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

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

DR WATERHOUSE: Thank you, Commissioner.

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

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

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

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

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

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

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

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

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

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

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

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

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

DR HISLOP: An oath, thank you.

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

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

you are, but for the record.

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

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

<BRUCE HODGE, sworn [10.05am]

<ROBERT GORDON HISLOP, sworn

<STEPHEN DONALD BEGBIE, sworn

<EXAMINATION BY DR WATERHOUSE:

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

DR HODGE: Bruce Hodge.

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

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

DR WATERHOUSE: And you are a general surgeon?

DR HODGE: I'm a general surgeon.

DR WATERHOUSE: Specialising in breast and colorectal surgery?

DR HODGE: Mainly breast and colorectal surgery, yes.

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

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

covering the broad range of medicine and surgery, rehabilitation and high-level cancer services, which Steve's involved in with the oncology unit and radiotherapy.

DR WATERHOUSE: I might move now to Dr Begbie. Can you state your full name, please, for the record.

DR BEGBIE: Yes, Stephen Donald Begbie.

DR WATERHOUSE: And you are a medical oncologist and cancer researcher?

DR BEGBIE: General physician, for my sins, as well.

DR WATERHOUSE: And also the executive clinical director for the same network that we just discussed?

DR BEGBIE: Yes, Hastings Macleay, yes.

DR WATERHOUSE: Dr Hislop, could you please give your full name for the record.

DR HISLOP: Robert Gordon Hislop.

DR WATERHOUSE: And you are an intensive care specialist and the acting of director of medical services for the same network, Hastings Macleay?

DR HISLOP: A small point of correction. At the time when the Commissioner came to visit us in Port Macquarie I was briefly the acting director of medical services. We now have a full-time appointee to that role so I no longer act in that role. I'm an intensive care specialist. I work as a general physician at Port Macquarie Base Hospital and I'm the chair of the medical staff council for the last 12 months.

THE COMMISSIONER: Just pausing there, how is everyone going for hearing that?

DR BEGBIE: It is a bit soft.

THE COMMISSIONER: Dr Hislop, I think we got the gist of what you said, but moving forward, we might just have to keep an eye or an ear on how clearly we can hear you.

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

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

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

DR HODGE: Yes.

DR HISLOP: Yes

DR BEGBIE: Yes.

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

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

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

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

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

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

DR WATERHOUSE: Thank you.

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

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

DR WATERHOUSE: Dr Hodge --

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

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

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

issue?

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

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

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

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

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

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

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

DR WATERHOUSE: So is it fair to say --

THE COMMISSIONER: Just pausing there, so I understand, in part of your answer there you said:

> *Even in colonoscopy it's a great example where you had defined things, that's actually been a complete failure because what they thought would be the outcome hasn't been the outcome ,,,*

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

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

THE COMMISSIONER: So it might be a symptom?

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

THE COMMISSIONER: I see.

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

THE COMMISSIONER: I see.

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

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

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

doing that.

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?

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

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

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

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

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

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

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

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

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

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

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

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

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

DR HISLOP: Very commonly, yes.

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

DR HISLOP: Very commonly, yes.

DR WATERHOUSE: Dr Begbie, do --

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

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

DR HISLOP: Well, in terms of intensive care admissions

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

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

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

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

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

Now, these kinds of conversations are extremely confronting.

THE COMMISSIONER: Yes.

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

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

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

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

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

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

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

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

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

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

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

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

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

DR BEGBIE: So both the operations you have talked about

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

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

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

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

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

DR BEGBIE: -- buying them years.

THE COMMISSIONER: Not another five months of life.

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

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

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

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

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

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

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

DR WATERHOUSE: If I can Just --

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

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

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

THE COMMISSIONER: Yes.

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

THE COMMISSIONER: Yes.

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

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

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

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

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

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

DR HODGE: That's right.

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

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

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

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

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

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

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

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

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

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

THE COMMISSIONER: Why?

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

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

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

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

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

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

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

DR BEGBIE: No, thank you.

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

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

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

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

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

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

what's appropriate?

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

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

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

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

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

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

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

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

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

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

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

DR HODGE: Emergency, yes.

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

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

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

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

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

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

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

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

THE COMMISSIONER: Not necessarily completely elderly

people either.

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

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

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

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

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

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

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

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

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

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

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

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

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

DR WATERHOUSE: That's okay.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

DR HODGE: It's often whatever's most convenient.

DR WATERHOUSE: I understand how the decision is made.

DR HODGE: No, but that's how the decision is made: whatever is convenient.

DR WATERHOUSE: So is there a lack of evidence?

DR BEGBIE: No, the data is there.

DR HODGE: The data is there, that's right.

DR BEGBIE: Not all clinicians read the data and the data is based on an analysis somewhere else of 80 patients over a five-year period that was 10 years ago, and, you know, we're always able to side-step those kinds of decisions by saying, "In my care, things are different", or "This patient is different", or "The family are making me and I have no choice."

DR WATERHOUSE: So whether or not the evidence is there, that's not the basis for the decision-making?

DR BEGBIE: No.

DR WATERHOUSE: I might go to Dr Hislop, who has his hand raised.

DR HISLOP: I was going to say that the fractured neck of femur, I think we're using that as an example because it's the case for us - it's a bit different to just a broken bone. So over the years, really, fractured neck of femur is a presentation that tends to go with a degree of frailty and often has been a highly morbid condition.

A lot of the time, you know, the survival after a fractured neck of femur historically in years gone by was quite low, because it wasn't so much the fact that the patient had a broken hip, it was that they broke their hip because it was a reflection of their frailty. So that's why this is an example that is used.

So when Dr Hodge is talking about operating and fixing the hip versus giving analgesia, what he's really meaning is operating and fixing the hip as a means to relieving the pain of an unstable fracture or giving morphine as a means

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

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

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

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

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

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

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

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

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

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

DR HISLOP: Yes.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

SHORT ADJOURNMENT

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

DR WATERHOUSE: Why?

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

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

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

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

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

same benefit but harms.

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

DR HODGE: I think it is.

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

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

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

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

DR HODGE: Yes.

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

DR HODGE: That's correct.

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

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

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

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

DR WATERHOUSE: Sure.

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

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

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

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

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

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

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

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

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

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

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

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

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

DR WATERHOUSE: And are they clinically informed or --

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

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

will accept that risk.

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

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

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

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

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

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

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

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

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

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

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

DR HISLOP: Yes.

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

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

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

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

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

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

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

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

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

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

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

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

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

DR WATERHOUSE: Any comment on that, Dr Hislop?

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

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

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

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

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

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

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

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."

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

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

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

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

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

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

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

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

DR BEGBIE: I'll look forward to that.

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

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

DR BEGBIE: So we have a death squad already.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

clinicians, because we're leaving it to individuals.

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

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

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

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

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

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

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

DR WATERHOUSE: Dr Begbie, sorry?

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

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

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

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

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

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

to clinicians?

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

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

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

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

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

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

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

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

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

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

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

THE COMMISSIONER: Yes. All right.

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

DR BEGBIE: No.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

DR HODGE: To represent at the board meetings?

DR WATERHOUSE: Yes.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

are required.

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 it want 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.

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

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

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

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

DR WATERHOUSE: Commissioner, I have no further questions.

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

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

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

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

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

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

THE COMMISSIONER: Why has that happened?

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

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

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

Probably that's our biggest - from a surgical

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

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

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

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

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

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

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

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

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

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

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

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

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

THE COMMISSIONER: Okay. We will do that.

Dr Hislop, is there any final observations from you?

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

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

THE COMMISSIONER: Thank you.

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

MR CHIU: I have no questions, thank you.

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

We will adjourn until - I will make it 2.15.

<THE WITNESSES WITHDREW

LUNCHEON ADJOURNMENT

THE COMMISSIONER: Yes, Dr Waterhouse.

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

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

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

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

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

<JAMES LESLIE MALLOWS, affirmed [2.17pm]

<STAVROS PRINEAS, affirmed

<NARDEEN HABASHY, sworn

<DARRYN GERARD EGAN, sworn

<EXAMINATION BY DR WATERHOUSE:

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

ASSOCIATE PROF MALLOWS: James Leslie Mallows.

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

ASSOCIATE PROF MALLOWS: Yes.

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

ASSOCIATE PROF MALLOWS: Yes.

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

ASSOCIATE PROF MALLOWS: Yes.

DR WATERHOUSE: And director of emergency medicine research for Nepean Hospital?

ASSOCIATE PROF MALLOWS: Yes.

DR WATERHOUSE: And you are a clinical associate professor at the Nepean Clinical School; is that correct?

ASSOCIATE PROF MALLOWS: Yes, Sydney University.

DR WATERHOUSE: Dr Prineas, could you please state your full name for the record.

DR PRINEAS: It is Dr Stavros Prineas.

DR WATERHOUSE: You are the chair of medical staff council for Blue Mountains district hospital.

DR PRINEAS: Yes, I am.

DR WATERHOUSE: You are the head of anaesthetics at Blue Mountains and Springwood hospitals; is that correct?.

DR PRINEAS: That's correct.

DR WATERHOUSE: And I understand you also run a patient safety consultancy firm by the name of ErroMed.

DR PRINEAS: That is correct.

DR WATERHOUSE: Dr Habashy, could I get you to please state your full name for the record?

DR HABASHY: Nardeen Habashy.

DR WATERHOUSE: You are an advanced trainee in endocrinology at the Nepean Hospital?

DR HABASHY: Yes, that's correct.

DR WATERHOUSE: Have you done all of your training at Nepean Hospital?

DR HABASHY: Yes, save for three months as a secondment at Ryde Hospital, but yes, otherwise yes.

DR WATERHOUSE: If we turn to you, Mr Egan, can you hear me clearly?

MR EGAN: Yes.

DR WATERHOUSE: Could you please state your fall name.

MR EGAN: Darren Gerard Egan.

DR WATERHOUSE: You are the team leader, as I mentioned, at Penrith community mental health team.

MR EGAN: That's right.

DR WATERHOUSE: And you are a registered nurse by background?

MR EGAN: Yes.

DR WATERHOUSE: I understand that you were previously a nurse unit manager in an inpatient setting; is that correct?

MR EGAN: Yes, so for the old Pialla unit and the high-dependency unit so at Nepean hospital, yes.

DR WATERHOUSE: At Nepean Hospital?

MR EGAN: Yes, yes.

DR WATERHOUSE: I might start by just referring to Dr Mallows' submission that you made on 1 November 2023. I understand that the other witnesses giving evidence were part of the meeting with the Commissioner and the Inquiry team on 21 October, but they haven't made separate submissions or statements.

Have you had a chance to review your statement - sorry, your submission, Dr Mallows?

ASSOCIATE PROF MALLOWS: I skimmed over it earlier in the week.

DR WATERHOUSE: And through that process, have you been able to confirm that it is true and correct to the best of your knowledge?

ASSOCIATE PROF MALLOWS: I'm comfortable with the contents of the submission.

DR WATERHOUSE: Commissioner, I would like to tender that document, if I may. I'll just read the number for the transcript. It's SCI.0011.0536.0001.

THE COMMISSIONER: I now have three copies.

DR WATERHOUSE: Excellent. I don't propose putting that up on the screen at all. It does, however, contain some helpful graphs that might be of interest going forward.

THE COMMISSIONER: Yes.

DR WATERHOUSE: If I can just talk about the content of that submission a little bit, you refer on the first page to the emergency department at Nepean Hospital being routinely completely overwhelmed.

ASSOCIATE PROF MALLOWS: Mmm-hmm.

DR WATERHOUSE: You say there are more patients or the presentations are increasing, the patients are sicker and there is a lack of inpatient beds that you can move them into; is that correct?

ASSOCIATE PROF MALLOWS: Yes.

DR WATERHOUSE: You also talk on that page about staff being very committed to trying to do the right thing by patients --

ASSOCIATE PROF MALLOWS: Yes.

DR WATERHOUSE: -- but some staff burning out in the process of going through the work that they do.

ASSOCIATE PROF MALLOWS: Yes.

DR WATERHOUSE: Can you just perhaps expand on that and, in particular, outline the period over which you have seen that situation develop?

ASSOCIATE PROF MALLOWS: Okay. First of all before we start, is it possible for me to get a copy of the submission to refer to? I didn't bring a copy. Sorry

about that.

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

Could you just repeat the question, please?

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

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

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

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

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

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

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

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

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

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

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

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

> *We're trying to do the best for our patients but in relatively substandard conditions.*

ASSOCIATE PROF MALLOWS: Yes.

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

ASSOCIATE PROF MALLOWS: Yes.

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

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

THE COMMISSIONER: These are ED patients coming in?

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

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

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

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

ASSOCIATE PROF MALLOWS: Hourly.

THE COMMISSIONER: Okay. So that means every day?

ASSOCIATE PROF MALLOWS: Yes.

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

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

DR WATERHOUSE: Is this something that you --

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

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

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

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

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

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

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

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

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

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

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

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

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

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

ASSOCIATE PROF MALLOWS: No.

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

ASSOCIATE PROF MALLOWS: Yes.

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

ASSOCIATE PROF MALLOWS: Mmm.

THE COMMISSIONER: Is that what you mean?

ASSOCIATE PROF MALLOWS: Exactly. Yes.

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

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

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

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

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

DR HABASHY: Yes.

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

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

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

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

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

DR WATERHOUSE: And of those 30 --

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

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

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

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

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

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

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

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

THE COMMISSIONER: Yes.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

ASSOCIATE PROF MALLOWS: Yes.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

hospitals where you work and more generally?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

THE COMMISSIONER: As an investment.

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

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

DR WATERHOUSE: Not on that particular point.

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

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

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

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

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

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

THE COMMISSIONER: Any of you, please.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

DR HABASHY: I don't know the name.

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

DR HABASHY: Does anybody know the name?

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

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

And just in regards to --

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

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

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

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

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

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

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

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

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

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

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

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

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

DR PRINEAS: Great.

THE COMMISSIONER: Sorry, go ahead.

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

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

Have you experienced that over the last 18 months?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

DR WATERHOUSE: I was actually going to come to that. So is that a particular avenue that people pursue going and doing locum work rather than continuing, in your experience?

DR HABASHY: Oh, definitely, especially once they finish their internship. I believe now, though, there are incentives where they have to complete certain - they have to be signed off for certain things now as residents to try and disincentivise that. But certainly, at least from my experience this year and last year, there are trainees who just say, "Look" - or they've gotten a training position at another hospital for the next year and they say, "Well, I'm just going to quit for the last few months of the year and do something else, earn a bit of money, go travelling." Yes.

DR WATERHOUSE: You mentioned that other hospitals have pharmacists on the wards and that's not something that you have at Nepean.

DR HABASHY: Yes.

DR WATERHOUSE: So in the end, it's the junior doctors doing medication reconciliation?

DR HABASHY: If it's done at all.

DR WATERHOUSE: If it's done.

DR HABASHY: Mmm-hmm

DR WATERHOUSE: And then you've also got junior doctors siting cannulas or placing cannulas?

DR HABASHY: Mmm-hmm

DR WATERHOUSE: So is this an example of where junior doctors are not able to work at the top of the scope of practice because they're so busy doing things that could, in fact, be done by other staff who might not even cost as much to employ?

DR HABASHY: Absolutely. There is so much that a junior doctor does on the floor that really could be alleviated pie having a social worker to coordinate a family meeting,

a pharmacist to reconcile medication --

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

DR HABASHY: Yes.

THE COMMISSIONER: Is that consistent?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

ASSOCIATE PROF MALLOWS: Yes.

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

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

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

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

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

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

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

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

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

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

THE COMMISSIONER: I can see them, but which one am I meant to be --

DR WATERHOUSE: I wasn't specifically going to any at this stage.

THE COMMISSIONER: Oh, right.

DR WATERHOUSE: It was just Dr Mallows was referring in general terms, I think.

ASSOCIATE PROF MALLOWS: I'm currently on page 9, which is documenting chronic kidney disease deaths, and I'm just going to go through the pages, but it's not just --

THE COMMISSIONER: Helpfully, my copy is black and white so I might wait until I get a colour copy. Is colour important? It looks like it is.

ASSOCIATE PROF MALLOWS: Not really, because the Penrith LGA is the top, is the short story.

THE COMMISSIONER: Yes, I can tell that.

ASSOCIATE PROF MALLOWS: And it's not just even a little bit. When you look at chronic kidney disease deaths it's triple or double, between two and three times of Northern Sydney. Cardiovascular deaths is again two or three times. COPD deaths, which is chronic respiratory, again, two or three times. Asthma deaths - obviously with all the bushfires, that's quite topical at the moment. Diabetes and obesity-related deaths, they are not small figures.

You look at diabetes-related deaths and it is clearly three or four times the mortality in Penrith LGA compared to the Northern Beaches. I've got a few other things I can sort of - you know, the Commissioner can go through it at his leisure.

DR WATERHOUSE: Can I just ask you, though, obviously you have talked about the social determinants of the population in your catchment area, for want of a better term --

ASSOCIATE PROF MALLOWS: Yes.

DR WATERHOUSE: -- that are obviously predisposing them to some of those outcomes, to a degree. Maybe I'm playing

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

DR HABASHY: Sorry, yes, yes.

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

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

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

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

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

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

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

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

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

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

So, for example, at Nepean Hospital we run

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

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

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

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

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

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

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

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

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

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

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

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

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

to our cost centre.

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

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

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

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

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

DR PRINEAS: I understand.

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

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

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

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

THE COMMISSIONER: Yes.

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

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

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

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

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

in crisis or chronically.

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

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

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

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

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

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

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

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

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

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

ASSOCIATE PROF MALLOWS: Yes, yes.

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

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

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

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

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

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

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

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

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

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

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

ASSOCIATE PROF MALLOWS: No.

DR WATERHOUSE: Why not?

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

THE COMMISSIONER: You mean spend money to avoid costs

later?

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

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

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

THE COMMISSIONER: Sure. Economically active people, yes.

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

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

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

DR PRINEAS: Can I just say, Commissioner, that it heartens me greatly that you take what I just said as a given because I have been to many a dinner party where it is not a given at all.

THE COMMISSIONER: Look, there's lots of literature on that, there's lots of literature on the economics of just wellbeing and happiness. Part of being happy and having wellbeing is, of course, being healthy, which is why you need good healthcare services. But there is a whole - there is a department at the London School of Economics, just on the economics of happiness, which is directly related to healthcare services and having a good NHS, because that's what we're talking about in the UK, and social services to support the NHS, because if they're cut, then the pressure, or more pressure, goes on the health system.

DR PRINEAS: Indeed.

THE COMMISSIONER: So that general topic is important to think about. Yes.

DR WATERHOUSE: Commissioner, I have no further questions but I think Dr Habashy is keen to say something.

DR HABASHY: Yes, please.

THE COMMISSIONER: Perhaps we can use this opportunity to invite all of you, starting with Dr Habashy, to say anything you feel as though you want to or need to that has been missed. So we will start with Dr Habashy.

DR HABASHY: I more so just want to expand a little bit on what Dr Mallows was saying as well regarding the NDIS and I guess thinking about practical solutions.

I'm not sure if this is too simplistic, so forgive me if it is, but I think just practically on the ward when we're talking about all these bed blockages for people who are pretty stable otherwise, medically, more avenues to get these people into a more sub-acute facility while they're waiting for services. I think that's something that's a really big blockage for us. When we can, we do, but

often, if we're blocked, I don't have anywhere to put these otherwise stable patients.

Regarding the NDIS, just an anecdote from only a couple of weeks ago, we had a lady who came in with low blood sugar. The problem resolved within 24 hours. She was fine. If it was an ordinary situation, she could have just gone straight home, no problem, we had adjusted her insulin.

She was a patient who had NDIS funding from a group home. When she came in, it was noted that she needed two assistants to transfer her to a wheelchair, instead of one, which she was funded for.

She ended up staying in hospital for three months waiting for funding because not only did we need to put an application in, wait for NDIS to come back, then apparently had to find a new group home, her new carers had to be educated in the new group home in order to get the patient out of hospital. All of that is just incredibly inefficient to me, and the way I think, It doesn't seem to make a lot of sense that that was the case.

I'd go to the nurse unit manager every day saying, "What's going on? What can we do? Is there anything we can do to facilitate things?" "It is just the system. There's two weeks to get a report in. There's six weeks for them to reply. Then if they have any adjustments it's another two weeks." It just seems like really protracted waiting times, when this lady was incredibly medically stable. She was in an acute ward because of "behaviours", where she would call out every now and again, certainly very re-directable.

This is just one example of countless, really, of this sort of inherent inefficiency in the system, and like I said, these are patients who are quite stable. I'm not really changing anything. Her blood sugars in hospital were beautiful. I would comment to my round every day, "They're beautiful. There's nothing I can really change." But, yes, that inability to get these patients into more sub-acute facilities while they're just waiting for, essentially, paperwork to be done and there's nothing else really for me to do.

Regarding the metabolic service, I do know that there

are really extended - there are extended waiting times for every clinic, really, that we work in, and the metabolic clinic being one of them. Often these are patients who are waiting for months just to get an appointment. Often as an inpatient team, we're getting referrals for weight management preoperatively on someone who needs an operation in a week, and we're like, "Well, there's really not much we can optimise in that time. This is someone who should have been seen months ago", and now we're trying to scramble and now they've got heart failure at 40 years old, which I saw the other week, someone who needs essentially a heart transplant. We're sort of saying, "Well, the ship has sailed. We've sort of lost our opportunity". So we're seeing a lot of incredibly young people who are very, very unwell, 30-, 40-year-olds on dialysis, who have lost limbs, who are blind. These are really young people who do need a lot of investment and need a lot of help. Once you're on dialysis, now you're a chronic patient in the system. You know, you're not going to be able to get out of the health system with that.

So yes, I echo, I think, what everyone else has said, and yes, I just thank you for the opportunity to raise our concerns, we really appreciate it.

THE COMMISSIONER: Just so we're clear, though, the patient that came in with the low blood sugar problem and ended up there for - what did you say, three months --

DR HABASHY: Yes.

THE COMMISSIONER: -- which you described as an inefficient process, perhaps fairly, but the inefficiency there and the delays are in the Commonwealth system; correct?

DR HABASHY: Sorry?

THE COMMISSIONER: They're in the Commonwealth system, because you were talking NDIS?

DR HABASHY: Yes.

THE COMMISSIONER: Just like when we were at the roundtable, we did have a discussion that we don't need to repeat here about the thinness or general lack of availability of GP services for people putting pressure on

your hospitals. That's primarily, at least, obviously a Commonwealth responsibility.

DR HABASHY: Yes.

THE COMMISSIONER: You're nodding so I'm going to take that as a yes?

DR PRINEAS: Yes.

THE COMMISSIONER: I think it is fairly obvious. Sorry, is there anyone else with some final comments for the three of you?

ASSOCIATE PROF MALLOWS: I do have a major point, just to get back to the whole funding problem, but I would like everyone else to sort of finish first if that's all right.

DR PRINEAS: I think it would be remiss, from the conversation I have had with multiple colleagues, if I didn't talk about an issue that I'm sure is well trodden ground through the course of your Inquiry, which is the estrangement of governance between clinicians and non-clinical managers within LHDs. But I also think it's important to refer to this in the context of I think it's a cultural problem that starts with ministry and goes all the way down.

So to give an example of something that just happened last week, we're having a major anaesthetic workforce crisis within our unit, we're trying desperately to recruit and we've come up with an idea that what we should do is we should figure out how many hours each of our hospitals need within the district at Nepean, at Hawkesbury and at Blue Mountains, and that we should pool those hours and then advertise for VMOs to come and work in the district, as a district-wide resource, rather than being trapped within the facility contract systems in which it currently operates.

So we asked the very simple question from finance, "How many hours are you budgeted for?" And - because the hours that they had quoted, they came back with a number, and I said, "Those hours don't match our assessment of our available resources compared to our actual and projected needs." And their response was, "Well, our answer is: whatever we spent last year plus 10 per cent." Okay?

So we brought this up at a broad forum and we said to the executive, "You can't have one half of our organisation having a completely different mental model of how to evaluate and analyse service planning, which is purely financial, while you're making us sit down and work out how many hours we need, but in fact, that bears no relationship to how finance are actually going to calculate what they release to us.

Here's the kicker. When I said that to the executive, they said, "Oh, can't we figure out just some other way that I don't have to tell finance that we have to have this discussion?" So then it dawned on me that this estrangements of clinical and non-clinical governance is not just that it's tolerated, it's validated and it's unchecked.

Now, when you think about that, a second example was when we were talking about the clinical services plan that we were going to take to ministry, at the very, very first meeting, the planners from the LHD came and they said - they didn't want to have a discussion. They basically wanted to give a PowerPoint presentation of what they had already decided, and then they were going to take that meeting with us as a form of consultation, and we - I had to actually go in to the board and I actually had to - I said, "Look, this clinical services plan needs to be the product of a negotiation between the planners and the frontline clinicians. The frontline clinicians have the knowledge." It was only after a very arduous and not a particularly pleasant process that we actually came up with a clinical services plan that was informed by clinician input that actually went to ministry.

My concern is that for as long as we have an organisation that doesn't grasp that very difficult nettle of ensuring that there are communication networks and organisational lines of authority that mandate that those discussions take place, you are going to continue to have people making decisions that create iniquitous service delivery problems. And that - I think that starts with ministry and it goes all the way down. That's all I wanted to say on that. Thank you.

THE COMMISSIONER: Mr Egan, is there something you would like to say?

MR EGAN: Look, the only thing I would say on that is that it would be great if NSW Health could actually speak to the local health districts sometimes before they give us funding for things that we don't particularly need.

For example, we had - we got funding for, off the top of my head I can't remember the name, but it was a suicide prevention team. It was going to be three to four FTE on the plains and also up in the mountains. That's what my team does, right? That's part of what we do.

Now, they need a - before these ideas come out, I don't know where the funding came from, I'm not the executive so I'm not sure where it was, but we definitely were not consulted. It just landed on our doorstep. It would be fantastic if we could make that - if they could maybe, before approving funds for things like that, actually speak to us about what we actually need.

THE COMMISSIONER: Yes.

DR PRINEAS: Hear, hear.

ASSOCIATE PROF MALLOWS: I am very mindful of time, but there was a really important point I wanted to bring up with respect to funding models and that is the concept of a cancelled admission. Has that come up at the Commission before? So a cancelled admission is basically a patient who, all intents and purposes, would be admitted with a condition and they would go to the ward, but for access blocks, stay in the ED for the entirety of their clinical episode and be discharged from the ED.

In that situation, those patients get less NWAU than if they'd actually gone to the ward. So I will give you an example of one of my colleagues' mum, who was at North Shore hospital, who ended up presenting to ED and ended up staying 24 hours in hospital, I believe, but from triage was identified as being suitable for their medical short stay, something Nepean doesn't have, went straight to a ward, had all the treatments, investigations, got managed, stayed overnight and was discharged, whereas that patient, because of our access block problems and the number of ward bed resources that we have, would have probably stayed 24 hours in a chair in the emergency, forget about the care that goes along with that, in

comparison. That patient gets less money under the NWAU and under the funding model than a patient at North Shore that would have gone to the ward. And so fundamentally, that's a problem with the funding model in hospitals like Nepean which struggle to get its patients to the ward.

The figures I have been given recently are 17 per cent of all admissions through the ED are cancelled admissions. So one in six patients go home from the ED after staying a number of hours, maybe even overnight, maybe even a couple of days, and those consultants are rounding in the ED and sorting those patients out. That's a particular thing that I think needs to come up with respect to the funding models, the concept of cancelled admissions.

DR WATERHOUSE: Could I just clarify one thing: that term "cancelled admissions" is that a local Nepean Blue Mountains term?

ASSOCIATE PROF MALLOWS: I believe it's a ministry term, and it's appropriate, because there's always gaming. The idea is you could potentially bump up your NWAU by admitting everybody, you see what I mean, and then discharging, so the Ministry of Health calls those cancelled admissions, but they are not actually admissions, they are actually counted as an admit and discharge within the ED for a variety of reasons - some of those are quality, some of those relate to KPIs, but obviously they relate to funding as well.

THE COMMISSIONER: Can I just ask you a clarifying question, Dr Prineas, about what you called the major anaesthetic workforce crisis that you're talking about. You and your colleagues - tell me if I've understood it correctly - worked out how many hours the hospitals in your LHD, as a pool, need for anaesthetic services?

DR PRINEAS: Yes.

THE COMMISSIONER: And then you asked finance, "How many hours are we budgeted for", and they came back with a figure, and you then said, "Those hours don't match our assessment of our available resources compared to our actual and projected needs." Do I understand that to mean that the answer you were given by finance was a number of hours less than - just dealing with actual need - actual need first?

DR PRINEAS: It was. I employ VMOs and I am given a - sort of I'm required each year, and on an ad hoc basis, to submit a VMO hours distribution form, based on the contracted hours that people have been given, I add that up and if I ask for more hours than I had last time, I have to go through a six-person sign-off process in order to have that validated. In addition to that, I have staff specialists who - they're much simpler because they're employed under an award, they have a fixed number of hours.

THE COMMISSIONER: Sure.

DR PRINEAS: So when I asked our finance, "How many hours do you have?", they gave me this number, which was 7,126, and so then I said, "Well, actually, we agreed that the" - and they said, "That includes the staff specialists that you have." So then I said, "That's a bit strange, because the total that we have agreed on, that we have six-person sign-off on, for the VMOs alone is 6,773. So what you are saying is that the one staff specialist that we have" - we calculated that a 1 FTE of a staff specialist, is 1320 hours. Well, if I add 6,773 with 1320, I get a lot more than 7,000 - and they went, "Oh, we don't do it like that, we just do what you claimed last year and we add 10 per cent."

THE COMMISSIONER: Plus the 10 per cent.

DR PRINEAS: I said, "Okay, can we agree on a common methodology and a common language and a common currency by which" - and I got stonewalled for weeks and weeks and weeks, and eventually the administrator said, "Can we just find another way to figure this out, because I'm not going to get finance to agree." It's like, "But you're the boss, so why is it that you are tolerating this Tower of Babel approach to being able to articulate and plan services?" So that's the answer to that.

THE COMMISSIONER: Thank you.

Nothing came out of that?

DR WATERHOUSE: No.

THE COMMISSIONER: Mr Chiu, do you have any questions?

MR CHIU: We don't have questions, thank you.

THE COMMISSIONER: To all four of you, thank you very much for your attendance today. We know you don't have much spare time, so we're very grateful for the time you have given us and for the assistance you have given the Inquiry.

Thank you, and we will adjourn until 10 o'clock tomorrow morning.

<THE WITNESSES WITHDREW

AT 4.20PM THE SPECIAL COMMISSION OF INQUIRY WAS ADJOURNED TO FRIDAY, 15 NOVEMBER 2024 AT 10AM

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