STATEMENT FOR BUNDABERG HOSPITAL COMMISSION INQUIRY DEALING PRIMARILY WITH CERTAIN QUESTIONS PUT ON BEHALF OF THE COMMISSION

Dr Edwin Charles Nankivell in the State of Queensland, Medical Practitioner, states:

1. I am a Medical Practitioner registered to practise in the State of Queensland as a General Surgeon.

2. I hold the following qualifications:

- Bachelor of Medicine, Bachelor of Surgery (University of NSW) 1981.
- Fellow of the Royal Australasian College of Surgeons (1989)
- Fellow of the Royal College of Surgeons of England (1989)
- Fellow of the Royal College of Surgeons of Edinburgh (1989)

3. I am registered as a Doctor in Queensland

4. I commenced work at Bundaberg Hospital in February 1995 and resigned there in January 2002.

Before addressing the following questions, I would like to provide some background information about Bundaberg. The Bundaberg area has a large population of both elderly and young people, a large proportion of these groups are either on pension or welfare payments. Bundaberg is essentially a non-bulk billing town and as these patients cannot afford to see specialists privately, they therefore have no choice but to attend the hospital outpatient department for specialist treatment and often attend the Accident and Emergency centre for their GP needs. I had a long-term commitment to Bundaberg and my resignation sparked an uproar in the town.

Why did I leave Bundaberg?

I left Bundaberg for a number of reasons.

1. Funding and resource allocation: I left Bundaberg Hospital because I was frustrated by the system, in particular lack of resources allocated to Bundaberg Hospital and the fact that my concerns were not addressed. There was a wide spread belief among the senior medical staff that the funding allocation to Bundaberg (based on an historical funding model) was not equitable with other regions.

2. Staffing and Rostering System: Bundaberg Hospital employed only two general surgeons to cover a population of 78,000 people. (At times with limited support from one VMO). This meant I was often required to work two or three weekends

in a row as well as being on call after hours every night of the week. Taking into account annual leave, sick leave, conference leave etc, for approximately three months of the year, Bundaberg Hospital was reduced to only one surgeon to cover for 78,000 people. It was almost impossible to attract locum surgeons especially with the conditions applicable to working in Bundaberg.

In addition, the private surgeons in Bundaberg generally did not see privately insured patients for out of hours for emergencies, therefore these patients presented to the Accident and Emergency Department which added to the number of patients presenting there. A & E was generally staffed by junior overseas trained doctors on working holidays for a short period of time, usually one year. These doctors did not have sufficient experience to thoroughly 'work up' patients. Therefore, I was called regularly to come and assess patients far beyond what doctors in a larger centre would need to do. Sleep disturbance due to night phone calls was the norm.

Because of the lack of staff, rostering system and after hours calls I worked excessive hours, however I was not given time off in lieu. The end result was that it was impossible for me to have any personal life or feel that I was doing my job to the best of my ability.

3. Registrar training position: We lost our Advanced Training Registrar position because after surgeon resignations we could not fulfil the college requirements for having such a position. The loss caused a major gap between the junior doctors and the senior doctors. The advantage of having Registrars in their latter years of training was that they can reliably assess emergency patients, organise appropriate investigations, communicate sensibly on the phone, and perform some emergency surgery unassisted; that **is** the Consultant was not required to come in and supervise. Without their presence the Consultant had to attend to the needs of all emergency patients after hours and on weekends.

4. Specialist Outpatient Clinics and Waiting Lists: The clinics were always over booked causing long delays in patients being seen. Because of over booking I was unable to see all the patients booked into the clinic, which meant inexperienced junior doctors, had to see patients without adequate supervision. Further, the three tiered classification system (recommended by the Queensland Health) was such that it was impossible to see category I patients in 30 days and category 2 patients within 90 days as recommended. Instead patients had to often wait up to one year to be seen which resulted in delayed diagnoses of their conditions.

5. Anger and frustration expressed by patients: Frequently not only myself but other staff members suffered verbal abuse from patients in our Outpatient Clinics. These patients were not angry at myself or the other staff per se, but angry about the delay in getting a booking in the outpatient clinic in the first place and then having to wait up to two hours to be seen once they arrived because these clinics were heavily over booked. Further, there was insufficient seating available in the waiting room and as many as five patients at a time standing at the Receptionist desk providing confidential information.

   It becomes soul destroying to be abused thus by patients when you are trying to do your best with the limited resources available.

General Treatment by Management

The response by management to issues noted above was that there was no funding available. It seems at the District level at least, the manager was unable to implement changes because any decision regarding funding came from Corporate Office of Queensland Health in Brisbane. Part of the problem with resource allocation is that Bundaberg Hospital comes within the same zone as the northern Brisbane area. Given Bundaberg is in a provincial setting, it is impossible for it to fit into the same model.

In my discussions over the years I discerned an inadequate understanding by city based beaurocrats of the peculiar nature and needs of provincial and rural services. Models of health care developed for Brisbane cannot be applied in Bundaberg. .

I was aware of the culture of fear that existed particularly in relation to revealing areas of concern to our democratically elected representatives or to the media.

Funding situation for elective surgery

The funding for elective surgery was grossly inadequate. This is evidenced by the long waiting list for surgical outpatient appointments. Further, the guidelines that were provided to us with respect to waiting lists were impossible to follow because of the lack of resources. Statistics for elective surgical waiting times, while appearing satisfactory, are misleading because they fail to disclose the long queue to be placed on the surgical waiting list in the first place.

Bundaberg being predominantly a non-bulk billing town meant the specialist outpatient clinics always had a large referral base which in part reflects the large number of Medicare patients and also patients preferred surgical follow up at the hospital based clinic.

A related problem was the long waiting list for patients who required endoscopies. Once again the long wait to have an endoscopy resulted in delayed diagnoses. Dr McGregor a local surgeon in private practice, had indicated at various times that he was available and willing to do endoscopic examinations. However, for some unknown reason, a decision was made at Corporate Office in Brisbane that a doctor from Royal Brisbane Hospital would fly to Bundaberg Hospital every fortnight to perform endoscopies. While grateful for the provision of this service from Royal Brisbane, I do not understand this decision because it would have been cheaper for the Hospital to have Dr McGregor do endoscopies and he would have been available for any emergency follow up required.

What was the complaints handling process?

Patients: The complaints handling process for patients who had concerns about their treatment in Hospital were, as far was I am aware dealt with by the Hospital management team. Any complaints I was involved in were dealt with in discussion with the Director of Medical Services.

Staff: With respect to complaints that staff may have, I wrote to both the Director of Medical Services and the District Manager. I also discussed issues mainly relating to clinical matters with the Zone manager whenever the zone manager attended Bundaberg Hospital for meetings. No response was received by me other than that the funding restrictions meant little could be done.

Who did I complain to?

I complained to the following people: The District Manager, Director of Medical Services, the Zone Manager, the former Director-General and my local Member of Parliament, Mrs Nita Cunningham. My concerns were also expressed to a representative of the Australian Council of Health Care Standards in a meeting in 2001.

Difference in management teams pre and post current management

I am unable to comment, as I was not employed at Bundaberg Hospital when Mr Keating was employed there.

How many surgeons in Bundaberg? Why didn't they want to work there?

I cannot comment specifically on individual surgeons however, I can make the following comments which I consider apply to surgeons in general working in Bundaberg: -

- The inflexible attitude of Queensland Health to surgeons doing private versus public work;
- No support from management at Bundaberg Hospital or at Corporate Office;
- Not feeling valued and no job satisfaction because of lack of funding;
- The excessive hours surgeons are required to work which leads to 'burn out' and feeling that one is not able to do one's job properly

Recommendations for Improvement

- A different and or separate model for funding and service delivery for provincial and rural areas as opposed to city areas. Rural needs are vastly different to city needs.
- An improved system when wanting to transfer a patient who is in a serious condition but not requiring surgical intervention, so that it is easier to transfer a patient from a rural setting to one of the city based hospitals particularly neurosurgical head injury patients.
- More emphasis on VMO positions so that specialists are attracted to work in rural areas like Bundaberg. The reality is that it is not viable to have totally separate public and private sectors in rural Queensland. There needs to be joint appointments of all surgeons at both public and private hospitals. If you replace 2 full-time public doctors with 4 part time VMOs you immediately solve the night/weekend/holiday roster issues, provide a good team environment, and create an attractive opportunity for new surgeons to take up positions in the town.
- Action by Hospital administrators to fully support specialists so that the expertise and number of specialists can be maintained in Bundaberg with the result that they then may be able to get back their Surgical Registrar training scheme.

- Changes to the working conditions including overtime, restricted working hours and on call arrangements and employing more surgeons. This needs to be dealt with effectively in the up-coming EB6 agreement.

- More funding to Bundaberg Hospital in particular with respect to specialist outpatient clinics and elective surgery;

- Employed doctors must have a legitimate way of speaking to members of parliament with a special provision so that a doctor speaking out will not attract recriminations from Queensland Health;

- A change in the current management models so that senior doctors have input into how the hospital is managed in terms of resource allocation and program funding so that the scarce resources are distributed in keeping with the client population;

- Substantially reduce the number of hospital meetings;

- The medical board must give clear guidance on safe working hours for all doctors, both junior and senior.

- Funding for audit activities. Appropriate data collection and retrieval requires substantial clerical time, as well as paid non-clinical time allocated for attendance by medical staff.

- When questioned, Queensland Health did not have a model to say how many general surgeons, orthopaedic surgeons, physicians, paediatricians, obstetricians, anaesthetists etc were needed for a given population. The development of such statistics is an essential basis for building up appropriate provincial and rural services.

.....E.C. Nankivell.....

DR Edwin Charles NANKIVELL

Dated: .....3.6.05.....

BUNDABERG HOSPITAL COMMISSION OF INQUIRY
LIST OF DOCUMENTS

1. Letter to Dr Thiele (Director of Surgery) dated 2 December 1997 from Dr Anderson.

2. Letter to Dr Anderson, dated 7 April 1998 from Dr Nankivell.

3. Letter to Dr John Wakefield, Acting Medical Superintendent dated 25 May 1999 from Dr Nankivell. This letter refers to letter number 1.

4. Letter to Mr Peter Leck (District Manager) dated 23 July 1999 from Dr Nankivell re length of time patients have to wait to be seen by a surgeon.

5. Letter to Dr Anderson (Director of Surgery) dated 4 October 1999 from Dr Nankivell re outpatient clinic.

6. Letter to Dr Peter Leck (District Manager) dated 14 October 1999 from Dr Charles Nankivell.

7. Memorandum to Dr John Wakefield (A/Director of Medical Services) dated 13 December 1999 from Dr Nankivell re visit by Mr Lindsey Pyne and Mr Martin Jarman setting out his concerns regarding the outpatient clinic.

8. Letter to Dr John Wakefield, Director of Medical Services dated 15 December 1999 from Dr Nankivell re waiting time for patients to be seen in the Outpatient Clinic.

9. Memorandum from Dr Anderson dated 20 April 200 to Dr Wakefield cc Dr Nankivell re endoscopy service.

10. Letter to Dr Nankivell dated 3 May 2000 from Dr Anderson

11. Memorandum to Dr Anderson dated 22 May 2000 from Dr Wakefield cc to Dr Nankivell re the endoscopy service.

12. Letter to Dr Barry O'Loughlin dated 10 August 2000 from Dr Nankivell re coding of patients in public outpatient clinics (provided in response to article in RACS Qld newsletter seeking comments on the coding system).

13. Letter to Mr Lindsey Pyne, Zonal Manager dated 19 October 2000 from Dr Nankivell regarding the issue of on-call in rural centres.

14. Letter to Dr Nankivell from dated 31 October 2000 Lindsey Pyne, Central Zone Manager acknowledging his letter of 24 October re issue of on-call duty in rural centres.

15. Letter to Dr Nankivell dated 19 January 2001 from Dr J G Youngman, General Manager (Health Services).

16. E-mail to Dr Nankivell dated 27 July 2001 from Karen Smith regarding the endoscopy waiting list.

17. Letter to Mr Peter Leck (District Manager) dated 1 October 2001 from Dr Nankivell regarding length of time for patients to be seen in Outpatient Clinic.

18. Letter to Dr R Stable, (Director General of Queensland Health) re surgical problems at Bundaberg Hospital. Although the letter is undated, I recall personally handing this letter to him around November 2001 during one of his visits to Bundaberg Hospital.

19. Letter to Dr Hawken (Acting Director of Medical Services) dated 1 November 2001 from Dr Denise Powell (Chairperson of the College of General Practitioners) re the resignation of Dr Nankivell.

PA/ks

2 December 1997

DEPARTMENT OF SURGERY

Dr Brian Thiele
Director of Medical Services
BUNDABERG BASE HOSPITAL

FILE COPY

Dear Brian

Re: P364

Just a note to let you know that this lady had a transanal excision of a villous adenoma in June 1995. She was followed up but then put on the colonoscopy list 12 months ago. When she came to colonoscopy on 31 August she had a small palpable carcinoma present in the lower rectum. This was excised transanally today, but she may face an abdomino-perineal resection if the histopathology is unfavourable. Delayed diagnosis seems to be a result of her being on the colonoscopy waiting list for so long and not having regular three monthly sigmoidoscopies and rectal examinations.

Kind regards

PITRE ANDERSON
Director of Surgery

FILE COPY

CN/gs

DEPARTMENT OF SURGERY

7 April 1998

Dr Pitre Anderson
Bundaberg Base Hospital
PO Box 34
BUNDABERG 4670

Dear Pitre,

Re: P365

I wish to put in writing yet again my deep concern at the length of time for the endoscopic waiting list. As discussed with you only last week on the 1 April 1998 I endoscoped this lady with gastric carcinoma who had waited six months. As previously discussed this is a repetitive problem and needs to stay on our agenda to try and get the hospital administration to do something about this extremely worrisome pattern.

Yours sincerely

cnankivell

Charles Nankivell
Staff Surgeon

CN/ns

DEPARTMENT OF SURGERY

25 May 1999

Dr John Wakefield
Acting Medical Superintendent
Bundaberg Base Hospital
PO Box 34
BUNDABERG 4670

Dear John

RE: P364

I feel obliged to follow up on this lady about whom Dr Anderson wrote a letter to Dr Thiele in 1997. This lady had a colonoscopy that was delayed a year longer than scheduled after Dr Anderson had previously excised a villus adenoma of the rectum. Dr Anderson was in no doubt at the time that progression to carcinoma had been significantly delayed diagnosis because of the excessive colonoscopy wait.

After reviewing this lady in my clinic she is currently dying of liver metastases and will not last the year. The family are aware that the delay in diagnosis has contributed to her terminal illness and in Dr Anderson's absence of course I am seeing this patient. I do not believe they will sue the hospital for the delay but if they did I do not believe the hospital has a legitimate defence. This demonstrates so clearly the need to keep the colonoscopy and gastroscopy list within reasonable limits and certainly the waiting list is < than one year we used to have.

Yours sincerely

CN

Charles Nankivell
Staff Surgeon

CN/ns

DEPARTMENT OF SURGERY

23 July 1999

Mr Peter Leck
District Manager
Bundaberg Base Hospital
PO Box 34
BUNDABERG 4670

Dear Peter

I am becoming more and more concerned by the unsafe length of time patients are having to wait to see a Surgeon at this hospital.

The number of referrals we get each week are more than we can cope with. We have a system of classifying the patients 1, 2 or 3 according to the perceived urgency of the case. It needs to be stated quite emphatically that although I make a very conscientious effort to categorise people appropriately there is obviously a huge logical error in categorising people who have never been seen. As a consequence some people will be categorised 1 who really are not 1's at all when seen or people might be called a 3 when in actual fact they have something serious. The classification decision is made upon the basis of the GP referral, which is often inadequate. One might say philosophically if the GP knew what the problem was he would probably deal with it himself whereas the fact that they are being referred often means it is a problem that is beyond the level of the skill of the GP, and therefore the referral letter might reflect that lack of diagnostic certainty in not giving me the crucial information that I might need.

The current situation in my clinics is the patient's given a Category 3 Category are put on a limbo list. These patients are not even given an appointment date. It is unlikely that any would be seen this year anyway. Any patients called Category 1 are seen within the month which is of course appropriate. The problem is the Category 2 waiting list which is currently five months long for the next routine appointment. That is likely to increase in size due to holidays/Christmas shut down etc. Patient's frequently complain to the me about this problem often involving a delay in cancer treatment. Some patients may well seek legal damages against the hospital for having waiting lists that are out of control. Invariably over time some patients who are called 2 or even possibly 3 will turn out to have a cancer unbeknown to us. These patients would be justified in seeking legal action against the hospital. In a court of law I would have to absolve myself of any responsibility as there is nothing further I can do. The clinics are already badly overbooked and the patients are frequently not given the amount of time that they actually need.

This is clearly not a problem that can be put on the waiting list of problems to be fixed but needs urgent attention because the condition is dramatically deteriorating year by year.

Yours sincerely

Charles Nankivell
Staff Surgeon

cc Dr J Wakefield
United Medical Protection Society

COPY

CN/ds

DEPARTMENT OF SURGERY

4 October 1999

Dr P Anderson
Director of Surgery
Bundaberg Base Hospital
PO Box 34
BUNDABERG 4670

Dear Pitre

We need to have a meeting to formalise just how many patients we can be seeing at the clinic.

This afternoon, for example, in my follow up clinic, I have 28 patients to see. They all get jammed in over a 2 hour period which of course is not possible and as a consequence two things happen.

Firstly the patients are all seen late which leads to irritation and grumpiness. One patient stormed out today, although she had only had to wait 25 minutes at the time she left which I think was pretty exceptionally good for our clinic. But to wait an hour is quite standard and I think is not acceptable when it is happening all the time.

The second problem is that I can't see so many people and it is left to the juniors to get through what they can. This lessens my control over the patient care and lessens patient satisfaction. The other problem of course is that we are on call on a roster which usually corresponds with every 2nd clinic and if the registrar is being called away or phoned regularly it makes even further disruptions.

Personally I think we should see no more than 4 patients per hour as I think the sort of patients we see demand an average of 15 minutes each. We are under unrealistic pressure to see the patients referred to us and I think the time has come where we just simply cannot keep going with bigger and bigger clinics, giving second rate care to our patients.

Yours sincerely

Charles Nankivell
Staff Surgeon

Copy to: Dr John Wakefield. Acting Director of Medical Services

CN/ds

DEPARTMENT OF SURGERY

14 October 1999

Mr Peter Leck
District Manager
BUNDABERG BASE HOSPITAL

Dear Peter

I am getting more and more concerned about the abuse of staff, by patients, that is occurring regularly in this hospital. One area that must be looked at is the Specialist Clinic area. This area at the moment can only be described as a shambles. There is frequently not enough seats for patients to sit down on. The receptionist's desk is in the middle of a heavy traffic area and usually there are 5 patients standing around all at once giving, what is private information. There is regular aggression being expressed by patients, usually quite unfairly. Because of heavy clinic over booking, which unfortunately seems to be unavoidable, it is not uncommon for patient to have to wait an hour to see a doctor, even an hour and a half at my clinics sometimes. All of us are working very hard to do our best and we are getting sick and tired of the abuse that is being hurled at the staff here. It may be appropriate to have a close circuit television in this area with a videotape, so that everything can be recorded. Certainly a security officer needs to be on close standby.

Yours sincerely

Charles Nankivell
Staff Surgeon

QUEENSLAND HEALTH

MEMORANDUM

To: Dr John Wakefield - A/Director of Medical Services

From: Dr Charles Nankivell - Staff Surgeon **Contact No:** (07) 4150 2220

Subject: **Visit by Lindsay Pyne & Martin Jarman**

In case I am unable to attend this meeting, because of my operating session, I wish you to bring up my comments regarding the Guidelines for The Management of Specialist Outpatient Clinic Waiting Lists. The Government guidelines recommend a three tiered classification system. This is in fact identical to what I have been using for years now and thus this otherwise excellent document has no major contribution to make to our appointment system.

What has to be spelt out in the strongest possible terms is that it is absolutely impossible for us to see the Category 2's within 90 days. As you know, I am recording prospectively all the cases of delayed diagnosis of cancer caused by the excessive waiting period for patients in this health district. I believe patients have died because we are under staffed and I unfortunately will end up proving it as the statistics are collected.

There are five areas of questions to bring up:

- Can Lindsay Pyne guarantee us in writing that all electorates receive basically equal funding.
- Does the Government have a formula for how many surgeons (or other doctors for that matter) that the public system requires *per head of uninsured population.*
- What is the Government's plan for those health districts that fail to achieve their Category 3 targets?
- Strict observance of this classification system means in practice that Category 3's have an indefinite wait as they do if they were a Category 3 surgical case.
- The Government must be aware that Categorisation of patients, many of whom the general practitioner did not know what the diagnosis was, or who have not yet had relevant examination and tests etc, inevitably leads some patients who really are Category 3 to be called 1 and vice versa. Of course that is unavoidable, but if all patients could be seen within 90 days it probably wouldn't matter. However, when the waiting time blows out like it has here it can lead to the patient's death as a result of delayed diagnosis.

I would appreciate a written reponse to the issues raised.

Yours sincerely

Charles Nankivell
Staff Surgeon

13/12/99

[PYNE.DOC]

CN/lm

15 December, 1999

Department of Medical Services

Dr John Wakefield
Director of Medical Services
BUNDABERG BASE HOSPITAL

Dear John

Today I have examined the outpatient waiting list for surgical clinics with Mrs Kaye Dansie.

Patients referred from their general practitioners in July 1999 will be seen in February 2000. This waiting time is enormous and way outside Government guidelines.

Please make sure Mr Pyne is aware of this.

Yours sincerely

Charles Nankivell
Staff Surgeon

QUEENSLAND HEALTH

MEMORANDUM

To: Dr John Wakefield – Director of Medical Services

Copies to: Dr Charles Nankivell – Staff Surgeon
Jenny Church – CNC Theatre
Karen Smith – Elective Surgery Coordinator

From: Dr Pitre Anderson – Director of Surgery **Contact No:** (07) 4150 2220

Subject: **Endoscopy Service**

Dear John,

I am writing to let you know that in a recent conversation with Dr Derek McGregor he mentioned that a patient who was on our waiting list for an upper endoscopy finally got sick of waiting and came to have an endoscopy with Derek. This revealed a carcinoma of the oesophagus. It is one further patient who has come to grief while on the endoscopy waiting list.

Dr McGregor offered to do an endoscopy list at the Bundaberg Base Hospital and I would hope we would take up his offer in the near future. I hope that some of the funds that have been freed up from the orthopaedic service could be channelled into this activity. Dr McGregor did specify that the endoscopy equipment must be of good quality if he were to be offered a session.

Kind regards

Pitre Anderson
Director of Surgery

20/04/00

PA/gs

DEPARTMENT OF SURGERY

3 May 2000

Dr Charles Nankivell
Staff Surgeon
Bundaberg Base Hospital
PO Box 34
BUNDABERG 4670

Dear Charles,

Re: P363

As you know Dr McGregor recently mentioned he performed an endoscopy on P363 and diagnosed a mid-oesophageal carcinoma. She was referred to the Base Hospital and the letter was dated the 24th January. It was requested by Dr Kerswill that she be seen as a Category 2 patient as she complained of epigastric discomfort post swallowing over the last three months. Ranitidine had not helped her symptoms.

She was categorised 2 and filed in your Outpatient allocation folder. Happily she has taken on herself to see Dr McGregor privately and have the pathology diagnosed. This is one further case of delayed diagnosis caused by our long appointment waiting time.

Kind regards

Pitre Anderson
Director of Surgery

cc: Dr John Wakefield

QUEENSLAND HEALTH

MEMORANDUM

To: Dr Pitre Anderson, Director of Surgery

Copies to: Dr Charles Nankivell, Staff Surgeon
Karen Smith, Elective Surgery Coordinator
Jenny Church, CNC Theatre
Mr Peter Leck, District Manager / Executive Agenda
Theatre Advisory Committee Meeting Agenda

From: Dr John Wakefield
Director of Medical Services

Contact No: (07) 4150 2210

Subject: **Endoscopy Service**

Dear Pitre

Thank you for your letter highlighting the continued risk for patients due to the endoscopy waiting list at Bundaberg Base Hospital.

The current budget situation does not allow the employment of the additional medical and nursing staff required without allocation of additional monies from outside the district. This is made more difficult by virtue of the fact that endoscopies are not recognised as elective surgery activity. This means that we cannot access surgical incentive fund money to address this issue.

A business case for (1) a full-time additional general surgeon (2) a four session a week visiting medical officer surgeon has been prepared and forwarded to Corporate Office in approximately March of this year - to date we have had no response. I have also indicated to the District Manager and Executive of Bundaberg Health Service District the potential adverse impact upon patients of excessive waiting times for clinics / endoscopy services. This also obviously exposes the District to significant risk from litigation.

To further enhance the District's chance of attracting recurrent funds to address this issue, I am currently accessing all available data with respect to general surgical throughput / clinic throughput / excessive waiting periods. Once this has been developed into a brief report, I will seek your advice prior to meeting with the Zonal Office on the issue.

Yours sincerely

John Wakefield

22.5.2000

CN/ds

DEPARTMENT OF SURGERY

10 August 2000

Dr Barry O'Loughlin
Royal Brisbane Hospital
Herston Road
HERSTON 4029

Dear Barry

I meant to get back to you as soon as I read the article in the RACS Queensland Newsletter, regarding the coding of patients in Public Outpatient Clinics.

I have complained about this ad nauseam, not only to the appropriate administrative staff at this hospital, but also to our zonal representative.

The General Practitioner's letters are usually of substandard quality and I have also pointed this out to our Local Medical Association to try and improve it.

An example of a classic referral I receive is "epigastric pain, unresponsive to Zantac." This of course can be anything from irritable bowel syndrome to stress, alcoholism, peptic ulcer disease, gastric cancer, you name it. A patient with that sort of referral to Bundaberg Base Hospital is currently waiting 11 months if we categorise them as a 2.

There are two main problems with the coding system. The first is that many patients are sent to us precisely because the General Practitioner does not know the diagnosis. No-one is going to argue with a referral saying "left inguinal hernia". The patient of whom the General Practitioner does not know the diagnosis upon, or for whom the General Practitioner is requesting investigations, such as ultrasound, barium enema, etc. (the patients in Bundaberg can't afford to have these done in the private sector, so everything gets sent to the Base), clearly cannot be coded appropriately at all.

Often on reading the General Practitioner's letters, I haven't the faintest idea of the true urgency.

.../2

Dr Barry O'Loughlin

The second problem in the coding system is the sheer impossibility of achieving the goals. Although Category 2's are meant to be seen in 3 months, it is currently 11 months at the Bundaberg Base Hospital. As a consequence of that, one is reluctant to classify anything as a Category 3, because it is our policy to put them in a box and not see them. This invariably leads to a certain amount of aggression from patients and family. On the other hand, because Category 2's are taking 11 months, we now are calling almost everything Category 1 which then totally defeats the whole purpose of the coding system.

I see very serious medico-legal problems. I know I classified one Category 3 who turned out to have cancer. (That was many years ago when the lists weren't too long.). I know I have classified Category 2's and they have turned out to have cancer. I regard myself as being very legally vulnerable on this coding issue and I think it needs to be examined very quickly by the College.

Yours sincerely

Charles Nankivell
Staff Surgeon

CN/ds

DEPARTMENT OF SURGERY

19 October 2000

Mr Lindsay Pyne
Zonal Manager
Central Zone Management
Queensland Health
GPO Box 48
BRISBANE 4000

Dear Lindsay

I feel I need to clarify with you, a lot of the issues relating to on-call in rural centres.

Frequency of on-call duty

In Bundaberg it is one in two, whereas in major centres it is frequently one in four or more. It goes without saying, this has a huge influence on quality of life and interruption to planned elective lists, because surgeons with frequent on-call are always getting patients displacing their planned list.

Frequency of attendance whilst on-call

Of greater importance though is not the frequency of call, but the frequency that the surgeon is required to be in attendance. In a major centre such as Royal Brisbane Hospital, there are lots of Registrars in the latter years of their training who can perform unassisted, most emergency surgery. The Consultant is not required to come in to supervise the Registrar. This means that the common cases done on the weekends, such as abscesses, appendixes, bowel obstructions, lacerations etc., etc., do not require Consultant attendance, whereas in the rural areas, the Consultant has to usually come in because there is nobody else who can do it.

In Bundaberg we were getting an Accredited Registrar, usually in their first year who could perform surgery only with supervision. However, that Registrar was only on at best, every 3rd weekend anyway. Next year, because of the disruption to Surgical Services at the Bundaberg Base Hospital, we have had to voluntarily forego our Advanced Training Registrar position, until such time as we have restabilised. That means, next year, our junior staff level will be lower with more emphasis yet again placed on the Consultant staff.

Attracting staff to rural areas is always going to be difficult. However, it is likely that the situation is going to worsen rather than get better.

.../2

No-one in their right mind would take a position where they are going to be on call every 2nd weekend and in addition, be required to be in regular attendance. Holiday and leave cover is usually left to the other surgeon, doing a one in one type roster. Whilst I applaud efforts by the Zone to establish a Rural Locum Service, it is highly unlikely that that will be really able to deal with the crucial problem which is the fact that a one in two roster, working either with Junior House Officers, Principal House Officers or a 1st year Registrar, is not a viable long-term lifestyle.

Solutions:

May I propose that Queensland Health undertakes a serious study of this issue. There needs to be a focus on the safety of provincial surgeons' work practices. In most professions the person working over the weekend would get a day off in lieu during the week. This allows them personal time necessary for physical and mental well-being. There should be some mechanism set up for those doctors working unsafe practices, such as myself, to take time out during the week. Even if it was one day a month, it would be sufficient to make rural positions more attractive and viable. This day off would not be counted as Annual Leave. By being only a single day, rather than, say a full week, would not require Locum cover, nor would it impact on health care provision if properly planned for ahead of time.

I look forward to your reply.

Yours sincerely

Charles Nankivell
Director of Surgery

QUEENSLAND GOVERNMENT

QUEENSLAND HEALTH

Enquiries to: Kate Ricketts
Telephone: 322 52678
Facsimile: 323 40790
Our Ref: 1908-0023-009

Dr Charles Nankivell
Director of Surgery
Bundaberg Base Hospital
PO Box 34
Bundaberg Q 4670

Dear Dr Nankivell

Thank you for your letter dated 24 October 2000 concerning issues related to on-call duty in rural centres.

This matter is being followed up with Dr John Youngman (General Manager Health Services), Dr Steve Buckland (Southern Zone Manager) and Mr Terry Mehan (Northern Zone Manager). A response will be forwarded to you as soon as possible.

Yours sincerely

Lindsay Pyne
Central Zone Manager
21 /10 /2000

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Queensland Government

Queensland Health

Enquiries to: (Dr) J G Youngman
Telephone: (07) 3234 1078
Facsimile: (07) 3234 0270
Our Ref: HS000837

Dr C Nankivell
Director of Surgery
Bundaberg Base Hospital
PO Box 34
BUNDABERG Q 4670

Dear Dr Nankivell

I refer to my recent visit to Bundaberg Base Hospital on 16 January and your letter of 5 January 2001, which was passed to me at the time of the visit. Discussions did occur in relation to some of the matters you have raised and it is appreciated that there are no short term easy solutions. A decentralised state does have additional barriers particularly to lifestyle as it is not possible to engage enough staff to facilitate a roster in some disciplines. However, I do hope the matters were addressed and will be pursued.

Thank you for providing your views.

Yours sincerely

(Dr) J G Youngman
General Manager (Health Services)
19 / 1 /2001

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From: Karen Smith
To: Charles Nankivell; Sam Baker
Date: 24/07/2001 3:06pm
Subject: Scope Waiting List

Dr Nankivell & Dr Baker
Could you please reinforce the waiting times for scopes with the newer members of your teams.
New patients Cat 5 = Cat 2 is a 12 to 14 month
Cat 6 Follow up scopes only are 2 months more than due dates. For Cat 6 scopes please indicate 1 year or 2 year etc.
Thank You
Muddy

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Bundaberg Health Service District
Bundaberg Base Hospital
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FILE COPY

CN/ds

DEPARTMENT OF SURGERY

1 October 2001

Mr Peter Leck
District Manager
BUNDABERG BASE HOSPITAL

Dear Peter

I am still concerned about the length of time patients wait to be seen in clinic. Today I saw a lady who was referred on 15 February and was coded as a Category 1 who has taken until now to get seen.

This lady has significant skin cancers on the face which have grown considerably since the General Practitioner saw the patient and one of the lesions may well need a plastic surgical procedure to try and clear it out. This lady is a very shy person and didn't "jump up and down" about the wait.

Another one which I saw in September was a man who was referred to me in May 2000 because of a complication from a hernia repair done elsewhere. Because he still hadn't been seen in May this year, the General Practitioner re-referred him. He was coded as a Category 1 and was not seen until September. The initial diagnosis the General Practitioner made was wrong. There was no recurrence of the hernia. He in fact had a malignancy. By the time he saw me he had advanced malignancy and was urgently referred to Brisbane. He will, if still potentially treatable, need to have the whole of his leg and half of his pelvis removed to try and control this.

This illustrates two points:

1. Our Category 1 patients are waiting way in excess of normal 1 month guideline.
2. Codings can only be made on the basis of General Practitioner's provisional diagnosis which is frequently unsubstantiated and may simply be quite wrong.

Yours sincerely

Charles Nankivell
Director of Surgery

Confidential

To Dr R. Stable
Director General Of Queensland Health

Re: Surgical Problems at the Bundaberg Base Hospital

Key Surgeon Issues

- 1:2 Roster unbearable. (No advanced training registrar to do all the work like they have in Brisbane).
- Rare to have locum cover for leave.
- Often work 2 or3 weekends in a row.
- No time off "in lieu" during the week when doing excessive overtime.
- 3 months of the year we are reduced to only one surgeon for 78,000 people.
- We have to do the on call for the private patients as well.
- We suffer frequent verbal and psychological abuse from patients complaining about waiting all year to see a doctor, or complaining about hours of delay in massively overbooked clinics. (The clinics are overbooked because of the concern we have for our patients. I never say "No" to a sick person.) Worse still is the abuse of patients and relatives who have waited excessive time to have their cancer diagnosed.
- One of our Surgical VMOs (Dr Thiele) does no on call for general surgery as he is a vascular surgeon and feels not capable of doing general call.

Patient Welfare Issues

Patients still wait exceedingly long times to see a surgeon.
Numerous examples of unneccessarily delayed diagnosis of cancer.
We do not have the resources to fulfil the Govt guidleines for waiting lists (*Guidelines for the management of surgical outpatient clinics*. The problems of coding patients as Code 1-2-3 has been well pointed out to Q Health).
The Endoscopy list remains a disaster despite years of begging for help. The arrival of the Brisbane Gastro-enterologists is a boost but with the extra expenditure we have gone from having 3 endoscopy lists a week to now having 3 lists a week! Dr McGregor in town had been willing to do a VMO scope list but had been denied this in the past.
There is clear psychological stress caused to patients because of waiting too long for treatment.

Communication Issues

- Our clinicians' meetings with Q Health have identified the problems with the Dept of Surgery as the No 1 problem effecting the Bundabergn Base Hospital for several years . There has been no effective response to our concerns. This has flabergasted the staff as this has clearly been listed as our no 1 priority.

- We seem to have no effective communication with Q Health. Clearly identified issues are not addressed and we don't seem to get appropriate feedback on why not.

Lack of Progress Issues

Accident and Emergency still remains a shambles. This has a significant impact on surgical workload as juniors in A&E cannot work up patients properly.
Loss of training registrar in Surgery and Obstetrics and Gynaecology is a beg negative.
No staff increase in surgery despite the
Major effect of the renal unit (all these patients require surgery)
Increase in aged population

No proper library still.
Clinics have not improved.
No one is going to elect *Option B* until the billing process in the hospital is improved.

Some of Dr Nankivell's Issues

Achievements since becoming Director of Surgery in September 2000.

- 20% increase in the number of surgical clinics with no staff increase. (Staff Surgeon doing an extra clinic per week).
- Dr Kingston called upon to do specially targetted "catch up" clinics.
- Weighted separations quota met despite last year's troubles because of surgeons doing extra lists to catch up.
- Revision of mastectomy "*care path*" to reduce unnecessary length of stay
- Work with the GPs to train them as part of the Clinical Assistanship Programme.
- Work on *integrated health care* with the Division of GPs.
- Signed off with the gastro-enterologists guidelines to assist the GP community regarding appropriate referral for endoscopy for certain conditions.
- Maintaince of Surgical Waiting list times within Government guidelines.

I had my resignation letter ready one year ago. As it turned out the same day I signed my resignation Dr Anderson was stood down. So it was not handed in. I stayed on in Bundaberg an extra 12 months to try to help the patients here, and with hope that things might improve. I have for several years now been urging for a 3-session-a-week VMO position for the Dept of Surgery, and have put this in writing. I would have been prepared to stay in town had it been offered.

When Dr Anderson left I was treated wrongly. My study leave was booked for a month in August-September 2000. I cancelled this at short notice to save the hospital from a dire mess after Dr Anderson's departure. Minor help from the private sector to cover some nights and weekends (they did not look after the patients the next day), did not stop the shattering experience of virtually being the sole surgeon for 78,000 people for most of 3 months before Dr Daly arrived. (Limited support from locums was given for a few weeks). I was not offered any extra time off or other reasonable benefit for this. I did not ask for, nor want, more salary. During this period no one from Q Health ever thanked me or rang me up to give me support. No action was taken to *force* other surgeons from other districts to help out. I suffered enormous physical and mental exhaustion and was operating on patients when I was totally unfit. Essentially I lived like a hermit for 3 months. It has taken most of this year to recover from that. I will not allow any other person to go through this. This very ugly episode is well known throughout Queensland and is a big turn off for surgeons thinking of coming to Bundaberg.

The concern I have with the surgeons' roster, and the key points of difference in the work-load of city and country surgeons has been well communicated to Q Health both verbally and in writing. No effective response has been forthcoming.

When I arrived in Bundaberg I was told I could only get 6 months free rent. Thus I was forced to buy a huse in a town with no capital growth. I have just sold for $29,000 loss on the original purchase price. This does not take into account 7 years

rates (currently >$1,000 p.a.), termite treatment ($1,490), repainting (>$2,000), installation of air conditioning ($1,800), grounds maintainance (>$4,000), and other mainainance. In addition the mortgage to buy the house would have cost me about $20,000 or more in interest repayments. Now that I have sold my house the hospital has no accommodation to house me. I have to pay $750 for just one week in a furnished unit because of it now being the Christmas period. I write this simply to demonstrate that I am certainly not a greeedy doctor taking all the perks I can get out of the system. I have given the best I could to Bundaberg.

I understand that others have not been given housing and that should be investigated.

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Dr Lynn Hawken
Acting Director of Medical Services
Bundaberg Health Service District
PO Box 34
BUNDABERG QLD 4670

Thursday, November 01, 2001

Dear Dr Hawken

It is with disappointment and concern that we note the resignation of Dr Cha Nankivell from his position as Director of Surgery with Bundaberg Health Ser District, as reported in today's News Mail.

Dr Nankivell is an integral part of the Clinical Assistantship Program underway at Bundaberg Base Hospital. He has provided support to both Minor Ops and Sur Outpatients rotations for two terms, despite carrying a high clinical workload him Feedback from participating general practitioners confirms his popularity as a clini and an educator.

The quality of Dr Nankivell's care of patients, and his willingness to participat research and education, distinguish him as a crucial asset to the health services of region. He has recently sought to engage local GPs in a shared care model for management of women undergoing breast cancer surgery. This initiative demonstr his commitment to the integration of general practice and hospital-based services means to improve the continuity of care for patients.

Whilst we recognise that the recruitment and retention of Queensland Health me staff is your responsibility, we wish to emphasise that the impact of Dr Nanki resignation on other service providers, particularly GPs, is most significant. From patients' perspective, it represents increased doubt and uncertainty about the cap of local health services to meet the needs of the community within accep timeframes. It does little to reassure us that our valued public medical practitioner being supported in ways that enhance their long-term retention in a region that is than adequately resourced.

Therefore we seek your comment on what steps you have taken to addres Nankivell's long-standing concerns, with a view to retaining his valuable servic Bundaberg. These concerns have been substantiated by a collection of data th been accepted as true and correct.

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Dr Lynn Hawken
Acting Director of Medical Services
Bundaberg Health Service District
PO Box 34
BUNDABERG QLD 4670

Thursday, November 01, 2001

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Dr Nankivell is an integral part of the Clinical Assistantship Program underway at the Bundaberg Base Hospital. He has provided support to both Minor Ops and Surgical Outpatients rotations for two terms, despite carrying a high clinical workload himself. Feedback from participating general practitioners confirms his popularity as a clinician and an educator.

The quality of Dr Nankivell's care of patients, and his willingness to participate in research and education, distinguish him as a crucial asset to the health services of this region. He has recently sought to engage local GPs in a shared care model for the management of women undergoing breast cancer surgery. This initiative demonstrates his commitment to the integration of general practice and hospital-based services as a means to improve the continuity of care for patients.

Whilst we recognise that the recruitment and retention of Queensland Health medical staff is your responsibility, we wish to emphasise that the impact of Dr Nankivell's resignation on other service providers, particularly GPs, is most significant. From our patients' perspective, it represents increased doubt and uncertainty about the capacity of local health services to meet the needs of the community within acceptable timeframes. It does little to reassure us that our valued public medical practitioners are being supported in ways that enhance their long-term retention in a region that is less than adequately resourced.

Therefore we seek your comment on what steps you have taken to address Dr Nankivell's long-standing concerns, with a view to retaining his valuable services in Bundaberg. These concerns have been substantiated by a collection of data that has been accepted as true and correct.

Clearly this is an issue of major concern that has repercussions throughout our region. As such, we look forward to your early response.

Yours sincerely,

Denise Powell.

Dr Denise Powell
Chairperson

c.c. Members
Bundaberg & District Division of General Practice

c.c. Mr Peter Leck
District Manager
Bundaberg Health Service District

b.c. Dr Charles Nankivell
Director of Surgery