Special Commission of Inquiry into Healthcare Funding

Statement of Dr Karen Murphy

Name:	Dr Karen Murphy
Professional address:	Suite 2, Level 2, 67-71 King Street, Warrawong NSW 2502
Occupation:	Acting Executive Director Medical Services and Clinical Governance, Illawarra Shoalhaven Local Health District

1. This statement made by me accurately sets out the evidence that I would be prepared, if necessary, to give to the Special Commission of Inquiry into Healthcare Funding as a witness. The statement is true to the best of my knowledge and belief.

A. INTRODUCTION

2. My name is Dr Karen Murphy. I am the Acting Executive Director Medical Services and Clinical Governance of Illawarra Shoalhaven Local Health District (**ISLHD**). A copy of my curriculum vitae is at **(MOH.0011.0002.0001)**.

3. This statement addresses Term of Reference G concerning the current education and training programs for doctors and medical specialists and their sustainability to meet future needs and mechanisms for recruitment and retention. It is provided in response to the letters of 23 May 2024 and 1 July 2024 issued to the Crown Solicitor's Office, and also Issues Paper 1/2024, and addresses the topics set out in those documents relevant to my role.

4. In my current role, I am responsible for professional leadership of doctors, pharmacy and other medical services, and clinical governance within ISLHD. I am a member of the core executive group of ISLHD which is responsible for the strategic and organisational focus of ISLHD across all sites. My team comprises a number of professional medical leaders and responsibilities across three main sites in ISLHD including:

   a. Three Directors of Medical Services.

   b. The Medical Workforce Unit, which has oversight over the medical workforce including Junior Medical Officers (**JMOs**), Senior Medical Officers, wellbeing, and education. I have oversight of these areas but do not have operational accountability for them.

c. A Senior Staff Specialist Medical Officer, who is responsible for developing the leadership skills of, and offering professional guidance, to all medical officers working within ISLHD.

d. The District Director of Pharmacy, who oversees all pharmacists across ISLHD.

e. Clinical Governance Unit, which manages, monitors and supports safe and effective healthcare provision for patients.

f. I also offer professional guidance to those working in research within ISLHD, but I do not have operational accountability or responsibility for this work.

g. I have oversight of the support mechanism for the voluntary assisted dying service as there is not currently a medical director for this service. I will relinquish this role shortly when the medical director role is filled.

5. Overall, much of the work in my portfolio is dedicated to enhancing the ability of our organisation to provide training for junior doctors within our health services so they can receive the required training and become senior doctors within the organisation.

B. DETERMINING THE NUMBER AND DISTRIBUTION OF MEDICAL SPECIALISTS

6. Current ISLHD medical specialist staffing and junior medical doctors in specialist training are set out in the tables below. I note that some doctors hold two positions (i.e. as a specialist and as an academic).

ISLHD Medical Specialist Staffing

				Breakdown					
Speciality	Total headcount	FTE		Staff Specialists	Visiting Medical Officers	Honorary Medical Officers	Consultant Emeritus	Clinical Academic	PGF
TOTAL	548	159.16		217	298	31	2	1	1

ISLHD Summary

Site	Senior Reg /Pfellow	BPT	CMO	Reg	AT/ SET	UAT/ PreSET	SRMO	Resident	Intern	Total JMO per specialty
Total JMO per grade	5	34.7	33.81	159.45	60.2	22	42.5	87.5	79	524.16

7. Determining the adequate number of specialist training positions is based on the needs of a local population. This is managed at a national level and is based on population data from the Australian Institute of Health and Welfare and the Commonwealth Government. As a result, ISLHD cannot influence the numbers of specialists, and the services to be provided are determined based on population determinants in ISLHD's Service

Agreement with the Secretary, NSW Health, however, we can assess changes in population and demographics to predict where the need for specialists will be.

8. As an example, predictions in relation to the growth of the population and a demonstrated growth in the age range 30-65. This influenced the new build of Shellharbour Hospital and the projection that there will be an increased need for obstetricians and gynaecologists.

C. RELATIONSHIP WITH MEDICAL COLLEGES

9. The number of specialist training positions is highly dependent on medical colleges. Colleges look at the distribution of patients in an area and determine how trainees can obtain the experience they need to qualify as fellows of the college. For example, colleges may observe that the ageing population in Shoalhaven will not give a trainee enough exposure to a younger population, and the requisite training may only be available at sites such as Shellharbour Hospital and Wollongong Hospital.

10. Historically, colleges based in larger cities have tended to provide all the training and education in those cities. I have observed that the colleges are beginning to recognise a need to move away from this centralised model, and that supervisors are also recognising that they may have to travel to provide supervision for junior doctors.

11. I consider that the current approach is sensible however it does not necessarily provide ISLHD with broad enough supervision coverage for the pastoral care that the junior doctors require to enable them to provide care to patients. Colleges and LHDs and health services across Australia are collaborating to explore alternative ways of training in order to ensure that junior doctors gain necessary exposure and can provide the full range of care from an operational perspective. For example, some colleges are considering remote supervision of junior doctors rather than assuming specialists are all based in one hospital and expecting all training to be undertaken in a centralised, larger site. An example of this is that remote supervision at Bulli Hospital Urgent Care Centre is currently under consideration by the Australasian College for Emergency Medicine (**ACEM**).

12. I am aware of some colleges actively working with the NSW Ministry of Health (**MOH**) and other jurisdictions to develop alternative training opportunities, particularly in very remote areas. A remote supervision process can involve Telehealth services and support from mentors who may fly in and fly out. I consider that many of the colleges are being proactive in relation to this.

13. There have been significant improvements in the number and distribution of specialists in ISLHD and the flexibility of training programs over the last 2 – 3 years. For example, the ACEM is more flexible in allowing Shoalhaven Health Service, which is in a Modified Monash Model 4 area, to provide training to a general practitioner who also wants to develop emergency department training capacity. The ACEM is working directly with the Emergency Department at the Shoalhaven Health Service to facilitate this.

Accreditation

14. The process for accreditation is based on the number of junior and senior doctors in the LHD, the type of patients being seen at a site, the services that are provided at a site, and the ability to provide support and exposure for the training of registrars in the college training process. If a college is satisfied that each of these aspects is fulfilled, it would visit the organisation, meet with a number of people including medical leadership, senior doctors, junior doctors, the multidisciplinary team and core executive members including the Chief Executive. The college would then assess whether training could be provided with the appropriate level of support. If they do so, the college would provide the LHD with an agreement to recruit trainees. The LHD can recruit trainees directly or, in some cases, is a site provider for a larger training process.

15. ISLHD has undergone a number of accreditation visits in the past year. There are a number of accredited training positions across different specialties in ISLHD. As an organisation, ISLHD centrally supports medical specialists to apply for additional training positions, particularly general surgery, anaesthetics, neurology, and emergency physicians, as the organisation has grown big enough to warrant an increase in training and the ability to meet requirements imposed by the colleges. As a teaching and training LHD, we will support any specialty that wishes to enhance its service by providing a supervised training position by reviewing a number of factors prior to applying for accreditation including clinical need, skills mix, support service provision, adequacy of supervision and opportunity to meet skills training requirements.

16. Accreditation can be withdrawn in a number of ways. Common instances are where there is no dedicated supervision available from a senior doctor, junior doctors' feedback suggests training is inadequate to meet requirements, or where the LHD approaches the college to inform them that the service is not currently robust enough to maintain the level of supervision or provide sufficient exposure at that site. As an example, ISLHD is currently in discussions with the College of Surgeons because we have lost a number of senior specialists in plastic surgery and cannot support trainees in that specialty. We are

currently reviewing the service and models of care across ISLHD and asking the College of Surgeons not to reaccredit ISLHD in plastic surgery for the next 12 months until the service has been enhanced and adequate training can be provided for junior doctors training to become plastic surgeons.

17. The Health Education and Training Institute (**HETI**) provides a positive oversight function in advance of accreditation processes and enhancing clinical schools of trainees. We liaise with HETI if we are having issues with training positions and applications for increasing supervisory training positions. As an example, there is a certain aspect of cardiology training that requires access to a procedure that cardiothoracic surgeons who work in a private hospital within the LHD perform. HETI oversaw and approved a process whereby cardiology trainees employed by ISLHD could work in that private hospital to get exposure to that specific procedure and meet training requirements.

18. In my view, the medical colleges are slowly coming onboard with flexible approaches to training. I consider there to be an opportunity to encourage colleges to listen further to the operational and organisational needs of health services when undergoing the process set out in paragraph 16 above.

19. The onus is on leaders in the organisation to demonstrate to the junior workforce that we can provide the support they need. We are regularly and actively considering how best to support trainees across their rotations – for example, by rotating them across our different sites so junior doctors get experience and exposure in a larger hospital at Wollongong and in rural settings.

D. CHALLENGES IN DISTRIBUTION OF MEDICAL SPECIALISTS

20. The unequal distribution of medical specialists across NSW is largely based on population distribution and the personal preference for people to live in large cities by the sea. At ISLHD, there is a challenge in attracting doctors who have a preference towards a large hospital in a city centre. I have also observed that there is a perception amongst clinicians that in metropolitan areas they will get an enhanced opportunity to provide more varied kinds of care to a larger number of patients and that they would not be able to maintain their skill level in a rural or remote area.

21. There is a significant disparity in remuneration for doctors at different levels in different areas across Australia. NSW has the lowest salary for staff specialists in Australia and thereby a high proportion of Visiting Medical Officers (**VMOs**). There is also a significant funding tension between the federal and state systems. For example, primary care and

aged care is funded by the Commonwealth government and public health in secondary, tertiary & quaternary services are funded through the state system. Given patients traverse often between service level modalities, the funding differences can be challenging. For example, when the funding available for care to be provided through primary care (general practitioners) is inadequate and does not cover the general practitioner cost to provide the service, the general practitioner may not offer a bulk-billing service (Medicare items may not be contemporaneous with the cost to provide the service) and where patients do not have the funds to pay the fee for general practitioner support, they often default to presenting to a public hospital Emergency Department where all their acute care is provided for.

22. There are also large incentives in Queensland and Western Australia for doctors working in some of the most remote areas that are not available in NSW. While such incentives may not be a priority for most doctors, there is a view that having gone through the extensive educational process and wanting to support oneself as best you can, doctors are likely to be encouraged to work somewhere very remote in another state for a short period if there is an incentive in place, before returning to large cities in the long term.

23. At a high level, there is quite a siloed approach across health services in NSW not only between professions but between clinical and non-clinical staff, across disciplines and health agencies. In a multifactorial and complex health system, I believe that there is a need from a leadership perspective to demonstrate on a daily basis that it is not effective to work in silos and that we each have a responsibility for looking after patients. There is no one area of health that is the single point of focus, so working within organisational silos risks the patient's journey being fraught with delays and detours. Internal LHD silos between disciplines, modalities, practitioners and support providers only exacerbates this delay in a patient's journey. ISLHD is working to reduce the barriers to this by advocating for JMOs to complete all of their rotations at one LHD and move across sites within the LHD, and moving towards a model of employing senior doctors who provide training to work across the district rather than being siloed to one site.

24. There is also sometimes a disparity between the availability of specialists in certain specialties. As an example, there are challenges around adequate numbers of plastic surgeons to supervise trainees in the public sector because there is a greater incentive for them to work in the private sector, which applies across the country.

E. ATTRACTION OF SPECIALIST DOCTORS

25. ISLHD is developing innovative ways of attracting and employing specialist doctors in order to meet the needs of the LHD, through a combination of ISLHD / MOH or state initiatives. Examples include:

    a. Offering a dual contract for senior doctors to work as staff specialists or VMOs as required. Staff specialist hours being supplemented by VMO contracted hours at another site or in a different modality supports coverage at a secondary site and incentivises senior doctors to work there where they otherwise may not. For example, a staff specialist general physician may also have a secondary qualification in endocrinology, for which there may only be a small need but where they can work supplementary hours as a VMO where there is need. A dual contract allows ISLHD to optimise the skills of the clinician to service requirements.

    b. Offering a fee for service for senior doctors who may not be staff specialists and work exclusively as VMOs. For example, If we run an extra service to reduce our waitlist we can also provide an incentive for senior doctors to work at the site and take trainees with them to gain relevant exposure.

    c. NSW Rural Generalist Single Employer Pathway for junior doctors seeking a career as a rural generalist. Trainees on the pathway are employed for up to four years by the LHD while completing training in both primary care and hospital settings. As NSW Health employees, they retain award entitlements as other specialist trainees employed by NSW Health do.

    d. Rural Health Workforce Incentive Scheme. This NSW Health scheme provides an incentive package of sign-on and retention bonuses for hard to fill and critically vacant positions in rural LHDs.

    e. Offering the opportunity to work in rural areas for doctors undertaking specialist training which might not be available at larger or metropolitan sites that are currently unable to facilitate training in rural areas that are not within the catchment of the LHD.

26. ISLHD is strongly engaged with and supported by partner universities. This relationship provides opportunities for innovation in recruitment. For example, ISLHD offers final year medical students at the University of Wollongong employment as assistants in medicine where they are registered to work on wards and complete certain tasks. This allows

students to earn a salary on a part-time basis and enhances their education, embeds them at a site and prepares them for the role of becoming an intern. ISLHD has received funding from MOH to provide those positions over the last 3 years.

27. ISLHD is innovative and dynamic with international recruitment and does not exclude international graduates, because we recognise the finite pool of Australian doctors. ISLHD is actively recruiting a central repository of international junior doctors to become part of the fabric of the organisation in the hope that they will make the move to ISLHD permanent. As an example, ISLHD runs a work based assessment process where senior doctors can assess doctors undergoing Australian Medical Council processes so that they do not have to sit exams directly or do a viva voce and rather can be assessed while working at the health service. There is also a centralised ISLHD JMO Relief Pool where international medical graduates are on two year contracts and are allocated across ISLHD to support all JMOs with their rotations, leave coverage, improving rostering and fostering additional skills, which also reduces the financial pressure of external locums.

F. NATURE AND ADEQUACY OF WORKFORCE PLANNING

28. The clinical services planning process takes into consideration requirements for numbers of doctors at a specific service or considers the role of alternative clinicians. This often looks like reducing the number of doctors required in some areas and enhancing the services provided across other modalities. I am of the view that care can be provided across the continuum by a number of clinical specialties and am focused on how ISLHD can look at what services can be provided by nurse practitioners in certain areas to reduce the need for a doctor on site, and ensuring clinicians are all working at the top of their scope of practice. This, in turn, makes a role more attractive and makes it easier to recruit.

29. I work closely with the Executive Director of Nursing and the Executive Director of Allied Health to encourage staff to work at the top of their scope of practice and increase flexibility. An example within my portfolio is the development of a program whereby community pharmacists are employed in the Emergency Department to provide prescriptions for simple presentations and patients that meet certain criteria, with the benefit that those patients spend a reduced amount of time in the Emergency Department, and also potentially as an inpatient.

30. A number of significant capital works projects and builds in ISLHD over the next 3 – 5 years means that ISLHD has a continued focus on ensuring it is aware of areas of need in certain specialties, and planning is flexible.

Dr Karen Murphy	Witness: Penelope Aivaliotis
12/7/2024	12/7/2024
Date	Date