fixed nursing pool. It's the same
33 nurses that are on during the day that are most likely to
34 be on during the night, and they're pushing a three in
35 one - a one in three or a one in four, and it's a very,
36 very small pool. We've already lost three anaesthetic
37 nurses in the last two months because of --
38

39 THE COMMISSIONER: You had better just explain for the
40 transcript when you mean when you say, "they're pushing
41 a three in one - a one in three or a one in four".
42

43 DR PRINEAS: I didn't mean three in one. I meant a one in
44 three, so one night in three or one night in four. They're
45 not only working during the day fully a 10-hour shift,,
46 they're actually on call for whatever happens during the
47 night, right? And they do that because they actually are

1 a family, they act like a family, they look after each
2 other. You come into the tearoom. The tearoom is already
3 full of sweet stuff. They know that they're beleaguered.
4 They know that it's just them and they have to look after
5 each other. But in the last three months we've lost three
6 anaesthetic nurses. They wouldn't say that they were burnt
7 out, but they were burnt out.

8
9 My point being that, as a result of that, when Nepean
10 ask us, "Can't we book that extra patient, just so that we
11 can get that waiting list down?", it's like, "You don't
12 understand that we can't actually afford to overrun because
13 our workforce is that fragile." That's my point.

14
15 ASSOCIATE PROF MALLOWS: May I make a couple of points in
16 response to --

17
18 THE COMMISSIONER: Yes, of course. All of you should feel
19 free to add to whatever your other colleagues have got to
20 say at any time.

21
22 ASSOCIATE PROF MALLOWS: There are a couple of things that
23 Nardeen brought up. The first point was, in short stay, is
24 this a reasonably common thing, patients just waiting in
25 three or four beds?

26
27 I want to give a little bit of background very
28 quickly. The emergency medicine short stay is 10 beds.
29 The target length of stay is 24 hours. It's for very rapid
30 and very quick turnover of emergency department patients
31 that don't require a ward bed, and there are a lot of
32 models of care for various patients.

33
34 Nardeen gave an example of a patient who has been
35 waiting there three or four days. It's almost routine.
36 Nardeen covers endocrinology but there are cardiology,
37 respiratory, general surgery, gynaecology patients. Name
38 a specialty. We have 10 beds, it's routine for a number of
39 patients in the ward to be waiting beyond the 24 KPI mainly
40 because there are so many other specialties.

41
42 For example, on Monday - we've got a 10-bed ward -
43 five beds were ward patients waiting for ward beds, and so
44 that, you know, affects how we can flow patients through
45 the ED in our 10-bed when we're actually functioning as
46 a five-bed.

1 The next question was is there pressure to discharge
2 patients from the ward? Yes. Because the example I will
3 give as medical staff council chair is that senior medical
4 officers get daily - up until recently, I'm not sure it
5 still happens now, but they would all get texts daily from
6 patient flow saying, "Can you discharge patients? Can you
7 discharge patients", which is, first of all, unnecessary,
8 because they're trying to discharge patients, they know
9 it's a problem, because every senior medical officer has
10 a patient in the ED waiting for ward beds. They want to
11 get done upstairs.

12
13 Then, second of all, it's just anxiety inducing. It's
14 like, "I know, I know, I know". See what I mean? They are
15 just the two points I wanted to make in response.

16
17 DR WATERHOUSE: If we go back to your submission, you talk
18 there about Nepean Hospital being underfunded compared to
19 peer hospitals with the same workload and also when taking
20 into account the needs of the local community.

21
22 ASSOCIATE PROF MALLOWS: Yes.

23
24 DR WATERHOUSE: Is there anything you want to expand on,
25 because I would like your colleagues to expand on that but
26 is there anything else you would like to say in relation to
27 that?

28
29 ASSOCIATE PROF MALLOWS: So I've been talking to a lot of
30 colleagues and I've got some talking points from different
31 specialties about what they have at Nepean Hospital and
32 what they have - what they've experienced in other
33 hospitals in LHDs, and across the board.

34
35 It's difficult because, as a doctor I can't really
36 talk about funding but certainly the resources available to
37 them to look after patients is significantly worse than
38 hospitals - other hospitals I have worked in the eastern
39 suburbs of Sydney.

40
41 There are two or three examples I will just touch on.
42 One is renal dialysis. There are patients getting
43 inadequate amounts of dialysis because of the lack of
44 dialysis in the western suburbs. So the standard is three
45 treatments a week for a certain number of hours. There are
46 patients who are getting two and there are patients that
47 are waiting a lot longer than they should to get on to

1 dialysis, compared to, you know, other hospitals in the
2 Sydney metro, where there's very, very little waiting
3 period to get on to dialysis and they're all getting the
4 standard treatment.

5
6 Cardiology, a massive, you know, wait for
7 catheterisation and angiography electively, and then
8 respiratory. We're the obesity capital of the world.
9 Obese patients get lots of respiratory problems, they get
10 sleep apnoea, they get respiratory failure, they get heart
11 failure, they need adequate assessment and adequate
12 treatment and there is no sleep lab at Nepean, whereas
13 there are sleep labs, sleep registrars, sleep nurses at
14 other units, other hospitals, and those patients are
15 getting, you know, massive amounts of care that we just
16 can't deliver at Nepean.

17
18 I have multiple other examples but I thought they
19 would be the big three that I would bring up.

20
21 DR WATERHOUSE: Mr Egan, can I go to you from the mental
22 health point of view, are you able to comment on what's
23 being talked about here and the comparison between what you
24 see in your district and what your colleagues might
25 encounter, if you are aware?

26
27 MR EGAN: Yes, look, one of our biggest issues is that
28 we're a very inpatient focused mental health service.
29 We've got a number of inpatient beds, but what tends to
30 happen is again, like, you know, 70, 80 per cent of the
31 people we look after, whether they've got a serious mental
32 illness, personality disorder or have got massive trauma
33 backgrounds, but the ideal model for looking after these
34 sorts of people is that you basically need to be doing
35 long-term psychotherapy in the community actually to
36 prevent self-harm attempts and admissions to EDs,
37 et cetera, and long-term recovery for these people.

38
39 I'll give you an example in my team. I've got
40 a psychologist here. Her wait list at the moment is up to
41 18 months, right? There's a number of community mental
42 health teams in the district, don't even have
43 a psychologist. Now, we try and make do by doing modified
44 programs, et cetera. There's one particular program for
45 people that have got severe trauma called dialectical
46 behavioural therapy. I know that Hunter New England has an
47 area that basically has the model that we ideally would

1 love because they can basically do group sessions,
2 individual sessions and people can contact them out of
3 business hours. We've got nothing like that.

4
5 What tends to happen is that when our guys become
6 overwhelmed, et cetera, or if their mental state
7 deteriorates, where is the first place they go to? They go
8 up to Nepean Hospital. If they have overdosed, they go
9 into Nepean ED. Often what happens then is that they get
10 put into our inpatient units which are quite traumatic by
11 nature. We have a hell of a lot of people in those units
12 on methamphetamine, with methamphetamine issues, et cetera.
13 They are quite aggressive, agitated, they come out
14 retraumatized again. They've actually come in for help,
15 they actually come out probably long term worse. Then
16 a lot of these guys won't even basically want to get help
17 because of what happens in the inpatient units.

18
19 So the whole prevention strategy for mental health,
20 it's just we don't - I can't see - we're basically so -
21 we'll build more and more inpatient beds. I know we're
22 building an adolescent unit at the moment, which is great,
23 but where is the real proactive preventative strategies,
24 which they're not - they're things that you can't just
25 throw a tablet at. These are things that we're talking
26 about, you know, rewiring people's brains, which takes
27 years.

28
29 DR WATERHOUSE: Just on that, you gave the example of one
30 particular local health district. Do you know from talking
31 to colleagues whether or not they do have sort of more
32 access to psychologists and the types of therapies you're
33 discussing in other districts?

34
35 MR EGAN: Yeah, look, I've got - yeah, I've basically
36 spoken to a couple of my guys who worked at Concord, in
37 that Sydney west, and also someone who has worked in at St
38 Vincent's. They've certainly got more access to some of
39 these sort of - I can't give you exact details but they're
40 saying that they certainly have more access to these
41 services. So if not the full program, like I'm talking
42 about that Hunter New England have got, they've certainly
43 got more resources that might be modified and more
44 supported.

45
46 DR WATERHOUSE: Dr Prineas, can you comment on whether
47 this is consistent with your experience in the two

1 hospitals where you work and more generally?
2

3 DR PRINEAS: Absolutely. The big ticket item, in respect
4 specifically to your question, which I'd like to bring to
5 your attention is the issue of perioperative assessment and
6 optimisation of patients.
7

8 Now, prior to working for Nepean district I worked for
9 Prince of Wales Hospital. Prince of Wales have got
10 a wonderfully well-coordinated multidisciplinary
11 perioperative unit that's run by the department of
12 anaesthetics, but it is an umbrella unit that encompasses
13 surgery, it encompasses cardiology, it encompasses
14 physiotherapy, respiratory, there's a full pre-habilitation
15 program, there's a move towards thinking of no longer
16 calling waiting lists waiting lists but calling them
17 preparation lists, so from the minute that someone has
18 booked, they're actually on track to being made ready.
19

20 Now, prior to about five years ago, while my
21 predecessor as head of anaesthetics at Blue Mountains
22 hospital was in charge, he inherited a system whereby,
23 because we don't have adequate critical care backup,
24 because we're far away, because we've only got two
25 operating theatres and limited staff, if we don't screen
26 our patients appropriately - and this used to happen
27 really, really frequently at our hospital - patients would
28 develop complication, the surgeons and the anaesthetists,
29 perfectly capable of managing those complications, but then
30 that patient became someone that could no longer stay at
31 that facility, had to be shipped down the road.
32

33 The rest of the list would be trashed. All those
34 patients would be cancelled because there was nowhere for
35 that patient to go and they would have to stay there and be
36 attended to by the anaesthetists until such time as the
37 retrieval team could come and take the patient down the
38 hill. And this used to happen quite a lot. Now, you could
39 only imagine the kind of unnecessary extra expense and
40 disruption to service provision that that would entail.
41

42 So my predecessor very, very - made a very, very
43 prompt decision that we were actually going to adopt a kind
44 of perioperative model. Even though we didn't have the
45 facility to do it, we decided that for our small cohort of
46 patients we would adopt the same kind of model that they
47 had at Prince of Wales.

1
2 We have a modest screening triage and assessment
3 program that we are very, very proud of and it's a model
4 that we've actually tried to offer to Nepean Hospital, that
5 deal with 5,000 patients a year, we only deal with, you
6 know, less than 1,000.

7
8 My experience of Nepean's perioperative management
9 system is that it's not a system at all. It's a poorly
10 coordinated ragbag of people trying to put things together.
11 As a result, a lot of patients present that - it's not that
12 they're not ready for care, but they could have been better
13 prepared for care. Some of them get cancelled in the
14 anaesthetic bay. Of course, that is an obvious unnecessary
15 expense. But then there are other people whose
16 perioperative course is nowhere near as smooth as it should
17 have been, and so these people end up having an extended
18 length of stay. They have to go to intensive care, or what
19 have you.

20
21 THE COMMISSIONER: Just to fill in the gaps, I take it
22 that the patient that you're referring to that gets
23 cancelled in the anaesthetic bay is because the
24 anaesthetist has made a decision that it's unsafe for that
25 particular patient to undergo anaesthesia for a particular
26 reason?

27
28 DR PRINEAS: Yes. That's our job. Our job is to be risk
29 assessors. I've had surgeons --

30
31 THE COMMISSIONER: But should it, with that reason, with
32 a better perioperative system, have been picked up far
33 earlier, ideally, is the point; correct?

34
35 DR PRINEAS: Yes, and not only picked up but optimised.
36 So you identify a problem, so you know there are going to
37 be problems, you're going to prepare appropriately for
38 that, but also you're going to act in a timely way to
39 approve improve that person's diabetes, to stop that person
40 smoking, to do various things to get them into a condition
41 where they --

42
43 THE COMMISSIONER: "You're too heavy for an anaesthetic
44 you need to lose some weight over the next three or six
45 months." I know that's tough but --

46
47 DR PRINEAS: Absolutely. Now, despite the fact that we

1 presented data I actually was - about four or five years
2 ago I wrote a revised perioperative model of care for the
3 district with the blessing of the head of my department.
4 We basically said, "What we need is we need the kind of
5 perioperative unit that is modelled on Prince of Wales
6 Hospital", and the pathway to doing it, the tool kit for
7 that is already provided by NSW Health. They've actually
8 created a template for how to create this thing.

9
10 We said, "You just need to spend a little bit of
11 money, create that unit, and it would pay for itself within
12 three years." But what we've experienced is that the
13 financial constraints imposed by the ministry on our LHD
14 are such that, even with all the evidence and all the logic
15 behind it, the managers were terrified to outlay that
16 money.

17
18 THE COMMISSIONER: As an investment.

19
20 DR PRINEAS: As an investment. So if I'm going to pitch
21 anything in terms of how do we streamline care so that it
22 is - so that we don't invite this false economy of saving
23 money by not investing in a perioperative unit only to find
24 that we're actually spending more money in complications
25 and lengths of stay - perioperative unit.

26
27 THE COMMISSIONER: Do you want to ask any more questions
28 on that point?

29
30 DR WATERHOUSE: Not on that particular point.

31
32 THE COMMISSIONER: Not on that particular point. Do you
33 mind if I just ask - this is for all of you, and it doesn't
34 flow precisely from what we've just been discussing, but
35 it's something I should have asked at the roundtable and
36 it's my fault that we didn't. But it was comments by your
37 chair and it was his introductory comment so I didn't want
38 to interrupt him and then I forgot to ask.

39
40 He was talking about the social determinants of health
41 in your LHD and lots of diabetes, lots of obesity, domestic
42 violence issues, Nepean Hospital chewing up 80 per cent of
43 the LHD's expenditure.

44
45 Then he was talking about - the first thing he really
46 raised with me - sorry, this is Mr Collins, your chair -
47 was that Royal North Shore Hospital has about the same

1 number of ED presentations as Nepean, but Royal North Shore
2 has 44 registrars and you have 15.

3
4 What I wanted to explore with him, and that I'll
5 explore with you now, if you can help me, is that gap must
6 be filled somehow, I imagine, whether it's locums or
7 I don't know, and what's the consequences of that gap?
8 Because obviously - let's make the assumption that Royal
9 North Shore doesn't have too many registrars, so 44 is
10 about right for the number of ED presentations, and bearing
11 in mind the health demographics of your LHD, how was that
12 gap between 44 and 15 filled and what are the consequences
13 of that gap?

14
15 ASSOCIATE PROF MALLOWS: Can I answer that first of all?

16
17 THE COMMISSIONER: Any of you, please.

18
19 ASSOCIATE PROF MALLOWS: Quantity begets quality. So when
20 you've got 44 trainees, they will usually be Australian
21 trained, know the health system, very good quality because
22 it's a highly sought after training position, and obviously
23 it's partly highly sought out because there's no burnout
24 and it is comfortable.

25
26 THE COMMISSIONER: Sorry to interrupt you, because I want
27 you to tell me this as well - I didn't explore this with
28 him, again my fault, but I made the assumption, which could
29 be right or wrong, that the gap between the 44 and the 15
30 was not some deliberate decision or even a funding issue;
31 it was probably more a workforce issue, but I might be
32 wrong about that as well. But anyway, throwing that in as
33 well.

34
35 ASSOCIATE PROF MALLOWS: No, it is absolutely, in part,
36 a workforce issue because we've had a lot of vacancies.
37 But even so, I feel as if Nepean is funded for 25 trainees,
38 accredited by the college, and we fill the gaps with more
39 junior staff, non-trainee staff.

40
41 I've sort of painted a picture of North Shore, and so
42 obviously Nepean, known to be busy, known to be stressful,
43 known to increase burnout, it's also a long way from where
44 a lot of doctors live and train, and so there are all of
45 those geographic factors. So what that leads to - I said
46 it to start with, quantity begets quality - so recently
47 we've had a model where we actually target international

1 medical graduates and we've got a number of doctors from
2 Sri Lanka, who have a moderately similar health system and
3 training to Australia, and we're essentially picking them
4 off the tree in Sri Lanka and they come over.

5
6 Don't get me wrong, they are very good people and will
7 turn into very good doctors and the cohort we've got are
8 highly satisfactory, very motivated and work hard. But
9 obviously they take time to get up to speed with the
10 Australian system that, you know, the 44 registrars at
11 North Shore don't need to. So there are the quality issues
12 there.

13
14 Then we also have a very junior cohort. I almost see
15 Nepean as - because I was director of training for about
16 10 years at Nepean - almost the A-league of emergent
17 medicine training, they start their training there, they
18 get good, they get a reputation and they finish off their
19 training at bigger units. So we will always have a junior
20 cohort because the senior guys want to move on, and often
21 they come back. We've probably got about 10 consultants on
22 staff who were trainees at Nepean, finished their training
23 elsewhere and came back, so definitely people see it as
24 a very good place to work, but in terms of the trainees, a
25 very difficult place to attract very good trainees.

26
27 The short summary is a very junior training cohort,
28 a lot of non-trainees filling the gaps, and then a lot of
29 international medical graduates filling those gaps.

30
31 THE COMMISSIONER: Anyone else want to - yes, go ahead.

32
33 DR PRINEAS: I can only speak for anaesthetic workforce.
34 I think one of the issues that our LHD executive has
35 struggled with is the idea that in fact, we are actually on
36 an unlevel playing field, because we are west of
37 Strathfield and everybody wants to live east of
38 Strathfield, and they don't like commuting, all their
39 friends are by the water or all the things they love to do
40 are by the water, and so it's challenging.

41
42 It's even more challenging going up the highway of
43 death to Katoomba hospital. So it's even more remote, and
44 so enticing people to come to fill out a workforce requires
45 incentivisation, which the LHD has said, "Yeah, okay, as
46 long as it's cost neutral." So now we've had to kind of
47 think of creating ways. So we're basically saying, "Okay,

1 what we'd like to do is we'd like to make Nepean a centre
2 of excellence for, I don't know, airway management or
3 regional anaesthesia or human factors, so we need to be
4 able to have resources that will create something to make
5 people attracted to come."
6

7 But then as soon as you say that, you get the look of
8 the cat and vegetables meme, where we're screaming at them
9 to give us stuff and the cat is just sitting there. So
10 they don't get that, in fact, we are in a disadvantaged
11 situation where we, in order to have equity, in order to
12 achieve equity, we need to do more than what is done
13 further east.
14

15 So our CEO would get very, very defensive when
16 I'd bring this up at board meetings. She would say "We're
17 not doing anything - we're doing everything that's
18 according to the New South Wales rule book in terms of
19 doing things, we have to do things like this." I'm saying
20 "Well, we're just going to have to get more creative about
21 how we address the fact that people just don't want to come
22 west."
23

24 DR HABASHY: Am I able to just extend on that? I actually
25 think, yes, I agree with both, of what has been said.
26 I think of an example, and again this is a bit anecdotal,
27 but I know in the urology department at Nepean Hospital,
28 they've put a lot of effort in, and you can correct me if
29 I'm wrong, but they have a robot. That has been a huge
30 source of incentivising senior trainees to come to Nepean.
31 So Nepean Hospital actually in urology is quite sought
32 after as a training position, because you know you're going
33 to get good training, you're going to have a robot which -
34 I think even Concord doesn't have a robot.
35

36 That has required an up-front investment into
37 something that they know will attract trainees to the site
38 to actually want to learn, and having really engaged, you
39 know, surgeons who are willing to teach and that sort of
40 a thing. And I think they have also put a lot of effort
41 into their junior trainees and everything to get them on to
42 training, so that's been a way that they've been able to
43 incentivise people to come to Nepean and actually want to
44 be here and train.
45

46 THE COMMISSIONER: Knowing how to operate this robot is
47 probably outside myself terms of reference. I don't need

1 to know, but what kind of robot are you talking about?

2

3 DR HABASHY: I don't know the name.

4

5 ASSOCIATE PROF MALLOWS: Can I come in there? Oh, Stavros,
6 actually; you might have seen it.

7

8 DR HABASHY: Does anybody know the name?

9

10 DR PRINEAS: I've anaesthetised for these people all the
11 time. It's wonderful, it's a robot called the Da Vinci.
12 Basically, if you're trying to operate in a very, very
13 confined space, where in order to get line of sight and get
14 your hands in, there's simply not enough space, what they
15 do is they have a surgeon that sits in a virtual booth with
16 goggles and with hands on, and is able to operate the
17 electronic arms, which are very, very delicate and fine,
18 but they're metallic, they're robot arms, and they're able
19 to get into nooks and crannies that you can't get into.
20 They make what would otherwise be a very, very bloody,
21 very, very messy and very, very challenging operation
22 faster and simpler.

23

24 DR HABASHY: My understanding is that they're extremely
25 expensive as an outright cost but it's been something that
26 has sort of paid off in having trainees actually come and
27 want to train. So I guess that was just an example of
28 something that has been effective.

29

30 And just in regards to --

31

32 THE COMMISSIONER: It is an example of a non-financial
33 incentive, I suppose, isn't it?

34

35 DR HABASHY: Yes. And then just in regards to the junior
36 workforce, I touched on this previously, but again, a lot
37 of them - there is no incentive to stay at Nepean Hospital,
38 and as I mentioned, when you short staffed chronically and
39 you are being asked, as a junior staff member, to fill in
40 the gaps for other things, then you can't focus on your
41 clinical work, you can't focus on study, you can't focus on
42 getting through your training or advancing yourself, and
43 therefore, you leave, you go to greener pastures or, you
44 know, you just burn out, essentially.

45

46 Again, I think I mentioned some of these things at the
47 previous roundtable discussion, but things like lack of

1 pharmacy support on the ward, that the JMOs have to pick up
2 that slack and that often leads to medication errors;
3 things like increased lengths of stay, because you are
4 getting reviews of someone with high blood pressure it's
5 actually it's just because their medication wasn't
6 correctly charted at the beginning of the admission, things
7 that are very avoidable; or the patient's medications were
8 not translated to an outside pharmacy and therefore they've
9 come back as a readmission because they've been continued
10 on a medication that was supposed to be stopped.

11
12 So all of these things that could be fixed by that
13 up-front by having that pharmacy support, junior doctors
14 having to do all the cannulas in the hospital. I think
15 it's very select - you know, there's maybe one nurse in ED
16 now that's there, but otherwise it's really all the junior
17 doctors who, between all of their clinical duties, between
18 just having to do all the other things they have in a day,
19 have to do all of the cannulas and all of the blood taking
20 and - not all of the blood taking, sorry, I retract that,
21 but have to take on that additional load.

22
23 Having to, as the inpatient team, call for family
24 meetings, call everyone involved and call the family to try
25 to organise and coordinate something that could be done by
26 a social worker or a discharge person, all these are
27 additional roles that are being increasingly asked of us to
28 just take on this role to fill in that underlying gap that,
29 if we had that workforce, could be alleviated.

30
31 To what Dr Mallows was saying before, I totally agree,
32 I think we need more beds on the ward but I think not just
33 beds, we need people to actually staff those beds, because
34 we're not even staffing the beds we have at the moment
35 appropriately and we're just trying to fill in the gaps.

36
37 I think one of the other points that was made was,
38 you know, that not wanting to take the extra mile. I have
39 definitely seen that progressively become worse in my time
40 at Nepean. I think what happens is you have someone who is
41 really motivated, who wants to work hard and then what
42 happens is more and more gets asked, and eventually there
43 comes a point where you say, "Well, I'm getting nowhere,
44 I'm doing more and more to try and do what's right and do
45 what's right for the team and not let anyone down and do
46 what's right for the patient", but they're just getting,
47 you know, worn down, essentially.

1
2 DR PRINEAS: I want to give some good news, in the sense
3 that last - about two weeks ago we had our interviews for
4 VMOs, and six of the candidates that we had for those
5 positions were actually VMOs who had trained at Nepean, who
6 wanted to come back. The things that they specifically
7 said, the two things that they said were, "We've come back
8 because we love the sociability of our department and, two,
9 we want to give back."

10
11 So what is very interesting about the department and
12 the people that are at the top, which are really quite
13 special - and the only thing that's keeping our department
14 afloat, I think - is the sense of camaraderie and
15 compassion and collegiality that we have within our
16 department, because we feel like we have to - like the
17 nurses in Katoomba, we feel like we have to take care of
18 each other if we're going survive, and that rubs off on the
19 trainees and it builds a very, very robust and healthy
20 ethic within them.

21
22 So the message I would give to the system is: while
23 we're thinking about funding, do not underestimate the
24 value of appropriate social spaces within a hospital
25 system. So appropriate coffee rooms, appropriate teaching
26 rooms, places where people can gather and places where
27 people can share, debrief if necessary, quiet places.
28 These things often get dismissed by architects and planners
29 because they're focused on clinical spaces, but these
30 non-clinical spaces are just as important.

31
32 ASSOCIATE PROF MALLOWS: Can I add to some of Nardeen's
33 points?

34
35 THE COMMISSIONER: Yes. That point has been made.
36 I mean, it's good to hear things again and sometimes again
37 and again, because it reinforces what we're being told, but
38 that point has been raised before.

39
40 DR PRINEAS: Great.

41
42 THE COMMISSIONER: Sorry, go ahead.

43
44 ASSOCIATE PROF MALLOWS: Thank you, Commissioner. I did
45 want to add to Nardeen's point and maybe if she's
46 experienced some of this recently.
47

1 Nepean Hospital probably hit rock bottom about three
2 or four years ago with respect to basic physician training,
3 and the problem is self-perpetuating. So we had a year
4 where no-one passed the exam, like 17 trainees sat the exam
5 and no-one passed, and that's because they're short
6 staffed, they're working hard, working very, very hard,
7 lots of overtime, difficulty studying, and commensurate
8 with that, they just didn't pass, and so it's
9 self-perpetuating because Nepean is seen as a very hard
10 place to work, lots of overtime, but it is also seen as
11 a place where you don't pass the exam, so people aren't
12 going to go there. That's the kind of thing that it's
13 a vicious cycle, people don't go there. They work hard,
14 they don't pass the exam, so they don't go there. Do you
15 see what I mean?

16
17 Have you experienced that over the last 18 months?

18
19 ASSOCIATE PROF MALLOWS: Yes, definitely people who want
20 to pursue physician training choose not to stay at Nepean
21 Hospital, because they feel as though their chances of
22 passing the exam are not going to be as strong as other
23 places.

24
25 My year, we had a very motivated group of trainees,
26 I knew I wanted to do endocrinology and I wanted to stay at
27 Nepean Hospital. So we had a group and studied together
28 every week and therefore we managed to get through the
29 exam. But I definitely agree. I think it's not seen as
30 a very sought-after hospital for that reason and therefore
31 people go elsewhere, places with higher pass rates.

32
33 In a lot of those places, they're quite protected as
34 trainees, they have other people looking after the wards so
35 that they can go and study and things like that, that we
36 just don't really have access to at Nepean as trainees.

37
38 DR WATERHOUSE: Commissioner, I'm mindful we've got
39 someone on line.

40
41 I don't know whether, Mr Egan, you wanted to add to
42 that. Do you have anything - any comment to make on that?

43
44 MR EGAN: Not specifically to that. I might as well raise
45 it now. Like, one of the things, too, about this district
46 as far as mental health goes is that, again, I said before,
47 we seem to be very inpatient focused because we don't have

1 the resources in the community, but the biggest problem for
2 me is attracting staff out in the community.

3
4 So where we're trying to have the best staff working
5 in the community doing the preventative work, they're
6 probably making the least wages. So, you know, the
7 inpatient guys are getting weekend work, getting penalty
8 rates, et cetera. The level of responsibility my guys
9 have, plus they're individually case managing clients, in a
10 pretty high-risk job, and they're getting paid basically
11 base RN, OT, base social worker rates.

12
13 If you look at the awards on a lot of these, these
14 guys are operating probably at CNC - if I'm talking
15 nursing, clinical nurse consultant 1 for the work they are
16 doing, but they're at least clinical nurse specialist 2.
17 Right? There just is not the funding to adequately
18 remunerate or try to attract the level of staff that I need
19 here.

20
21 So we actually - I'm very lucky, it's taken me a long
22 time to get this team back to where we are now, but it was
23 probably three or four years, we were four to five FTE down
24 and I had all junior staff here, I just couldn't get anyone
25 else. So, you know, if we're looking at preventing - the
26 whole thing about prevention, et cetera, it goes back to
27 what I was saying before, and even assisting in ED,
28 et cetera, with presentations, we need the people out here
29 and they need to be attracted to work out here. There's
30 plenty of mental health nurses living in Western Sydney who
31 would probably work in the community, who have extensive
32 experience, but they're not going to give up 30 or 40K of
33 inpatient work a year to do that.

34
35 DR WATERHOUSE: So it's really a financial incentive that
36 you're looking for in order to be able to recruit?

37
38 MR EGAN: Absolutely. Especially with the younger guys
39 here who have mortgages that are, like, all over a million
40 dollars, you know, they need the money. It's as simple as
41 that. They love the work but they need the money.

42
43 DR WATERHOUSE: Having very junior staff and gaps in being
44 able to recruit, does that have an impact on the actual
45 patients that you can care for in terms of either numbers
46 or how much time can be spent with them?

1 MR EGAN: We'll take on any patient. So there's no -
2 nothing in regards to that we would basically say that we
3 don't have the level of skill here to take someone, we will
4 take someone on regardless. I'm lucky that I've got two or
5 three really experienced people and we take on - they see
6 a lot of the role of educating staff up and being - well,
7 they're being seconds.

8
9 A lot of what we do, especially in my job here, is
10 basically supporting the guys to make decisions because
11 they're not confident, they don't have the years of
12 experience in making the decisions that get good outcomes
13 so they have to run them by us. But the problem is, you
14 know, I am probably going to retire in seven or eight
15 years. Where's the people coming behind me? Especially in
16 the community.

17
18 DR WATERHOUSE: Dr Habashy, I just wanted to go back over
19 one thing that you touched on before. Or a couple of
20 things, actually, you mentioned, first of all, that there
21 were 30 vacancies amongst the resident staff at the moment,
22 is that because of resignations because of either burnout
23 or going to other better opportunities or is it because of
24 an inability to recruit at the beginning of the year, a
25 combination - what?

26
27 DR HABASHY: Yes, so I have spoken to the JMO unit about
28 this, but, you know, I must admit my understanding -
29 I could be incorrect, but from what my understanding is, we
30 do have a large number of international graduates who come
31 to Nepean Hospital, and as of late, there have been lots of
32 opportunities overseas for them to go back home that they
33 then take. So a lot of them have to complete their
34 internship here, and then when residency comes around,
35 there's a job in Canada, there's a job in Singapore,
36 there's a job somewhere else, which is higher paying and
37 they're going to go back home to their families so they to
38 take up those opportunities.

39
40 Some of those resignations are for people leaving for
41 other reasons, such as getting into, for example,
42 psychiatry training, and then some of those have actually
43 just, yeah, been from burnout. From conversations that
44 I've had with certain trainees, I've had residents who have
45 quite literally just told me, "I'm going to take three
46 months off and just locum because I'm too burnt out",
47 essentially.

1
2 DR WATERHOUSE: I was actually going to come to that. So
3 is that a particular avenue that people pursue going and
4 doing locum work rather than continuing, in your
5 experience?
6
7 DR HABASHY: Oh, definitely, especially once they finish
8 their internship. I believe now, though, there are
9 incentives where they have to complete certain - they have
10 to be signed off for certain things now as residents to try
11 and disincentivise that. But certainly, at least from my
12 experience this year and last year, there are trainees who
13 just say, "Look" - or they've gotten a training position at
14 another hospital for the next year and they say, "Well, I'm
15 just going to quit for the last few months of the year and
16 do something else, earn a bit of money, go travelling."
17 Yes.
18
19 DR WATERHOUSE: You mentioned that other hospitals have
20 pharmacists on the wards and that's not something that you
21 have at Nepean.
22
23 DR HABASHY: Yes.
24
25 DR WATERHOUSE: So in the end, it's the junior doctors
26 doing medication reconciliation?
27
28 DR HABASHY: If it's done at all.
29
30 DR WATERHOUSE: If it's done.
31
32 DR HABASHY: Mmm-hmm
33
34 DR WATERHOUSE: And then you've also got junior doctors
35 sitting cannulas or placing cannulas?
36
37 DR HABASHY: Mmm-hmm
38
39 DR WATERHOUSE: So is this an example of where junior
40 doctors are not able to work at the top of the scope of
41 practice because they're so busy doing things that could,
42 in fact, be done by other staff who might not even cost as
43 much to employ?
44
45 DR HABASHY: Absolutely. There is so much that a junior
46 doctor does on the floor that really could be alleviated
47 pie having a social worker to coordinate a family meeting,

1 a pharmacist to reconcile medication --

2

3 THE COMMISSIONER: Just on the pharmacist, tell me if I'm
4 wrong, but I think the evidence we've had to date is that
5 doctors, whether they are junior or not, actually prefer
6 those sorts of duties that could be done by a pharmacist to
7 be done by the pharmacist.

8

9 DR HABASHY: Yes.

10

11 THE COMMISSIONER: Is that consistent?

12

13 DR HABASHY: Definitely, and because there is a bit of
14 running around when it comes to chasing medications, it's
15 not as simple as just getting a list. Often you are
16 calling a GP practice and if you call a GP practice they
17 want a written letter to request a medication list. Then
18 you fax it and then they might fax you something back, so
19 it's quite time consuming. Otherwise, you'll call the
20 patient's pharmacy, try to get some sort of ad hoc list,
21 and if you have 10 admissions, or five to 10 admissions
22 overnight, plus your existing patients, plus your clinical
23 duties, it's just not your priority. And then oftentimes
24 three days into the admission, someone says, "Oh, actually,
25 This person doesn't have this medication charted", or
26 whatever it might be. The list goes on.

27

28 But also doing cognitive assessments on patients,
29 that's also an issue where we have occupational therapists
30 who say, "We don't have the ability to do the cognitive
31 assessments on patients." So us, with quite a rudimentary
32 understanding of the interpretation of these tests, which
33 test is most appropriate for the patient, we're now sending
34 our junior doctors to go and spend half an hour with a
35 patient, do a cognitive assessment and then try to
36 interpret it in some way or talk to the OT, who then says,
37 "Oh, maybe that wasn't the right test to do" and you think,
38 "Well, that's a bit of a waste of our time, isn't it",
39 because now we've spent all this time trying to do this
40 test and now it's either not interpretable, or whatever the
41 case may be, or it is done a few days down the track.

42

43 DR WATERHOUSE: I appreciate that you've only spent three
44 months in another hospital. I don't know if you're able to
45 answer this from talking to your junior colleagues in other
46 hospitals. Do you find that they are not doing the same
47 types of - well, the cognitive tests, the cannula siting,

1 the medication reconciliation, is it done by other groups
2 in those hospitals?

3
4 DR HABASHY: Yes, at the Ryde Hospital, I was blown
5 absolutely blown away by their pharmacy service. They're a
6 very small hospital. They had a pharmacist on every ward.
7 They would reconcile all the medications; they would call
8 you with the correct medications to chart; they would
9 counsel patients on the medications to be started; and they
10 would hand over to the outpatient pharmacy.

11
12 Part of my feedback after that term was, "This is
13 incredible, this should be at every hospital." But us at
14 Nepean, which is so much bigger, we don't have that. So
15 that's one thing.

16
17 There was an excellent discharge planner, for example,
18 at Ryde Hospital who would be really proactive and get on
19 top of things and tell you, "You know, as the medical team,
20 have you considered this avenue for discharge?" And you're
21 like, "Oh, yeah, that's a great idea", and you actually
22 could action that, but at the moment, we're just, you know,
23 trying to keep our head above the water.

24
25 I have a friend from North Shore who has come to
26 Nepean and she was shocked by how we were running things
27 because, again, on top of the other things that junior
28 staff are asked to do, it's booking all the appointments
29 for patients, calling patients. One of my junior staff at
30 the moment actually calls a patient every day on
31 a Thursday, because we have a clinic on a Tuesday, to
32 ensure that that patient won't just not attend the
33 appointment, because we have such a high rate of people who
34 don't attend appointments.

35
36 So their time is again being clogged up doing that,
37 and my friend from North Shore was saying, "Oh" - I think I
38 said this before as well - "we just give the patients
39 a card and they will just call up and follow up at private
40 rooms". That's almost unheard of at Nepean. We're trying
41 to book people into appointments that they often don't
42 attend. So it's also quite demoralising as well, because
43 you're trying to do absolutely everything to get someone to
44 an appointment, shy of picking them up for the appointment,
45 and it's sort of not being effective, and wasting a lot of
46 time to do that.

47

1 DR WATERHOUSE: I want to move on to some questions about
2 the funding model and views about equity of that, but did
3 you want to say something just finishing, Dr Prineas?
4

5 DR PRINEAS: I just wanted to say, at the risk of inviting
6 discussion of a controversy that's fashionable at the
7 moment, we're not necessarily - from what Nardeen was
8 saying, we're not necessarily talking about recruiting an
9 entirely new class of practitioner like a physicians
10 associate or an anaesthesia associate. What Nardeen is
11 describing is just that the roles that are currently
12 clogging up the junior doctors' workday could quite
13 comfortably and easily be accommodated by existing roles if
14 they were delegated properly and they were recruited
15 properly.
16

17 ASSOCIATE PROF MALLOWS: Could I just respond very quickly
18 to a couple of points?
19

20 We got the story from mental health about there are
21 nurses in Western Sydney that could be working in Nepean
22 but they're not. That's across the board. There are
23 people in the mountains that drive past Nepean Hospital to
24 work at other hospitals. So geography is not everything,
25 part of it is going to be the conditions and the wages and
26 the amount of work and the amount of burnout at Nepean
27 Hospital.
28

29 Nardeen touched on the Canadians, so what actually
30 happens - just to give you some background, we're 30FTE
31 down with the junior cohort of about 150, so it's about
32 20 per cent. But one of the things that happened is Canada
33 is also short. They contacted all of their graduates
34 working in Australia and offered them a bonus to go back to
35 Canada, basically, and it's a large figure, you know, five
36 figures, I believe, without knowing the exact figure - for
37 some reason, 40,000 Canadian dollars comes to my mind, but
38 don't quote me on that.
39

40 The last point was pharmacy. It's well versed in the
41 literature that inpatient pharmacists save lives, increase
42 quality, decrease lengths of stay, decrease costs, decrease
43 medication-related harms and that's just something we're
44 not able to supply at Nepean Hospital.
45

46 DR WATERHOUSE: One of the things, as a segue to that,
47 that you raised in your submission was that the funding

1 model, as it currently stands - and sorry, this is in the
2 fifth paragraph - is associated with increased mortality
3 rates and other poor health outcomes in the district.
4

5 ASSOCIATE PROF MALLOWS: Yes.
6

7 DR WATERHOUSE: I know you have attached some graphs which
8 are very helpful, are you able to give just generally a few
9 words in relation to explaining some examples of that?
10

11 ASSOCIATE PROF MALLOWS: So which paragraph are we talking
12 about?
13

14 DR WATERHOUSE: The fifth paragraph on the first page.
15 The paragraph immediately above "1. Current funding".
16

17 ASSOCIATE PROF MALLOWS: These are publicly available
18 figures and I've got some graphs. What I did, for
19 a variety of reasons, was just look at three different LHDs
20 I looked at Western Sydney, because it's right next door,
21 and the population overlaps; and then Northern Sydney,
22 which includes Northern Beaches and Royal North Shore
23 Hospital; as well as Nepean Blue Mountains. It was amazing
24 that these figures are actually publicly available, but
25 they basically show that patients in Western Sydney are
26 dying quicker, is the short story, when you look at
27 mortality by population. You know, you've got --
28

29 THE COMMISSIONER: I'm sorry, it's my fault. What page of
30 the submission should I be looking at?
31

32 DR WATERHOUSE: The paragraph to which I was referring was
33 on the first page, immediately above the paragraph - sorry,
34 immediately above the headline "Current funding".
35

36 THE COMMISSIONER: So the paragraph commences "Nepean
37 Hospital is underfunded by --"
38

39 DR WATERHOUSE: Correct. That's right. That's what I was
40 referring to in relation to mortality rates.
41

42 THE COMMISSIONER: The witness is now looking at some
43 graphs.
44

45 DR WATERHOUSE: And there's a whole lot of graphs
46 attached.
47

1 THE COMMISSIONER: I can see them, but which one am I
2 meant to be --
3
4 DR WATERHOUSE: I wasn't specifically going to any at this
5 stage.
6
7 THE COMMISSIONER: Oh, right.
8
9 DR WATERHOUSE: It was just Dr Mallows was referring in
10 general terms, I think.
11
12 ASSOCIATE PROF MALLOWES: I'm currently on page 9, which is
13 documenting chronic kidney disease deaths, and I'm just
14 going to go through the pages, but it's not just --
15
16 THE COMMISSIONER: Helpfully, my copy is black and white
17 so I might wait until I get a colour copy. Is colour
18 important? It looks like it is.
19
20 ASSOCIATE PROF MALLOWES: Not really, because the Penrith
21 LGA is the top, is the short story.
22
23 THE COMMISSIONER: Yes, I can tell that.
24
25 ASSOCIATE PROF MALLOWES: And it's not just even a little
26 bit. When you look at chronic kidney disease deaths it's
27 triple or double, between two and three times of Northern
28 Sydney. Cardiovascular deaths is again two or three times.
29 COPD deaths, which is chronic respiratory, again, two or
30 three times. Asthma deaths - obviously with all the
31 bushfires, that's quite topical at the moment. Diabetes
32 and obesity-related deaths, they are not small figures.
33
34 You look at diabetes-related deaths and it is clearly
35 three or four times the mortality in Penrith LGA compared
36 to the Northern Beaches. I've got a few other things I can
37 sort of - you know, the Commissioner can go through it at
38 his leisure.
39
40 DR WATERHOUSE: Can I just ask you, though, obviously you
41 have talked about the social determinants of the population
42 in your catchment area, for want of a better term --
43
44 ASSOCIATE PROF MALLOWES: Yes.
45
46 DR WATERHOUSE: -- that are obviously predisposing them to
47 some of those outcomes, to a degree. Maybe I'm playing

1 devil's advocate here, but you've attributed them to the
2 funding model. So what is about the funding model that
3 that says that's what's causing these worse outcomes, not
4 just population figures?

5
6 ASSOCIATE PROF MALLOWS: I want to preface this by this:
7 this submission was 18 months - sorry, 12 months ago, and
8 based on information that might have been six months old at
9 that time. So my understanding has probably evolved a
10 little bit more. But we have a sicker population.

11
12 I've got a graph here that's department of stats, so
13 it's again publicly available. It's a graph of the
14 socioeconomic status of different areas of the Sydney
15 metro. So when you look at health determinants, a lot of
16 the northern and eastern suburbs have - you know, they're
17 in the first quintile of socioeconomic status, and
18 that's the SEIFA report - the Socio-Economic Indices for
19 Access. Whereas when you look at our local population,
20 they're in the fifth quintile. So these are very
21 poor socioeconomic status patients or clients, they are not
22 health literate, they are not wealthy, they have
23 significant health issues, such as obesity, cardiovascular
24 disease, respiratory disease, diabetes.

25
26 And so when you get back to the funding model, you
27 know, it's really looking at the patient that comes in
28 through the front door, and there's a pot of money
29 allocated to a single patient with this. Now, does that
30 funding model actually capture the complicated nature of
31 the patients who present to Nepean Hospital? My belief is
32 that it doesn't and I think we're getting penalised for
33 that. We have patients with increased lengths of stay
34 because they are sick.

35
36 Anecdotally, we've hired two cardiologists recently,
37 they're on staff, they're on call, they're getting these
38 patients in and they are just flabbergasted at how sick
39 these patients are compared to where they've come from.
40 They have all got massive comorbidities, they're not simple
41 patients.

42
43 We've had a large cohort of emergency physicians who
44 have started over the last 12 or 18 months and they again
45 are saying, "Wow, these patients are really complicated,
46 really sick. There's a lot going on. They're all on lots
47 of medications." So my belief is that the funding model

1 doesn't actually capture that. These patients are sicker,
2 they require more resources, but the funding model is such
3 that it's not capturing that and we're not - we're spending
4 the money but we're not getting the money, because these
5 patients are more expensive to look after.

6
7 DR WATERHOUSE: So what you're saying, if I'm correct in
8 understanding this, is that while there may be some
9 adjusters to take into account, socioeconomic factors, they
10 are not actually capturing the breadth of the disparity
11 between these different socioeconomic groups; is that
12 correct?

13
14 ASSOCIATE PROF MALLOWS: Yes. So for example, when you
15 look at community - and I would love mental health to come
16 in at some point in this answer - when you look at
17 community available, we have to do a lot more in hospital -
18 and Nardeen as well - a lot more in hospital than maybe we
19 could sort out in the community and that's increasing our
20 length of stay, increasing inpatient costs.

21
22 We're transferring patients in from Katoomba to get
23 diabetes education because we don't have community
24 outpatient. Renal dialysis, peritoneal dialysis, we don't
25 have great community resources for peritoneal dialysis.
26 And so we have to do a lot of the education, a lot of the
27 training of these patients in hospital rather than in the
28 community.

29
30 DR WATERHOUSE: Is it the case - and I will come to the
31 others to comment on this - from your point of view, that
32 it is the activity based funding model aspect of it that
33 affects your ability to set these things up in the
34 community instead? Is that what is causing the difficulty
35 from your perspective?

36
37 ASSOCIATE PROF MALLOWS: Oh, it's very chicken and egg.
38 This is where my understanding sort of falls down a little
39 bit. What I will say is that we're doing stuff in hospital
40 that maybe in other areas of Sydney get done in the
41 community, and maybe the ABF funding model is not capturing
42 that activity.

43
44 DR WATERHOUSE: I might just go - I think that Mr Egan is
45 wanting to say something; is that right?

46
47 MR EGAN: Look, just talking about funding, I'll tell you

1 something that has had a massive impact on mental health,
2 has been the NDIS. Jordan Springs is a suburb that's quite
3 close to where I work here, and it's like the supported
4 independent living accommodation capital of Sydney.

5
6 So what has happened is it's a new estate, and
7 a number of providers have come out and basically, because
8 of the cheaper housing option, have bought housing out
9 there, and what has happened, we have a number of people
10 that are getting transferred to our area from Northern
11 Beaches, inner city, even out west, into SIL accommodation
12 out here into places that - these people can be really
13 highly behaviourally disturbed, big challenges as far as
14 violence, et cetera, goes, and the guys that are looking
15 after them or the staff that are looking after these people
16 in the homes are getting like two hours, basically,
17 training from one of their behavioural support clinicians;
18 right?

19
20 What happens is that - it's happened a number of
21 times, I can't give you the exact number, but, for example,
22 they get basically dumped at Nepean ED or Nepean TAC,
23 right, and then they end up - basically, there is nowhere
24 to put them so the end up - especially if it's a mental
25 health issue, they end up in the mental health units up
26 there and can be blocking beds for up to 12 months, all
27 right?

28
29 Now they're not one-offs. Again, I was working up at
30 the hospital yesterday, we had one of the group homes
31 ringing in about one of the clients who they had just taken
32 on who was destroying the house. They had no idea what to
33 do and they demanded we come out and see them straightaway.
34 That's not how it works.

35
36 THE COMMISSIONER: When you say "blocking beds for up to
37 12 months", is that because the NDIS home won't take the
38 patient back?

39
40 MR EGAN: Yes. Yes, basically it's beyond their scope and
41 they basically - they basically abandon them to the
42 inpatient units. So it's a massive - that sort of money
43 that goes to these businesses, I tell you, if we could get
44 some access to some of that, the impact we would have would
45 be so much higher.

46
47 But, yeah, it's not just a one-off, it's actually

1 quite common and, you know, I've got stories where we've
2 had people that have landed - we had one person transferred
3 from the Northern Beaches to us, they lasted two hours at
4 the group home, and then they were basically transported
5 straight up to our mental health unit.
6

7 DR WATERHOUSE: In terms of obviously there is the
8 additional cost of having someone as an inpatient, but is
9 it also fair to say that that's not the best clinical
10 environment for them either?
11

12 MR EGAN: One hundred per cent, but, unfortunately,
13 there's nowhere else to put them, because a lot of these
14 people have intellectual disabilities, comorbid with
15 schizophrenia, et cetera, there's nowhere else that's
16 basically appropriate to look after them now.
17

18 So the biggest issue is there's a - we've only got
19 a certain number of beds out here, so if we've got someone
20 taking a bed for 12 months, that means that, you know,
21 we've got big delays. In our Triage and Assessment Centre
22 that we've got, there are regularly people just sleeping on
23 lounges in there. It looks like a semi-acute unit with
24 basically just benches, and people can be staying in there,
25 sleeping on benches for up to four days.
26

27 Now, that's multifaceted, because it gets back to what
28 I was saying before about if we had more of a preventative
29 plan or preventative model of how we care for these people,
30 that probably wouldn't be happening as much, but it's -
31 yeah, it's not appropriate.
32

33 DR WATERHOUSE: Dr Habashy, were you going to say
34 something?
35

36 DR HABASHY: Oh, yes. I think I agree with what
37 everybody's been saying, but I guess in regards to what you
38 mentioned about the socioeconomic state, I think it does
39 definitely put us at a disadvantage and it does mean that
40 we are having to put in a lot more in order to keep people
41 safe and out of hospital. But I do think that there are
42 interventions that can be made.
43

44 Something that comes to mind is we have our young
45 adults diabetes clinic at Nepean Hospital, and there is one
46 senior diabetes nurse who pretty much runs that, with one
47 junior diabetes nurse who chips in.

1
2 She ran a study where she, for a month, just took on
3 calls and was calling the young adults in the area.
4 I think she took about 150 calls but was able to prevent
5 about seven or eight admissions by doing that.
6

7 A lot of these patients, you know, you do have to,
8 I think, be a bit more proactive in order to keep patients
9 out of hospital. But in that demographic specifically you
10 have people who, you know, "Oh, I didn't get to my GP so
11 I didn't take my insulin", therefore they end up in
12 hospital unwell; or they have some sort of mental health
13 crisis or a social crisis and they don't take their
14 insulin, they come into hospital unwell.
15

16 Just to what Dr Mallows was saying about how unwell
17 our patients are, we have the highest rate of DKA, which is
18 a diabetic emergency, in the state. There are doctors from
19 other hospitals who, you know, might get one or two in a
20 month, maybe. We get - I mean, when I was on call a few
21 months ago, almost every day we were getting a DKA come
22 into the hospital.
23

24 DR WATERHOUSE: Can I just clarify, does DKA stand for
25 diabetic ketoacidosis?
26

27 DR HABASHY: Sorry, yes, yes.
28

29 DR WATERHOUSE: Is that when a person who is reliant on
30 insulin does not have their insulin and they can become
31 comatose?
32

33 DR HABASHY: Yes. Yes, they can become really, really
34 unwell, and in terms of - so we have the highest rate in
35 the state of DKA. But not only that, we have statistics
36 from other hospitals to say that we have the second highest
37 rate of DKA admissions for the ICU, superseded only by
38 Liverpool. The only reason for that is because Liverpool's
39 policy is that every DKA admission goes to ICU, because
40 they're so labour intensive, whereas we send our mild to
41 moderate DKAs to the ward. These are patients who need
42 very frequent bloods, who need hourly blood sugars, hourly
43 blood testing, and they're being sent to the ward because
44 there's no capacity for them to go straight to ICU.
45

46 We also have a very high rate of another diabetic
47 emergency, HHS, that's when your blood is so viscous from

1 all the sugar, essentially, and that's a lot of the time
2 due to insulin omission or non-adherence to some of the
3 therapies that we have. So making those interventions,
4 like what our diabetic nurse educator did, to actually call
5 these people ahead of time, check in on them, you know,
6 ideally you wouldn't have to do that but I think that
7 that's what - it's been shown to work and be effective in
8 helping to keep people out of hospital and having
9 readmissions.

10
11 DR WATERHOUSE: Just on that, does that call need to be
12 made by a diabetes nurse educator or could it be made by
13 somebody else because it's more about touching base with
14 the patient?

15
16 DR HABASHY: It could - I mean, ideally a diabetic nurse
17 educator, because then they are able to troubleshoot
18 things. So often they'll get on the phone and say, "Oh, you
19 know", that they're running into acidosis, and they are
20 like, "What do I do?", and that way, that is better
21 trouble-shot by a diabetic nurse educator, but certainly
22 you could have someone, another middle person making a
23 call, potentially.

24
25 A lot of these people, when they come into hospital,
26 when you say, "Why? Why did you come into hospital with
27 this emergency", it's almost - I wouldn't say always, but
28 very frequently, it's because of some sort of financial or
29 social stressor that's triggered that presentation to the
30 hospital. Yes. So - yes.

31
32 DR WATERHOUSE: Okay. Dr Prineas, what are your thoughts
33 about the funding model?

34
35 DR PRINEAS: I'd like to make a general comment as a segue
36 to making some individual observations about the funding
37 model. It has often been described that safety is
38 a dynamic non-event. You know, if you work really hard and
39 you get it right, nothing happens.

40
41 So I guess a question that's preying on my mind while
42 I'm listening to all of this is, how can an activity based
43 model that is based on diagnoses and disease interventions
44 adequately fund for preventative measures? How can it fund
45 infrastructure? How can it fund education, in-servicing?

46
47 So, for example, at Nepean Hospital we run

1 15 operating theatres. We actually have to have two
2 members of staff that are devoted entirely to being on the
3 floor running a theatre. Now, if we didn't organise and
4 apply that, it wouldn't happen, but that can't be applied
5 to any kind of DRG; that can't be applied to any kind of
6 model. It's basically infrastructure that we have to
7 create in order for a large metropolitan teaching hospital
8 to function.

9
10 So one of the issues that I am grappling with is,
11 obviously, a funding model that is based just on or focuses
12 on interventions and focuses on disease can't be the whole
13 picture.

14
15 Segueing from that, given the funding model that we
16 have, even within the diagnostic groups, there are
17 problems - the socioeconomic problems that James and others
18 have described.

19
20 At Katoomba, we have an elderly population. We have
21 one of the oldest demographics, most elderly demographics,
22 in the country, which means that there are certain things
23 that can't get captured adequately well by the funding
24 model.

25
26 The thing about elderly people is that they don't
27 bend, they break, so there has to be a disproportionate -
28 well, when I say "disproportionate", I mean an appropriate
29 apportionment, an adjustment of investment in preventative
30 measures, in outpatient clinics, in community work, in
31 community outreach, in psychogeriatric stuff to prevent
32 these people having to become inpatients, because once they
33 become inpatients, other things tend to fall apart and they
34 tend to deteriorate very, very quickly.

35
36 We also have a fundamental inequity, which is peculiar
37 to the Blue Mountains hospital, in that we essentially have
38 a lot of the features of a rural hospital but we're treated
39 as metropolitan. In fact, the VMO determination classifies
40 Blue Mountains as a rural facility which entitles VMOs to
41 have certain benefits in terms of conference leave and
42 stuff like that. But interestingly, Blue Mountains
43 hospital is not treated as a rural facility in any other
44 respect. So the submission I would make respectfully is
45 why allow that inconsistency to exist?

46
47 If you're going to - if you've got the discretion to

1 set boundaries, as governments do, why not make those
2 boundaries clear, so that if a hospital is within - meets
3 certain criteria, that it can be - it can enjoy the
4 benefits of being a rural facility? You've got a number of
5 LHDs, I'm pretty sure that Blue Mountains - Nepean Blue
6 Mountains is not the only one - where you have
7 a metropolitan hospital with some rural bits tacked on.
8 More thought needs to be put in to how to cater for those
9 things because it has all sorts of impacts in terms of,
10 one, being able to attract staff but also to attract
11 funding that's appropriate to the inequities that exist.
12

13 The one other glaring thing that I want to point out
14 is - again, just talking for myself as an anaesthetist -
15 anaesthetic departments now have undergone a revolution in
16 growth in the last 20 years. We recently did an audit and
17 we found that over 45 per cent of our regular scheduled
18 sessions occur outside of the operating theatre.
19

20 Now, this is a significant departure from the
21 traditional notion of anaesthetists being, you know, light
22 adjusters for surgeons, that all our activity is based
23 around what we do while the surgeon does their thing. We
24 do so much more now that occurs outside the operating
25 theatre, some of which is in the service of the surgeons
26 still, in terms of surgical patients - we run
27 pre-anaesthetic clinics; we run postoperative pain routes -
28 but we also service gastroenterology endoscopy services; we
29 also service cardiology for cardioversions and TOE
30 interventions; imaging - we do a lot.
31

32 The anaesthetic departments find themselves falling
33 between two stools, because the DRGs get put in, the money
34 gets sent to that particular cost centre, whether it's
35 surgery or cardiology or imaging, but then when we ask,
36 "Well, where's our cut in order for us to be able to fund
37 the anaesthetic machine that goes to imaging or to finance
38 the nurse", or whatever, we again get the cat with the
39 vegetables look from people. It's like, "Well, that's not
40 our problem."
41

42 DR WATERHOUSE: But it is part of the DRG, isn't it? The
43 DRG makes up a whole lot of components of what goes into
44 that care, which will include anaesthetic or sedation or
45 whatever?
46

47 DR PRINEAS: In our practice, we find that it doesn't come

1 to our cost centre.

2

3 DR WATERHOUSE: But is that an issue at a local level or
4 are you saying that that is a statewide issue, that it
5 should be earmarked in some way?

6

7 DR PRINEAS: It's both, because anaesthetic departments
8 have grown so much, and I'm pretty sure that, in fact -
9 I mean, the anaesthetic department represents the single
10 largest consultant craft group within Nepean Hospital. I'm
11 pretty sure that that's also the case in most other
12 metropolitan hospitals. They've grown significantly in the
13 last 20 years. And yet when you look at the DRG codes, the
14 code modifiers that inform whether a DRG is going to be an
15 A, a B, a C or a D, when you look at the descriptors for
16 anaesthetics, they're very, very crude, they don't actually
17 reflect the great diversity of effort that can sometimes
18 need to be put in, in order to perform even a "simple"
19 general anaesthetic or a "simple" spinal anaesthetic.

20

21 So to me, I think that the - and I know that there
22 have been some audits on this, but I think we are now
23 moving into an arena where I feel that there probably needs
24 to be an activity-based funding model just for
25 anaesthetics, which can, in a more sophisticated way,
26 modify the DRG modifiers. I believe that should be the
27 case.

28

29 THE COMMISSIONER: Just pausing there, though, for
30 a second, whether or not that's the case, and this is not
31 a criticism, but one of the things you said much earlier in
32 your answer was that the question preying on your mind,
33 listening to all the evidence, was how can an
34 activity-based model that is based on diagnoses and disease
35 intervention adequately fund for preventative measures?

36

37 I think one answer might be that it's not intended to,
38 that ABF is a means of funding activity in public hospitals
39 based on numbers and case mix at an efficient price, and
40 that funding streams for prevention - which might include
41 preventions within community or primary care, et cetera -
42 really have to come from other streams of funding than ABF.

43

44 DR PRINEAS: I understand.

45

46 THE COMMISSIONER: I'm sure you do, but is there some
47 other point you were trying to make, that I have missed?

1
2 DR PRINEAS: Well, it is. It is. Okay, I guess it comes
3 down to an anaesthetist's stock in trade is actually
4 prevention. Our job is 95 per cent boredom and 5 per cent
5 panic.

6
7 THE COMMISSIONER: The ABF model doesn't respond to it at
8 least to the anaesthetist's role or desire to be involved
9 in what might be a preventative measure; is that --

10
11 DR PRINEAS: Well, implicit in what I do is anticipating
12 risks. Even when a diagnosis has been made, even when an
13 intervention is being contemplated, there is still risk of
14 that intervention going south or that disease getting more
15 complicated or more severe, and a lot of an anaesthetist's
16 time is spent evaluating, preparing, optimising, spending
17 time basically making sure that either we get it right
18 first time or that we are prepared for what happens. That
19 preparation - sometimes a lot of that will get thrown away,
20 but that preparation needs to be done. Is it actually
21 catered for within the funding model is my question.

22
23 THE COMMISSIONER: Yes.

24
25 DR WATERHOUSE: Dr Mallows, apart from inequity in the
26 funding model, do you see it as having other flaws and what
27 do you believe the solutions are to improving the funding
28 system?

29
30 ASSOCIATE PROF MALLOWES: Okay. Wow. So I want to - are
31 there going to be specific questions about the NDIS,
32 because I wouldn't mind making a point, if there is time?

33
34 DR WATERHOUSE: I'm happy for you to make a point about
35 this, either now or after.

36
37 ASSOCIATE PROF MALLOWES: So I think part of the funding
38 equity comes back to these NDIS patients and it is because
39 of the real estate prices in Penrith that we are getting
40 increasing numbers of these patients that are very, very
41 difficult to manage and will decompensate and then come to
42 the ED.

43
44 Arguably, when these patients get admitted, because
45 the hospital is really - these patients are homeless, they
46 come in homeless, basically, because the NDIS situation,
47 the accommodation they are in, cannot cope with them either

1 in crisis or chronically.

2

3 DR WATERHOUSE: Can I just clarify before you go on, are
4 you talking purely about people with intellectual
5 disability, behavioural type issues, or are you talking
6 about physical disabilities as well?

7

8 ASSOCIATE PROF MALLOWS: It is mainly the behavioural,
9 because the physical, once you get those up to speed, they
10 should be okay, up to a point. But yes, it's more the
11 behavioural. They come in - and don't forget they're
12 moving in from out of area, so they lose their social
13 supports, whatever family supports, all that kind of stuff.

14

15 So they come and they're either - the situation is not
16 adequate for them, and there are reasons behind that, NDIS,
17 you know, have not - you know, the assessment process has
18 fallen down somehow or they're in acute crisis, which will
19 happen, but when they damage their accommodation or the
20 accommodation is not fit for purpose, they are actually
21 homeless, so the hospital mental health or a general ward
22 is an accommodation of last resort.

23

24 Now, when you look at the funding model, they are
25 completely healthy people. There is no diagnosis. Their
26 diagnosis is "homeless", if you see what I mean. So that's
27 a very, very pointy end of the funding model but it's
28 a great example of how, in certain circumstances, it's not
29 fit for purpose. There is no diagnose there.

30

31 DR WATERHOUSE: Just on that, are there data supporting
32 the fact that there is this ingress into your local health
33 district area or is that an anecdotal thing you have just
34 seen a rise in numbers through the emergency department?

35

36 ASSOCIATE PROF MALLOWS: I don't have any firm data but
37 anecdotally I can absolutely say they are increasing
38 because --

39

40 DR WATERHOUSE: I'm not questioning it. I'm just
41 clarifying.

42

43 ASSOCIATE PROF MALLOWS: I'll give you a couple of
44 examples where patients have come in and the first time
45 we've seen them, "What's happening here?" "Oh, they've
46 just moved in from blah, blah, blah, they've got a house
47 around the corner", and then we see them every day for

1 three months and there's a handful of patients, and we've
2 usually got three or four patients on the ward that are
3 sitting waiting for NDIS accommodation, you know, either
4 repairs to damage or their initial accommodation is not fit
5 for purpose.

6
7 DR WATERHOUSE: This is separate to those who might be
8 waiting for a plan to be finalised or supports to be set up
9 in the community?

10
11 ASSOCIATE PROF MALLOWS: Yes, yes.

12
13 DR WATERHOUSE: You are talking about the ones who need
14 housing?

15
16 ASSOCIATE PROF MALLOWS: Yes, so they already have a plan
17 and for whatever reason - and there are lots of reasons,
18 don't worry about that, and it may not be anyone's fault -
19 their accommodation is not fit for purpose because they
20 have under-appreciated certain aspects of their pathology.

21
22 DR WATERHOUSE: Mr Egan, did you want to add anything
23 about that, since it's a cohort that you're also dealing
24 with?

25
26 MR EGAN: No, it just backs up exactly what I was saying,
27 yes. It's actually - it's almost - I can't believe that -
28 some of these people are really, like, to the point where
29 you need police involvement, just getting dumped on these -
30 well, they're not getting dumped, it's actually the
31 businesses accepting them, they going into these homes
32 where people have no training, where really to effectively
33 manage these people you probably need 20 years' experience.

34
35 DR WATERHOUSE: And so in terms of solutions, what do you
36 see as needing to change?

37
38 ASSOCIATE PROF MALLOWS: Oh, it's difficult. One
39 fundamental problem is health looks like a zero sum game,
40 because obviously health is expensive and the budget is
41 thin. So if Nepean gets more money, a rebalancing has to
42 occur, and obviously that will lead to other institutions
43 getting less money, because it's a zero sum game. So I'm
44 certainly mindful of that context.

45
46 But I think there needs to be an appreciation of our
47 population and the health literacy and the comorbidities

1 and the chronic health conditions, you know, with respect
2 to any kind of funding model.

3
4 I always bring up the GST debate because the states
5 have overly complicated funding models and there's always
6 special conditions. In health there are special
7 conditions, special situations, all kinds of different pots
8 and pies and hollow logs that people get money out of, but
9 if it's a zero sum game, there definitely needs to be some
10 kind of redistribution. So maybe an answer is to actually
11 incorporate the health of the local population. So, you
12 know, I'm never going to have any specific solutions, but
13 the west needs more money at the expense of the east.

14
15 An example I will use is the educational outcomes in
16 girls versus boys in school. We were very happy to pour
17 lots of money in to increase the education outcomes of
18 girls when we noticed it was a problem, and I think now
19 they're on parity and even exceeding the boys, and I think
20 everyone is happy with that. But when you actually look at
21 this data and people are dying quicker out west than they
22 are in the east and the north, something - we need more
23 money and they need less money.

24
25 DR WATERHOUSE: And when you do identify innovative ways
26 that you might deal with some of the challenges you face,
27 can you implement those?

28
29 ASSOCIATE PROF MALLOWS: No.

30
31 DR WATERHOUSE: Why not?

32
33 ASSOCIATE PROF MALLOWS: Money. So it's difficult,
34 because a lot of those programs are outside of the ED.
35 I know, and maybe Nardeen can talk to this but
36 Kath Williams had some really, really good projects in
37 terms of integrated care of obesity and diabetes, and that
38 included community resources, and it fell over for
39 a variety of reasons. But the trouble is, you know, there
40 is such a paranoia about this. You know, I feel as if you
41 have to spend money to make money, in terms of a business
42 sense, but the starting point is that we have so little
43 resources and money that the money doesn't get spent, even
44 though down the track we're eventually going to get the
45 benefits of that. Do you see what I mean?

46
47 THE COMMISSIONER: You mean spend money to avoid costs

1 later?

2

3 ASSOCIATE PROF MALLOWES: Yes, yes. I mean, I understand
4 the distinction, but obviously hospitals are trying to
5 generate revenue as well. So we might open an outpatient
6 clinic and get patients in that we can actually generate
7 new billings that we weren't able to before, so there's
8 probably - I totally accept that, yes, you spend money to
9 reduce costs, but you're also reducing costs, in terms of
10 inpatient admissions, but you can also generate revenue by
11 opening a clinic or, you know, buying a CT machine or
12 hiring another cardiologist to run an echo lab.

13

14 THE COMMISSIONER: Dr Prineas, I saw you wanted to say
15 something on that.

16

17 DR PRINEAS: Well, I agree in part with the idea of if
18 you've got a fixed bucket of money, then you should be
19 looking to redress inequities in exactly the way that James
20 has described. But when people talk about it being a zero
21 sum game, in my brain a little light comes on, because
22 I don't think - I think it's a trap to think of health care
23 as a business. I think that if you look at it from
24 a Keynesian perspective, the true economic function of
25 a healthcare system is to facilitate the creation of
26 a productive tax-paying population.

27

28 THE COMMISSIONER: Sure. Economically active people, yes.

29

30 DR PRINEAS: From that respect it is an investment, it is
31 an investment in that population. And so to that extent,
32 not so much that you're spending - you have to spend money
33 to avoid costs, you actually have to spend money to
34 lubricate the economy by adding value to it. So that's the
35 only comment I would make.

36

37 ASSOCIATE PROF MALLOWES: Actually, can I come back, sorry
38 to interrupt everyone, but you talked about the funding
39 model and what should be changed. I think there also needs
40 to be an acknowledgment of private health insurance rates,
41 because looking at AIHW data, you know, Nepean Hospital's
42 around the 3 to 5 per cent mark, North Shore's around the
43 12 to 15 per cent mark, and that's in the public,
44 remembering that there's quite a tall private hospital next
45 door that alleviates a lot of the stress and workload from
46 the public hospital and Nepean doesn't necessarily have
47 that. So there are all these, you know, factors that need

1 to be incorporated into a model which currently isn't
2 there.

3

4 DR PRINEAS: Can I just say, Commissioner, that it
5 heartens me greatly that you take what I just said as
6 a given because I have been to many a dinner party where it
7 is not a given at all.

8

9 THE COMMISSIONER: Look, there's lots of literature on
10 that, there's lots of literature on the economics of just
11 wellbeing and happiness. Part of being happy and having
12 wellbeing is, of course, being healthy, which is why you
13 need good healthcare services. But there is a whole -
14 there is a department at the London School of Economics,
15 just on the economics of happiness, which is directly
16 related to healthcare services and having a good NHS,
17 because that's what we're talking about in the UK, and
18 social services to support the NHS, because if they're cut,
19 then the pressure, or more pressure, goes on the health
20 system.

21

22 DR PRINEAS: Indeed.

23

24 THE COMMISSIONER: So that general topic is important to
25 think about. Yes.

26

27 DR WATERHOUSE: Commissioner, I have no further questions
28 but I think Dr Habashy is keen to say something.

29

30 DR HABASHY: Yes, please.

31

32 THE COMMISSIONER: Perhaps we can use this opportunity to
33 invite all of you, starting with Dr Habashy, to say
34 anything you feel as though you want to or need to that has
35 been missed. So we will start with Dr Habashy.

36

37 DR HABASHY: I more so just want to expand a little bit on
38 what Dr Mallows was saying as well regarding the NDIS and
39 I guess thinking about practical solutions.

40

41 I'm not sure if this is too simplistic, so forgive me
42 if it is, but I think just practically on the ward when
43 we're talking about all these bed blockages for people who
44 are pretty stable otherwise, medically, more avenues to get
45 these people into a more sub-acute facility while they're
46 waiting for services. I think that's something that's
47 a really big blockage for us. When we can, we do, but

1 often, if we're blocked, I don't have anywhere to put these
2 otherwise stable patients.

3
4 Regarding the NDIS, just an anecdote from only
5 a couple of weeks ago, we had a lady who came in with low
6 blood sugar. The problem resolved within 24 hours. She
7 was fine. If it was an ordinary situation, she could have
8 just gone straight home, no problem, we had adjusted her
9 insulin.

10
11 She was a patient who had NDIS funding from a group
12 home. When she came in, it was noted that she needed two
13 assistants to transfer her to a wheelchair, instead of one,
14 which she was funded for.

15
16 She ended up staying in hospital for three months
17 waiting for funding because not only did we need to put an
18 application in, wait for NDIS to come back, then apparently
19 had to find a new group home, her new carers had to be
20 educated in the new group home in order to get the patient
21 out of hospital. All of that is just incredibly
22 inefficient to me, and the way I think, It doesn't seem to
23 make a lot of sense that that was the case.

24
25 I'd go to the nurse unit manager every day saying,
26 "What's going on? What can we do? Is there anything we
27 can do to facilitate things?" "It is just the system.
28 There's two weeks to get a report in. There's six weeks
29 for them to reply. Then if they have any adjustments it's
30 another two weeks." It just seems like really protracted
31 waiting times, when this lady was incredibly medically
32 stable. She was in an acute ward because of "behaviours",
33 where she would call out every now and again, certainly
34 very re-directable.

35
36 This is just one example of countless, really, of this
37 sort of inherent inefficiency in the system, and like
38 I said, these are patients who are quite stable. I'm not
39 really changing anything. Her blood sugars in hospital
40 were beautiful. I would comment to my round every day,
41 "They're beautiful. There's nothing I can really change."
42 But, yes, that inability to get these patients into more
43 sub-acute facilities while they're just waiting for,
44 essentially, paperwork to be done and there's nothing else
45 really for me to do.

46
47 Regarding the metabolic service, I do know that there

1 are really extended - there are extended waiting times for
2 every clinic, really, that we work in, and the metabolic
3 clinic being one of them. Often these are patients who are
4 waiting for months just to get an appointment. Often as an
5 inpatient team, we're getting referrals for weight
6 management preoperatively on someone who needs an operation
7 in a week, and we're like, "Well, there's really not much
8 we can optimise in that time. This is someone who should
9 have been seen months ago", and now we're trying to
10 scramble and now they've got heart failure at 40 years old,
11 which I saw the other week, someone who needs essentially
12 a heart transplant. We're sort of saying, "Well, the ship
13 has sailed. We've sort of lost our opportunity". So we're
14 seeing a lot of incredibly young people who are very, very
15 unwell, 30-, 40-year-olds on dialysis, who have lost limbs,
16 who are blind. These are really young people who do need
17 a lot of investment and need a lot of help. Once you're on
18 dialysis, now you're a chronic patient in the system. You
19 know, you're not going to be able to get out of the health
20 system with that.

21
22 So yes, I echo, I think, what everyone else has said,
23 and yes, I just thank you for the opportunity to raise our
24 concerns, we really appreciate it.

25
26 THE COMMISSIONER: Just so we're clear, though, the
27 patient that came in with the low blood sugar problem and
28 ended up there for - what did you say, three months --

29
30 DR HABASHY: Yes.

31
32 THE COMMISSIONER: -- which you described as an
33 inefficient process, perhaps fairly, but the inefficiency
34 there and the delays are in the Commonwealth system;
35 correct?

36
37 DR HABASHY: Sorry?

38
39 THE COMMISSIONER: They're in the Commonwealth system,
40 because you were talking NDIS?

41
42 DR HABASHY: Yes.

43
44 THE COMMISSIONER: Just like when we were at the
45 roundtable, we did have a discussion that we don't need to
46 repeat here about the thinness or general lack of
47 availability of GP services for people putting pressure on

1 your hospitals. That's primarily, at least, obviously
2 a Commonwealth responsibility.

3
4 DR HABASHY: Yes.

5
6 THE COMMISSIONER: You're nodding so I'm going to take
7 that as a yes?

8
9 DR PRINEAS: Yes.

10
11 THE COMMISSIONER: I think it is fairly obvious. Sorry,
12 is there anyone else with some final comments for the three
13 of you?

14
15 ASSOCIATE PROF MALLOWS: I do have a major point, just to
16 get back to the whole funding problem, but I would like
17 everyone else to sort of finish first if that's all right.

18
19 DR PRINEAS: I think it would be remiss, from the
20 conversation I have had with multiple colleagues, if
21 I didn't talk about an issue that I'm sure is well trodden
22 ground through the course of your Inquiry, which is the
23 estrangement of governance between clinicians and
24 non-clinical managers within LHDs. But I also think it's
25 important to refer to this in the context of I think it's
26 a cultural problem that starts with ministry and goes all
27 the way down.

28
29 So to give an example of something that just happened
30 last week, we're having a major anaesthetic workforce
31 crisis within our unit, we're trying desperately to recruit
32 and we've come up with an idea that what we should do is we
33 should figure out how many hours each of our hospitals need
34 within the district at Nepean, at Hawkesbury and at Blue
35 Mountains, and that we should pool those hours and then
36 advertise for VMOs to come and work in the district, as
37 a district-wide resource, rather than being trapped within
38 the facility contract systems in which it currently
39 operates.

40
41 So we asked the very simple question from finance,
42 "How many hours are you budgeted for?" And - because the
43 hours that they had quoted, they came back with a number,
44 and I said, "Those hours don't match our assessment of our
45 available resources compared to our actual and projected
46 needs." And their response was, "Well, our answer is:
47 whatever we spent last year plus 10 per cent." Okay?

1
2 So we brought this up at a broad forum and we said to
3 the executive, "You can't have one half of our organisation
4 having a completely different mental model of how to
5 evaluate and analyse service planning, which is purely
6 financial, while you're making us sit down and work out how
7 many hours we need, but in fact, that bears no relationship
8 to how finance are actually going to calculate what they
9 release to us.

10
11 Here's the kicker. When I said that to the executive,
12 they said, "Oh, can't we figure out just some other way
13 that I don't have to tell finance that we have to have this
14 discussion?" So then it dawned on me that this
15 estrangements of clinical and non-clinical governance is
16 not just that it's tolerated, it's validated and it's
17 unchecked.

18
19 Now, when you think about that, a second example was
20 when we were talking about the clinical services plan that
21 we were going to take to ministry, at the very, very first
22 meeting, the planners from the LHD came and they said -
23 they didn't want to have a discussion. They basically
24 wanted to give a PowerPoint presentation of what they had
25 already decided, and then they were going to take that
26 meeting with us as a form of consultation, and we - I had
27 to actually go in to the board and I actually had to -
28 I said, "Look, this clinical services plan needs to be the
29 product of a negotiation between the planners and the
30 frontline clinicians. The frontline clinicians have the
31 knowledge." It was only after a very arduous and not a
32 particularly pleasant process that we actually came up with
33 a clinical services plan that was informed by clinician
34 input that actually went to ministry.

35
36 My concern is that for as long as we have an
37 organisation that doesn't grasp that very difficult nettle
38 of ensuring that there are communication networks and
39 organisational lines of authority that mandate that those
40 discussions take place, you are going to continue to have
41 people making decisions that create iniquitous service
42 delivery problems. And that - I think that starts with
43 ministry and it goes all the way down. That's all I wanted
44 to say on that. Thank you.

45
46 THE COMMISSIONER: Mr Egan, is there something you would
47 like to say?

1
2 MR EGAN: Look, the only thing I would say on that is that
3 it would be great if NSW Health could actually speak to the
4 local health districts sometimes before they give us
5 funding for things that we don't particularly need.
6

7 For example, we had - we got funding for, off the top
8 of my head I can't remember the name, but it was a suicide
9 prevention team. It was going to be three to four FTE on
10 the plains and also up in the mountains. That's what my
11 team does, right? That's part of what we do.
12

13 Now, they need a - before these ideas come out,
14 I don't know where the funding came from, I'm not the
15 executive so I'm not sure where it was, but we definitely
16 were not consulted. It just landed on our doorstep. It
17 would be fantastic if we could make that - if they could
18 maybe, before approving funds for things like that,
19 actually speak to us about what we actually need.
20

21 THE COMMISSIONER: Yes.
22

23 DR PRINEAS: Hear, hear.
24

25 ASSOCIATE PROF MALLOWS: I am very mindful of time, but
26 there was a really important point I wanted to bring up
27 with respect to funding models and that is the concept of
28 a cancelled admission. Has that come up at the Commission
29 before? So a cancelled admission is basically a patient
30 who, all intents and purposes, would be admitted with
31 a condition and they would go to the ward, but for access
32 blocks, stay in the ED for the entirety of their clinical
33 episode and be discharged from the ED.
34

35 In that situation, those patients get less NWAU than
36 if they'd actually gone to the ward. So I will give you an
37 example of one of my colleagues' mum, who was at North
38 Shore hospital, who ended up presenting to ED and ended up
39 staying 24 hours in hospital, I believe, but from triage
40 was identified as being suitable for their medical short
41 stay, something Nepean doesn't have, went straight to
42 a ward, had all the treatments, investigations, got
43 managed, stayed overnight and was discharged, whereas that
44 patient, because of our access block problems and the
45 number of ward bed resources that we have, would have
46 probably stayed 24 hours in a chair in the emergency,
47 forget about the care that goes along with that, in

1 comparison. That patient gets less money under the NWAU
2 and under the funding model than a patient at North Shore
3 that would have gone to the ward. And so fundamentally,
4 that's a problem with the funding model in hospitals like
5 Nepean which struggle to get its patients to the ward.
6

7 The figures I have been given recently are 17 per cent
8 of all admissions through the ED are cancelled admissions.
9 So one in six patients go home from the ED after staying
10 a number of hours, maybe even overnight, maybe even
11 a couple of days, and those consultants are rounding in the
12 ED and sorting those patients out. That's a particular
13 thing that I think needs to come up with respect to the
14 funding models, the concept of cancelled admissions.
15

16 DR WATERHOUSE: Could I just clarify one thing: that term
17 "cancelled admissions" is that a local Nepean Blue
18 Mountains term?
19

20 ASSOCIATE PROF MALLOWS: I believe it's a ministry term,
21 and it's appropriate, because there's always gaming. The
22 idea is you could potentially bump up your NWAU by
23 admitting everybody, you see what I mean, and then
24 discharging, so the Ministry of Health calls those
25 cancelled admissions, but they are not actually admissions,
26 they are actually counted as an admit and discharge within
27 the ED for a variety of reasons - some of those are
28 quality, some of those relate to KPIs, but obviously they
29 relate to funding as well.
30

31 THE COMMISSIONER: Can I just ask you a clarifying
32 question, Dr Prineas, about what you called the major
33 anaesthetic workforce crisis that you're talking about.
34 You and your colleagues - tell me if I've understood it
35 correctly - worked out how many hours the hospitals in your
36 LHD, as a pool, need for anaesthetic services?
37

38 DR PRINEAS: Yes.
39

40 THE COMMISSIONER: And then you asked finance, "How many
41 hours are we budgeted for", and they came back with
42 a figure, and you then said, "Those hours don't match our
43 assessment of our available resources compared to our
44 actual and projected needs." Do I understand that to mean
45 that the answer you were given by finance was a number of
46 hours less than - just dealing with actual need - actual
47 need first?

1
2 DR PRINEAS: It was. I employ VMOs and I am given a -
3 sort of I'm required each year, and on an ad hoc basis, to
4 submit a VMO hours distribution form, based on the
5 contracted hours that people have been given, I add that up
6 and if I ask for more hours than I had last time, I have to
7 go through a six-person sign-off process in order to have
8 that validated. In addition to that, I have staff
9 specialists who - they're much simpler because they're
10 employed under an award, they have a fixed number of hours.

11
12 THE COMMISSIONER: Sure.

13
14 DR PRINEAS: So when I asked our finance, "How many hours
15 do you have?", they gave me this number, which was 7,126,
16 and so then I said, "Well, actually, we agreed that the" -
17 and they said, "That includes the staff specialists that
18 you have." So then I said, "That's a bit strange, because
19 the total that we have agreed on, that we have six-person
20 sign-off on, for the VMOs alone is 6,773. So what you are
21 saying is that the one staff specialist that we have" - we
22 calculated that a 1 FTE of a staff specialist, is 1320
23 hours. Well, if I add 6,773 with 1320, I get a lot more
24 than 7,000 - and they went, "Oh, we don't do it like that,
25 we just do what you claimed last year and we add
26 10 per cent."

27
28 THE COMMISSIONER: Plus the 10 per cent.

29
30 DR PRINEAS: I said, "Okay, can we agree on a common
31 methodology and a common language and a common currency by
32 which" - and I got stonewalled for weeks and weeks and
33 weeks, and eventually the administrator said, "Can we just
34 find another way to figure this out, because I'm not going
35 to get finance to agree." It's like, "But you're the boss,
36 so why is it that you are tolerating this Tower of Babel
37 approach to being able to articulate and plan services?"
38 So that's the answer to that.

39
40 THE COMMISSIONER: Thank you.

41
42 Nothing came out of that?

43
44 DR WATERHOUSE: No.

45
46 THE COMMISSIONER: Mr Chiu, do you have any questions?

47

1 MR CHIU: We don't have questions, thank you.

2

3 THE COMMISSIONER: To all four of you, thank you very much
4 for your attendance today. We know you don't have much
5 spare time, so we're very grateful for the time you have
6 given us and for the assistance you have given the Inquiry.

7

8 Thank you, and we will adjourn until 10 o'clock
9 tomorrow morning.

10

11 <THE WITNESSES WITHDREW

12

13 AT 4.20PM THE SPECIAL COMMISSION OF INQUIRY WAS ADJOURNED
14 TO FRIDAY, 15 NOVEMBER 2024 AT 10AM

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