Concord Repatriation General Hospital
Medical Staff Council
MSC meeting

September 28th , 2023

Present:

M. Rickard, A. Hallahan, C. Yeong, S. Limaye, J. Lowe, I. Cunningham, D. Wechsler, A. Cottee, P. Yahyavi., L. Waite, P. Katelaris, Z. La,. L.Trieu, J. Trotman, R. Cross, S. Morris, T.Kanhere, S. Condon, P. Arulanandam, P.Blinman, C.Cho, K.Hill, J.Jewitt, W. Cheung, J. Kang, G.Becerril, P.Spring, L. Ridley, R. Holland, A. Linton, R. Pope, P.Howson, N. Spalding, K. Shannon, F. Davidson, A. Wagh, H. Davie, S. Merten, M. Krishnaswamy, D. Sumpton B.Hokin, J. Han, J. Yang, J. Cullen, T. Gray, R. Choit, G. Molland, Gluch, H. Xiang, J. Burrell, F. Doull, C. Sengupta, T. Bui, L. Izzo, I. Tohidi-Esfahani, B. Zicat, L.CHan, M. Seibel, N. Spalding, K. Shannon, E. Cheong, A. Ritchie, E. Veitch

[Winston Cheung]

Welcome everybody to the medical staff council meeting with the Execs 28th of September. We're using the auto transcript but we're not recording the meeting. So, it's just to help us with the minutes. I'd like to welcome any First Nations colleagues with us today. And acknowledge, that Concord Hospital sits on Wangal Land.

We acknowledge them as the traditional owners of the land at Concord. And we pay our respect to elders past present and emerging.

We send our apologies again in terms of the minutes. We're halfway through the minutes, but we hope to have that out soon.

Might start with updates from the executives. Andrew are you able to give us an update? Joseph you're on the line as well. Are both you able to give us an update?

[Joseph]

I'm happy to go through. There's probably not as much to update this meeting than as usual because it's just been 2 weeks since our last meeting.

But in terms of key things. From a radiology point of view the reporting of the backlog in the GE system has commenced and we're anticipating about 5,000 images are going to be reported each week.

We're pretty confident that that will mean that we will reasonably quickly get on top of the backlog within the old system.

Work is continuing with the vendor in relation to our current sector system and once we've been able to sort out the sort of interface between their system and sector.

As the background is being dealt with, we will be in a position also to then help with the afterhours reporting, as well as an ongoing strategy to managing the workload.

In terms of updates from last time in terms of recruitment of diagnostic radiologists.

I think last time I had said that we're on boarding new specialists, but we've also still got some vacancies.

There are interviews that are happening next week for the remaining vacant positions. So hopefully that will be productive in terms of being able to fill the remaining vacancies in diagnostic methodology.

Previously talked about interventional radiology, so that's all fine.

The capital works for CT. The replacement for the second CT in radiology, those works of commenced.

We're on track for those works to be completed and for the staff training etc. and commissioning to be completed by the end of October.

So hopefully that will continue to be on track. We will start the program of capital works in the emergency department for the third CT scanner from Wednesday next week, the fourth of October.

So that obviously will start with, moving from its current location in the ED up to level 5 into 5 East. Then we'll start the capital works in making it suitable for fast track. Relocate fast track into the new space and then we're able to start the work in that fast-track area.

That will become the area for the third CT scanner. The whole work program of works I think I've said previously in the emergency department will take 10 months.

Because obviously there's a need to carefully manage that couple of works around the operations of the ED, but also there's quite a significant amount of work that needs to occur to.

Reinstate the clinical space is lost, but the end outcome of that will be some significant refurbishment of the emergency department which I think will be, really valuable.

The work is ongoing in terms of the second MRI.

Continuing with the planning with capital works around creating the space for the second MR, in order to enable its installation and the ongoing kind of planning for the procurement of the MR as well.

In terms of clinical services plan we've finalized our consultation with neurosurgery. We had a follow-up meeting with them since we last met. And being able to finalize part of that plan and so that will allow us to submit an updated plan to the ministry.

In terms of overseas recruitment, we've had some additional nurses. Nurses start from the overseas recruitment we've still got more coming on board. We've got about another 20 coming on board, which we hope will occur over the next month or so.

This is obviously sort of dependent on all the different hurdles that are needed to bring … in from overseas.

But certainly, it is a program that is starting to start to bear fruit.

I've also flagged last meeting that we are implementing our own program to support registered nurses who don't have recent acute experience.

So, they've been working in other parts of the health system, who routinely apply for our positions and then get screened out because they don't have that recency of experience.

We will be providing them with the training and the support needed to build up that experience. And that will allow us to move rapidly on-board nursing staff to fill our vacancies, but also to open up the additional areas that we need.

So, we've had approval for the nurse manager to manage that program and we'll be piloting that program for the district.

So, it's an exciting new initiative that will be starting here at Concord and if it works it will be something we'll promote across the rest of the district.

I think that's probably all I have in terms of new updates. The update from 2 weeks ago for the other items kind of remains the same.

[Winston Cheung]

Great Joseph. Any questions for Joseph?

[Ilona Cunningham

Just a quick check and I might have missed this as I as you were talking Joseph, but with regards to capital works you were talking about capital works for radiology.

Any other capital works in progress with regards to the main building?

[Joseph]

We are about to start a refurbishment of the ACE unit, which I think I flagged last time.

With all of the sort of approvals and sign-off has occurred, it's just a matter of planning the program.

Of those works around ACE operations, they will lose a procedure room whilst those works are occurring.

And so, we're just working with the service just to make sure that we can effectively manage that.

A lot of those works will probably happen around the Christmas period, so it minimizes the impact, but we'll look at what we can do to extend the hours of service of the other remaining procedural rooms.

Just to minimise the impact. We've also flagged last time that we are doing the planning work.

For a program of decanting several wards from the multi building into building 60 into one of the vacant wards so that we can be able to get in and do quite extensively refurbishment of those old areas.

In the same way that we have with 5 East. Because that allows us to really get in and do the nurse call system, the services behind in the walls, etc, as well as a real good refresh of the ward itself.

So, in engineering are currently doing work. To help us prioritize based on the sort of, you know, the works that are needed in each of those areas.

And we've also been doing work around between those ward areas and other clinical services in the Multi, to begin to pull together a program. So, some services will be able to easily move into building.

Because there's not a lot of critical interdependencies. And so, we will be doing that and refurbishing their areas.

And then for the other areas where being far away from their other clinical services, for instance, potentially respiratory given the bronchoscopy and outpatients and other things all sort of co-located at the moment.

They could potentially when we refurbished their ward moving to one of the newly refurbished wards in the multi so that the distance isn't so great. And that way we can ultimately over a period of time get through and make some significant inroads in terms of refurbishing those areas.

So, we are working on that but it's obviously requiring quite a bit of planning and consultation, etc.

[Ilona Cunningham]

Yes, and the funding for this comes from directly from the ministry or from the district.

[Joseph]

It's the district. It's us needing to do.

[Ilona Cunningham]

Okay.

[Joseph]

We've not had approval for stage 2 program. Which you know when we do, we'll be able to obviously do some very significant work, capital work.

This is stuff that we are doing, and this is we're doing this in house with our own capital works team, etc. as a way of trying to manage that within existing resources. But to be able to do this in a coordinated way.

[Ilona Cunningham]

And the car park is about to start or not?

[Joseph]

The car park has started and it's on track to be finished with December 2024. And once that's done, the total number of car parking spaces will increase by 800 odds. We lose a few, for the mental health unit, but there will be a significant increase after that.

[Judith Trotman]

Okay, thank you.

[Joseph]

Available parking on site and the use of access, I understand that the moment obviously with the construction happening in the middle of the car park on the other side of hospital road.

That creates some level of disruption because we've got these multiple independent sites so people can park but it will mean we have fantastic new parking facilities so that will make life much easier.

[Winston Cheung]

Judith.

[Judith Trotman]

Great to hear the net increase in and parking thanks for that Joseph that's great just a little question the demountable from the with the name Roberts construction or whatever that are down near the helipad parallel to the Roberts construction or whatever that are down near the helipad parallel to the helipad.

They're all still there. Are they going to be deconstructed or they're going to sit there until we work out what happens with the phase 2?

[Joseph]

Sort of. There are a couple of different things in relation to that. We have got some services from a district level at Sydney Olympic Park that we are using space there at the moment. So, we've keeping those to mount those because we may have to decant those services from the Sydney Olympic Park, those leases expire back into district facilities so they could potentially go in there.

Stage 2 up. So rather than actually get rid of them and then have to reinstate them, would be that we would then have that capacity to, if not whole host the project, teams have space where we could decant services out if we needed to in order to make room for the capital works to occur.

[Winston Cheung]

Joseph, have you heard about the CT at Canterbury and the issues there and how is that going to affect us?

[Joseph]

And the planning for that is still happening. It won't happen before we have our 2 CT scanners back up and running.

But there will be a need to install a CT scanner replace the CT scanner at Canterbury and there will be a need for both RPA and us to support Canterbury during that time.

[Joseph]

But we are working through that plan at the moment, and they haven't come back to us yet with the that plan.

[Winston Cheung]

There was a rumour that it's going down in a couple of weeks for a service. Do you know much about that? That's what I was talking about.

[Joseph]

No, I don't. I don't know anything about what's going on in Canterbury.

[Winston Cheung]

Because if that's true, that's going to significantly affect Concord if this if they have to come here for scanning.

[Joseph]

It won't be happening whilst we're down to one scanner. Because obviously that would be a significant issue for this.

[Winston Cheung]

Okay.

[Joseph]

But it might be planning for it at some future point, but it won't be happening. At that same time.

And I just have to say, radiology has done a fantastic job. In managing the … during this period of construction. The team have been fantastic at getting through actually, the same volume of work on the one scanner.

That would not have been done across the 2 scanners. Just so you know.

A whole lot of extra effort in making sure that we've been very tight at the throughput and being doing a really good job managing expectations and communicating with patients and services and even when we had an unplanned downtime that was managed incredibly well and well-coordinated.

They worked really well on that and just want to acknowledge the tremendous effort that they are they are making whilst we get through this more tricky period with the works that are happening to improve our medical imaging infrastructure.

[Judith Trotman]

Could I just make one extra comment about the transfer of patients over for interventional radiology?

Particularly patients with biopsy and just to flag to people that I've discussed with Rob Loneragan and also with Dicky Waugh that core biopsies that are done on Concord patients will be sent to Concord pathology.

And likewise flow cytometry because otherwise we end up with a delay in getting the specimens over for MDT review and I think that's I don't think that was something that was really thought through.

But I think we've got a really good solution there, but that probably needs to be communicated.

I don't know whether any oncology colleagues are on site, on this meeting or respiratory, but that's important.

[Winston Cheung]

If you're able to communicate that.

[Joseph

Yeah, follow up.

[Judith Trotman]

Yeah, maybe just check that it's all formally done with Reuben.

[Joseph]

Yeah. No problem, I'll make sure.

[Judith Trotman]

Thanks.

[Winston Cheung]

So, any other questions for Joseph?

[Winston Cheung] 17:20:12

Okay, if there are no other questions, Andrew, do you have anything to add?

[Andrew Hallahan]

I really have no additional news from 2 weeks ago, Winston.

Annual medical recruitment preceding well.

And I think lots of offers have been accepted, which is great. Quinquennium's going along and lots of panels of being going, and so my thanks to those who've contributed to those.

Apart from that really nothing.

[Winston Cheung]

Okay, any questions for Andrew from the floor?

Okay, well if there's no other questions we'll go to the next item. Which is the proposed vote of no confidence in Sydney Local Health District board.

And the New South Wales Health leadership. Now I sent an email around earlier on the week. I know there's been a lot of discussions.

I want to devote a lot of time. And I want everyone who wants to speak to this, to speak.

I also want to hear from sort of people who have been involved with the cultural review process to, to let us know how they're going. And how they feel the process is running and whether they are any things which we can do?

Matt, do you want to kick things off?

[Matt Rickard]

Thanks, Winston. I just wanted to talk first because I'm talking at the head of department twilight meeting which happens in 5 min which unfortunately clashes with this, but I just wanted to say right beginning that I don't agree with either of those votes of no confidence. I think it's a crazy idea and it risks us becoming just a laughing stock. And I honestly wish you'd stop firing these things off without thinking about the consequences.

So, I really think it's silly. And it's going to be not helpful. And I'm not even sure if the previous vote of no conference were that helpful.

They're a little bit helpful because I think we've got the executives here at the moment. And perhaps we're getting things done. But I think you just need to calm down a bit to be honest.

So, and I know you and I've talked about this, and I've told you that to your face.

But I really, really think it's unhelpful. And you've got to, if you do these things, you've got to think about the possible outcome. And I don't know if you've thought that through properly. And I apologize, but I have to go, but I just want to get that in before I go.

[Winston Cheung]

Thank you, Matt.,

[Ilona Cunningham]

So, similarly, I think these are nuclear options. And I would have thought that we have an orderly sequence in place at the moment and that's working with Proactive as well as thinking about approaching the ombudsman.

Before the rest can incredibly occur. I think if you pass these 2 motions. I think we would lose impact for the reasons that Matt outlined. Because we just rushing, rushing, rushing. And secondly, I think it would cause us reputational damage.

[Winston Cheung]

Thanks a lot.

Judith?

[Judith Trotman]

Can I just echo what my 2 previous colleagues have said and also note that at the last meeting when this was raised by you Winston, I believe both Fergus and I were the only 2 people who spoke to it and advised against making such a move.

We felt that it was not prudent while the current process was underway and needed to be seen through.

And also on another side, I think making a vote of no conference or moving a vote of no confidence in New South Wales Health maybe, I mean, it's just untenable and a really to me I think it's a crazy proposal. But undermine any negotiations that are getting underway in terms of an award that is modern and appropriate for quality, patient care and, you know, appropriate recognition of salaried medical officers. I think it would be distracting from what I would rather be focusing on, and that's advocating for phase 2 of redevelopment and advocating for a modern award.

[Winston Cheung] 17:24:56

Thanks Judith.

[Prunella Blinman]

Thanks, Winston. I just want to express my, surprise at the email that you sent around it.

Raising the possibility of those motions because my understanding after the last meeting was that you did raise the possibility of a vote of no confidence in the board, but the discussion then was amongst members was largely around, hang on, we've got something going on at the moment.

We should sit tight and see how this pans out and not rush into things like this. Until we've seen. What is the result of the current review process? So, I just feel like the email went against that discussion. Whether or not there was a consensus that came out of the meeting I'm unsure. I don't quite have that recollection, but I certainly remember that discussion.

So, I'm just expressing my surprise. And I endorse everything that Ilona and Judith have said so far.

Thanks.

[Winston Cheung]

Thanks.

[Winston Cheung]

Any other comments?

[Lloyd ridley]

I guess there's 2 things I need to talk to.

The first was we have been involved in the mediation session with Proactive. We had 8 people from the department who went.

They universally were grateful that Proactive were there and gave them an opportunity to raise a number of very serious issues about the department.

I would have to say that the response we got was somewhat muted. There was no apology as somebody pointed out.

In fact, I'd say there was very little explanation of why things have become as dark as they've become.

Just as a specific example about one of the issues that's been discussed through the MSC here which was the procurement of the second MR.

Which there was that memo that went out 3 or 4 weeks ago that said the second MR had been procured.

That was one of the things we got an explanation on. So apparently there's a new policy that hasn't yet come out, but is about to come out, that people who use major equipment are no longer part of the procurement process.

Procurement is done at statewide level. And I also think we've had several people expressing their concern about going ahead with votes and no confidence.

Obviously the previous one got Proactive involved. Just to point out that since we've started the Proactive process, we've had a third person today who's in the process of discussing resigning from Concord. There's not 6- or 12-monthsmonths' time that can be given to allow this process, the Proactive process and any other process to go through, without the department just completely folding.

[Winston Cheung]

Sorry, so 3 from your department or 3 from the general hospital?

[Lloyd ridley]

From our department. There's a registrar who's leaving. 2 thirds of the way through her training.

And there's, we talked about, a staff specialist not coming back from maternity leave.

I think that was at the last meeting. And there's somebody today who's going to be moving a long way from Concord and not be able to be on site next year and is currently discussing whether they should work remotely or whether they should be leaving.

So that's one of the issues that came up that our department has proposed the so-called work from home model for reporting radiology.

So, it's on the table, but there weren't any resolutions.

There were just committees. Based on the Proactive mediation session to look at the many issues that base radiology.

[Winston Cheung]

Thanks, Lloyd. Fergus, I know you've got your hand up next, but I thought just while we're on radiology and I know there's other radiologists on the line.

I might ask. Any another radiologist that just wanted to want to say something. Jessica?

[Jessica Yang]

Thanks Winston. My concern is about recruitment of staff. So, we are getting new CTs.

We are possibly getting a second, all right? Hopefully this time round will have the other district movement, not like last time.

But unfortunately, so as Lloyd pointed out, someone is not coming back from leave, and you know we've advertised. We continue to advertise things months ago. Regardless of advertising at the moment. We have got 1 Registrar who is yet to finish. That will be becoming a specialist in February.

But that person is going to do a fellowship. In June of next year. So, they'll only be here for a few months before they go away to do a fellowship.

There is possibly another registrar who might do that, but on the horizon, we have no new staff.

The most recent recruitment round, 2 radiologists actually applied, interviewed and they have been given weeks to ponder their decision. They have both been offered the position. But they have not said yes. I spoke to one of them today and I think it's going to be unlikely.

So really on the horizon we have no new staff. Where North Shore has recruited recently.

They were successful in recruiting radiologists. We have lost 2 staff specialists to Royal North Shore Hospital.

We've lost one register as well, to North Shore hospital. Okay, so they've got radiologists.

So, we need to look at what is wrong here at Concord Hospital? Why are we losing staff?

And so, where I'm sitting, management is not actually addressing the core issues here.

Proactive has come and we've talked about the issues in radiology. We have talked about what can be improved.

But really, we're not addressing the core issue. And the truth is there is no new diagnostic radiology staff on the horizon.

That's the truth.

[Winston Cheung]

Joseph, do you want to comment on that.

[Joseph]

I'll take it on notice and go back to Reuben. If people are having conversations with individuals about who are part of a recruitment process, that's not being communicated through to us from those candidates that I'm aware of.

But I'll take that on notice and go back and speak to Reuben.

[Jessica Yang]

Please do, Joseph.

[Winston Cheung]

I was going to ask, what actually is the problem?

If we had to look at the fundamental issue that is not being addressed in radiology.

We had to fix things, what do we actually need to do? Because if we lose more radiologists, from where I'm sitting, Concord Hospital is in pretty big trouble. If we lose one more, we're in big trouble. If we lose 2 more, we're in big trouble.

I understand the workloads already pretty huge. After weekends and that sort of thing in Canterbury.

What do we actually need to fix it? What is it that the hospital needs to do? What is it that Proactive needs to do?

What is it that anyone needs to do? To actually fix this. Lloyd?

[Lloyd ridley]

We've told them what they need to do. In very simple terms for this meeting, the first thing is to stop the bullying.

Stop blaming the radiologists for the problems that have been caused by management. And it's really the only word I can use is bullying over the last 5 years since we've raised this issue.

And then the second thing is.

[Winston Cheung]

But the bully, the bullying's ongoing?

[Lloyd ridley]

Well, not in the last week, but our staff have been continually hassled. One of the things I forgot to mention earlier is a plea for staff throughout the hospital.

Our clerical staff and our, technical staff, the radiographers are under a lot of pressure from a lot of people in the hospital. So, we've got patients ringing up and complaining. We've got doctors. We've got several VMOs that have become quite aggressive to some of our staff.

We don't have the capacity to put patients in and it doesn't help when you have a department that's under a lot of stress to have people being quite aggressive. Dealing with the staff and making complaints. They can't do anything about it.

[Winston Cheung]

Can I ask, I was told by radiologists yesterday that nobody wants to work Mondays?

[Lloyd ridley]

So, the second issue is about, we want a fair working condition. Reasonable working conditions or put it another way, safe working conditions.

[Lloyd ridley]

To stop being asked to … when we do twice the benchmark for a staff specialist radiologist. To stop people saying that we're not doing enough.

To stop being rostered for multiple things at the same time. Like I'm being rostered for doing neuroimaging.

I haven't reported a neuro-MR at Concord for more than a decade, but there's nobody at Concord who can do it.

My name's been put on the list. You know, you need to have the appropriate people in the appropriate place doing a fair workload. Because the workload is too high.

[Winston Cheung]

… workload is too high. Everyone's here till 9 o'clock on a Monday because of the work? Can you actually just give us an idea of what the workload actually is?

[Lloyd ridley]

That's where I think I need to go into the details about how we actually do our work.

But basically, it's the body and it's the chest and abdominal work where the workload is particularly high. And you've got a lot of stuff that gets done over the weekend, understandably. That's the nature of a hospital.

And when I did the figures to work out the roster, which I did 3 or 4 years ago.

You needed 3 or 4 people on. And we've got one or 2 people.

So, on the Tuesday next week on the long weekend. There's 2 of us covering what the roster says should be about 5 people's work. And we'll be doing clinical meetings on top of that as well. That clinical work needs 5 people, but we're being asked to do … Tuesday is one of our busiest days with many departments having meetings on Tuesdays. They will still be going on. It just doesn't work. So, what happens is that people who've been particularly diligent, they will keep working, many of them stay back, they get more and more stressed and upset. And the ones that have been affected the most. Which is the way we do our roster, is about the different body systems.

The ones with the heaviest workload on Monday's have said they don't want to work Mondays anymore. So, the workloads are far heavier than anywhere else. There's no respect. The pay for what it's worth, we get less than other hospitals.

Why would you want to work on Monday? I can work in private and get and do less work and get far better paid. And of course, I do work in private now because of the issues at Concord over the last 5 years.

[Winston Cheung]

So can I ask you, Lloyd and the other radiologists. We undertook this vote of no confidence in the chief executive in June.

Proactive started on the tenth of August. In that time has anything substantial actually happened? Has anything actually improved? Over those many months till now?

[Lloyd ridley]

I guess that there has been progress on the outsourcing, which was of course actually talked about from maybe, January, February. Probably February actually because there were issues in January. So probably about February.

We've spent 6 or 7 months talking about it. We've had multiple advertisements go out, so that's a positive.

At least we're trying to recruit, which is different from what happened before when we had a radiologist who wanted to work at Concord.

And it took 12 months from the time that he said he wanted to work before he could actually start work because of waiting for the advertisement to go out and then the process.

So yes, that some of those things have improved. I'm not sure that that's really from Proactive.

As I said, the meeting last week. A lot of things were said. The quickest and cheapest way of dealing with it in my mind is to apologize, to acknowledge or to use the medical description open disclosure. So, in a clinical incident, so you'd have open disclosure. You would give some explanation about why things have gone wrong so that people have a sense that they won't continue to go wrong.

That didn't happen, so we're now left with the situation of a whole lot of subcommittees that need to come up with recommendations and if that is successful, then, as I said last time, actions speak louder than words.

It's just a way of doing things when people are very seriously thinking about whether they should be staying at Concord.

[Winston Cheung]

Thanks, Lloyd.

Are there any other radiologists who want to speak to this before I go to Fergus?

[Fergus Davidson]

Thanks very much. What we're discussing here is the merits of, moving a vote of no confidence against the board and also the health department and I totally concur with that.

All the views expressed regarding the health department. That's a nebulous concept.

There's no basis for it really. I think we do need to consider the Board's response to the vote of no confidence in the CE.

You know that surely is a sentinel event and I'm really surprised that they haven't been more proactive.

And acknowledging the concerns and you know trying to understand why that vote if no confidence was carried. You know, there's been a lot of talk, about Qantas and other boards and plus Waterhouse Coopers and the role that they have in managing their executives.

And it's just a little bit ironic that, our Board seems to be remaining completely silent and on that, and yet they don't seem to even want to acknowledge, let alone understand.

So, I do think it's worth considering the merits of a vote of no confidence in the board.

That's all I wanted to say. Thanks very much.

[Winston Cheung]

Thanks, Fergus.

[Winston Cheung]

Prunella.

[Prunella Blinman]

Oh, that might be from before. I'll take that down.

[Winston Cheung]

Oh, sorry. Liz.

[Elizabeth Veitch]

Hi, everyone. Look, I agree. I'm not keen on a, well, I don't think a vote of no confidence in New South Wales Health would help us in any way at the moment.

I think the board have been pretty appalling and I would think that a vote of no confidence in them at some time might be warranted.

I'm not convinced now is the time. I think we've set a course. Course has been set with Proactive solutions in a sort of mediator's role and I think we need to give that some time, but I think we need to be pushing very hard.

And I hope the members of the executive that are here have heard how unbelievably stressed radiology are.

And I think that it's a given that we can't just suddenly make new radiologists that are desperate to come to Concord and therefore accept jobs.

[Elizabeth Veitch]

If we can't do that though, I would think it's imperative that we do whatever we can to make their workplace and workload more supportive and achievable.

And if that's working from home, I just can't see why. If that is helpful to the radiologist, I just can't see why something like that, more administration staff, etc.

Why those things can't be provided. Absolutely within, a matter of days or weeks at the most.

I really feel very strongly that our hospital is teetering on becoming completely unworkable without a functioning radiology department.

So that you know, I think that's what I feel at the moment is that we have set a course and we need to give the process some time, but some departments don't have much time and we need to give the process some time. But some departments don't have much time and they need solutions right now and if those solutions can't be actually more staff, more radiologists, then it has to be another solution that they propose that will help them to, to work in a way that, that is, is better and helpful to them and still achieves good patient care.

Thanks.

[Winston Cheung]

Thanks, Liz. If I can just let everyone know. Because I think this is an important meeting, I'm going to let it run past 6 pm.

I'm going to let it run as long as it's necessary for everyone to talk.

Lloyd, Jessica, my understanding is you've lost your IT guys as well. Is that correct?

[Jessica Yang]

Yes, that's correct. So, there's currently no IT personnel in radiology across.

[Winston Cheung]

So how many IT personnel did you have before?

[Jessica Yang]

We had 2.

[Winston Cheung]

And so, what effect will that have in terms of working from home?

[Jessica Yang]

I believe one of the radiologists, was asked to set up IT equipment possibly.

If anyone here knows anything about this. A radiologist is not an IT person, even though some radiologists are pretty savvy, but still.

I don't know why radiology resources has to be used to do that when that should be performed by an IT person. Currently if I have issues with IT, I have to email.

[Winston Cheung]

Fergus.

[Fergus Davidson]

Just wanted to say, this is the result of some reputational damage that has already occurred.

That we've been trying to improve, and I think that, as Liz said, every effort needs to be made to hear what we need and respond to it.

We have to make up the deficits that have been created. In a reputational way.

I mean and in an attractive way, you know, we've got to make Concord a place that people want to work at again.

[Elizabeth Veitch]

Why would our radiologist not get paid the same as radiologists at other hospitals? I mean, that's just unbelievable to hear.

[Winston Cheung]

Comments from Andrew or Joseph about that?

[Joseph]

No, we discussed that in the meeting last Friday. I'm not aware of what arrangements occur at other hospitals to know what the comparison is. But obviously we are doing work to because we know that meeting supply the practice is a challenge.

And Lloyd, as you've said previously, part of that has been the work that has been seeping out of the hospitals into private. In order for scans and other things to be done but that's why we've been such a focus on trying to get the additional infrastructure in place in terms of the additional scanners.

This is taking off that non-billable work. So, we've got the capacity to do more billable work to the department. So, I know that these things are tricky because you increase the number, your imaging capacity, increase the staff, but you can't increase the staff unless you seem like a viable place to come and work. So, when we are working very hard to make sure that we get all of the pieces in place and hopefully get to a point where they can be aligned.

We are seriously at their reporting from home. We've heard that message loud and clear last week and we came to look at what we could do. We've got to balance that with the need to provide supervision into our registrars though. That can't be, the college is really quite clear that this can't be done remotely at home, that there needs to be presence on site and when we will need to kind of look at how we balance that.

Ideally, I mean, what we're all trying to work really hard to get to be that full complement of staff because we do have the ability to get the billable work through as well as meet the other needs of the hospital. And be able to get that really good balance between, the onsite presence that is needed as well as the flexibility to allow people to work from home.

And we're looking at 10 h days for instance. So that that is more attractive for people in order to be able to manage their hours.

It also allows people balance that with private commitments, etc, as well. So, we are looking at all those things, but it is a matter of making sure we get all of the things that are needed to support those initiatives properly in place and so a lot of work is happening in order to make sure that we do that. And I know that there is a level of impatience with things, but we are trying to get these things to a better place than what they are now.

[Jessica Yang]

Thanks. Elaine just posted a question. I just wanted to answer to Elaine. So, I mean, you know, there's a set path of training that registrar's have to do before they become a radiologist etc.

But also, I know in the newspaper recently, there have been, I think the district has come out to say that there's a shortage of radiologists, etc. I would respectfully disagree with that. You know, like I said, we've lost staff specialists to North Shore. North Shore has recruited. We had a registrar that should have come back to us that went elsewhere. Prince of Wales has recruited. They had 7 radiologists apply. So, I would disagree that that the current situation because of a shortage of radiologists. Concord had a full complement. Well, not I wouldn't say full complement, but many of you here would know that Concord Radiology 5 7 8 years ago was a fully functioning radiology department. We could handpick the registrars that we wanted to come back and be staff specialists. When I was appointed as a specialist at Concord Hospital, I was immensely proud to come back, you know, to come to this department, to be a staff specialist here. But now our radiologists, our registers finish. They don't want to come back. They can see what's happening in our department.

Our own registrars don't want to even come back to us. So, it is not really a shortage of radiologist, that's the issue.

There is a core issue at Concord radiology and in some way as well.

You know, there are registrars who don't want to go back, but other departments, at Prince of Wales for example, they know their registers are happy to move on to there, so it is not true that there is such a shortage of radiologists that the registrar's need to step up and be accredited. No that's not the case. There is actually an issue here at Concord and because Concord was not like this 5 years ago. We were efficient and you will remember things were reported on the day and it was not like this at all.

[Winston Cheung]

Ilona was next and then Lloyd then Fergus.

[Ilona Cunningham]

I'll just be very quick and, you know, presumptuous as a haematologist to the comment, but there's so many aspects to the operations of radiology and obviously and obviously so many aspects to the downfall and reputational damage of this department. I'm assuming that a lot of work is being done with John McDonald's help, in a coordinating work with the head of the acting head of department and with the stream director as well as the executive.

That's a question.

[Winston Cheung]

Lloyd? Do you want to answer?

[Lloyd ridley]

I don't think it's appropriate for me to answer that question. Rob has been involved.

Unfortunately, he was sick last week. So, he wasn't at the meeting last week.

What I was going to say is, I just like to make a little positive, which is sort of half positive, half negative.

Today is the first time I think that I can recall for well over 5 years that somebody from the executive has praised radiology for doing a great job.

So, thanks Joseph for your support of our radiographers in CT. I agree with you. They're doing a great job.

[Winston Cheung]

Fergus

[Fergus Davidson]

I thank you also Joseph for hearing and offering some ideas. That seem to marry up with the kinds of things that we're suggesting rather than taking an instinctively defensive position which we've heard a lot of over the last 6 months or so.

I really appreciate that you know, I'm sorry that I've lost my train of thought.

I'm operating at the moment as well. I'll come back in just a moment, please.

[Winston Cheung]

One of the comments I had earlier on the week from a radiologist was with this financial issue. There is tremendous pressure on deciding which scans to actually report. Do you report the complex scan that's not billable but needs reporting urgently and is very important.

Or do you report the simple non-complex CT scan that is billable and there is that sort of financial pressure in terms of the backlog and the current reporting.

Given that you can't report everything. Any comments? In regard to that. Is that pressure real?

Because I think if that's the case, I think it's pretty damning. It's pretty damning in terms of if you don't have the staff to be able to do that.

If that's the sort of pressure that the radiologists are under. To decide which scans they actually have to report.

[Fergus Davidson] 17:55:29

Look, I was going to say. Does anyone have any inkling of why the board doesn't want to hear about this information and hear and understand these things?

Because they have been offered the opportunity quite a number of times and they have basically put their hand up and said nothing to hear here.

If you're worried, just talk to the ombudsman. The health department has initiated, the investigation, or not the investigation, but the mediation, but the board has not expressed an iota of interest in this matter.

Does anyone have any inkling why that might be?

[Winston Cheung]

Well, I have an inkling, but I'm not going to say it. I think I think everyone else in the room has an inkling, but I don't think they going to say.

[Fergus Davidson]

I just don't, you know, this is about the confidence in the board. Because they're radiology issues I've been listening to for 10 years now.

[Fergus Davidson

This is not an accident. This was this has been a train wreck for a very long time. And the emergency department has been distressed for a very long time. This is not an accident.

[Winston Cheung]

If you want to know what the problem is in radiology. All you have to do is go down to radiology and talk to the radiologists.

So, if people don't know the problems. They're not going down there; they're not talking to the grassroots.

Simple as that.

[Fergus Davidson]

Andrew, do you have any idea why the board wants to remain so silent on this matter?

You don't speak for the board, you are not the board, but you have any idea, why they do not.

We are trying to be reasonable. We are humans, we are not robots, we have been committed for so long to the district.

Is there any reason why they would not want to listen and hear?

[Andrew Hallahan]

I was at the session where the board actually listened for quite a long time.

[Fergus Davidson]

Sorry, Andrew I got very negative feedback, the sense of feedback from the board, and the chair of the board said that we don't allocate the funds. That the government allocates the funds. It's not us, it's them.

That there was an attitude and there was not any expression of empathy. I didn't think that they were listening. They were there hearing, but they weren't listening, if you like. So, I just wanted again if you had any idea of why they might not be wanting to engage with us?

But I understand that you're not the board. I just wondered if you, you do seem to speak up sometimes at a district level and I just wanted to know if you had any sense of what is going on.

[Andrew Hallahan]

I can't really speak for the board as you guys said first. I can advise you from an executive perspective and from what I understand of the board they do very much want to see resolution of this matters and there's a process which has been put in place.

And we're looking to work through with the process.

[Fergus Davidson]

Yeah, because the signals that we're hearing when I talk to people on the ground as well as still that they don't seem to think that the boards actually interested.

Just as the Price Cooper Waterhouse, you know, board was not interested. And the PWC board, you know, initiated investigation.

They might have influenced the outcome, but they initiated the investigation. They didn't refer that on to somebody else.

They showed signs that they wanted to listen. That's not what we're hearing. I think that's what the distress is in this particular matter.

And it would be terrible if it came to a vote of no confidence in the board because we do want to be confident in the board. But they're not giving the signals that we can be confident.

[Andrew Hallahan]

As I said, they actually, the whole of the board, listened to a very long session, multiple presentations from members of this medical staff council.

And I'm not sure what else, what again, I can't speak for them.

[Fergus Davidson]

Okay, thank you, Andrew. Thank you.

[Winston Cheung]

Belinda, did you have your hand up?

[Belinda Hokin]

I had it up briefly and then took it down. I think it's also really concerning the lack of engagement by the board.

There are some very serious concerns and in that meeting a number of people raised very serious concerns about bullying and harassment. And at the end of it, all they really talked about was allocation of funds and deferred responsibility and there was no acknowledgement, empathy or even comment in relation to some really distressing stories from across a number of departments.

And that also really concerns me in terms of the board. The other thing that concerns me is how we've got and how Concord has arrived at the position that it's currently in.

And to get to where Concord is now really has required failures on multiple, multiple levels.

And both within Concord, at district, at the board, at ministry level. Right across the board. There's been failures all the way up.

To allow this system to have got to the stage we're in and to develop the problems that it's got.

And I haven't seen any sort of accountability to try to understand how we've got here or unravel how we got here.

You know, I think the engagement with Proactive has been really, really good. I think and I know I missed the last meeting but understand there was a lot of sentiment about it's actually been really nice to be listened to.

And have our feelings and emotions validated, which has never happened previously. And how important it is to actually talk to people.

And even though I'm still, I'm technically on leave, I've heard from a number of different sources.

Over the last week that Joseph walked down into radiology. And made himself known and said, what can I do to help?

It's that sort of engagement and face-to-face interaction. An actual care and compassion consideration from the executive and the interaction with the clinicians that we've lacked and haven't seen for such a long time and has been so damaging I think to the way the facility has run and I'm hoping that we can see more of that face-to-face interaction.

Do you want me to talk a little bit more about the Proactive process as well? That I think could be useful because I guess this all started really primarily with radiology and neurosurgery.

[Winston Cheung]

It'll be nice to hear how that's progressing.

[Belinda Hokin]

Clearly the problems in radiology are far more time critical. The emergency problems and a lot of the problem in emergency are old and they're sort of remain, all of the damage that was done to the department and staff as a result of past things. And there's ongoing issues in in the emergency department in relation to that and we've still got staff shortages in terms of JMOs and registrar shortages and the sick relief rate.

Leave rates are still very high. So, there's a lot of problems that have that stem from that past and there's a reputation that goes with that which also challenges us in terms of recruiting stuff.

And I know that there are social media platforms statewide that the JMOs use, and we have a bad rap.

On those networks and the only way, we can fix that is to actually fix the underlying problems. And Proactive.

Sorry, I sort of got a little bit distracted there. But the Proactive guys, they do listen, and I think they actually.

Because they are validating people. I am actually starting to believe that on the local grassroots level they can start to induce some positive change.

And I think the work that they are doing is actually very, very good. But I don't think it's going to get to the bottom of actually fixing the underlying problem and they don't hold people accountable.

There's still, I'm not sure what's happening at this stage in ED, but I at the moment because I'm not there, but I know that there is going to be a process that's similar to radiology.

So, I think we need to watch what's happening in radiology. To see how successful that's going to be but the problems in ED. are different. There's also a lot of, I've also been doing some work privately with Proactive just in terms of my own.

And you know it's been very good for them to be involved they listen, but when it comes to actually negotiating and resolving problems it's not really, there's not really an aim for reconciliation. It's really a one-sided discussion where one side is expressing views.

And the other side is just listening and not responding and there's no accountability, there's no empathy, there's no apologies and there's nothing to go with it to actually tie it all back in.

Which is disappointing. I think sometimes that they actually needed to come in and be able to say actually no what you did was wrong, and I'm not seeing that.

And I think we need to see that sort of accountability, and I don't know that Proactive are going to necessarily give it give us that.

The other thing that is. Concerned me a little bit is they tried to, I had a meeting with ASMOF earlier in the week and they tried to come into that meeting and that really concerned me as well. Certainly, as an ASMOF member there are things that I potentially want to talk to ASMOF about that I wouldn't want an external body to be hearing and listening to. So, I think there there's some red flags in that process in terms of, the way that they're trying to resolve problems. But overall, I think that their overall approach is going to induce some positive change, but I don't think it's the only solution and I think there needs to be other things happening as well.

And I think that needs to lead to actual accountability and actually addressing the problems. And identifying what the problems were and where they started from and holding people to account for those problems. And I think that's where we still need to be going to the Ombudsman and things like that.

In terms of the votes. The board really, really concerns me. And in terms of the ministry and the leadership of New South Wales I think there are major problems there, but I think that's really a symbolic thing to say, hey look we're not happy and things are taking too long and we're not getting the outcomes that we were hoping for in the time frame that we were really looking for.

I think I'll see.

[Winston Cheung]

Belinda, can I ask you, so in regard to the rest of the, I know you're not there on the ground, but what's how things going with Proactive and the rest of ED and the issues? Are things being looked at?

Or if any of the other ED physicians, here, are happy to speak up?

I'm interested to see. I know they're listening to you, Belinda. Are they listening to the others?

Have they interviewed the others? The word on the street is that the nurses, I don't know if this is true, the nurses have been barred from speaking to Proactive.

Yes. That's my understanding as well. So, in terms of, so I guess there's 2 groups of the emergency staff in ED are the people who were here as a part of the original. The group who signed the initial formal industrial complaint. And many of those have left, they've spoken to 2 of that group.

So, they've spoken extensively to both me and Richard. The others. One of the others is not necessarily involved.

The third one who is still present is still refusing to speak to them. And the other members who have left who have actually got probably some of the best input are also refusing to be engaged in the process.

Of the new consultants.

[Winston Cheung]

What's the reason for that? I guess you can’t put words in their mouths.

Why do you think they're not engaging?

[Belinda Hokin]

There's a lot of trauma. In a lot of people and if you look at the list of consultants that were present in the department of the time at the time of that complaint and who signed.

Of the 10 who signed, 6 of those people have really, really substantial psychological injury. Many of them have left and the others have it had injury that's not as severe, but still have injury.

That degree of injury is very very really real and really significant. And many of us went through a process with the ECI as an external process that actually compounded that injury substantially and made things a lot worse. So many of us not only if we got injuries from the original process and what led us to put the industrial complaint in in the first place. We've actually got big injuries as well from the ECI process and the processes that were employed to try and fix it as well as the injury from what John has called the institutional betrayal.

So those of us who were involved in that process have been really reluctant to speak out when we can't be guaranteed of an outcome at the end of it.

Because we're all sort of concerned for our psychological safety when we speak up. I've opened up a little bit, but it's taken me a long time to get to a state that I felt comfortable opening up. But in terms of my stuff, I don't necessarily believe there's going to be necessarily any resolution.

But people are fearful to speak. Speaking up because they worried about making things worse. So that's that group.

In terms of the new group. They're all very new junior consultants who haven't been involved in in much of this process.

Some of them would have useful insight in terms of what they've seen and how it differs from others.

But I don't know that any of those have necessarily spoken. That they've certainly spoken to Phil.

But really very limited. In terms of speaking. Nursing staff. There are still big problems in there. Has been for a long time with nursing culture within the ED.

And even before I went on leave early this year there was one Monday evening. Which is a very busy shift where my nurse in charge you know, broke down in the middle of a shift in tears saying she's sick of the bullying, and thinking that's, you just don't want to be seeing that with your staff.

In the middle of the clinical floor on a Monday evening shift. So, there are problems in nursing. Many of the senior nurses have left and the pool that are there now are very, very junior. That is all that itself is also causing rift between the doctors and the nurses because they're so junior.

There's that that's compounding. There's always been a rift between medical and nursing in ED.

It's been one of those things that's been an ongoing issue even since the time I started at Concord in 2014 it's just been there the whole time. And I think Phil has started to unpack that, but it's never really been properly unpacked and addressed.

And even when the department was truly in crisis. Which was only 2 years ago. Really in many of the other departments I think that crisis drew and brought the nursing and medical teams together.

It didn't do that in ED. And I don't quite understand why that is.

But that never happened. But there's a major riff there and I really think one of the big things I would like to see Proactive be able to help us with in the ED is to try and bridge that rift.

Between medical and nursing. But unless the nursing staff are able to engage in this process. The chances of any successful outcome in ED, I think are much less.

And the moment I had I've tried to engage the nursing staff, but that's been difficult offsite, and I understand that they've not been allowed to be involved and I'm certainly going to be speaking more particularly as I get back to work in terms of trying to sort of help that.

Now, Payam's got his hand up. He's actually on site and may have some insight in terms of what's going on on the floor.

[Winston Cheung]

Payam.

[Payam Yahyavi]

Hey guys. So, John contacted me, few days ago. We had a bit of a chat and, he told me he's going to arrange some sort of departmental discussion about the events of the past few years.

With my understanding of what he said, it doesn't happen yet. It's going to happen in the future.

Within the next few weeks. I know that he's been in some discussions with Phil. I'm not aware of the has obviously those discussions. So, my understanding is that pretty much. With what he was telling me, I think, the way he's working is that he's going through different departments pretty much in a series. So technically his work with it is about to start. That was my understanding from what he was saying so I think the bulk of his discussions with the ED stuff is going to be in the next few weeks.

[Winston Cheung]

Thanks, Payam. So, if I was put a question again, just like radiology to Payam and, Belinda and any, at the other ED physicians who are here.

What actually needs to be done? What do we actually need to do? To fix the issues.

In ED. Can you guys comment on that?

[Payam Yahyavi]

Yes, you want to go first, or do you want me to go first?

[Belinda Hokin]

Yeah, that's good for you.

[Payam Yahyavi]

I think the start point, as John said, I said was, I think it's a good start point to start.

I'm having some sort of discussion to unpack what was going on. I think, as Belinda said, Also, was new to the department.

I myself started in 2018, so maybe some of those things that people were talking about happened way before I started.

And almost half of the department currently is pretty much starting after me. So, then I think it's good to have a discussion to unpack what was going on and see what was and what are the problems and then think of solutions.

I'm not convinced that everyone is pretty much, at least, maybe putting over some other people who have been here for a longer time, are aware of what's is being addressed.

At least with some issues that was happening during the time that I was here. Currently I'm not with this thing the same page as Belinda is, but I think, talking through it and unpacking it can help to get on the same page.

[Winston Cheung]

Thanks. Belinda.

[Belinda Hokin]

I think I agree with what Payam said. You know there's not much we can't change the past and the damage that was done in the past has been done.

Clearly there are those of us who want to see some sort of outcome and resolution to those events of the past but that they don't necessarily affect many of the majority of the staff specialists right now, certainly the majority of the staff specialists group at the time.

And it's actually a very different environment now. I think what we're dealing with now is the after-effects of that on the JMO group.

Where we've got very low numbers and their morale is extremely low and I think we need to be talking to that group to try and see what we can do to help them.

Because I think as a group they're struggling. We need to be working on that medical nursing interfacing and we, and we need to bring these 2 groups into a room and actually just talk it out.

And so, okay, what are your problems with the medical staff? What are your problems with the nursing staff and actually air what the problems are and talk it out, and that's never happened.

Will Proactive help that process. I think they can if I think Max is probably better at that sort of thing than John. Max is a trained maybe, and I think he's probably better at being able to get those sorts of feelings and emotions out. I think that could potentially help with, you know, we've talked about team building things and things like that in the past.

I'm not sure but that's serious but we are starting to see a little bit more stuff there. The other problem is there's this nursing culture in general. So, the ED now has had 2 separate processes.

There was a formal external review of the department in 2018 which basically said we're bullying each other.

And then within 2 years of that after there was no response. Within a formal industrial complaint signed by 10 staff specialists highlighting bullying. So those 2 complaints and the processes have all been medically oriented processes and even the external review didn't look at nursing culture.

So, nursing culture has never ever been addressed. So even though at a senior level, there's been some process to look at medical.

We need that process to look at nursing. As well to try and sort of bridge that gap as well.

And I think the fact that medical has had some things done and nursing has and is also a part of that divide and I think they think that we're just whingers because we complain and there's been some process and there is, but not been a path for them to complain. I think that's part of it. But I think the whole thing really needs to be unpacked and I think that's probably the most time critical and important thing to do in ED is to try and unpack that divide.

And try and see if we can bridge that gap. The other problem is that with nurses is they are so junior because the senior guys left is we really need to find ways to support this nursing team to try and get on their feet to get new nursing staff and get them trained and we need resources to get them trained.

At which at the moment I think has still been lacking as well. But you know the process in ED, we're behind where radiology is in terms of the stuff with Proactive and John's now away for 4 weeks.

So, I think the process in ED is going to start after that, but I don't know that the fine details and I and because I haven't been on the floor to be advocating for ED. I don't know what the fine details of that process are going to look like, but it's certainly, it's still a few weeks away yet.

[Winston Cheung]

But it sounds like we have to keep a very close eye on it then, especially if the nursing staff are not going to be allowed to engage with Proactive.

That for me is a major, major issue.

[Belinda Hokin]

Yeah. I'm certainly aware that Phil is certainly not blocking the nursing staff and he's happy for the nursing staff to be involved.

I think that block is potentially coming from higher up. I'm not, I don't know the politics of that.

But it's certainly concerning, and I think to fix ED I think because the nurses are such a predominant part of ED.

And even when you're on the clinical floor it's really the nursing staff that are in charge of the clinical floor.

While you're on shift. So, and they're certainly the majority of staff. To fix ED they have to be engaged.

I don't know where that block is.

[Winston Cheung]

Thanks.

[Elaine Cheong]

I don't want to, detract from the conversations of ED and radiology because I don't really want to speak to that, but I've got to head off soon.

Look I just have a couple of comments. I have not really spoken at these meetings. I have participated in pretty much all of them.

And voted and I guess my couple of things I'd like to raise are number one the distress that we're hearing from particular colleagues and departments.

I don't know what the solutions are. Clear, they're multi-factorial, but I think in watching the various events and the processes and the descriptions of the staff under pressure, particularly in radiology and ED. I do, I am very concerned that we're going to get through a critical event.

Where there may not be a service, you know, because I cannot understand how one or 2 individuals are going to continue to provide the sort of a hospital wide service or 2 hospital wide services without some you know, possibly a catastrophic event.

And then I think we all need to think about what that might look like if we don't actually have that service and I don't just mean just taking x-rays, but I mean you know the service that Lloyd and his colleagues provide in the clinical support of our patient services.

And already this is, not to be critical, we're aware of very important imaging that hasn't been reported that we're as clinician are sort of like, finding out at our own clinical review. So, I just like to point that out, you know, when we have a very horrific service which is under such stress you know how are we going to feel when they're not able to function? So, I would like to congratulate Lloyd and his department from continuing to provide the service under such duress.

The second thing I'd like to comment about is, you know, to give my opinion about the issue around the vote of no confidence around the board.

I've spent most of my 30-year career at Concord since I was an intern.

It continues to be a fantastic place to work, but I've never seen such a degree of distress. That distress has been escalated to executive and to the boards.

At a personal level, I don't have issues with working of the boards. I cannot claim that I'm subjected to bullying.

But I think my opinion is that the board has been given an opportunity to listen. Very extensively as Andrews pointed out I think there has been a solution or a so-called should we say action put into place with the appointment of this review and that's undergoing so let's see how that goes, but I have to say that, you know, the board, these things happen on your wake.

And you know, I think that it is their responsibility to actually perhaps show more leadership and engagement. I don't believe in the vote of confidence, no confidence against New South Wales health like some of the previous speakers I can't understand how that's going to be a benefit, but I do think that the board has been underwhelming thus far in their engagement of the concerns of the hospital. And we're not talking little concerns, we're talking really, really big concerns and thus my comment really about you know getting to a place where services may not actually be available.

I think that's a really big concern. So that's my comment and I'd just like to say that I really still enjoy working with all of you and coming to work and I do respect some of the stories that have been presented, at this forum and other forum.

So, thanks very much.

[Winston Cheung]

Thanks Elaine. Peter.

[Peter Katelaris]

Thanks, Winston. My computer rebooted a bit earlier, so I hope I don't repeat anything that was said.

Getting back to the issue of the vote, I really concur with what's been said. It's not that we couldn't vote no confidence, but you've got to say what is the goal of doing it?

What are we going to gain? I think it's pretty much unanimity that voting no confidence in the Ministry of Health is not going to be helpful.

It opens the front, and we don't know where it goes, and we don't know what we gain.

With respect to the board, I also don't think now is the time to be voting no confidence.

We've already made a point by voting no confidence in senior management. Opening another front is really just emphasizing what we've already done.

Having said that, the board did listen, but the optics and the feeling I got was that they were very reluctant to have a meeting.

They were reluctant to listen and the optics while they were listening were really poor. There was one person on their phone and so forth and it just seemed inherently hostile rather than a board listening and actually caring about the people that they're charged to be from.

So, I don't think the board, I was deeply disappointed with the way that meeting went in terms of what we heard back from them.

It just seemed hostile. That might be like took a hostile view because we'd voted no confidence and so forth.

But you know sensible doctors at a sensible hospital don't do that for no reason.

So, I don't think the board has done well, but I also don't think they're likely to help and I don't think that voting no confidence in them is going to do anything that other than create heat rather than light.

So, I think for the time being, we've got to work with what we've got. Now in terms of what we've got, I have no faith in the John McDonald process.

Several people have said they felt listened to, as I did, and he's spoken to 40 or 50 people now.

Feeling listened to and that translating into anything meaningful to solve our problems are 2 different things. And that guy is I'm sure he's psychologically trained, and he knows how to make you feel good and listened to, but there'll be … written report and there'll be no outcome of it other than he'll have done his work and taken his fee and some people will feel listened to.

That is not going to solve a problem. Now there's a number of problems, but there's the really acute ones and we've heard this distress of our radiology and ED colleagues.

For me, I'm closer to ED in terms of the nature of my work. And really the distress that we hear coming out of that department has to be our focus and the question is how do we, enable the process to go quicker?

They've had a meeting and we've heard from Joseph that there's plans for another scanner and so forth.

But I think the MSC needs to put all the pressure it can at every level of management to fix this and fix it quick.

I don't believe it can't be fixed. I don't know exactly how it can be fixed, but dollars will have something to do with it, and a reconciliation process will have something to do with it.

Which leads to recruitment and so forth. It's also impacting our activity. I mean, I was talking to Joseph about this today.

That's something, something's drives our activity down. I haven't ordered an ambulatory routine scan from radiology for months, because I know I can't get it and they can't provide the service.

I'm sending them outside. Look at all the lost activity that that's happening because I don't a burden my colleagues with work they're not staffed to provide, and these are billable procedures so the hospital loses revenue.

So, I think the approach that we need to take as an MSC is not saying let's fire off angry votes of no confidence in various people which we can always do at a later day to things that work out, but I just don't think that's going to be the solution.

I think when we need to be writing and pressuring every level of management to say as clinicians trying to work in a hospital that's trying to be functional, you must fix this as an emergency.

You must fix radiology and immediately, not with a project in plan, not with, you know, we're working towards this and that.

We need immediate action. Because, you know, we've all heard this for years now, not just months, and it's not only here. PA has a problem, but I'm hearing that other hospitals don't have the problem.

So, it is possible to have a functional radiology department in a hospital. It's not unachievable.

And I think our efforts should be to work at every level with correspondence to every level. To see how immediately this can be addressed, not with some future plan.

The bit I don't know is whether the personalities can reconcile and that's an issue for others to deal with.

[Peter Katelaris]

But there's nothing that money l and hard work can't fix with radiology.

I presume, but I'm less close to the issues that ED is something similar. So, my view is that a further vote of no confidence just creates heat not light, but the MSCs focus and soul issue at the moment should be fixing these departments in crisis and working with management. We have management here now and letting them know that every clinician and every other doctor in the hospital needs these departments to be fully fledged and fully functional.

So that we can look at colleagues in the eye and not see the pain and hurt that they're working with day in day out.

[Winston Cheung]

Thanks, Peter.

[Payam Yahyavi]

I thought, I was trying to listen to the comments, and my plan was not to get involved in the discussion as much as I could.

But listening to the how the Emergency was pictured I thought probably being present and not saying anything would, imply, agreeing with that.

Peter. I know that some of it can be pretty much and that's of personal opinion.

I just wanted to say, my personal opinion is that I don't see our department the way it was pictured. The divide between the nursing staff and the medical stuff, at least I don't say, maybe there's this, maybe I'm blind to it, I don't know, but I don't see it that way.

The distress of the department, yes, the department is obviously under the distress, mainly because of staffing issues, but it's first of all not just limited to Concord. … are working several of different other hospitals as well.

I think emergency medicine as a whole is becoming a bit distressed with lack of the staff.

Wanting to work in the emergency departments. Is not even limited to Australia. … is on the same page.

You might have heard it from the college, the nursing stuff being under the pressure and feeling bullied and all of that again.

I haven't heard of it. Oh, I'm not aware of it. I think I've got reasonably good relationship with most of our NUM, and we talk with Sharon all the time and I haven't heard it from her either.

Again, maybe it's something that they don't disclose to me. That's a possibility.

And, same for how the majority of the Doctors working in the department.

I think everyone is under a lot of pressure because of the workload and again this is not just limited to Concord. It is pretty much everybody. Except some few hospitals which don't have stopping issues then it is most of other hospitals that do.

Feeling being bullied? I don't feel it that way and I don't think it's the feeling by the majority but having said that maybe the majority have not disclosed that to me.

The plan that John is having them have a group discussion with the rest of my colleagues and to get their point of view is a good plan.

I just wanted to share that opinion that there are different views on what's going on, especially Phil not being in the meeting to pass this opinion.

I thought it's important to mention that. The picture that was painted from, may or may not be accurate.

[Winston Cheung]

Thanks, Payam. Belinda.

[Belinda Hokin]

I just wanted to comment on Peter's thing. I thought that was a really good summary and analysis, but you know I don't know what ability to induce change that they've got.

And I'm certainly going into this with an open mind hoping that they can induce some change. But I still have reservations as well about whether or not they can actually address and fix the underlying problems.

[Winston Cheung]

I'm aware of time, but I'm also aware that I want everyone who wants to speak to be able to speak.

Does anyone want to comment? On any of the issues or anything or give their opinion.

[Winston Cheung]

Lloyd.

[Lloyd ridley]

Just a quick comment. I think one of the issues with Proactive is that they're mediators.

I came out of that meeting with them last week and basically said, well, what's the difference between mediation and other forms of dispute resolution and things like conciliation.

Or arbitration. So, the main difference is that with mediation he just listens to both sides and tries to encourage both sides to come together.

So, there's no component of truth seeking. And again, the message that I got from the meeting was that people had an opportunity to talk, but there wasn't the acknowledgement of the issues.

And there wasn't the teasing out of what the truth around the problems is.

Which comes back to the need for an investigation rather than mediation of course.

[Winston Cheung]

Thanks, Lloyd. Anyone else want to say anything?

[Jessica Yang]

Winston, sorry. I didn't have my hand up but thank you Peter for your support.

I think time is the essence here because radiology is in real distress and we need to get more staff, we need to make sure that our current staff is looked after.

And we, we can't wait for that. So, time is essence. And patients can't wait forever.

Their … are not being reported.

We need to get it fixed.

[Winston Cheung]

Any other comments from anybody? Thanks. Peter.

[Peter Katelaris]

Winston, I think you're hearing pretty much that, a lot of people haven't spoken, hard to know what they think.

We're getting a theme here that the body corporate of the hospital wants radiology fixed.

Now, I'm sure our administrators have heard this and I'm sure they have in their minds the way.

I don't know what the way forward is from administrative point of view, but I simply don't believe it can't be fixed.

I don't believe that. Now I agree with Lloyd, there needs to be some truth telling.

It's the way of bringing things out in the open. But that can't get in the way of recruitment and … and staffing and … people and all that sort of stuff.

So, I guess what I'd like to hear from this very long meeting is a little pathway where the MSC can play its role in this.

Each of us individually can't do a lot. I think you're hearing that the MSC doesn't have a great appetite for more votes of no confidence, but we need a little plan.

That maybe there needs to be a small MSC executive. This is a very big group and it's hard to have a group collective agreement.

In the old days there was sort of like a cabinet where a small group took to the membership what the group thought about a way forward.

We need a plan. We need to be able to do our bit. Like I don't need to come to another meeting and hear the problem.

I know the problems. I need to be on a pathway where we can all help. To be part of the solution.

So that's what I want to come out of meetings such as these. Now I know we don't have it all within our individual remit, but we need to have a collective plan to do our bit.

To try and help this problem to enable our colleagues to feel respected and work in a good environment and to tell our administrators that we want them in the tent.

We want them on board sorting out the problem, but we do want it now. We really can't just have a meeting in a month and ventilate about how bad radiology is.

That's what I think should come out of today's meeting.

[Winston Cheung]

That's great.

[Ilona Cunningham]

May I respectfully suggest that such an executive should include our hospital executives. And maybe Andrew Hallahan.

Because and maybe even the stream director, but certainly the heads of departments because otherwise it'll never get anywhere, we don't know as Peter said what needs to be done to fix the department.

[Winston Cheung]

Thanks a lot. Fergus.

[Fergus Davidson]

You're like, I think we've got 2 levels of problems. One is we've got a whole lot of fires around that need to be sorted out, and the other is the question of how we've got to where we are at the moment.

That's a different level of problem. I think we just need to distinguish it's not just about the solutions to the available issues at hand.

They are very important. But there is this underlying question of how we are Concord at this point now, which is so different from how it's been.

Up until maybe the last 5 7 8 years ago.

[Winston Cheung]

Okay, thanks for that.

Any other comments?

Well, look, I might start to wind things up. I'll just give you my opinion and then we can have some further comments after that, if we need to. But I sort of look at this from the views of 3 key points that lay ahead immediately after the vote no confidence went through.

The first point was when I first took this job on and when you all voted for me to be the chair, I said that there were 3 things in my view that were absolutely non-negotiable in terms of us moving forward. The first thing that I said was absolutely not negotiable was I wanted every staff member no matter who they were to be able to speak openly and freely about the issues which they have at work. Without any fear of reprisals.

And that was the first thing which I said was non-negotiable.

The second thing that I said was I wanted immediate action. Immediate action. To stop further staff from leaving this hospital.

And that was not just radiology, but that was nursing, allied health. All the distressed disciplines and departments.

When I was elected chair, I said that I wanted that to happen.

And the third thing that I said which was going to take a little bit longer was I wanted better planning for every department and every discipline in terms of their workforce.

We all know that our services are growing. We all know roughly what our requirements are going to be in the next 10, 20 and 30 years and we know the population projections. And what I said was I wanted some planning to start to look at how we're going to get that workforce requirement up to scratch. And that workforce could be specialists. They could be nursing. It could be supporting staff, secretaries, all that sort of thing. But what we don't want to see is we get to the 10-year mark and all of a sudden, we decide to go on recruitment drive to recruit those staff.

Gradually over the next 10, 20, 30 years and that's the long-term thing, but the primary 2 issues were allowing staff to speak openly and freely without reprisals and taking immediate steps to stop our valuable staff from leaving.

Now. In regard to the process that has happened since the vote of no confidence. If any clinician in this room or in this audience, if someone had a concern about one of us. Or one of you. And that concern was serious, and that concern involved significant patient harm. And on top of that, if 60% of your staff did not have confidence in your clinical decision making, that would be referred for an investigation. That would be taken very seriously. And you would be investigated.

Depending on the findings you could be disciplined and depending on the findings you could be put on the blacklist.

But there would not be a cultural review into those concerns. If 60% of your nursing staff or your doctors had a clinical concern about your decision making.

Yet when we have an administrator. We raise a concern about an administrator. And those concerns potentially have adverse consequences for dozens if not hundreds of patients.

What we get is we, we, we are told that this is a culture problem.

And there's no investigation. There's no need to investigate this.

And when we remind the decision makers for this with 2 letters. We are told there's no problem here, but if you don't like it, you can complain to the Ombudsman.

And so, I sent a letter to both the board and a letter to New South Wales Health. And the person I sent the letter to do bother replying. They got someone else to reply on their behalf. And can I remind you with the board?

The board initially refused to meet with us. It was only once John came and we forced the issue that the board reluctantly agreed to meet.

So I have a major problem with the process. And I have a major problem with this cultural review. When the allegations that have been made are significantly serious enough to warrant an investigation. Especially the allegations of bullying, intimidation and harassment. And also, the allegations of maladministration.

I think those are significantly serious and I think the way this has been handled, the process has been handled, has been very, very poor.

Now I guess the third point of view is if this was a court case or a trial. And if we saw that the presiding judge or the jury that was going to make the decision had a significant conflict of interest, we would raise a concern. We would appeal. And especially if that Conflict of interest was a financial conflict of interest.

And if that finance, if the jury or the judge was being paid substantial amount of money by one of the parties which they're ruling on.

I can remind everybody that the article in the Australian from 2 weeks ago managed to dig the vendor documents out and John is getting paid over $300,000 for this review. Over $300,000.

Now he has a significant conflict of interest. Because he's being paid by New South Wales Health if they newspaper article is true.

And so, if this was a court case, you would appeal that and you would ask for the jury to be dismissed and a new jury put on, or you would ask for the judge to step down and get a new judge.

The problem is if you wait to the end of the process, if you wait for the verdict to be handed down and then you appeal, then it's a lot more difficult. It's very difficult to overturn a verdict on appeal. It's far easier to address the conflicts of interest while the case is running.

And this is the problem that we face. With this current culture review. Is that we all know, we all know. What the result is going to be. We know what the result's going to be. The result is highly unlikely to be unfavourable to New South Wales Health.

So, the issue is what we do in the meantime. Because if we wait for the review, find that we don't like the result, and we appeal. Then it looks like sour grapes.

So, the question is what do we do?

And the Board and New South Wales Health have suggested that if we don't like what's happening, we go to the Ombudsman. They've put that in writing.

And I think that's a very good idea and I think that's where we will go. The question, the question is do we take any other action in the meantime?

Because I think we have to realize that it's not just the board, that is accountable, it's not just New South Wales health that is accountable for all that has happened.

It is also governments that are accountable.

And so, these actions are not actions of individuals. Alone these actions that have occurred over the last 10 years are actions of individuals who have been supported by individuals further higher up.

Now I also understand that there's a lot of anxiety amongst people and I also understand there's a lot of fear.

And I also understand that there's many people here who want us to tread cautiously.

One of the big problems is that we don't have a forum where we can all meet up and talk together.

Without the executives being around. And so, I've had to talk to many of you and many others over the last 3, 4 weeks in regard to this action. Because I wanted to know exactly what the feeling was on the ground.

So, I didn't take this action. I didn't take this action spontaneously, and willy-nilly.

I took this action after speaking to many, many people. After getting significant legal advice. On what we should do.

Now having said that. Having said that, I think timing is everything. And I am prepared. And what I will do today. I will put this action on hold. As I have discussed with several of you. So, I will not go ahead with the vote of no confidence. I will not move a motion of no confidence in the board, nor will I go ahead with the vote of no confidence in New South Wales Health today.

And in discussion with many of the parties who are most affected, not just from radiology and emergency, but from the other departments who haven't spoken up and the other disciplines.

I propose that we park this for another 2 weeks.

Because I'm really interested to see what happens in the next 2 weeks. To emergency. To radiology and all the other departments.

I'm also really interested to see whether we get our members meetings back. Where we can discuss all these issues and I don't have to go around talk to you all individually. We can discuss them all together as colleagues. Without what I consider to be significant intimidation. From the executives.

There are many people who do not want to speak in this forum because the executives are here, that's just natural.

And I think we can speak more openly and freely, which is one of the things that I've been talking about with the executives not here. So, I am not planning on moving those motions today. And I'm going to suggest that we can reconvene in 2 weeks' time.

And I want to see significant action. Now I know what the solution is.

I know what the solutions are for all these departments. And everyone, everyone in those departments knows what the solutions are.

You know, we're not telling everyone in the audience here what we actually think.

And I think everyone here knows we don't need more meetings; we don't need more executives.

You've got the executives. You've got the departments. Get together and sort it out. And I give you 2 weeks.

And if there's no action in the next 2 weeks. Then we reconsider. Because we started this in June with the vote of no confidence. And quite frankly, I've been very disappointed at what has happened.

And I've be pretty disappointed with John. Not that his fault. John McDonald's company.

That's his remit. His remit is to try to mediate. And to listen. And you know, that's his terms of reference, I understand that.

But what really disappoints me is the way our executives, the way our board, and the way New South Wales health has handled our grievances.

But I'm prepared. To wait just a little bit longer. To see what happens.

But if there is no progress. And if the bullying and the harassment and the intimidation of staff continues, then we will take further action.

Ilona.

[Ilona Cunningham]

I just wanted to ask you whether you would consider face to face meetings now that, the COVID restrictions have been lifted fully.

[Winston Cheung]

I think face to face meetings are far better. The problem now is that because everyone's so used to video conferencing.

This is so much more convenient for many, many people. They can, they can listen to them from their rooms.

And so, I'm in favour of face-to-face meetings. I don't know if we'd get this many people at a face-to-face meeting.

I doubt it and you know Hybrid meetings just generally in my experience just don't work as well.

You either have one or the other, but I'm very happy to try to run face-to-face meetings.

I'm worried that we're going to lose engagement, but that's all.

I guess we can. I don't want to take up people more people's time today.

I think we can just have everyone think about that. I know we've taken up a significant amount of time, but we can think about that over the next little while.

[Winston Cheung]

Rachel.

[Rachel Choit]

Sorry, I don't normally speak at these like, and obviously I'm quite new to Concord but I think just in terms of a few things you've just said Winston, there's just a few things in there that I disagree with that I don't think are correct and some I know aren't correct.

For one under the legislation, the medical staff council can ask the executive to leave to discuss their performance.

That's very clear. So, we can discuss the executive's performance without them present if you think that will help. More people you know having observed a lot of these meetings people don't seem to be pulling many punches when it comes to the executives.

The other thing is about the kind of the analogy you've made with the legal system. And again, I disagree.

You there is a process involved and you have to go through the different stages. Before you can lodge an appeal.

You can't be unhappy with your trial judge and go straight to the Supreme Court. There is a process and I think the steps to Health Minister took to engage Proactive solutions is really quite extraordinary.

I think it happened quite quickly. And I think in the in the greater scheme of bureaucracy, 3 months is not a long time to talk about what our really big issues and I don't think issuing a threat that if nothing happens in 2 weeks there's going to be further action is it all helpful. You know, part of the resolution process, the first step is mediation. And I think that's what we're going through.

I don't think if we the Concord community is unhappy with the result that taking a further step will be viewed as anything then taking a further step.

So, I think unfortunately you've got to have some patience. I mean, you've heard from Lloyd and Belinda, so 2 of the departments and the people, very affected who have found it a positive thing.

And I think unfortunately we just need to give it some time and jumping the gun is not going to be helpful in any way.

[Winston Cheung]

Thank you, Rachel.

With the Health Services Act, we can ask the executives to leave if we are discussing an issue in regard to specific performance.

The issue that we have is that we would like members meetings to discuss other issues as well, not just the performance of the executives.

And so, I think it's very important that we have our members meetings back. And I think that's a sign of engagement from the executives.

It's a sign that the executives are actually willing to change their culture and to allow this culture of feedback.

And to allow this culture of openness, being able to speak openly and freely without reprisals.

And, you know, I agree this is going to take time. I agree this is definitely going to take time.

What we need to see is progress, and that's what to see.

What I don't want to see is money being tossed around, you know, tokenism.

And nothing tangible actually changing at the end. I think that's really important.

That at the end there must be significant change to improve things at Concord Hospital.

So, I'm going leave it there if there're no other comments.

I know there's other things on the agenda, but I think we've had a long night and I think we should reconvene in 2 weeks' time.

I'd like everyone to think about what's happened, tonight. And I want everyone to keep a very, very close eye on what's happening with other departments, and I'd like to hear from everybody. So, I've heard from a lot of you, but there's a lot of you who I haven't heard from.

And so, I appreciate everyone's views. Because at the end of the day, I'm here to represent all of you.

I'm here to represent every department. I'm here to, I feel even though we've been banned from doing it. I feel that I have an obligation to represent nursing staff, our health and our support staff as well.

But I know we've been banned from doing that. But I feel very strongly that we should advocate for them as well.

[Rachel Choit]

When I just say on that point as well, cause I'm a bit pedantic, it's not within the remit of medical staff council.

And I think that's really important about what a medical staff council is, what the powers it has and what it is supposed to do.

We are the group that speaks for the senior medical staff of a hospital, the staff specialists, the VMOs like I am, and the CMOs if there are any at Concord.

So, it's not there are others for I'm not taking away that that might be their experience, but I think it's really important that we stay within our scope.

Because like Matt's comment 2 h ago acting outside our scope just it makes it very difficult for the legitimate points that have been made to actually be taken seriously.

[Winston Cheung]

You know, the word medical in the health services act and the bylaws is very, very loose.

What is medical? So, our scope you know, it's defined by that act. And of course, though, we've also had an instruction from the chief executive that we are not to discuss those issues, which I find that extraordinary. I think we should as medically staff council should be able to talk about any issues attaining to patient care. Pertaining to staff health and well-being I think that's that should be within our scope.

They are no nursing staff councils and also no allied health staff councils.

[Rachel Choit]

There are clinical councils, Winston and there's others. This is not, it's just not the correct forum.

And I think what a medical staff council is, which came out of the Garling review, it's very important.

There are other forums for other craft health groups. The Medical Staff Council is for senior medical practitioners.

That is very clear. Just like the JMOs have the GCTC.

This is a forum for staff specialists VMOs and CMOs.

[Winston Cheung]

Thanks.

[Fergus Davidson]

I was just going to suggest 2 weeks goes in a blink of an eye and I just think maybe meeting in a month might be more constructive.

Rather than 2 weeks is just nothing. The reason I'm choosing 2 weeks is there are some pretty important meetings happening in the next 2 weeks. And those, those meetings are going to be pretty defining in terms of the way forward for some of the departments.

[Winston Cheung]

And these are the meetings which have happened after the previous meetings. And so, these meetings will tell us whether there's actually going to be any progress made. Or whether all we're seeing is tokenism.

What I want to see after all these other meetings that will happen in the next 2 weeks. I want to see progress in these coming meetings.

We don't have to do anything in 2 weeks' time, but I'm interested to hear reports from what's going to happen in the next 2 weeks, because I want to see whether there's actually a genuine move to actually improve things at this hospital or whether all we're seeing is tokenism. And lip service.

[Fergus Davidson]

It might even still be school holidays in that stage.

[Winston Cheung]

In 2 weeks', time is not school … That's why I picked that time period, but you know, we don't have to make a decision. You know, we don't have to making decisions then.

I'm just interested to hear what's happening and the progress that's being made if there's any.

Peter.

[Peter Katelaris]

2 weeks is a short time, and the CE is away for 3 weeks in any case. So, the senior management is not even on site or in the area. I think we've established; avenues of dialogue and I think we really need to push those to give a two-week ultimatum sounds very much like a threat.

And if I was on the other side of management of a hospital, I would see it as a threat and I wouldn't respond to it in a very favourable way.

So even though we've always got the option of threatening, I just think we have got a dialogue.

We've got meetings between senior administration department heads. We have the Proactive thing going on and there's other avenues for discussions so maybe we should be discussing pushing more discussions within this time rather than the implicit threat that unless things are better in 2 weeks, we go ballistic.

It just might be more fruitful than the tone that we need to give you a 2-week ultimatum.

It just might be more fruitful.

[Winston Cheung]

Thanks, Peter. Anthony.

[Anthony Linton]

I completely agree with Peter. I think 2 weeks is insane. I think that it's very clear from the members who have spoken in today's meeting that they do not agree that that timeframe is appropriate, that we need more time for this.

And it is sounding very, very threatening and actually sounding it's against the will of what the majority who are speaking in this MSC are staying.

I think it's been clearly acknowledged by radiology and ED that there has been some progress that has been made. That the interactions are positive, so I think we have to give a chance for Proactive to play out and see what the response will be.

Going in too far into this will only disadvantage it. And I think it's very clear that the group does not agree with the New South Wales Health Call.

And only will do a disservice to this hospital because let's be clear if they run an investigation … about the general hospital, we can guarantee that any hospital west of Concord Hospital or southwest of Concord Hospital will have a mirrored complaints that, will actually serve to … our hospital and what our needs are at this time.

[Winston Cheung]

Thank you. Anthony.

Well, if there are no other comments, I might close the meeting. Any last comments from anyone?

Okay, well thank you everybody.

[Winston Cheung]

Peter?

[Peter Katelaris]

Sorry. This is a very big group. We need an MSC executive to coalesce the ideas that we've discussed today and then formulate a plan.

This goes from a big group. Down to you and that's not really functioning very well, I don't think.

[Winston Cheung]

Yeah, to have an executive, we need a term of reference. So, the terms of reference need to be rewritten to decide who's in the executive. So, I'm all for it. But I think we need to determine the terms of reference. We can't hand pick people for this. I don't think that's a reasonable thing.

That's one of the reasons why we got into this problem in the first place.

[Peter Katelaris]

We could just have an informal chat between those people who want to get together and chat about in a small forum to plot a way forward.

Take to a meeting that has a term of reference.

[Winston Cheung]

No, we can’t consider that. If you recall previously, that was considered an MSC meeting.

And the executive needed to be invited to that meeting.

[Peter Katelaris]

Not a bad thing. Yeah, invite executive to the meeting.

I mean, that breaks down the barrier. I mean, if you're invited to the meeting, they hear what's said.

You know, it doesn't have to be filtered back to them. In other words, that's what dialogue is about, but it's very hard to have a meeting with executive with 60 people on the call.

So just sometimes you've got to cone it down to a smaller group. I'm not being elitist or anything or saying senior doctors only, but sometimes you need a smaller group to have these sorts of conversations that break down the us and them barriers and helps us sort of open doors and get things done.

A 2-week hostile deadline is not going to get things done. It's just the real world.

It's the way politics works.

[Winston Cheung]

Thank you, Peter.

Any final comments?

Okay, well thank you everybody. I'll close the meeting. And we will reconvene in 2 weeks' time, and that you all know we've been doing the meetings every 2 weeks. But if people think that having this meeting every 2 weeks is too much of this stage.

We can stretch it out to every 4 weeks if we want, so we can discuss that at the next meeting.

But for the time being, we'll reconvene in 2 weeks' time. And if people want to meet at, less frequently, then we can consider that the next meeting.

So, thank you everybody. We'll see you all in 2 weeks' time. I look forward to hearing more comments from all of you. Thank you.