The Royal Australian and New Zealand College of Radiologists®

Special Commission of Enquiry into Healthcare Funding in NSW
Witness Statement

This statement sets out the evidence that I am prepared to give to the Special Commission of Inquiry into Healthcare Funding as a witness. This statement is true to the best of my knowledge and belief.

Introduction

1. The Royal Australian and New Zealand College of Radiologists (RANZCR) is a non-profit professional organisation dedicated to clinical radiologists and radiation oncologists in Australia, New Zealand, and Singapore. RANZCR is dedicated to setting standards, professional training, assessment and accreditation, and advocating access to quality care in both professions to create healthier communities.
2. RANZCR creates a positive impact by driving change, focusing on the professional development of its members and advancing best practice health policy and advocacy, to enable better patient outcomes.
3. RANZCR members are critical to health services: radiation oncology is a vital component in the treatment of cancer; clinical radiology is central to the diagnosis and treatment of disease and injury.

Question 1. A brief overview of the College

4. RANZCR's key activities and responsibilities include:

   i. **Training Programs**: RANZCR oversees training programs, which include selection, assessment, and examinations, for individuals seeking to enter the professions of clinical radiology and radiation oncology.

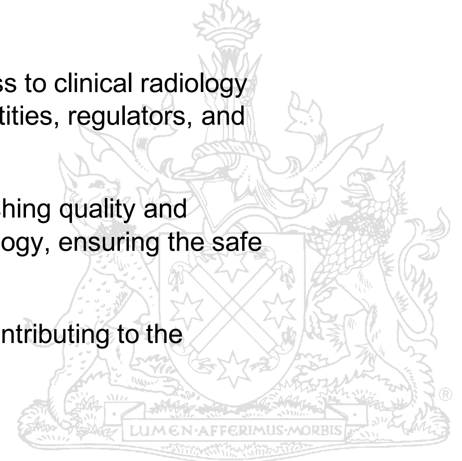
   ii. **Assessment of International Medical Graduates (IMGs)**: RANZCR conducts assessments for IMGs, providing them with an opportunity to practice in Australia and New Zealand.

   iii. **Continuing Professional Development (CPD)**: RANZCR operates a CPD program for its members, ensuring they stay updated with the latest advancements in their field. RANZCR is a CPD Home.

   iv. **Policy and Advocacy**: RANZCR advocates for the patient access to clinical radiology and radiation oncology, promoting these fields to government entities, regulators, and other stakeholders.

   v. **Quality and Standards**: RANZCR plays a crucial role in establishing quality and standards for the practice of clinical radiology and radiation oncology, ensuring the safe and highest quality of patient care.

   vi. **Research**: RANZCR is actively involved in research activities, contributing to the advancement of radiology and radiation oncology.



a. any recognised subspecialties.

5. RANZCR comprises two faculties: the Faculty of Clinical Radiology (FCR) and the Faculty of Radiation Oncology (FRO). These faculties are the leading bodies for their respective professions in Australia and New Zealand. Each Faculty represents its own speciality. RANZCR is governed by clinicians who are democratically elected by the membership and overseen by a Board of Directors, who are primarily elected from the membership. This structure ensures that the College's activities and policies are aligned with the interests and needs of its members.

6. There are no Ahpra recognised subspecialities within clinical radiology or radiation oncology.

b. the relationship with any subspecialty representative organisation or body.

7. RANZCR does not have any relationships with representative organisations in relation to the delivery of the specialist training program.

The current state of the specialty/workforce

Question 2. Information as to the following within NSW

a. Accredited trainees

8. RANZCR accredited trainee number are as follows:
   - Clinical Radiology – 154 trainees
   - Radiation Oncology – 56 trainees

b. Unaccredited trainees.

9. RANZCR does not oversee or manage unaccredited trainees or keep track of their numbers. This falls outside of RANZCR's scope of responsibilities.

10. RANZCR's additional comments on unaccredited trainees are detailed below at question 13.

c. Fellows able to supervise trainees

11. All Fellows of the Royal Australian and New Zealand College of Radiologists (FRANZCR) who are working in a RANZCR-accredited teaching sites have the ability to supervise trainees. While the numbers of these fellows are noted during accreditation visits, RANZCR does not track the employment of all its fellows. It's important to note that the workforce at each hospital fluctuates, making the number of fellows fluid. With the increase in the number of Visiting Medical Officers (VMOs), there is growing concern that the VMO model may not provide an optimal structure to support trainees in the accredited training program. This is due to the nature of VMOs' roles, which often involve balancing responsibilities at multiple sites, potentially limiting their availability for consistent trainee supervision. RANZCR is aware of these concerns and continually works to ensure the quality of its training programs.

d. Training sites

12. In NSW there are a total of 56 training sites accredited by RANZCR:
   - Clinical Radiology – 40
   - Radiation Oncology – 16

Question 3. The extent to which the current number of practising specialists can meet the demand for services within New South Wales – generally and in the public health system

13. The current capacity of clinical radiologists and radiation oncologists to meet the demand for services within NSW, particularly in the public health system, faces significant challenges and limitations. Across both specialties there has been a noticeable increase in workload driven by multiple factors. The surge in demand for services has placed considerable strain on the existing specialist workforce. Discussions with key stakeholders, including healthcare administrators, consistently highlight the need for additional specialists to address existing and projected service gaps. This is due to the number of positions vacant, and growing demand for imaging at hospitals It is clear that recruiting more specialists in both metropolitan and regional settings is essential to alleviate pressure on the current workforce. There has been a steady increase in part-time positions, job sharing, telehealth opportunities and flexible scheduling.

14. NSW has less clinical radiologists compared to the population than most of the other States in Australia. RANZCR cannot confirm why NSW has less radiologists than other states, however paragraph 26 outlines some differences between state employment conditions.

15. Active Clinical Radiologist per 100,000 population

State	Active CR	% Total	Population July '24	CR per 100k pop
NSW	778	29%	8,434,800	9.2
ACT	58	2%	470,200	12.3
VIC	714	27%	6,906,000	10.3
WA	323	12%	2,927,900	11.0
QLD	546	20%	5,528,300	9.9
NT	5	0%	253,600	2.0
SA	215	8%	1,866,300	11.5
TAS	52	2%	574,700	9.0
Total	2691	100%	26,961,800	10.0

Source: ABS & RANZCR CRM Data July 2024

16. Active Clinical Radiologist Trainees by state

State	Active CR Trainees	% Total	Population July '24	CR Trainees per 100k pop
NSW	163	29%	8,434,800	1.9
ACT	18	3%	470,200	3.8
VIC	135	24%	6,906,000	2.0
WA	45	8%	2,927,900	1.5
QLD	117	21%	5,528,300	2.1
NT	0	0%	253,600	-
SA	61	11%	1,866,300	3.3
TAS	14	3%	574,700	2.4
Aus	553	100%	26,961,800	2.1

Source: ABS & RANZCR CRM Data July 2024

17. Active Radiation Oncologists per 100,000 population

State	Active RO	% Total	Population July '24	RO per 100k pop
NSW	165	37%	8,434,800	2.0
ACT	15	3%	470,200	3.2
VIC	112	25%	6,906,000	1.6
WA	28	6%	2,927,900	1.0
QLD	98	22%	5,528,300	1.8
NT	1	0%	253,600	0.4
SA	24	5%	1,866,300	1.3
TAS	9	2%	574,700	1.6
Total	452	100%	26,961,800	1.7

Source: ABS & RANZCR CRM Data July 2024

18. Active Radiation Oncology Trainees by state

State	Active RO Trainees	% Total	Population July '24	RO Trainees per 100k pop
NSW	53	42%	8,434,800	0.6
ACT	4	3%	470,200	0.9
VIC	24	19%	6,906,000	0.3
WA	4	3%	2,927,900	0.1
QLD	29	23%	5,528,300	0.5
NT	0	0%	253,600	-
SA	9	7%	1,866,300	0.5
TAS	4	3%	574,700	0.7
Aus	127	100%	26,961,800	0.5

Source: ABS & RANZCR CRM Data July 2024

Question 4. If there is a maldistribution of specialists across New South Wales (either geographically or between the public and private health systems)

a. The nature of the maldistribution.

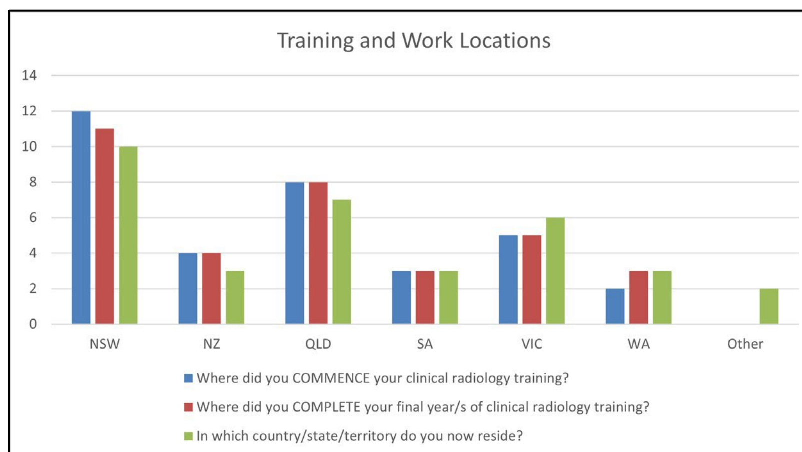
19. There has been a maldistribution of clinical radiologists across Australia that has been consistently recorded in the RANZCR Clinical Radiology Workforce Census **[SCI.0011.0268.0001]** for the last decade. There is a disproportionately high number of clinical radiologists present in major cities (MM1), and as such, tertiary and quaternary care is concentrated in MM1 locations also. The geographical workforce maldistribution is compounded by a generally older cohort of clinical radiologists in regional areas (MM3). In MM3 areas, 33% of the clinical radiologists are 60 years of age or older, compared with 21% of radiologists as seen in MM1 and MM2 locations.

20. In Radiation Oncology, through data from RANZCR's biannual facilities surveys **[SCI.0011.0267.0001]**, we have witnessed stronger growth in private radiation therapy facilities when compared to public, with a 10-year Compound Annual Growth Rate (CAGR) of 8% in private practice, compared to 3% in public. The public system is still bigger, but the high growth in private RO suggests that this may change over time.
21. Linear accelerators are consistently concentrated in metropolitan areas, with 78% of LINACs located in MM1 areas as of the 2021 facilities survey. However, we have witnessed growth in the number of LINACs in MM2 and 3 areas, with an 8 percent CAGR noted in MM3 areas alone. This growth, however, does not constitute a growth in specialists, with a 10-year average of only 1.1 Radiation Oncologists per LINAC in MM2 and MM3 areas, compared with 1.5 in MM1. This represents a bigger workload for rural and regional doctors.
22. It should be noted that even within MM1, there are significant maldistributions, with services in the metropolitan areas concentrated where the specialist population resides, usually in the more established and wealthier areas of MM1. This results in shortages in the outer metropolitan areas such as western Sydney at levels that can approach levels seen in MM2 and MM3 zones.

b. The factors that contribute to that maldistribution.

Clinical Radiology

23. As reported in the demographic section of the RANZCR Clinical Radiology Workforce Census, the geographic maldistribution of medical specialists in Australia is not getting better. While it might be expected that market forces would drive the generally increased clinical radiologist numbers out to regions of workforce need, there is a large body of Australian and international evidence that shows that for doctors, the most predictive factors that relate to where a doctor chooses to reside and work are:
    - Site of origin (metropolitan versus rural) and that of their life partner
    - Training time spent in metropolitan versus rural locations.
24. Given that there are very few non-metropolitan clinical radiology training posts, it is no surprise that the geographic maldistribution is entrenched and needs to be addressed by increasing the numbers of rural training sites.
25. RANZCR regularly surveys its new clinical radiology fellows soon after gaining Fellowship, the below table compares the location of training compared to the location of employment after Fellowship.



26. RANZCR conversations with NSW Health officials have revealed their belief that Clinical Radiologists are being "greedy" and opting to move from the public sector to the private sector, where their remuneration is significantly greater. In our conversations with our Clinical Radiology Fellows, they suggest that NSW Health has in recent years reduced the remuneration received by Clinical Radiologists and that the conditions they are operating under, both in workload and in hospital and departmental administration, has increased substantially. Our Fellows also assert that the remuneration being offered by NSW Health is less than that being offered by most, if not all, other Australian States. RANZCR understands that some of our NSW public system Clinical Radiologists have written to the Minister detailing these concerns. One of our NSW public system Clinical Radiologists claims that working in the NSW public system is a calling rather than a career, due to the remuneration and conditions gaps that exist.

27. RANZCR is concerned that without an honest and unbiased examination by an independent party of specialist remuneration and conditions compared to the private sector and other states, proposed solutions to the specialist workforce in NSW Health may not provide a sustainable solution.

Radiation Oncology

28. Strong demand for effective cancer treatment and a willingness to pay has likely led to the growth in private radiation oncology centres. Coupled with the high fixed cost of equipment this has presented an opportunity for private radiation therapy facilities to close the gap in numbers of the public system.

29. Data from the 2108 Radiation Oncology Workforce Census **[SCI.0011.0268.0001]** suggests that new trainees are more likely to work in metro practices when compared to rural and regional. This results in a lower number of RO's working in regional settings, we have instead witnessed increased numbers of support staff in MM2 and 3 settings, for example, RO medical physicists, nurses and Radiation therapists all have comparable numbers per LINAC in MM2 and MM3 settings when compared to MM1, suggesting that the burden of work is falling on support staff in lieu of more onsite specialists.

30. RANZCR notes that some commentators advocate for an increase in IMGs to address the maldistribution issue. This point has been illustrated via the Kruk Report **[MOH.0010.0051.0001]** and in public comments made by the Federal Health minister [https://www.health.gov.au/ministers/the-hon-mark-butler-mp/media/government-cuts-red-tape-for-overseas-trained-doctors]. It is RANZCR's experience and will likely be supported by NSW Health data, that IMGs tend to follow the pattern established by Australian trained specialists – that is, once qualified, IMGs tend to enter the private sector and/or move to MM1 areas to practice, worsening the maldistribution.

Specialist training programs

Question 5. A summary of the specialty training program(s) administered by the College in New South Wales, by reference to the relevant policy documents and including:

a. Entry requirements.

31. To be eligible to apply for a specialist training, the applicant must:

    (a) Be a graduate of a medical school recognised by the Medical Board of Australia and the Board of RANZCR (or have successfully completed both Part I and Part II AMC examinations for overseas Medical Graduates in Australia) OR

    (b) Be registered in a general scope of practice by the Medical Council of New Zealand. OR

(c) Be a graduate of a medical school recognised by the registering authority of the country in which the RANZCR training program is conducted and the Board of RANZCR AND

(d) Must hold general registration as a medical practitioner by the registering authority recognised by the Board of RANZCR, in the state or country in which RANZCR training program is conducted, without any restriction, conditions, suspension or cancellation (unless otherwise specifically approved in writing by the College) AND

(e) Have completed at least two full years in an accredited hospital as an intern/resident or equivalent by the planned commencement of the advertised training position AND

(f) Eligible to work in the relevant jurisdiction, either Australia, New Zealand or Singapore.

32. Furthermore:

(a) Applicants are required to register with RANZCR and obtain a RANZCR College Registration Verification Number (CRVN) prior to application to jurisdictions for selection.

(b) A RANZCR CRVN will be issued to applicants who meet eligibility criteria.

(c) Applicants are required to include their RANZCR CRVN with applications made to jurisdictions.

(d) Applicants will not be considered for selection if they do not have a RANZCR CRVN.

(e) Registering with RANZCR does not guarantee an interview for selection into training, nor does it guarantee appointment to a training position or continuing employment. Employment decisions rest solely with the employer.

(f) CRVN will be valid for applications in the calendar year in which the CRVN was obtained.

(g) The selection process changes on an annual basis and no application data is carried over from one year's selection process to the next. Evidence that was accepted in the past will not be accepted on the basis that it has been accepted previously. All evidence must comply with the regulations for the current selection process.

(h) By submitting an application, applicants are consenting to the collection, use, disclosure, and storage of the information by RANZCR or its agent. RANZCR is committed to maintaining the privacy of individuals who interact with the College.

b. length of program

Clinical Radiology

33. The Clinical Radiology Training Program is designed as a five-year training program and structured in three major phases. This sequencing is to ensure that trainees develop foundation knowledge and skills during Phase 1 and then have the opportunity to further develop abilities and breadth of practice during Phase 2 of the training program. In Phase 3, trainees consolidate skills and focus on areas of interest.

** Designed as a 5-year program over 3 phases*
** Trainees progress between phases as competencies are achieved*

34. Training is undertaken through accredited network training sites. Trainees rotate to several training sites throughout their training and must ensure that they train at more than one site.

Radiation Oncology

35. The Radiation Oncology Training Program is structured in two major phases. This sequencing is to ensure that trainees develop foundation knowledge and skills during Phase 1 and then have the opportunity to further develop abilities and breadth of practice during Phase 2 of the training program.

   - **Phase 1** extends from a minimum of 18 months to a maximum of 30 months
   - **Phase 2** is dependent on trainees demonstrating competency (usually a minimum of 36 months).

36. Training is undertaken through accredited network training sites. Trainees rotate to several training sites throughout training and must ensure that they train at more than one site.

c. Location of delivery (metropolitan/rural).

Clinical Radiology

37. The Clinical Radiology Training Program is based on a partnership between trainees and their training network. Trainees have the primary role of directing their own learning. The training network and training site are responsible for ensuring trainees have access to learning opportunities, focussed teaching and support that will allow trainees to complete their training.

38. ‘Network Training’ is a term used to describe a group of sites that provide comprehensive training by supporting a trainee as they rotate across a number of hospitals, private practices, regional practices and specialty sites. Network Training exposes trainees to a range of training experiences and environments and prepares trainees with broad skills and knowledge of multiple sites and systems.

39. Network Training is a structured system of training delivery where training sites are joined together in a network to best deliver all aspects of the training program. Network governance arrangements vary in the different State Branches of RANZCR (Branch), dependant on Branch size and geographic distribution:

   - Branches consist of at least one Local Area Network (LAN)

- In larger Branches there may be more than one LAN, and the Branch then becomes a Wide Area Network (WAN, consisting of more than one LAN).
- A LAN consists of at least one main site with private and rural linked, and sub-specialty sites. The LAN must be able to provide all aspects of the training program within its component. The structure and function of a LAN is detailed in the Clinical Radiology Trainee Handbook on page 15.

40. The Network Training structure therefore lies within the RANZCR Branch structure. Each Branch has a local Branch Committee which is independent of the network training and does not have responsibility for training matters. The Branch Education Officer (BEO) sits on the local Branch Committee and may or may not be Chair of the Network Governance Committee in jurisdictions with a WAN.

41. Trainees are expected to rotate to a number of accredited training sites throughout their training. Training departments and networks work with trainees to plan for their rotations. Each trainee is hired into a network and will be assigned to a LAN. The specific details of rotational arrangements to various training sites within the network will be determined by the Network Training Director (NTD) and the Network Governance Committee (NGC) in consultation with trainees.

42. Training sites work together as a network to provide trainees with the opportunity to fulfil the training program requirements as outlined in the Learning Outcomes **[SCI.0011.0253.0001]** and Clinical Radiology Training Program Handbook **[SCI.0011.0252.0001]** by the end of the Training Program. While not all individual sites within a network can support learning in every aspect of the learning outcomes, it is expected that a combination of experience at multiple sites will.

43. Trainees should have the opportunity to rotate to private and regional or remote sites. All trainee rotations within the network must be prospectively planned. At least six months' notice should be given for rotations requiring relocation, to allow the trainee to make appropriate arrangements. Rotations should be devised in order to assist the trainee to gain exposure to all the learning opportunities they will require in order to satisfy training requirements. Trainees must spend no longer than four years at any single training site during the training program.

Radiation Oncology

44. For Radiation Oncology, a Training Network is a term used to describe a group of training sites (minimum of two), which are separated geographically, administratively and with respect to radiation oncologist staffing.

45. Networks are governed by the Network Governance Committee (NGC), formed by the Directors of Training (RANZCR members who oversee the delivery of the delivery of the RANZCR training program at their place of employment) at each training site. The NGC is chaired by a Training Network Director (TND) and supported by an Education Support Officer (ESO). The Network supports comprehensive training for a trainee as they rotate across a number of hospitals, private practices, and regional practices.

46. Training in a network allows trainees to access multiple radiation oncology facilities that provide exposure to different clinical settings, range of different types of cancer, clinical supervisors and patient groups. Each network must be able to provide or ensure the provision of experiences necessary to fulfil the training program requirements as outlined in the Learning Outcomes **[SCI.0011.0255.0001]** and Radiation Oncology Training Program Handbook **[SCI.0011.0252.0001]**, within a reasonable timeframe (approximately 5 years).

47. A formal, documented teaching program comprised of network-wide and department-level activities is provided (for example, Oncology Sciences Workshops, tutorials, journal clubs). Both the network and individual training sites are measured against specific standards.

These standards apply to the accreditation of radiation oncology networks and training sites located in Australia, New Zealand and Singapore.

48. Accredited sites within a network work together as a network to provide trainees with the opportunity to attain all the competencies required by the end of the training program. While not all individual sites within a network can support learning in every aspect, a combination of experiences at multiple training sites within the network will provide trainees with access to a range of different learning experiences described in the Radiation Oncology Training Program Learning Outcomes.

49. Networks should ensure that there is as broad a mix as possible of trainees at different stages of their training in individual departments (this is to avoid any individual department only ever having junior trainees (unless it is the department's explicit preference). Trainee preferences may be taken into account if the request is made within the Networks proposed deadlines. Rotation requests may be considered on the capacity of the requested training site to provide the breadth of training experience required by the trainee.

50. Rotations between networked departments should be of a minimum duration of six months. All trainee rotations within the network must be prospectively planned. At least six months' notice, and ideally twelve months, should be given for rotations requiring relocation, to allow the trainee to make appropriate arrangements. Rotations should be planned to assist the trainee to gain exposure to all the learning opportunities they will require to satisfy training requirements. The specific details of rotational arrangements are to be determined at the local level by the Network Governance Committee (NGC). Planned rotations are subject to change at any time, as determined by the NGC to accommodate any qualifying circumstances. All trainees must have rotated to another training site, other than their home training site, for a minimum of 12 months FTE (in total) prior to sitting the Phase 2 Examination. If a trainee has any concerns regarding their allocated rotation, the concerns should be discussed in the first instance with the Director of Training or Education Support Officer. If unresolved, they should be raised with the Training Network Director.

Accredited Training Site Listing.

51. Training site accreditation information is available from the following links:

    a. **Clinical Radiology Accredited Training Site Listing** **[SCI.0011.0251.0001]**

    b. **Radiation Oncology Accredited Training Site Listing** **[SCI.0011.0254.0001]**

d. Program structure.

Clinical Radiology

52. The Clinical Radiology Training Program is designed as a five-year training program and structured in three major phases. This sequencing is to ensure trainees develop foundation knowledge and skills during Phase 1 and then have the opportunity to further develop their abilities and breadth of practice during Phase 2 of the training program. In Phase 3, trainees consolidate their skills and focus on areas of interest.

53. Phase 1 extends from the trainee's commencement in training through to 12-24 months into the program. Phase 2 continues through to 48-72 months, and Phase 3 is 12 months duration.

54. Trainees continue in each phase until they have achieved the expected standard of competence and completed the training requirements of that phase. The length of each phase is determined by each trainee's progress. Trainees will progress at different rates; some trainees who have completed similar learning prior to commencing the training program may progress more quickly, others may need additional time to acquire the expected knowledge and skills to demonstrate competence.

55. Completion of the Training Program leads to certification as a Fellow of RANZCR (FRANZCR). Fellowship of RANZCR is the only post-graduate qualification which leads to recognition as a specialist radiologist in Australia or registration in the vocational scope of practice of diagnostic and interventional radiology in New Zealand. Fellowship is awarded after all training program requirements are met

Radiation Oncology

56. The Radiation Oncology Training Program is structured in two major phases. This sequencing is to ensure trainees develop foundation knowledge and skills during Phase 1 and then have the opportunity to further develop their abilities and breadth of practice during Phase 2 of the training program.

57. Completion of the Training Program leads to certification as a Fellow of The Royal Australian and New Zealand College of Radiologists (FRANZCR). Fellowship of the RANZCR is the only post-graduate qualification which leads to recognition as a specialist Radiation Oncologist in Australia or New Zealand. Fellowship is awarded after the required training and assessments are completed, and all requirements are met.

58. Trainees commence training in Phase 1 and are required to achieve both an expected standard of competence and complete all training requirements prior to progressing to Phase 2. Phase 1 extends from a minimum of 18 months to a maximum of 30 months. In Phase 2, trainees broaden and develop their skills and knowledge across multiple areas to become competent, safe and ready for independent practice. Completion time depends on a trainee demonstrating competency, usually a minimum of 36 months. The maximum time in the training program is 10 years (inclusive of Phase 1 and Phase 2). Trainees progress from Phase 2 to Fellowship following achievement of full competence and completion of all training requirements.

59. The duration of each phase is determined by each trainees' progress. Trainees will progress at different rates based on their learning and completion of certain training milestones during each phase. Trainees must hold an accredited training position for the full duration of training.

e. Number of trainees admitted in the relevant period, including how that number is determined.

60. RANZCR does not determine the number of trainees admitted to the program. This is determined by the number of positions funded by the jurisdiction, in this case the NSW Department of Health.

61. In the year 2024, a total of 34 NSW trainees commenced their training programs with the College. This includes 27 Clinical Radiology (CR) trainees and 7 Radiation Oncology (RO) trainees. The number of trainees commencing training each year fluctuates but is generally between 25 and 35 for clinical radiology and between 6 and 10 for radiation oncology.

62. Traditionally RANZCR trainees were selected by the local network with no involvement by RANZCR. The Australian Medical Council (AMC) has mandated that RANZCR introduce a Selection into Training (SiT) program to ensure equitable selection outcomes, especially for under-represented groups. RANZCR has introduce this for the for first time in 2024, noting that the local network retains final interview and selection decisions.

63. RANZCR typically has more qualified candidates than available trainee positions. Should any jurisdiction increase the number of funded training positions available in an accredited site, RANZCR would happily move to fill these new positions.

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Question 6. An overview of the role/function of other agencies/bodies, etc., in administering specialty training programmes relevant to the college, including NSW Health.

64. RANZCR Clinical Radiology and Radiation Oncology Training Programs are a collaborative process between trainees, radiologists and RANZCR staff, each with their specific roles. The Training Programs are also based on a partnership between trainees and their training network. Trainees have the primary role of directing their own learning. The training network and training site are responsible for ensuring trainees have access to learning opportunities, focussed teaching and support that will allow trainees to complete their training.

65. RANZCR delivers its services under Federal Government accreditation standards, regulated by the Australian Medical Council (AMC), on behalf of the Medical Board of Australian (MBA). RANZCR must meet exacting standards and conditions, and submit itself to regular rigorous AMC assessments, to retain this accreditation. AMC operates on a cost recovery model, meaning that RANZCR reimburses the AMC for expenses the AMC incurs in assessing RANZCR's compliance with the Federal Government standards. RANZCR was subject to an AMC mid-term review in 2023 and this resulted in an AMC cost to RANZCR of nearly $100,000.

66. NSW Health, as the employer of all doctors and trainees providing medical services at public hospitals, is responsible for all employment infrastructure and conditions required by law. RANZCR has no role in any employment issues within a jurisdiction. NSW Health is also responsible to ensure that each training site is provided with the resources required to meet the RANZCR Accreditation Standards. These accreditation standards must satisfy requirements set out in the AMC accreditation standards. RANZCR recognises the systemic tensions that can arise when Standards are established at a national level and RANZCR is obligated to impose these standards onto a state organisation.

67. RANZCR members contribute considerable volunteer hours in the development and oversight of the training program, trainee wellbeing, accreditation of training sites and setting and conducting examinations, with extensive support from RANZCR staff. This work is presently provided to the jurisdictions at no cost other than the jurisdictions own internal staff salaries. Aside from direct member time RANZCR currently funds the considerable costs via membership fees with no impost upon government or public.

Accreditation of training sites

Question 7. A summary of the process for the accreditation of training sites/places in New South Wales by reference to relevant policy documents, including:

a. The role/function of the College in the accreditation of training sites/places.

68. RANZCR, as the provider of the Clinical Radiology and Radiation Oncology specialist training program must meet the AMC *Standards for Specialist Medical Programs and Professional Development Programs.* This includes the requirement to have a clear process and criteria to assess, accredit and monitor facilities as training sites and ensure the criteria link to the outcomes of the training program.

69. Accreditation of training sites is managed in accordance with all relevant RANZCR regulations, policies and procedures are developed within the framework set by the AMC Standards and are governed by various internal committee bodies. These bodies ensure that training sites meet specific standards and provide adequate supervision and resources for trainees.

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b. The criteria applied for accreditation of training sites/places.

70. Across all jurisdictions, the accreditation process for training sites follows a structured framework outlined in RANZCR's accreditation standards. These standards are designed to ensure that training sites meet specific criteria essential for delivering high-quality training programs. RANZCR's accreditation standards are comprehensive, setting out the essential requirements that a training site must fulfill to be accredited to deliver either the Clinical Radiology or Radiation Oncology Training Program. All standards and requirements are mandatory.

71. The criteria applied for the accreditation of training sites typically include, but are not limited to the following key aspects:

    - Clinical supervision
    - Educational resources
    - Curriculum and Training Program
    - Workplace environment
    - Compliance and governance

72. The accreditation process typically involves a thorough assessment which includes a site visit, interviews with key personnel and review of documentation and facilities. The aim is to evaluate the training site against each criterion outlined in RANZCR's accreditation standards to ensure compliance and readiness to deliver an accredited training program.

c. The process by which new sites are identified for possible accreditation.

73. RANZCR attempts to identify new sites for accreditation in regional/rural settings only, normally via the Speciality Training Program (STP) Operational Framework facilitated by the Federal Department of Health and Aged Care (DoH&AC) or other government schemes with the purpose of addressing workforce shortages in regional areas.

74. It is the more common practice that sites seeking to become accredited notify RANZCR via written correspondence and the submission of an application seeking accreditation. After the submission of an application with documentary evidence on how the site meets the accreditation standards and how they would deliver a training program, a paper-based review is conducted. A recommendation on the application is made to the Chief Accreditation Officer (a RANZCR officer bearer role) for consideration. The application then undergoes governance approval via review by the RANZCR's Accreditation Committee and other relevant RANZCR committee bodies.

75. An initial assessment of the site is conducted within 12 months of a registrar commencing their training onsite. The aim being to assess whether the training site's capacity and proposed plan for training meets the RANZCR Accreditation Standards – including intended rosters, supervision, timetable for provision of education etc.

d. The process of determining how many training places will be accredited at a particular training site, and who is responsible for making those decisions.

76. The number of accredited training places at a particular site is closely tied to the availability of consultants (RANZCR Fellows) who can supervise the registrars (trainees). The ratio of full-time equivalent (FTE) consultants to registrars varies by specialty:

    - Clinical Radiology: a ratio of 1 FTE consultant to 1.5 trainees
    - Radiation Oncology: a ratio of 1 FTE consultant to 1 trainee

77. As such, for each specialty, the more consultants available onsite, the higher the number of accredited training places a site can accommodate.

78. The responsibility for determining the number of accredited training places lies with the training sites, depending on the level of resources and funding the hospital or health jurisdiction chooses to allocate to meet the RANZCR Accreditation Standards.

79. These sites employ our members/Fellows who contribute towards the supervision and training of registrars. Such Fellows may also volunteer their time to the College and contribute to various RANZCR committee bodies that are responsible for assessing and monitoring training sites to ensure that appropriate structures and resources are provided for the delivery of quality and safe vocational training in Clinical Radiology or Radiation Oncology. These committees assess training sites against accreditation criteria and make decisions based on:

    - Availability of sufficient FTE consultants to ensure adequate supervision.
    - Compliance with education standards and guidelines as set out by RANZCR's relevant committees.

80. In addition to the above, RANZCR has identified a significant influence on the accreditation of training places and availability of consultants is the number of funded consultant positions allocated to each training site by the relevant jurisdiction. By this we mean the number of salaried radiologists employed to work in a particular department, as opposed to staffing a department with visiting medical officers (VMO). The allocation of funded consultant positions directly affects the capacity of a training site to support additional registrars by providing financial support for consultant roles and associated resources.

81. Funding plays a crucial role in attracting and retaining consultants as it supports their involvement in training activities without compromising clinical service delivery.

e. The processes for reviews of accreditation, including the withdrawal of accreditation.

82. RANZCR's preferred approach is to work closely with the relevant jurisdiction to avoid the withdrawal of accreditation. The option of accreditation withdrawal is used as a last resort when lengthy remediation attempts have failed or have been rebuffed by the accredited site. This point is only ever reached after an extended timeframe, often years. In some jurisdictions, only when the option to withdraw accreditation is raised, does the jurisdiction engage in a constructive manner.

83. RANZCR's experience is that NSW Health consistently fails to engage in a constructive and cooperative manner when accreditation issues are raised. Discussions on accreditation issues are often met with: denials; deflections; counteraccusations; threats of legal action; demands that RANZCR take responsibility for the workplace behaviour of NSW Health employees; demands that RANZCR place local population access to health resources over the wellbeing of trainees; arguments that the accreditation standards are wrong; and, in some instances, voluntary withdrawal of accreditation by the site with comments that they will now use "unaccredited trainees" to fill the gaps left by trainees. Details of meetings which support these experiences are provided in Section 14 under case studies.

84. On the issue of local population access to health services, RANZCR understands the need to offer appropriate health services to the population. RANZCR is accredited by the AMC to prioritise the physical and psychological well-being of trainees above other stakeholders. Legally and morally, RANZCR cannot and will not permit RANZCR trainees to remain in a situation where their career aspirations are being damaged by a substandard training site, or where they are being psychologically or physically damaged by the behaviours of others at a site. RANZCR would argue that relying on trainees to fill critical health gaps constitutes a failure to provide for the local population.

85. RANZCR is concerned that the Minister becomes aware of accreditation issues only when RANZCR has issued a formal letter of accreditation withdrawal and that this decision may

be communicated to the Minister as an unreasonable spur-of-the-moment decision, not the end result of sometimes years of unsuccessful negotiations.

86. RANZCR's current accreditation cycle of training sites is generally five years and a re-accreditation assessment will be conducted towards the end of the cycle. RANZCR may also initiate an accreditation assessment at any point within the five-year cycle, in response to issues identified through monitoring. Upon implementation of RANZCR's new accreditation standards in 2025, the accreditation cycle will be extended to six years with yearly monitoring.

87. A training site may also request a re-assessment during the cycle. This could be in response to a significant change at the training site, which may impact upon the accreditation status or if the training site would like to appoint additional trainees and an assessment is required to determine whether the site has the capacity to do so.

88. An accreditation panel is appointed to conduct each accreditation assessment. The panel comprises of RANZCR Fellows who volunteer as accreditation assessors. All members of the panel are required to declare any conflict of interest related to the training site being assessed. In the event it is determined that a declared conflict of interest cannot be managed, a new panel member will be appointed. Observers of various kinds may also be involved during an accreditation assessment.

89. Accreditation assessments may be conducted by various means:

- Documentation/desktop review
- Video conference or onsite visit

90. Training sites are requested to complete a Site Self-Assessment Form and provide documentary evidence to support the application. The accreditation panel will review relevant documentation prior to the assessment. The assessment is then conducted by a series of scheduled interviews, with representatives of the training site. by the accreditation panel.

91. Clinical Radiology or Radiation Oncology providers may face the potential of losing accreditation when the training site fails to meet the accreditation standards. This could occur if a training site is found to compromise trainee safety or if a majority of the accreditation standards are not met. The process leading to a withdrawal of accreditation is deliberate and supportive. When issues are identified, the relevant RANZCR committee thoroughly reviews the situation. Recommendations are provided to assist the site in meeting the standards. Additional support, including frequent communication from the College, is extended to aid in the implementation of these recommendations. This support involves both online and onsite meetings with RANZCR staff and member volunteers such as the Chief Accreditation Officer.

92. Typically, a training site is given a period of 12 months to address and meet all recommendations provided upon receipt of their accreditation assessment report. However, in practice, this timeframe has extended to 18 months or even up to 2 years, depending on the complexities involved and the progress, or lack of, being made by the site.

93. The decision to withdraw accreditation would be discussed robustly and considered by the relevant RANZCR committee body, based on the specific features of the situation. Any decision of a committee body to withdraw accreditation would be referred to the relevant Faculty Council and RANZCR Board for consideration. Following a decision to withdraw accreditation, official notification will be made to the site and other stakeholders will be informed.

94. This structured approach ensures that while maintaining high standards, RANZCR also provides ample opportunity and support for sites to rectify deficiencies and regain

accreditation status, ensuring the quality and safety of training environments for our trainees.

95. RANZCR is also a signatory to the Communication Protocol for accreditation of specialist medical training sites/posts in Australian public hospital and health facilities, which illustrates RANZCR's ongoing commitment to observing the principles of fairness, transparency and accountability when engaging in accreditation activities.

96. A site may request a re-assessment of an accreditation outcome via the process defined in RANZCR's Reconsideration, Review and Appeals of Decisions Policy.

f. The body responsible for setting criteria applied for accreditation of training sites/places, and the process for the review of those criteria.

97. Accreditation of training sites is managed in accordance with all relevant RANZCR regulations, policies and procedures, and undergo a transparent process through RANZCR's established governance structure.

98. The criteria for accreditation undergoes review and development through a structured and transparent process within RANZCR. This process includes several governance bodies including working groups, committees and councils. The involvement of these various bodies ensures that the standards and criteria are evidence-based and reflects the evolving needs of trainees and the specialist workforce.

Question 8. An overview of the role/function of other agencies/bodies in the accreditation of training sites/placements.

99. RANZCR is solely responsible for the accreditation of training sites. There are no other agencies or bodies involved in this process, ensuring a consistent and centralised approach to accreditation.

100. The financial burden associated with the accreditation of training is entirely shouldered by RANZCR. This includes a wide range of costs, such as those related to site visits, the review of accreditation documentation, and communications with various stakeholders at the sites. These stakeholders include hospital executives, heads of departments, trainees, and supervisors. Additionally, there are costs associated with fulfilling reporting requirements.

101. RANZCR presently provides these services at no cost to NSW Health.

102. As of late 2022, RANZCR had implemented an intensive monitoring program for sites who had been identified as high risk of losing accreditation. The program is designed to provide support to such sites, assisting them to meet the accreditation standards set by RANZCR, however this pathway cannot be made available to all training sites and is subjective to the circumstances of the training site at risk. Even so, this initiative further underscores RANZCR's commitment to maintaining high standards of training.

103. Despite the extensive contribution of volunteer members to the accreditation processes, the direct and indirect costs to RANZCR of accreditation are substantial. These costs, which include travel expenses and staff time, exceed **$700,000 per year across Australia and New Zealand**. This significant investment reflects the importance RANZCR places on the accreditation process and its commitment to ensuring the highest standards of training.

Internationally trained doctors

Question 9. An overview of the process by which internationally trained doctors may attain Fellowship of the College.

104. RANZCR has no control over the number of IMGs who apply for registration in Australia or New Zealand. RANZCR assesses each applicant in a consistent and transparent manner and there are internal mechanisms to ensure this consistency of approach. RANZCR welcomes IMGs and this cohort forms an important part of our college. In 2023, the three highest elected positions in RANZCR (President and the two Deans), were all originally IMGs.

105. There are two pathways in which an IMG can apply through the College:

- Specialist recognition assessment
- Area of Need assessment

Specialist recognition assessment

106. Eligibility for Specialist Assessment:

- Have completed specialty training in either clinical radiology or radiation oncology overseas and;
- Be recognised as a consultant specialist in country of training.

How an IMG applies

107. Application.

- Submit primary source verification (PSV) application to the Educational Commission for Foreign Medical Graduates (ECFMG) for primary and specialist medical qualifications and set up an Australian Medical Council (AMC) portfolio.
- Download and complete the RANZCR application form to be assessed for recognition as a specialist.
- Submit the completed application form and supporting documents as detailed on the application form.

Assessment Process

108. As part of the application/assessment process IMGs are asked to participate in an interview. The interview assists with determining the level of comparability with an Australian or New Zealand−trained clinical radiologist or radiation oncologist.

109. The interview is conducted by two Fellows of RANZCR, both of whom are trained IMG assessors. The interview is a structured to provide an opportunity for the panel to clarify training, qualifications and experience.

110. It is also an opportunity for IMGs to:

- fully detail and explain previous training and working experience
- ask any questions of the panel about the assessment process.

Assessment Outcomes

111. The assessment outcome determination will be one of the following:

Substantially comparable

112. Applicants who are determined by RANZCR to be substantially comparable will require up to 12 months' peer review in a RANZCR-accredited training site. During the peer review period the IMG is also required to successfully complete a number of work-based assessments.

113. Upon successful completion of the peer review period, including all prescribed WBA the IMG is eligible to apply for Fellowship of the College.

Partially Comparable

114. Applicants who are determined by RANZCR to be partially comparable are required to undergo up to 24 months' upskilling prior to successfully completing RANZCR's Part/Phase 2 Examinations.

115. Upon successful completion of the upskilling requirements and the Part/Phase 2 Examinations, the IMG is eligible to apply for Fellowship of the College.

Not Comparable

116. Applicants who have been determined by RANZCR to be not comparable are referred to the Medical Board of Australia for other options to achieve medical registration in Australia.

117. RANZCR's requirements for IMGs found, substantially, partially or not comparable aligns with the Medical Board of Australia's comparability definitions as detailed in the MBA's Standards: Specialist medical college assessment of specialist international medical graduates **[SCI.0011.0256.0001]**.

Area of Need Assessment

118. Eligibility for Area of Need (AoN) Assessment:

    - Have completed specialty training in either clinical radiology or radiation oncology overseas and;
    - Be recognised as a consultant specialist in country of training and;
    - Have secured an AoN position in Australia

How an IMG applies

119. The employer and applicant are required to complete the AoN application.

120. If the applicant has not previously been assessed for Specialist Recognition, the applicant is also required to download and submit a completed specialist recognition application (See Specialist Recognition).

121. Submit the completed form and supporting documents as detailed on the application form.

Assessment Process

122. An interview is part of the application/assessment process, which will assist with determining the applicant's suitability for the AoN position.

123. The interview is conducted by two Fellows of the College, both of whom are trained assessors. The interview is a structured and thorough process that provides an opportunity for the panel to:

    - explain the assessment process
    - clarify the applicant's training and experience.

124. Additionally, for clinical radiology the AoN assessment includes a film reading component (reviewing and commenting on radiological images) and a cultural competency component.

125. The assessment is also an opportunity for the applicant to:

- detail and explain previous training and working experience
- ask any questions of the panel about the assessment process.

Assessment outcomes

126. The assessment outcome determination will be either:

    a. suitable for the position (with conditions) or,

    b. not suitable for the position.

127. All IMGs found suitable for an AoN position will have limitations placed on their practice. The limitations may include the required level of supervision and limitations on the scope of practice.

128. Upon successfully completion of the Part/Phase 2 Examinations, and having met all upskilling requirements, an IMG is eligible to apply for Fellowship of RANZCR.

129. RANZCR is presently exploring with Ahpra the potential for recognition of limited scope of practice, which will allow senior specialists to practice in Australia within a more limited scope than our generalist FRANZCR postnominal offers. This recognises that these specialists are no longer generalists but bring a high-level sub-specialty skill set to areas of need in Australia.

130. RANZCR would like to introduce limited place of practice to encourage these IMGs to stay in regional areas of need, but Ahpra does not appear interested in this as an option. Without limited scope of practice, initiatives to address maldistribution are less likely to be successful,

131. RANZCR recognises the need and benefit of IMGs in the specialist workforce in Australia. RANAZCR does not see the large-scale importation of IMGs as a substitute to the training and development of its own local workforce.

Workforce Planning

Question 10. The extent to which the specialist training programmes administered by the College are currently producing sufficient specialists to meet current and future demand in NSW.

132. The numbers of trainees are limited to the number of funded places prescribed by the jurisdiction. RANZCR has no control over the numbers of trainees admitted into a program. If more funded places at accredited training sites were made available, RANZCR would gladly fill these places.

Question 11. If the College considers that specialist training programmes are not producing sufficient specialists to meet current and future demand in NSW:

a. How many more specialists are required to meet that demand, including by reference to particular locations within New South Wales (i.e., metropolitan/regional, etc)?

133. There is a significant issue of 'maldistribution' of clinical radiology resources that extends beyond urban areas and affects regional and rural sites. This maldistribution is not limited

to public healthcare facilities but also includes private healthcare sites, with the issue being especially pronounced in New South Wales (NSW).

134. The term 'maldistribution' refers to the uneven allocation of resources, in this case, clinical radiologists, across different geographical areas and sectors. This results in some areas, particularly regional and rural locations, being underserved. RANZCR is finding that urban centres and outlying suburbs of major cities, particularly in NSW, are also facing an undersupply.

135. The impact of this maldistribution is multifaceted. It leads to backlogs in medical imaging, resulting in delayed diagnoses and treatment plans. The waiting time for treatment can be significantly longer in these underserved areas, which can negatively affect patient outcomes.

136. From a patient care perspective, the key question is: what constitutes an acceptable level of backlog and waiting time? The answer to this question can help determine the number of additional specialists required to address the demand and rectify the maldistribution.

137. An overriding issue for NSW is one of retention. Once a trainee has completed their training, they have a number of employment options open to them, including the private sector, interstate public health systems, New Zealand, and other international locations. NSW is in a global marketplace for medical specialists and needs to tailor its offering to make working with NSW Health an attractive option.

138. As mentioned earlier, RANZCR does not see the large-scale importation of IMGs as a resolution to shortages in NSW Health. While IMGs will always be part of a multifaceted solution, RANZCR notes that IMGs on attainment of Fellowship, follow the patterns established by Australian-trained specialists. That is, IMGs are attracted to higher remuneration in the private sector and competing public health systems and will tend to move towards higher status locations within major cities, worsening the maldistribution issue.

b. An identification of any particular impediments/obstacles/challenges in training sufficient specialists to meet that demand.

139. There are too few specialists working in teaching sites which in turn limits the number of junior doctors that can be trained. The move toward a VMO model within the hospitals removing salaried specialists away from teaching/supervising, reduces the capacity for training.

140. From the RANZCR 2020 Australian Clinical Radiology Workforce Census **[SCI.0011.0250.0001]**–

> *Adequacy of the workforce and trainee numbers: Ascertaining the intermediate and long-term needs for clinical radiologists is complex. The MBS data is the most robust available, but it does not capture all the work performed by clinical radiologists and does not measure complexity. Anecdotally, as per comments made by the Clinical Radiology Workforce Committee (CRWC) members, there is increasing pressure on clinical radiologists to perform more work per day and that this work is increasingly complex.*

Question 12. The extent to which the College considers the demand for specialist services – generally and between different locations within New South Wales – in the administration of training programs.

141. The RANZCR 2020 Australian Clinical Radiology Workforce Census identified that Australian clinical radiology continues to rely heavily on IMGs, with more than a third of practising clinical radiologists obtaining their medical qualifications overseas.

142. As mentioned earlier, RANZCR has no control over the number or location of accredited sites or trainee numbers.

143. RANZCR does work with the Federal regulators to secure funding for Rural and Regional Training Placements and has had considerable success in this initiative.

Question 13. In relation to "unaccredited trainees" working within the College's specialty area:

a. A description of an "unaccredited trainee" from the perspective of the College.

144. Junior Medical Officers (JMOs) often work in a junior or service capacity within a department. In this role, they may not receive structured or systematic learning or feedback, and their role may primarily be service-oriented. They may be known by other terms such as unaccredited registrar depending on the site, however the function of the role remains the same.

b. The role played by "unaccredited trainees" within the public health system in NSW.

145. RANZCR does not support the use of the term "unaccredited trainee". These positions are not RANZCR trainee positions, and they are not appropriately supported by appropriately trained specialists. Their time in these roles does not guarantee them access to a RANZCR traineeship and does not offer them advanced standing if they do apply for and secure a traineeship placement.

146. The use of this term is misleading and unfair on the doctors filling these roles.

147. Unaccredited trainees, support service delivery, backfilling vacancies and on-call and weekend work.

148. One advantage for unaccredited trainees in this position is that they can experience the specialty before formally applying to a program. This allows them to gain firsthand insight into the field, helping them make an informed decision about whether it aligns with their career goals. Working as an unaccredited trainee does not guarantee future acceptance into the RANZCR training program.

149. However, there are also disadvantages. As they are primarily filling a service role, they may not be receiving the structured learning and feedback that is crucial for professional development. They are not on a specialist pathway, which means they are not progressing towards becoming a specialist in their chosen field. There is also a risk that they can get lost in the system, with their learning and development needs overlooked amidst the demands of service provision.

150. International Medical Graduates (IMGs) often fill these positions for two main reasons. Firstly, it provides them with valuable experience in the Australian clinical environment, which can be significantly different from the healthcare systems in other countries. This experience can be crucial in helping them adapt to the local context and understand the nuances of practicing medicine in Australia.

151. Secondly, many IMGs are on the Specialist Recognition pathway. This means they have been assessed by RANZCR and are in the process of completing the requirements for Specialist Recognition. Working in these junior or service roles can provide them with the practical experience needed to meet these requirements. Despite the challenges, these positions can serve as a stepping stone for IMGs on their journey towards becoming recognized specialists in Australia.

152. RANZCR is however concerned with the proliferation of unaccredited training positions and believes it is an unacceptable way to meet the staffing requirements of a department and is not in the best interest of patients.

Case studies

Question 14. Suitable case studies to demonstrate:

a. Workforce challenges/issues/obstacles.

153. No comment

b. Challenges in implementing the training programs by the College, including examples of how challenges have been overcome.

Case study 1 – regional and rural training

154. RANZCR faced substantial challenges in setting up Dubbo as a Regional and Rural Training Program (RRTP) site. This was despite the fact that the Commonwealth had provided funding specifically for a clinical radiology trainee to undertake their training in Dubbo.

155. A series of bureaucratic hurdles within the New South Wales (NSW) Health system proved to be a significant obstacle. These issues revolved around the single employer model, which is a system where all public health employees are employed by the NSW Health, rather than by individual hospitals or health districts. In addition to this, there were complications related to employee entitlements. These entitlements, which include accumulated leave allowances, superannuation, and salary packaging, needed to be negotiated and agreed upon. However, the process was fraught with difficulties and delays.

156. Furthermore, there were complexities surrounding insurance arrangements. However, the process of setting up these arrangements was not straightforward and added to the overall challenges.

157. As a result of these bureaucratic processes and complications, the role for the clinical radiology trainee could not proceed as planned. This was a significant setback, as it prevented a local doctor from receiving training in a rural environment. This is particularly problematic given the urgent need for doctors in rural areas like Dubbo, where access to healthcare services is often limited.

158. In summary, while there was clear need, intent and funding to establish a RRTP training site in Dubbo, a combination of bureaucratic processes within NSW Health prevented this from becoming a reality. This has had the unfortunate consequence of hindering the training of a local doctor in a region where their skills are greatly needed. It underscores the need for streamlined processes and clear pathways for establishing such training programs in rural areas.

Case Study 2 – Radiation Oncology Site Accreditation Issues.

159. During a meeting between a senior NSW Health official and RANZCR representatives at the RANZCR office on 29 June 2023, a discussion was held on the ongoing accreditation issues of a NSW Health Radiation Oncology site.

160. For context, the site had been identified by RANZCR as a risk in September 2022 and informed of this. On 7 February 2023 a Progress Report was received from the site along with supporting evidence and excerpts from the External Cultural Review, commissioned by site, which raised significant concerns.

161. On 6 April 2023 the site received the RANZCR Radiation Oncology Training Committee (ROETC) Outcome Letter requesting that they show cause as to why their accreditation status should not be withdrawn. The site was given 21 days, until 27 Apr 2023, to respond. On 27 April 2023 the site responded to RANZCR's show cause notice with updated on progress and improvements made but did not address the cultural issues.

162. During a meeting of 29 June, RANZCR raised the ongoing cultural issues. RANZCR noted that repeated claims of bullying had been raised by trainees and by others at the site and that it appeared NSW Health had not managed to address this issue.

163. The NSW Health official said that it was RANZCR's responsibility to address bullying in the workplace as the people responsible were RANZCR members. The RANZCR CEO responded that NSW Health was the employer and under the law was responsible for this; RANZCR has no authority to enter NSW Health premises to conduct a bullying investigation, nor does it have the power to access documents nor to interview staff. RANZCR certainly does not have the power to sanction or dismiss NSW Health staff found guilty of bullying. We emphasised that if NSW Health conducted an investigation and found any RANZCR member guilty of bullying, then RANZCR would fully support NSW Health in this and review the Fellowship status of that member.

164. This point was debated and the NSW Health official refused to accept RANZCR's position on this, repeating that it was RANZCR's responsibility to manage the behaviour of our members.

165. The site was advised that its accreditation was withdrawn on 11 July 2023

166. RANZCR understand that NSW Health, including this official, has had input into the recommendations of the NHPO report. From RANZCR's perspective, it was disappointing to see that the issue of responsibility for workplace behaviour appears under Recommendation 13 of the NHPO report:

> *"The AMC should work with the colleges and other relevant stakeholders to develop a framework for managing concerns about accredited specialist medical training sites. (a) The framework should clarify how concerns related to bullying, harassment, racism and discrimination should be assessed and managed based on agreed and articulated roles and responsibilities. (b) The framework should also clarify how concerns about health practitioner performance or misconduct at an accredited specialist medical training site should be assessed and managed, including relevant referral and escalation pathways. (c) Once developed, the framework should be made publicly available and implemented with appropriate staff training."*

Case study 3 – South East Sydney LHD Radiology Site – hand written notes provided

167. RANZCR received a request from the Chair of the South East Sydney Local Health District Board (SESLHD). This person at the time was also a CEO of another medical college and knew the CEO of RANZCR well. This meeting was to discuss the situation at an accredited site that had ongoing accreditation issues in the SE Sydney region.

168. A meeting between the Chair and RANZCR took place on 1 November 2023 at the RANZCR office. The Chair said she was committed to try and fix this. The Chair alleged that RANZCR Network Training Director had been telling trainees that their sites accreditation was being withdrawn. A RANZCR officer at the meeting rejected that and said the NTD has only told trainees about the current review status, which was not at withdrawal stage.

169. RANZCR was told that the site had made great progress in reducing its backlog of unread images and that should be taken into account when reviewing the site, as should the impact on the local population, should RANZCR decide to withdraw accreditation. RANZCR was also told that the site was applying a different model that involved remote access to consultants for trainees and that RANZCR should be more flexible in its approach to different operating models.

170. The Chair was told that even after the September 2023 RANZCR report into the site, trainees were being left with no consultant on site for a 24 day period and only one consultant on site for another 9 day period. RANZCR was committed to working with the

site toward a positive outcome but the agreed process needed to be followed and improvements need to be visable.

Case study 4 – Meeting between NSW Health and RANZCR over SE Sydney Hospital accreditation

171. NSW Health and RANZCR met in the RANZCR office on 9 November 2023. During the meeting, NSW Health challenged the way that RANZCR measured accreditation success by focussing on process and not outcomes, stating that their trainees were performing well. NSW Health stated that the accredited site was applying a “new model” to reduce their imaging backlog and this needed to be taken into account for accreditation. That local population health should be RANZCR’s priority and so withdrawal of accreditation from the site should not be an option, due to the impact on the community.

172. RANZCR’s response was that the new model may be reducing the backlog of unreported images but that it was not providing the trainees with the access to consultant supervision and teaching that they needed to grow and develop; and to pass their assessments. Trainees should not be made to suffer professionally or personally for the failings of a site. RANZCR under its Federal Government AMC accreditation is mandated to ensure trainee safety and professional development and to take action where site accreditation standards were not being met. RANZCR also needed to take a college risk approach, recognising that if we do not meet the AMC accreditation standards for medical colleges, we could either lose our AMC accreditation, or possibly be subject to legal action from a trainee who has been adversely impacted by a lack of action.

173. It was noted that none of the trainees on the site were up to date with their Workplace Based Assessments (WBAs) and two trainees were to be exited from the training program because they cannot pass the exams. One trainee had engaged a lawyer claiming that the site provided zero teaching and supervision to him. He had failed his anatomy exam 5 times and wants a 6th attempt.

Case study 5 – Meeting between NSW Health (Sydney Local Health District) and RANZCR – final site assessment report outcome for an accredited Sydney Hospital site – two letters and hand written notes attached

174. A Microsoft Teams meeting was held between officers of NSW Health from the Sydney Local Health District and RANZCR on January 16 2024, to discuss a final site assessment report for a hospital site under their management.

175. The NSW Health team claimed the RANZCR process was different to any others they had experienced. They claimed the RANZCR team was very combative, even offensive. NSW health was not asked any questions but was subjected to 20 minutes of being berated about issues between management and clinicians. They claim not to have been given the opportunity to provide the district’s point of view. They also claimed that their Directors of Training (DoTs) were told not to discuss the report with management.

176. NSW Health claimed that when they read the report, the language was offensive and inflammatory; with nothing positive in the report. There were accusations that RANZCR had “bought into” the pay dispute and bad relations between management and clinicians at the site. A NSW Health representative claimed that the RANZCR team had “bought into” the dispute on the side of the clinicians. The RANZCR report had been leaked to the media and had not been given to management. NSW Health claimed that parts of the RANZCR report were outside of our scope to assess the site against accreditation standards; and called one recommendation around recommending a cultural review for a department or that an individual should be included, as out of our scope and “outrageous”.

177. One NSW Health official commented that they found it difficult to secure Radiology consultants because the private sector offered superior remuneration, but then other health

districts paid amounts outside the range permitted by NSW Health and they would not entertain this arrangement.

178. NSW Health also claimed that RANZCR was wrong to focus on process and not outcomes; and that the stie must be doing well as the trainees are performing to a high standard and achieving a high pass rate on RANZCR assessments.

179. NSW Health also noted where they had been making improvements to satisfy a number of the concerns brought up in the report.

180. RANZCR thanked NSW Health for their feedback and where they were making improvements. RANZCR explained our processes for distributing the report to the head of department as our contact point for distribution and comment. We also noted that the trainees on the site were of a very high quality and that due to the lack of consultant supervision, they had organised their own training sessions with the senior trainees helping the junior trainees in their training. This is why the assessment results were high but this is hardly an acceptable long-term solution for the site. RANZCR also undertook to speak with the members of the review team for their perspective on the report meeting and offered that if NSW Health wished to submit further information, then it would be considered as part of their 3-month progress report. NSW Health then sent a letter on 30 January 2024 with updates on some of the recommendations. RANZCR responded by letter on 21 February 2024 by acknowledging this progress and asking NSW Health to include it as part of the 3-month progress report. RANZCR then received another communication from NSW Health on 8 May 2024 (attached) misrepresenting RANZCR's offer in our previous meeting and complaining that the process that RANZCR had allegedly agreed to at our previous meeting was not being followed, and that NSW Health wanted another meeting with a "representative from the NSW Ministry of Health" present. RANZCR was concerned at the implicit threat that this escalation represented in the environment of the Kruk and NHPO reports and has not agreed to this meeting.

Case study 6 – Prince of Wales Hospital – 4 letters attached

181. RANZCR received reports from staff in early 2023 that a Director of Training (DoT) at the Prince of Wales Hospital (POWH) had made a series of unprofessional comments at two separate meetings about RANZCR, our staff, and the Network Training Director (who is a volunteer college position).

182. RANZCR sent a 'please explain' letter on 9 March 2023 (Attachment x) to this DoT asking him to justify why he should retain his position in the face of these comments.

183. The DoT responded by letter on 5 April 2023. RANZCR then replied to the DoT on 17 April saying it accepted his explanation but cautioning him on future behaviour.

184. RANZCR then received an emailed letter from the Director of Clinical Serviced (DCS) at the POWH, dated 27 April 2023. This letter says the author encouraged the DoT to consider taking legal action against RANZCR for its actions, that the letter claimed RANZCR may have defamed the hospital and their training program.

185. RANZCR was concerned that this robust response may be seen in context to the ongoing significant accreditation issues at the site. RANZCR was so concerned about this approach and the threat of legal action that it retained its own legal representation to respond to this letter. Several letters between RANZCR's legal representative and this officer ensued, with neither side retreating from their position. The issue eventually petered out.

186. When other NSW Health officials claim that RANZCR should take the lead role on bullying accusations, we have pointed to this exchange as the likely result of any attempt by RANZCR to address behavioural issues in the NSW Health workplaces. When RANZCR

has raised this situation, we have been told by a senior NSW Health official that they 'are aware' of the situation.

National Health Practitioner Ombudsman specialist medical training site accreditation processes review

Question 15. The extent to which the College agrees or disagrees with the conclusions and recommendations set out in the National Health Practitioner Ombudsman report titled *"A roadmap for greater transparency and accountability in specialist medical training site accreditation"*, dated October 2023.

187. RANZCR has made a firm commitment to integrate all recommendations put forth by the **National Health Practitioner Ombudsman (NHPO)** into its Training Accreditation Standards. This decision signifies the College's dedication to upholding the highest standards of training and education in the field of radiology and radiation oncology.

188. The RANZCR Training Accreditation Standards, which serve as the benchmark for radiation oncology and radiology (and other postgraduate medical training programs in Australia), have recently undergone a comprehensive update including the incorporation of the NHPO recommendations. This update reflects the College's proactive approach to continuously improve and adapt its standards in line with expert advice and industry best practices.

189. However, the process of integrating these changes into the RANZCR Training Accreditation Standards was not without its challenges. It required a significant allocation of resources, both financial and human. The expense was substantial, reflecting the complexity of the task and the importance RANZCR places on maintaining the highest possible standards of training.

190. The deployment of resources involved a wide range of activities, from the initial review and interpretation of the NHPO recommendations, to the detailed work of integrating these into the existing Accreditation Standards. This process also included consultation with stakeholders, drafting and reviewing new policy language, and implementing the changes across the training programs.

191. In summary, the College's decision to embed all NHPO recommendations into its Training Accreditation Standards, despite the significant expense and resource deployment, underscores its commitment to excellence in radiology and radiation oncology training. It also highlights the ongoing efforts of RANZCR to adapt and evolve in response to expert advice and changing industry standards. This commitment ensures that the training provided under the RANZCR Training Accreditation Standards remains at the forefront of radiation oncology and clinical radiology education and training.

192. As to the development of the NHPO report, RANZCR would have valued the opportunity to contribute to the report at its inception, rather than at the "review" stage after the report had been drafted. College involvement might have addressed some of the items raised in the report. These include understanding the public impact that the call for full transparency and public reporting on site accreditation status might herald.

193. A NSW Health demand has been that RANZCR takes responsibility for bullying occurring in NSW accredited sites and this appears in the NHPO report (Recommendations 13). RANZCR's view, supported by Workcover, is that NSW Health is the employer in these situations and is responsible for the actions of its employees. RANZCR has no power to investigate bullying in a NSW Health site no any power to penalise NSW Health employees for their actions. RANZCR has emphasised to NSW Health that if NSW Health investigates and takes actions against RANZCR members, RANZCR will support NSW

Health in this and consider withdrawing RANZCR Fellowship from that member. Details of meetings which support this statement are provided in Section 14 under case studies.

194. Recommendation 13 is given a "High" priority ranking, meaning that the NHPO sees this as an urgent issue for resolution.

195. The Review notes that the Ministerial Policy Direction outlined that Ahpra and the MBA require the AMC to review existing arrangements to ensure the scope of the standards is "clarified to matters relevant to the delivery of high quality education and training of medical specialist trainees." RANZCR fully supports this approach and offers that this approach should be taken for the entire MBA/AMC accreditation framework, concentrating only on the core elements that ensure high quality education and training of medical specialist trainees.

Other matters

Question 16. Any other relevant matters raised by the College in relation to the administration of specialist training programs and the sustainability of the workforce generally.

196. RANZCR notes and appreciates the outsized "heavy lifting" role played by NSW Health in funding accredited training sites and traineeships. The private sector is often the beneficiary of this investment by the public sector. Mechanisms to encourage the private sector to invest in specialist training or to otherwise contribute to the training burden should be considered as part of a larger platform for the future.

197. RANZCR welcomes the opportunity to provide additional information or any other support for the Special Commission of Enquiry into Healthcare Funding in NSW.

198. For further information, please contact Brendan Grabau GM Specialty Training at Brendan.grabau@ranzcr.edu.au or Melissa Doyle, GM Policy & Advocacy at melissa.doyle@ranzr.edu.au.

Duane Findley
Chief Executive Officer
Date: 15 July 2024