Submission No 6

INQUIRY INTO HEALTH OUTCOMES AND ACCESS TO HEALTH AND HOSPITAL SERVICES IN RURAL, REGIONAL AND REMOTE NEW SOUTH WALES

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To Whom it May Concern,

I commenced work as Director of Obstetrics and Gynaecology at Manning Hospital in April of 2015. I moved here from a regional hospital in Queensland where I was employed as a Staff Specialist. From my experience at Manning Hospital, I believe the major deficiencies in care provided by regional and rural hospitals within New South Wales derive from two related deficiencies:

- The lack of public outpatient clinics
- The lack of Staff Specialists

From the outset, I was shocked at the lack of public outpatient clinics compared to Queensland where I had worked. When I arrived at Manning Hospital there was no gynaecology clinic, no formal early pregnancy clinic, no colposcopy clinic, and only a small antenatal clinic run by a training registrar once a week. If a woman needed to see an obstetrician during their pregnancy they had to pay to see one of the private obstetricians in town. Prior to my arrival, this meant that many women who could not afford to see a private obstetrician simply went without the care they needed.

The hospital did not and still does not have the infrastructure required to run outpatient clinics efficiently. We now have three busy antenatal clinic sessions, including a multi-disciplinary diabetes clinic, a dedicated colposcopy clinic, three gynaecology clinics and an Early Pregnancy Assessment Service. However, the rooms in which patients are seen are scattered throughout the building. There is no central storage area. Time is wasted and sensitive appointments interrupted by junior doctors seeking advice from senior doctors, looking for the nurse/chaperone, or looking for equipment. There is a lack of secretarial support, and rooms which are adequate for purpose. When I arrived there was not even an appropriate examination couch for gynaecological patients, and when it was purchased it was through the funding from hospital volunteers.

Manning Hospital does not have any outpatient clinics for general surgery, general medicine or orthopaedics (other than a fracture clinic). And Manning Hospital is not alone, it is the same throughout regional NSW. Outside of metropolitan areas the men and women of New South Wales are forced to pay for the same care that their city cousins enjoy for free.

For example, at the time of this writing, the only functioning colposcopy clinic between the Tweed and Newcastle is at Manning Hospital. The consequences of the recent changes to the screening of cervical cancer is that many of the women being referred for colposcopy are retirees, and that the colposcopy is often recommended annually. These women simply cannot afford the hundreds of dollars being charged privately for this procedure every year. In contrast, women who dwell in metropolitan areas are able to freely access these services in any number of hospitals. The State Government has been derelict in its duties in not providing this basic life-saving diagnostic test in its public hospitals.

The lack of infrastructure in regional hospitals reflects the staffing which they utilise. There is a clear preponderance of Visiting Medical Officers rather than Staff Specialists in regional areas. Visiting Medical Officers admit patients to the hospital as public patients when required, treat them whilst they are inpatients as public patients, and operate on them as public patients. However, prior to admission or for follow-up of treatment these patients have to pay to see the VMO in his or her private rooms. This framework of care works well for the hospital, which does not have to pay for rooms in which patients are seen, the doctor,

or administrative staff for these visits. It also works well for the doctor who gets to charge what they want for the visit. It does not work well for the most disadvantaged in society, who often forego the care they need or have to travel hundreds of kilometres to receive that care in a public clinic. I personally see dozens of women a month from adjoining health districts who offer no public gynaecology or colposcopy services. These women represent the least socially advantaged in the community, retirees on pensions, women on invalid pensions, women with mental illness (including inpatients from neighbouring health districts) and women in custody (from neighbouring health districts). I can only assume that there are many other women who forego this care because they do not have the means of travelling to another health district or are unaware that this service is publicly available at another centre.

The health system encourages the VMO model. If a woman presents to the emergency department with a gynaecological condition requiring attention in a gynaecology outpatient setting, the emergency doctor can refer the patient to a VMO's private rooms, and the VMO can claim Medicare for the ensuing appointment. If the emergency doctor refers to a public gynaecology clinic, Medicare funding cannot be claimed for the appointment. The ridiculous situation arises such that the emergency doctor frequently refers the patient back to the GP (who can charge Medicare and the patient), so that the GP can refer the patient to the public gynaecology clinic so that they can charge Medicare for the visit. Medicare is thus charged twice (unnecessarily), valuable GP time is wasted, and a delay occurs in the patient receiving the care that they require. Nevertheless, the hospital is punished for using a public outpatient clinic, as Medicare funding cannot be accessed directly if the referral is from within the hospital.

In New South Wales, Visiting Medical Officers are paid for overtime and on-call and for call-ins. Staff Specialists are not paid for overtime, on-call or call-ins. They receive an annual salary. The consequence of this disparity is that it is particularly difficult to recruit Staff Specialists to the country. In cities at a large hospital, a Staff Specialist may be on call once every 3 weeks. They may have to cover the hospital 3 weekends a year. And when they are on-call, they are likely to have a senior registrar as first on-call who can manage most clinical scenarios without the assistance of the Staff Specialist. In contrast, a Staff Specialist in a rural hospital will be on-call once or twice a week, and one in every three or four weekends, all without payment. They are likely to have a very junior doctor as first on-call, or be first on-call themselves. The situation is worse in New South Wales because the award is substantially inferior compared to other States. For example, in Queensland, Staff Specialists are paid for on-call and call-ins and overtime. Consequently, they are paid for the work that they do. In Queensland, Staff Specialists are paid more if they work in regional and rural areas. That is, in Queensland there is incentivisation for moving to and working in a regional area.

Incentivisation is necessary because of the additional on-call requirements that the doctor is likely to face. On-call that removes the doctor from normal family life, and the pursuit of normal leisure activities that are so necessary to the maintenance of mental health. Incentivisation is necessary because moving to the country frequently incurs a large cost to the doctor. Medical schools are typically located in cities. The young doctor who wishes to pursue specialty training, then completes their first few years in city or country hospitals, before having to move back to a large tertiary city hospital for specialist training. In the case of Obstetrics and Gynaecology this is a six year training programme, of which only one year is typically spent in a rural setting. By this time the young doctor typically has a house, children in school, and a spouse who is also employed in a city. Moving to the country necessitates, moving house, changing the children's schools and the spouse finding new

employment. Thus, much has to be sacrificed to pursue a career in the country as a Staff Specialist, all for more on-call and no compensation. In contrast, the financial compensation for a Visiting Medical Officer can be substantial. Consequently, rural and regional New South Wales is largely staffed by Visiting Medical Officers rather than Staff Specialists.

The consequences of an unbalanced workforce consisting overwhelmingly of Visiting Medical Officers is evident. Firstly, as outlined above, there is a lack of publicly funded clinics to which rural residents can attend. Secondly, Registrars do not receive the training they require in outpatient care. Thirdly, there is lack of governance mechanisms to ensure that the right procedure is being performed on the right patient at the right time. Further, there is a lack of governance mechanisms to ensure that complications are adequately investigated and steps taken to prevent their recurrence. Finally, the VMO model encourages over-servicing as doctors are paid for the procedures that they perform rather than the time taken to perform the appropriate procedures thoroughly and diligently.

Concerning Registrar training, if Registrars are allocated to hospitals without outpatient clinics they neglect a vital area of their training. These Registrars may be learning how to operate in an operating theatre but obtain little exposure to assessing which patients will benefit from elective surgery and the best procedure to perform. Furthermore, the VMO-only model is inherently wasteful of resources. Hospitals staffed only by VMO consultants continue to be allocated trainee registrars. These trainee registrars could be seeing patients in an outpatient setting if clinics were provided at the hospital. The VMO only model which is the predominant model in regional NSW is failing both our trainees and the women for whom we care.

My concerns regarding the lack of governance associated with the VMO only model is not theoretical. I have been intimately associated with the exposure and investigation of the now disgraced Obstetrician and Gynaecologist, Emil Gayed. I have reviewed the cases of hundreds of women who have received inappropriate treatment from Gayed. I have assessed hundreds of women in clinic who were not only let down by Gayed, but by a health system which allowed Gayed to provide substandard inappropriate treatment in a regional setting for decades. I believe that with appropriate governance and oversight his malpractice and fraudulent activities would have been detected and prevented years earlier, and so prevented the suffering of hundreds of women. It was no co-incidence that within 9 months of the appointment of a Staff Specialist Director of Obstetrics and Gynaecology that Gayed was removed from his position, never to work in an Australian Hospital again. Gayed's substandard care was not addressed until the appointment of a Staff Specialist Director, with the expertise and dedicated paid time to ensure that relevant procedures were followed, safety mechanisms adhered to, appropriate treatment provided and to provide critical review of complications and complaints.

Until that time Gayed performed contra-indicated procedures with fatal consequences (e.g., Endometrial Ablation). His patients suffered adverse outcomes that were not reported or were not investigated thoroughly, because there was no-one with the necessary expertise to do it, and because follow-up unless needing an admission was completed entirely within his private rooms. Procedures were performed by Gayed without the standard required proceeding investigations (e.g., LLETZ procedures without colposcopies). Babies suffered birth injury because there was no-one in the hospital available to deliver them in a timely manner.

In the case of Gayed, the lack of rural Staff Specialists and over-reliance on VMOs at Manning Hospital meant that the hospital became overly reliant upon a few VMOs, particularly Gayed. I believe that the hospital service slipped into the mindset that they were better with a substandard doctor than no doctor at all. Mistakes, errors and misdemeanours of Gayed were overlooked or excused. Similarly, I have come across multiple cases where timely treatment was not obtained for patients in emergency settings because the VMO on call was operating at a private hospital, or busy seeing patients in his private rooms. Gayed failed to attend patients or was slow to attend patients who required emergency treatment, because he was fatigued from covering too much of the after-hours roster.. Again this was excused because there was no-one else to cover the after-hours roster.

The VMO model, through the fee for service arrangement, encourages over-servicing. Over-servicing that is able to continue unabated without appropriate oversight. Gayed was able to perform hundreds of unnecessary procedures in the interest of financial gain (curettes). He claimed to perform hundreds of procedures without the patients' consent, again for financial gain (ablation of fibroids). No evidence for the pathology claimed to have been treated by Gayed was obtained or sought by the hospital. All clinic appointment prior to and after surgery were within his rooms, and there was a lack of governance procedures to ensure that images taken during endoscopic procedures were kept in the hospital record.

Only with the appointment of a Staff Specialist Director of the Department were Gayed's actions able to be detected and addressed. In regional New South Wales there may be dozens of Gayeds employed and acting without appropriate clinical oversight. To prevent further harms to the men and women of regional New South Wales, I urge the Parliament to address the lack of public clinics and public services in these regions.

I am more than happy to provide the Parliamentary Inquiry further details into the specifics of Gayed's actions should they request it. I am also happy to provide the Inquiry examples of correspondence I have sent the Health District, Department of Health and Minister of Health expressing these concerns over the last few years. I have included some of this correspondence as attachments to this submission.

Regards,

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