Special Commission of Inquiry

into Healthcare Funding

Before: The Commissioner,
Mr Richard Beasley SC

At Level 2, 121 Macquarie Street,
Sydney, New South Wales

Friday, 19 April 2024 at 10.00am

(Day 020)

Mr Ed Muston SC	(Senior Counsel Assisting)
Mr Ross Glover	(Counsel Assisting)
Dr Tamsin Waterhouse	(Counsel Assisting)
Mr Ian Fraser	(Counsel Assisting)
Mr Dan Fuller	(Counsel Assisting)

Also present:

Mr Richard Cheney with Mr Hilbert Chiu for NSW Health

THE COMMISSIONER: Morning.

MR MUSTON: Good morning, Commissioner. The first witness this morning is Professor Anthony Gill. I understand he is outside and ready to roll. While he is being brought in, can I hand up a copy of a proposed non-publication order which, in its current form, won't make as much sense as it will hopefully make when the attachments are included. The three documents which are referred to in the order are attachments to Professor Gill's statement and have subsequently been included in the tender bundle. The redacted material, when the attachments are provided and the redactions become clear, relate to some fairly irrelevant personal information about people's leave balances and the like.

THE COMMISSIONER: I see. That's what all these three documents relate to?

MR MUSTON: It's personal information. It is of relevance in the sense that it's important because it provides context to the emails, but it shouldn't be published.

THE COMMISSIONER: I will make that order.

MR MUSTON: In due course we'll attach the relevant documents to that with a view to a tender bundle including unredacted versions and a published version of the tender bundle and any other person who might want to publish anything from those documents obviously will not be allowed to publish those.

THE COMMISSIONER: The non-publication order number 2/2024 dated 19 April 2024, I make that order.

<ANTHONY JAMES MACDONALD GILL, sworn: [10.04am]

<EXAMINATION BY MR MUSTON:

MR MUSTON: Q. Good morning, could you state your full name for the record, please?
A. Anthony James Macdonald Gill.

Q. You are the head of the Department of Anatomical Pathology at Royal North Shore Hospital?
A. Correct.

1 Q. You have held that role since 2022?
2 A. Correct.
3
4 Q. And prior to that, have held a number of positions as
5 an anatomical pathologist at Royal North Shore Hospital.
6 A. I've been a staff specialist for about 20 years.
7
8 Q. You have prepared a statement in relation to the
9 issues we're discussing today to assist the Commission?
10 A. (Nods).
11
12 Q. Do you have a copy of that statement?
13 A. Yes, here.
14
15 Q. Have you had an opportunity to read that statement?
16 A. Do you want me to read --
17
18 Q. Have you had an opportunity to read?
19 A. Yes, I've read - I've signed it, yes.
20
21 Q. Are you satisfied that the content of that statement
22 is true and correct to the best of your knowledge?
23 A. Correct.
24
25 MR MUSTON: It will form part of the bulk tender in due
26 course.
27
28 THE COMMISSIONER: Okay.
29
30 MR MUSTON: Q. In paragraph 3 of that statement you tell
31 us that there is little community understanding of what
32 anatomical pathologists do. Could you, for our benefit,
33 expand on what anatomical pathologists do, as distinct from
34 other types of pathology?
35 A. Yes, sure. There is little community understanding,
36 and even with the medical field, about what anatomical
37 pathologists do. So I'm an anatomical pathologist, which
38 means I did five years, as a registrar, of advanced
39 training to achieve FRCPA, fellowship of the college,
40 solely in anatomical pathology.
41
42 In terms of the workforce of anatomical pathologists,
43 what we do, the simplest way I could put it is if you have,
44 say, a cancer, say a colon cancer, taken out, the surgeon
45 will put that in a bucket and send it to our lab and we
46 would receive it, dissect through it. We don't look at the
47 whole tumour under the microscope, we sample areas on the

1 slide to look at under the microscope, make microscope
2 slides, look at it under the microscope, which is the
3 primary way that cancers are diagnosed, and a whole lot of
4 non-neoplastic diseases, and we do ancillary testing on the
5 tissue to provide a report.
6
7 Back in the olden days, maybe 30, 40, 50 years ago,
8 people used to do general pathology training, where you
9 would supervise full blood counts and blood tests and
10 microbiology and things like that. Pretty much, now,
11 everyone who does anatomical pathology solely does
12 anatomical pathology, which is the tissue diagnosis.
13
14 I suppose one of the key points to make is that it's
15 very labour intensive and there is virtually no automation.
16 So a pathologist from 150 years ago, Virchow or someone
17 like that, could come to our lab and it would look very
18 familiar to him, whereas in the stat labs, so biochemistry,
19 haematology, it is a different world. There is a huge
20 volume of low-complexity high-volume tests that are
21 automated, done by machines, that are overseen by
22 scientists and then overseen by other types of
23 pathologists.
24
25 So every biopsy that someone gets for cancer or skin
26 cancer or whatever, is personally looked at by an
27 anatomical pathologist under their microscope and signed
28 out with a report that they authorise in the electronic
29 system, and that's a bit different to other fields where,
30 say, full blood counts, you could get thousands of full
31 blood counts through a lab run by the computer, supervised
32 by a haematopathologist, who generally wouldn't review any
33 of the slides under the microscope. So there is a huge
34 volume that they can do, that we can't.
35
36 So when we look at those cases, there is also
37 a varying degree of complexity. So you get paid the same -
38 if you base the cost of service on Medicare rebate, you get
39 paid by the same, by the nature of the biopsy, more than
40 what it shows. So the Medicare rebate would be the same
41 for a normal colon biopsy, which might be very quick to do,
42 as it would be for a cancer of the same type of biopsy that
43 can take a long time to do.
44
45 Q. Is that what you are talking about when you tell us in
46 paragraph 4, that about 10 per cent of your cases take up
47 more than half of your working day?

1 A. Yes, look, there are two levels to that. Firstly, the
2 Medicare rebate, and I think it is widely accepted in the
3 field, in anatomical pathology, doesn't come close to
4 covering the cost of anatomical pathology, particularly in
5 a teaching hospital or in the hospital setting, because of
6 the complexity of the patients involved.
7
8 There are some very big corporates in the space, in
9 this state and in Australia, who can make a good income,
10 but only when it's all packaged together so that the
11 anatomical pathology is the loss-maker that brings the tens
12 of thousands of blood tests and automated tests to their
13 practice.
14
15 So within pathology as a whole, I'm sure it is widely
16 accepted in the field that AP is a loss-maker. In fact I'm
17 consistently told by my managers, "Your department loses
18 money", because it is based on the scheduled fee.
19
20 Then, within anatomical pathology there is this
21 complexity. There are a couple of boutique pathology labs,
22 very few now compared to how many there were when I first
23 started, who could make a reasonable income if they just do
24 certain things, which are invariably skin biopsies that you
25 might see from a dermatology clinic or a GP practice, or
26 endoscopic biopsies that you might see with a
27 gastroenterology practice. Because of the way the Medicare
28 rebate is structured, you can't make a profit or a living,
29 or even probably be cost neutral, based off Medicare, for
30 major oncological resections and the sorts of biopsies that
31 we see in the hospital setting.
32
33 Q. When you tell us in paragraph 4 that 10 per cent of
34 your cases take up more than half of your workload --
35 A. Yes, so within that, I might see very straightforward
36 cases, do it really quickly, and then a few zingers, just
37 two or three a day, that could --
38
39 THE COMMISSIONER: Q. Give us an example of a complex
40 case?
41 A. Sure. I do a lot of consultation practice and I do
42 probably about six or seven hundred cases a year of that.
43 They are invariably where it's been seen by a pathologist
44 at another practice, who doesn't know what it is - they
45 don't know whether it is cancer, don't know whether it's
46 not cancer, but it can be extremely high-risk biopsy,
47 because you can commit to life-changing surgery based on

1 that biopsy.
2
3 They then send it away to the centre, normally where
4 the patient will be treated - they have to be admitted for
5 surgery in the hospital - and then we have to commit
6 whether it is cancer or not; and there are other things
7 where you could commit - actually, more high risk, to
8 commit that it is not cancer and say, "You don't need
9 treatment". That's great for the healthcare system, you
10 save all the costs; great for the patient - better than
11 curing cancer, it means you don't have it. But it is quite
12 time consuming.
13
14 I mention this later in the summary, that medical
15 renal biopsies - this is for people who have kidney
16 failure, and one of the first steps for lots of types of
17 kidney failure is to do a biopsy of the kidney. Their item
18 number is 72830, and they would take two hours of
19 scientists' time just to process everything, and two hours
20 of pathologists' time to process it, and they are often
21 time urgent. If someone has a renal transplant, you need
22 to know whether it is rejection, where you give one
23 treatment, or drug toxicity, where you give literally the
24 opposite treatment, and there is a time-critical nature to
25 that. As I said, that's item number 72830. That's about
26 I think $300, it would be on the schedule.
27
28 In that time it takes to do that, we could probably -
29 our lab could probably process 100 endoscopic biopsies for
30 a Medicare rebate of $100 and you could report that
31 number - that would be a busy day, but it is that sort of
32 complexity. So you will see that a lot of the big
33 corporates just don't do that sort of pathology, and their
34 practice is structured such that they don't do it, or move
35 against it.
36
37 Q. Has the Medicare task force looked at these more
38 complex cases that you are talking about as to whether the
39 rebate is appropriate?
40 A. Yes, I do know about this, because Bruce Robinson is
41 an endocrinologist at Royal North Share, who chaired that
42 task force back in - and I have collaborated with him and
43 worked with him for 20 years. We talked about this at the
44 time, and I said, "Well, there is an understanding of this
45 in the field", and I believe there was a lot of pressure
46 from the corporates and that environment, because their
47 income is based on the high-volume blood tests, and it was

1 made clear that the only way you could increase the rebate
2 for the relatively boutique field of anatomical pathology
3 is to cut the rebate for, say, a routine blood count, and
4 they didn't want to do that. They would be happy to
5 increase it as well as the blood count.
6
7 That was where it came in and, look, that's a big
8 dynamic where you've got the corporates in the outpatient
9 setting who are willing to do certain things, and we're the
10 provider of last resort for either the things you think are
11 easy but turn out to not be easy, or the things that are
12 always going to be hard.
13
14 So, we find ourselves doing renal biopsies from a lot
15 of places outside our hospital because of the complexity,
16 and they require a lot of training as well. And even
17 within our practice, as I said, if I could just get rid of
18 or move along one or two of my cases per day, I could
19 probably halve my workload. It is that complexity that is
20 hard to describe.
21
22 MR MUSTON: Q. When you are responding, just bear in
23 mind that the lady here has to take down everything you
24 say, so if you could try and speak as slowly as possible,
25 that would be great.
26 A. I will, thank you.
27
28 Q. Could I ask you to move forward to paragraph 8 of your
29 statement. You tell us there about your experience when
30 you first commenced as a staff specialist working as an
31 employee of the Northern Sydney LHD.
32 A. Sure.
33
34 Q. Or a precursor to it?
35 A. Yes.
36
37 Q. Two issues you raise there. Well, first of all, can
38 I ask you, what is it about that structure, as an
39 employment and decision-making structure, that you felt
40 worked particularly well?
41 A. Well, I think to do high-quality pathology,
42 high-quality medicine, you need to buy in to clinical care
43 and feel committed to clinical care, and from what I do, it
44 can be as simple as saying, on a biopsy, "I don't know",
45 and I could say, "I don't know, that's the end of it".
46 I can always say "I don't know" within a minute. Or you
47 can do a lot more work, come in after hours, be called in

1 the middle of the night, take 10 different phone calls,
2 because you buy in to clinical care, patient care, part of
3 doing the job well, and that's been really, I think,
4 important for high-quality clinical practice, to feel
5 ownership rather than a fly in, fly out approach, and to
6 have those relationships to really understand what is going
7 on, particularly when you have complex patients and
8 clinical situations that keep repeating.
9
10 Then we - I found that that management structure
11 then - if, for example, there was a decision to appoint
12 certain surgeons who might generate a lot of surgical
13 pathology, a lot of complex pathology, that's within the
14 same cost basis, and there will be consideration of, "Oh,
15 if we're appointing two new renal physicians who might do
16 100 renal biopsies a year, we will consider what impact
17 that has on pathology and radiology services at the local
18 setting". Now, we've got one funder providing, you know,
19 the clinical service, but we have to report all the
20 biopsies that come with those - from a different - without,
21 you know, I feel, any input into that.
22
23 So I feel it would be good to have the needs of our
24 department, in terms of staffing, considered when they're
25 staffing individual practices, and I think that a lot of
26 decision-making in the group environment, and
27 relationships, just having the senior people on campus that
28 you might see in a formal meeting, but you might just as
29 easily see at the coffee shop at lunchtime to discuss
30 issues, leads to a more agile and responsive management.
31
32 Q. When you tell us in paragraph 10 that the separated
33 decision-making structure that exists at the moment lacks
34 agility, is that what you are talking about?
35 A. Yes. Look, I mean there is agility, so being able
36 to - like, when I first - when I was quite a junior staff
37 specialist, maybe 18 years ago, there was a young resident
38 who wanted to do pathology, there was a shortage of
39 pathologists, it was hard to get people who do it, we were
40 able to speak to the local pathology director and said,
41 "We've got someone young, can you spare a bit of extra
42 money in this year's budget to facilitate the position for
43 20 weeks of work before it goes into next year's budget,
44 because we're short", because someone had left, and that
45 was able to be done, and we've got a similar situation this
46 year, and it's no longer able to be done. I had a meeting
47 about how can we do this, put in business case after

1 business case, and it hasn't really been done.
2
3 I think a lot of the hospitals and clinical practices
4 are quite different, and the expectations of turnaround
5 times for certain specialties and certain practices are
6 different to other practices, and that's very dependent on
7 all sorts of things in the local level, that, when there is
8 a management based a lot on KPIs, that's harder to get that
9 message across.
10
11 Q. What is it about the structure that you feel, just to
12 go to the last line in paragraph 10, means decision-making
13 isn't able to be made with a proper or a full understanding
14 of the different local needs?
15 A. Look, I remember having a conversation with a then CEO
16 maybe about six years ago, when I was acting head of
17 department, and we were talking about - they wanted us to
18 do some extra work from one of the country hospitals, it
19 had a shortage of staff - a staff crisis. She said,
20 "There's this other lab that's doing 10 breast biopsies,
21 and you can't do two", and I said, "Well, they are fine
22 needle biopsies that we could report in 10 minutes, but the
23 two you are asking us to do are mastectomies with no
24 dissections that will take four hours each". She said, "Is
25 that true?", and looked to one side, to one of the
26 advisers, a biochemical pathologist, who said, "I don't
27 know, I'm a biochemical pathologist" and I said, "I'm an
28 anatomical pathologist, I'm telling you that. You could
29 come to our lab". "Oh, we will have to get back to you on
30 that". So that's one idea, where we've got not a lot of
31 anatomical pathologists in that management structure.
32
33 There are other things. This is an example from just
34 yesterday, we had a meeting, a heads of department meeting,
35 talking about the IT requirements. So we're physically in
36 North Shore hospital, but the individual LHDs decide on the
37 IT and the computers they need, and all the different LHDs
38 have different computers.
39
40 So at the NSLHD we have to get a certain type of
41 computer, because we're on the hospital network, but a lot
42 of the statewide IT requires different computers that we
43 have no choice, and then we have a statewide structure that
44 is forced to have the computer choice that's appropriate to
45 the local level but isn't so appropriate to a statewide
46 structure. Either would be okay, but if we committed to
47 one or the other, it would be better.

1
2 There is an example towards the end where I talk about
3 research, I'm quite active in research, and when I first
4 started doing this, all the ethics committees were done at
5 the hospital level. You would get approval for pathology
6 research projects through the hospital ethics committee and
7 everything would be done through that. About five years
8 ago, that was changed - six years ago, maybe - where NSW
9 Health Pathology has their own governance committee, and
10 they outsourced ethics to the hospital, but then you would
11 have to get governance approval as an additional factor
12 from NSW Health Pathology.
13
14 That's fine, but often the LHD ethics committee and
15 the governance from New South Wales Health Pathology give
16 you contradictory messages - either pathway would be
17 appropriate, but they're giving you different messages and
18 the pathways aren't compatible.
19
20 THE COMMISSIONER: Q. Can you give us an example of that?
21 A. Yes, we were doing tumour banking. I do a lot of
22 stuff with pancreatic cancer tumour banking and there is
23 a research project to do --
24
25 Q. I don't know what - tumour banking, is that storing
26 tumours?
27 A. Yes. If a patient has, say, pancreatic cancer, one of
28 the primary goals for curative therapies is you resect it,
29 it comes to our lab and we say it is cancer and look at all
30 sorts of factors, and the patients provide informed
31 consent to donate the leftover tissue for research
32 purposes, frozen and all that sort of stuff.
33
34 The process - and we've had a longstanding
35 collaboration with the Garvan Institute where the
36 Australian Pancreatic Genome Initiative is. The process
37 for that to successfully - for patients to agree at North
38 Shore for tissue to be sent to the Garvan, took about
39 a year of back and forth, culminating in a series of
40 meetings where we were told, for example, to do this
41 process, put in this form, and then we were told by another
42 group that the form wasn't appropriate, and even most
43 recently --
44
45 Q. You're using the expression "and another group". Who
46 are you --
47 A. Say NSW Health Pathology would say, "You need to do

1 this form" and the LHD would say, "No, this is
2 satisfactory, you can do this form". And even with
3 delays - so we've got collaborators doing a research
4 project on CAR T cells, and similarly, they want ethics
5 approval, patients' consent to the biopsies to be used for
6 these projects. We achieved approval from the LHD for that
7 in December and there was - there is a requirement for what
8 is called a site-specific approval from NSW Health
9 Pathology, which is pretty straightforward. We submitted
10 that in January/February. It's still on someone's desk.
11 We sort of have emailed every couple of weeks - in fact,
12 the details of that application are there. I'm told by
13 email that, "We'll look at it tomorrow and get back to you"
14 and then a few weeks later I send another email, "and get
15 back to you", and that person is located in Newcastle, and
16 I reckon it would be different if the person was on campus,
17 because I could meet with them and I think they might feel
18 more buy-in to the local project. Because I guess, to
19 them, it's just another email, when you are getting a
20 thousand emails a day.
21
22 MR MUSTON: Q. Coming back to part of the role of an
23 anatomical pathologist, you tell us about your involvement
24 in multidisciplinary team meetings?
25 A. Yes.
26
27 Q. You tell us in paragraph 13 that, in your view, they
28 are integral to patient care?
29 A. Mmm.
30
31 Q. Why is the involvement of an anatomical pathologist,
32 in your view, integral to patient care, in those meetings,
33 I should say?
34 A. Yes, I think it is accepted by the Cancer Institute
35 and all governance - so back when I started, 20 years ago,
36 signing things out, if someone had a cancer, you would
37 write a report, that was cancer, and you might be called by
38 the surgeon if there was a complex thing, but that would be
39 a lot of - mostly, the end of your involvement.
40
41 Now, it is accepted that virtually all significant
42 malignancies should be discussed in a multidisciplinary
43 team setting, which normally involves a surgeon, an
44 oncologist, a radiation oncologist, pathologist, and plus
45 or minus other disciplines specific. So it is kind of
46 mandated that we have to discuss that.
47

1 That has gone from us not doing any MDTs to what we
2 calculated a 1.6 full-time equivalent pathologist MDT load
3 for that.
4
5 Q. We will come back to those calculations. At the
6 moment, though, the reason why they are integral to patient
7 care is, in part, because they are mandated, but I guess my
8 question to you is why are they mandated?
9 A. I mean, there is a lot more - I mean, I think outside
10 the field, people think, "The biopsy shows cancer, it's
11 cancer." But there is a lot of different cancers, and the
12 clinical context of some diagnoses profoundly impacts
13 everything. So there are some things that you would call
14 a cancer in one setting that you would call benign in
15 another setting, and that's not so well known. Like just
16 by under the microscope, yes, "If this was a" - you know -
17 "I'd call it cancer", but in a different location, "That's
18 completely benign."
19
20 So you need that input in planning management and
21 particularly, say, when we do a lot of rare cancers, and
22 part of the things I tell the registrars is, "If you see
23 a rare cancer, you have to be able to explain what it
24 means". Like, here is a cancer that, even in
25 sub-speciality practice, I might see once every five years,
26 and most surgeons and oncologists would never encounter
27 them. I need to be able to explain what that means, why
28 I made that diagnosis, which connotes the treatment. So
29 I might call it a certain name rather than a certain other
30 name, and using that name means that it can just be widely
31 excised and will never come back, whereas using a slightly
32 different name might mean that afterwards, the patient
33 needs surgery and radiation, or it might be that this
34 malignancy is so dreadful that it would be not in their
35 interests to have any further treatment. So there are all
36 those sort of things which can be very high risk and
37 profoundly impactful to patient care.
38
39 We also, for example, review biopsies of cancers
40 performed outside, to check that it is as reported, and
41 there is literature in the pathology literature that, you
42 know, misclassification or review, routine review of
43 biopsies done elsewhere - most of the data comes from the
44 US - at least a 10 per cent change in management outcome
45 from redoing it. That's all the sort of complex stuff that
46 there is a Medicare rebate for second opinions, which is
47 item 72858, 72859. You can't access that if it's a public

1 hospital public patient and, by their nature, those sort of
2 high-risk second opinions will always take way longer than
3 a low-risk case.
4
5 Q. Do we take it from your statement that participation
6 in these multidisciplinary teams by the anatomical
7 pathologists is something that's been requested by the
8 LHDs?
9 A. Yes, 100 per cent. And I would just add one thing.
10 We often - if it is your patient, if you have done an
11 operation on a patient or you look after the patient as an
12 oncologist, you know the patient. We actually prepare
13 a lot for these multidisciplinary team meetings. It might
14 be a biopsy reported by someone else that I have to review.
15 Whereas if it was a patient that I know, I can just come
16 with my notes and say, "This is Mrs Smith. I know" - that
17 sort of stuff.
18
19 Q. Can I take you back to something you started telling
20 us about a moment ago, the estimate that you have made of
21 the number of FTE or the amount of FTE time which is
22 attributable to these meetings. I think you tell us about
23 that at paragraph 18 of your statement.
24 A. Sure. So there was a workload audit --
25
26 Q. We will pause for a minute and have a look at
27 paragraph 18?
28 A. I know it. It is saying there is the 1.6 full-time
29 equivalent pathologist and a similar amount for registrar.
30
31 Q. How did you go about calculating that?
32 A. So when we had this relative workload audit, we were
33 asked to provide a list of all our regular meetings that we
34 do, and we provided that list and we were told that
35 a multidisciplinary team meeting with 20 cases discussed
36 might be X number of hours, and then we looked at how many
37 MDTs that we did, and that's how we came up with that
38 figure.
39
40 If you looked at the RTU workload document that has
41 been tendered in one of these documents, they came to 0.8
42 for that, because they said - they used a definition for
43 MDTs equated to the Medicare rebate. There is a Medicare
44 rebate for cancer MDTs requiring an oncologist, a surgeon,
45 nuclear medicine physician, or whatever. There are other
46 meetings where it's just us and, say, the renal physicians,
47 where we review all their kidney biopsies that are done,

1 every two weeks, and to us, it's still an MDT but it
2 doesn't meet the Medicare criteria for it.
3
4 So that's how we came up with that figure, and we do
5 them with registrars. That's important for their training
6 and also they help us do a lot of that stuff. So that's
7 how we came up with that figure, and I would stand by that
8 figure.
9
10 Q. In terms of the registrars, perhaps if we could go
11 back to paragraph 15 of your statement. You tell us that
12 you've got six registrars who are the only registrars who
13 do not report to the junior medical staff unit of the LHD.
14 Could you just expand a little bit on what that means in a
15 practical sense?
16 A. Yes, so it is a really odd setting. So our six
17 registrars are physically in our department, which is on
18 the fifth floor of the hospital, but their administrative
19 stuff is all done by a centralised NSW Health Pathology
20 admin, not by the hospital admin, and that causes problems
21 that, for example, if we wanted to rotate - if a registrar
22 in a clinical job, surgery or medicine, wanted to do a term
23 in pathology, it is not possible, because they are
24 different structures. Then, similarly with recruitment, it
25 is a different structure. So they are not available, for
26 example, to do ward on call, but because of that
27 administrative structure, we see problems, which I allude
28 to later on when I talk about the offer of a resident in
29 pathology - that structure was impossible to implement,
30 because we were offered, across the state, a 1.0 - across
31 the state, there was a 1.0 resident position offered in
32 pathology, in anatomical pathology, and I was excited by
33 this, because we were short staffed.
34
35 I spoke to the JMS unit who were very accommodating,
36 and they said the problem is, they would need - to staff
37 the hospital, they need a full year's position, because you
38 can't have 60 residents in January and 59 in March, because
39 of the way they rotate through.
40
41 We went back and forth about options to solve this,
42 where, say, our hospital could have the position for
43 a whole year, or our hospital could have one term and
44 Prince of Wales could have one term and RPA could have one
45 term, but it was impossible, and there was no possibility
46 for us to implement a resident term in pathology, because
47 although there was the offer of back-funding from NSW

1 Health Pathology, because of the different structures where
2 the local JMSU couldn't cope with one ten-week term because
3 they need to be equal, otherwise people are short staffed,
4 it wasn't able to be executed.
5
6 Q. So you tell us about the - this is in part, I gather,
7 part of this option or ability to adjust staffing by using
8 resident staff who might be doing a residency in another
9 area within the hospital --
10 A. Yes.
11
12 Q. -- as workforce within anatomical pathology as needed?
13 A. Yes.
14
15 Q. What is it, in a practical sense, that prevents that
16 from occurring, or perhaps let's take it back a step.
17 Before the creation of NSW Health Pathology, when it was
18 all dealt with within the LHD, was it your observation that
19 residents were able to be moved in and out of your
20 department in a way which was useful?
21 A. Yes. I know at other campuses - we never had
22 a resident in pathology through my training, but at other
23 campuses they were able to have a resident who does four
24 terms of the year on the wards and one term in pathology
25 and that worked really well, because there are some people
26 who do pathology for 10 weeks and realise it's not for
27 them, and that's actually equally good, as those who do
28 pathology for 10 weeks and fall in love with it and go on
29 to be fantastic pathologists. So that scope was able in
30 the past, but we can't do it now. And it is a pity because
31 there would be a synergy - we're often busiest - we're
32 often quietest in our department when sometimes the ward is
33 busiest. So in the winter surge of viral illnesses,
34 sometimes elective surgery or semi-elective surgery could
35 be cancelled or postponed, and we may be quieter then and
36 it would be a great synergy for us to have less resident
37 staff at that time and, in return, for whatever reason,
38 a lot more cancer diagnoses are made from mid-November to
39 mid-December, just - it just is something that there is
40 a dramatic increase and we are most busy then, and there
41 would be a synergy to have extra staffing at that time, if
42 we could move between the two, but we can't.
43
44 Q. Coming back to an issue you raised a moment ago about
45 the funding of the 1 FTE resident position across the
46 state, you tell us in paragraph 17 that you were told that
47 that decision had been made. Can I ask, when were you told

1 that?
2 A. Yes, that was fed back through the clinical stream
3 that, you know, there is a position for one --
4
5 Q. Just listen to my question. Do you recall when you
6 were told that?
7 A. What --
8
9 Q. In time, roughly?
10 A. Oh, it was last - this one was - I refer to was last
11 year.
12
13 Q. And who told you that, do you recall?
14 A. Yes, so that was fed back via the clinical stream,
15 which is a consultative group for anatomical pathologists,
16 via Michael Wiley, who was the director of medical services
17 and chief pathologist at the time, that they had offered
18 a 1.0 full-time equivalent, and that has been in place for
19 a couple of years. And I rang around a few places who had
20 that. I spoke to the pathologist at RPA who said, "We did
21 it for a term. It was a huge amount of administrative
22 staff work to achieve it and we're unable to achieve it now
23 because it was so much administrative work".
24
25 Prince of Wales had that for a few terms, but not the
26 full time. And I suppose what I found difficult about that
27 exchange was I was told that, "We have this position, speak
28 to the JMSU, do everything you can to make that happen" and
29 then down the track I received an email basically saying
30 "It can't be done".
31
32 Q. Can I ask you to turn to paragraph 19 of your
33 statement. You tell us later in the statement about
34 workforce challenges or workload challenges, and we'll come
35 back to that, but can I just ask you to focus on
36 paragraph 19 for the moment. You tell us that you reached
37 out to NSW Health Pathology to seek to backfill some
38 staffing. Who was it who you reached out to?
39 A. Yes, so I mentioned we had a workload audit last year
40 and --
41
42 Q. Just focusing on my question: paragraph 19, you tell
43 us that you reached out --
44 A. Yes, to several people.
45
46 Q. I just want to know who it was.
47 A. Yes, so to Michael Wiley directly, who was, as I said,

1 director of medical services, chief pathologist. That was
2 at a meeting attended by Wendy Cooper, who is chair of the
3 anatomical pathology clinical stream.
4
5 As recently as about two months ago I met with the new
6 CEO Vanessa Janissen and said, "We have an issue with the
7 MDT funding". I have also met with Anthony Schembri in his
8 role as the NSLHD CEO and said, "We've got an issue with
9 anatomical pathology funding", and they all agree it is
10 critical and it needs to be funded, but we seem to be at an
11 impasse of who will do it, and I was --
12
13 Q. Just, again, try to keep it slow, if you can. So when
14 you say you are at an impasse as to who is going to do it,
15 this is what has provoked the meeting with the CEO of the
16 LHD, or the CE of the LHD?
17 A. Yes.
18
19 Q. Who was the CE of the LHD who you met?
20 A. This is Anthony Schembri, this is about a month or two
21 ago, about - one of the - MDTs was one of the things we
22 discussed.
23
24 Q. Can I ask, in relation to that particular issue, do
25 you recall what the response from Mr Schembri was when you
26 discussed it?
27 A. Well, he was very supportive, saying he agrees that
28 these are really important, and I think he said words to
29 the effect of, "It's not so important where the funding
30 comes from, that it should come through". And he said that
31 he would meet with NSW Health Pathology and circle back to
32 me in about a month, although that was about six or eight
33 weeks ago since we've had that.
34
35 Q. So these particular discussions around backfilling
36 staffing to accommodate the multidisciplinary team
37 meetings, in relation to those meetings, can I ask, is it
38 the management of the LHD that is requiring you to attend
39 them or requesting your attendance, or is it clinicians
40 within the LHD?
41 A. Well, it is both, and so it is clearly - you know,
42 I've been cc'd on some emails about mandatory approaches to
43 MDTs and how they are structured and recorded. That has
44 come from the executive of the NSLHD, and I've been
45 requested directly by clinicians to attend the MDTs. It's
46 not uncommon that there will be a new specialty craft group
47 and they will say, "Yeah, we're just setting up" - what is

1 the last new one we had - "an interstitial lung disease
2 MDT", a couple of years ago, "and we're going to do it
3 every month and we'd like you to attend". There is
4 actually a Medicare requirement, for certain drugs to be
5 prescribed, that they've discussed it at MDT, and so it's
6 under a request to attend.
7
8 Q. In paragraph 20, you point out or you express a view
9 that the funding of these, this backfilling, might have
10 been different in the old LHD single-funding stream model.
11 What is it that makes you think that?
12 A. Look, I was told by one of my mentors, who was
13 a former head of department, Bob Eckstein, that when you
14 appoint a new position, as opposed to backfill, you are
15 meant to put in a form saying how the new appointment will
16 affect other faculties in the hospital, so if you appoint
17 a new surgeon who is doing a lot of prostate biopsies, you
18 need to make sure someone can do prostate biopsies, and
19 radiologists can report them. That's what he told me.
20 I haven't seen any evidence of that in recent times, when
21 new appointments and new craft groups are introduced, that
22 there is consideration for the pathology workforce sort of
23 behind the scenes that they bring.
24
25 Q. To the extent that that is happening behind the
26 scenes, you are not aware of it?
27 A. Well, I'm - I can tell you we, as a specific example,
28 talked about the neuroendocrine tumour craft group. They
29 are relatively rare tumours where there is a lot of
30 pathology input, and there is a multidisciplinary team
31 meeting every two weeks and we need to review a lot of the
32 cases because the biopsies are normally done outside and
33 need to be looked at in a certain way. And when that group
34 was started, there was funding for a nuclear medicine
35 physician and an oncologist, and not for a pathologist, and
36 we had a whole discussion about this.
37
38 Q. When you say "we", who did you have a discussion with?
39 A. That was myself and the then head of department, David
40 Neville, and they offered, as backfill, was it
41 0.1 anatomical pathologist for that, on a one-year
42 contract, and then they --
43
44 Q. When you say "they offered as backfill", who offered?
45 A. That was the group who were putting it together, the
46 nuclear medicine physicians and the oncologist had some
47 funding, and I think it was sort of semi-external,

1 semi-internal funding for this, and when we kicked up
2 a fuss, after a while, they offered us a 0.1 for 12 months,
3 and then that stopped.
4
5 Q. Again, when you say "they", are you talking about NSW
6 Health Pathology or the LHD?
7 A. No, no, no, it was funding external to NSW Health
8 Pathology from the craft group that wanted that to happen,
9 that were to backfill into NSW Health Pathology, a 0.1
10 salary equivalent. And, as I said, that was for 12 months,
11 agreed to, and then after 12 months, ironically, as the
12 workload increased exponentially, we were told there was no
13 more funding for that and we should just absorb it.
14
15 Q. You tell us in paragraph 21 about unsustainable
16 workload. Has the failure, in your view, to backfill for
17 these multidisciplinary team meetings contributed to that
18 unsustainable workload?
19 A. That's a very significant contributor. It's not the
20 only contributor but it's a very significant contributor.
21
22 Q. To make sure we understand paragraph 22 of your
23 statement, the first issue is, you have made an assessment
24 that each staff specialist is working for approximately
25 12 hours. How have you made that assessment?
26 A. Yes, so we have regular monthly staff specialist
27 meetings, and the first thing we always discuss is workload
28 and distribution of workload, you can't separate those
29 issues. As part of my desire to put another business case,
30 you know, to explain to the managers the hours that we are
31 doing, we, you know, conducted an audit in the department
32 and we said, "Well, we want to put down a figure but we
33 want everyone here to agree to it and we will minute in our
34 minutes that this is what we're doing", and there are some
35 people who are working more than 12 hours. We have a lot
36 of people who are working fractionally, who may be working
37 0.7, because if - they could work full time if it was an
38 eight-hour day, and so we came across it from auditing
39 that.
40
41 We talked about having a sign-in, sign-out thing just
42 for a week or two to see that, and a lot of the staff
43 members told me that they would take microscope slides
44 home - like pick up the kids from child care at 6 or
45 whatever, do all that, and then do some reporting from 10
46 until 11, 12, at night, or something, and they want that
47 workplace flexibility to do that, or to work remotely from

1 home when it can be done, and there wasn't keenness to do
2 a clock-in, clock-out basis.
3
4 And there is a lot of stuff that is hard, too, that
5 a lot of what we do is remote and reading through rare
6 tumours, reading through articles to work out what it is.
7 It was hard to quantify. But that was sort of agreed, that
8 figure was agreed to as the average hours, in our
9 department, by all the staff specialists who - you know,
10 all staff specialists in our department.
11
12 Q. The point you are seeking to make there is that that
13 is four hours more than the notional eight hours that
14 you --
15 A. Yes. We don't get paid any overtime as a staff
16 specialist. We've always tried to have a good turnaround
17 time, and we get a lot of pressure for turnaround time, if
18 you leave things for too long you get called for urgent
19 results and that's the only way that we can do that.
20
21 Q. And it's your view, based on some issues we'll come
22 to, that the workload within the department has been
23 increasing year on year?
24 A. Yes, so I think in one of the documents there are raw
25 numbers, but the raw numbers are 10 to 15 per cent. We
26 came off a bit with - we previously did the pathology for
27 Manly and Mona Vale and, when Northern Beaches came on, we
28 didn't, and that plateaued for a bit and then it is back to
29 that same rate. Again, there was a COVID dip that has
30 rebounded again.
31
32 But there is a consistent 10 to 15 per cent increase
33 in numbers of encounters per year. It's very hard to
34 quantify the complexity, because that's a subjective thing,
35 but we're also doing more complex work within those
36 numbers, which reflects that the average hospital inpatient
37 is sicker now than they were even 10 years ago. There are
38 all sorts of metrics that look at that that they talk about
39 at the LHD level.
40
41 So numbers easily show 10 to 15 per cent per annum,
42 and complexity I would add on to that, harder to quantify.
43
44 Q. Would it be right that the 10 to 15 per cent, whilst
45 it is some measure, it's not necessarily an indication of
46 the increase in the actual time required to work --
47 A. That's an underestimate of the time, a clear

1 underestimate, because of the complexity and the increasing
2 sickness and the other things that we do that we didn't
3 have to do in the past.
4
5 Q. In paragraph 23 you tell us about the Paxton review in
6 2018.
7 A. Yes.
8
9 Q. You tell us the report has not been made public, by
10 which I gather you are telling us you don't know what the
11 report says?
12 A. Yes, so that was - before I was head of department,
13 David Neville was head of department, and he lobbied - he
14 feels similarly to me about workload. He lobbied
15 extensively for this through the union, who then, they
16 agreed on this report by the consulting firm Paxton, that
17 I was told, but have not seen a report, recommended a
18 significant number --
19
20 Q. Told by whom?
21 A. David Neville. And I think he was told, without
22 seeing the report, that there was a recommendation for
23 a significant number of positions across the state, and by
24 no means trying to say that our department is any busier or
25 less busy than anywhere else.
26
27 Q. You don't, yourself, though, have actual knowledge of
28 whether a report was published?
29 A. Well, I was - when NSW Health Pathology received the
30 report, there was definitely a decision not to completely
31 accept it, to conduct their own review of the workload,
32 which was run by Paul McKenzie.
33
34 Q. When you say there was a decision made, how do you
35 know that?
36 A. He told us. He visited our department when he gave
37 his findings about how much staff we should get, which was
38 1.0 position, that he was asked to review the workload for
39 this, after this report.
40
41 Q. So is this the review that you are telling us about in
42 paragraph 24?
43 A. No, 24 is something separate. Yes. So paragraph 24,
44 we talked about again, after - in COVID we were actually
45 obviously quite quiet, relatively quiet during COVID,
46 because there were prolonged periods when there was not
47 much activity in our field at all.

1
2 Q. Just pausing there so I can understand the chronology.
3 There was lobbying which led to the Paxton report, which
4 was not, to your knowledge, published. Following that --
5
6 THE COMMISSIONER: Mr Neville said something, told you
7 something about it.
8
9 MR MUSTON: Q. Mr Neville said something which led you
10 to conclude that there was a report and it contained
11 certain information.
12 A. We were told that we were commissioned - that Paxton
13 was commissioned to conduct this report. They conducted
14 a similar report, I think, in Victoria and they used
15 similar metrics to that.
16
17 Q. Following the Paxton report --
18 A. That was 2018.
19
20 Q. -- in 2018, there was an internal NSW Health Pathology
21 review --
22 A. Correct.
23
24 Q. -- which - you used a name a moment ago, who conducted
25 that review.
26
27 THE COMMISSIONER: Q. Mr McKenzie?
28 A. Yes.
29
30 MR MUSTON: Q. He came and spoke to you as part of that
31 review?
32 A. Correct.
33
34 Q. During that process, he informed you that the Paxton
35 report had been received and he was reviewing its
36 recommendations --
37 A. Yes, he did.
38
39 Q. -- or conclusions?
40 A. Mmm-hmm, and his opinion, or the report, that
41 concluded that we should get one full-time equivalent above
42 our establishment.
43
44 THE COMMISSIONER: Q. Sorry, his opinion of the Paxton
45 report, or his own opinion?
46 A. Well - no. So my understanding is that the Paxton
47 report said one thing, and I was told that that was

1 a significant increase in staff, and then --
2
3 Q. What were you told?
4 A. -- NSW Health Pathology directed a review which showed
5 a significantly less increase in staff.
6
7 Q. What were you told Paxton said about increase in staff
8 and by whom?
9 A. Okay, I was told by David Neville a number, and
10 I cannot recall it now. I looked through my emails to see
11 if I could see that number, but it was more than one, and
12 it was - our disappointment was that we only got one out of
13 that process when it was re-reviewed.
14
15 MR MUSTON: Q. After the re-review, you did get the one
16 additional FTE?
17 A. Yes, in 2018.
18
19 Q. Then, between then and the events you tell us about in
20 paragraph 24 of 2023, what happened?
21 A. So between 2018 and 2023, our establishment stayed the
22 same. So there was no increase in staffing at all in that
23 period.
24
25 Q. And they were preoccupied during a lump of that time
26 by COVID?
27 A. Yes, there was a lot of COVID. As I said, COVID - we
28 don't do the PCR testing, that's not our department. So we
29 were quiet for a large amount of that time, although there
30 was some overflow surgery done from other hospitals, done
31 on our campus, that weren't as quiet. So we were quiet
32 during that time and then --
33
34 Q. Why was it - it comes to be relevant later, as
35 I understand it, but why was it that the anatomical
36 department was particularly quiet during the COVID period?
37 A. So a lot of surgery was cancelled. So there is
38 literature saying a lot of people with cancers weren't
39 biopsied and treated, because they wanted to stay away from
40 hospitals. A lot of the hospitals were shut for a lot of
41 sort of elective surgery, so our overall case numbers
42 dipped or didn't increase, because people weren't having
43 elective procedures, weren't having colonoscopies, weren't
44 having a whole lot of treatments.
45
46 Q. Okay. I distracted you, I think. So there was
47 the COVID period and then we come up to 2023, and you

1 describe in paragraph 24 increasing pressure.
2 A. Yes.
3
4 Q. What was the nature of that pressure?
5 A. Yes, look, several people contacted the union and
6 wrote to NSW Health Pathology saying that workload was
7 going up. There is an advisory group called the AP
8 clinical - anatomical pathology clinical stream, who made
9 the same point, and it was agreed to conduct this relative
10 workload review in 2023. I think the process started at
11 the end of 2022, and finalised in 2023.
12
13 Q. You tell us you have an issue with the fact that the
14 review was based on COVID-affected years or an assessment
15 of workload in COVID-affected years?
16 A. Yes, so the review was conducted using a metric called
17 relative time units.
18
19 Q. I will come back to that. The first issue is there
20 was an assessment made of the work being done by anatomical
21 pathologists --
22 A. Yes, and it was based on financial years 2020 and
23 2021, and 2021 and 2022.
24
25 Q. And your concern around that is that those years were
26 those affected by the dip in work referable to the COVID
27 pandemic?
28 A. Correct, and I pointed that out and I was told that
29 there would be no negotiation on that.
30
31 Q. Can I now ask you to turn your mind to the RTUs?
32 A. Yes.
33
34 Q. And I gather from what you tell us in paragraph 26
35 that it is your view that RTUs are not a fair measure of
36 the amount of actual work, in terms of time, that is
37 required to be done within a department?
38 A. Sure.
39
40 Q. Is that right?
41 A. Yes, look, I think --
42
43 Q. Just listen to my question.
44 A. Yes. Is it my view that --
45
46 Q. Is it right that the RTU is, in your view, not
47 a reasonable measure of the amount of actual work, in terms

1 of time, required to be done?
2 A. Correct.
3
4 Q. Can I ask you why?
5 A. Yes. So the RTU, relative time units, is based on
6 a college document from some years ago, and it ascribes the
7 time unit for certain anatomical pathology cases based on
8 the Medicare rebate.
9
10 Q. When you say "based on the Medicare rebate", what does
11 that mean? Give us an example of a particular test.
12 A. Item 72823 is a single endoscopic biopsy, and just one
13 encounter, and that will give a relative time unit of
14 whatever the figure is, and --
15
16 Q. Just again, so I understand it, is that because
17 Medicare, in arriving at a figure for the rebate, have
18 assumed that a particular amount of time will be required
19 to do that particular biopsy?
20 A. Yes, which it might be for the average 72823, but say
21 in the outpatient setting, you see a lot of normal
22 pathology, whereas we might see a lot more cancers in the
23 endoscopic biopsies, which take more. So a good example
24 would be item 72830, which is what we call a complexity
25 level 5, and the Medicare rebate I think is about $300 for
26 that, you get that item number also if you, say, look at an
27 adrenalectomy specimen or certain other, like a thyroid, a
28 benign thyroid, you get the same item number, but in the
29 teaching hospital, we have several hundred renal biopsies
30 that have the same item number. So whilst, if you looked
31 at all anatomical pathology in Australia, particularly, you
32 know, in the corporate setting, I think the RTU would be
33 a fair metric, it doesn't take into account the increased
34 complexity within item numbers.
35
36 Q. So again, maybe to make sure my basic understanding of
37 it is right, in arriving at the RTU, Medicare looks at the
38 average amount of time that it takes to do a particular
39 test across the board - just "yes" or "no"?
40 A. Well, the RTU is devised by the College of
41 Pathologists, based on the Medicare number. So they say
42 "This Medicare number is item 72823 and this takes X amount
43 of points", which translates into however many minutes.
44
45 Q. And the college, in arriving at that, at least as you
46 understand it, will take into account the fact that across
47 the board, perhaps the overwhelming majority of those tests

1 are something that can be done in perhaps minutes?
2 A. Correct.
3
4 Q. But then the complicated ones might take two hours,
5 hypothetically?
6 A. Correct.
7
8 Q. And the RTU works out, across the board, the total
9 number of those tests done, averages out those that take
10 the two hours with those that take a couple of minutes and
11 produces a number?
12 A. Correct.
13
14 Q. Which is much closer to the two-minute end of the
15 spectrum than the two-hour end of the spectrum?
16 A. Correct, because that's the greater volume of stuff.
17
18 Q. Very rough and hypothetical figures, but is your
19 general concern with using the RTU metric here that within
20 the acute hospital setting, you are dealing with a lot more
21 of the two-hour end of the spectrum --
22 A. Correct.
23
24 Q. -- than the run-of-the-mill two-minute end of the
25 spectrum test?
26 A. That's exactly the issue, and second opinions and
27 things like that.
28
29 Q. Now, coming to paragraph 27, you tell us that it was
30 made clear by NSW Health Pathology that the review was not
31 to assess registrar, scientific, technical or
32 administrative workload or the actual workforce
33 requirements of the department. Can I ask you,, how was
34 that made clear? Who made it clear and how was it
35 communicated?
36 A. I emailed Michael Wiley and said we need to assess the
37 registrar, scientific, technical, administrative staff and
38 I was told, "It is not to assess this", quite clearly, and
39 in fact, when he visited I made the same point and I was
40 told the same thing, and I also made the point about MDTs
41 and was told the same thing.
42
43 Q. And when you go on, then, to talk about the purpose
44 being to rank the degree of understaffing across different
45 departments, in a relative sense, how did you come to
46 understand that that was its purpose?
47 A. So it was made clear, I think, in some of the

1 documents that I wish I had submitted, although they will
2 be available, that this is to be solely a relative workload
3 review, which is to rank different departments. What
4 I indicated that I think should happen is an absolute
5 workload review, which is a review of how much staffing is
6 needed to properly staff a department like ours and other
7 similar departments across the state, and we were told very
8 clearly, and there is an email trail of this, "This is not
9 the intention of the review. It is only to rank the
10 workload crisis across different departments."
11
12 Q. So to try to put two concepts together, is it the fact
13 that the reason that it was being used solely for ranking
14 was given as an explanation for, at least for those
15 purposes, the appropriateness of using the RTU metric?
16 A. No, I suppose I formed the view that the reason that
17 it was to be a relative workload is that there wouldn't be
18 the money in the budget to fund the recommendations of an
19 absolute review. I believe the RTU --
20
21 Q. Perhaps let me put the question a slightly different
22 way. If the purpose of it was merely to rank the crisis,
23 as you have put it, between different hospitals, the RTU
24 metric would be an appropriate means to rank them, if that
25 was the purpose.
26 A. Yes, so to your point, yes, I agree that if a relative
27 time unit metric is used in a relative workload review,
28 noting that, say, some smaller hospitals would do less
29 complex stuff than some bigger hospitals, but peer and
30 near-peer hospitals would have a similar mix, case mix,
31 then that's a legitimate use of the RTU metric, and I also
32 understand that the RTU metric, one of the reasons chosen
33 for it is because it is based on the Medicare rebate, and
34 you can find that data with the click of a few buttons on
35 the IT systems. But I dispute that the RTU metric is an
36 absolute workload - an appropriate absolute workload
37 metric, but I agree that relative to similar hospitals,
38 it's a relative metric.
39
40 Q. So in terms of the ranking of the workload problems,
41 you don't have an issue with the way in which they have
42 been ranked in the subsequent report?
43 A. Correct. So when we look at the relative ranking --
44
45 Q. So "yes"?
46 A. Yes, I agree with the relative ranking. You know, for
47 all its big, broad-brush-stroke pictures, I think it is

1 a fair relative review.
2
3 Q. But your point, when we come to paragraph 29 and the
4 table you have extracted there, is relevant, say, to your
5 facility, Royal North Shore Hospital. The 7.7 hours of
6 diagnostic work is in fact, you believe, an understatement
7 or an underestimate of the actual diagnostic work, because
8 it relies solely on the RTU?
9 A. Yes, I believe that, for the reasons I have stated.
10
11 Q. Can I ask you, in relation to that, in paragraph 29,
12 at the foot of the paragraph, you tell us that, as a guide,
13 you think approximately half of an anatomical pathologist's
14 working day at hospital level should be spent at the
15 microscope.
16 A. Mmm.
17
18 Q. In a practical sense, what does that mean? Does it
19 actually mean with your eyes looking down the hole?
20 A. Yes, so it means with my eyes at the microscope. So
21 the time taken to report - I might get a tray of slides,
22 with a dictaphone in my hand, at the microscope, look at
23 it, report it. I suppose the metaphor "at the microscope"
24 includes when it is typed in, validating it, but doing the
25 routine what we call "pushing glass", you know, moving that
26 across the microscope.
27
28 Q. The 7.7 hours that's referred to in the table,
29 calculated by reference to the RTUs, that's the pushing
30 glass?
31 A. That's pushing glass.
32
33 Q. Do you understand the 50:50 split between pushing
34 glass and other activities within the hospital to be a view
35 which is shared by other anatomical pathologists as to what
36 is appropriate?
37 A. Yes.
38
39 Q. And in addition to the multidisciplinary team meetings
40 that we've already talked about, what else is occupied by
41 the non-pushing-glass time that makes up the other
42 50 per cent in the ideal scenario?
43 A. Yes, so as the sort of caption to table 1 says, this
44 metric excludes multidisciplinary team meetings, teaching,
45 administration and research, and I would add in to that,
46 things like practice improvement, getting new tests and new
47 things online, and everything that goes along with that -

1 taking phone calls about cases.
2
3 Q. So, following the report which you tell us about in
4 paragraph 29, and extract the highlights package from at
5 table 1, you tell us about a business case that you
6 submitted, at paragraph 31.
7 A. Yes.
8
9 Q. In relation to that request, in making it, were you
10 satisfied that workforce was available to fill the
11 positions, if funded?
12 A. Yes, we could attract --
13
14 Q. What led you to conclude, in the context of, as you
15 tell us, a serious shortage in the world of anatomical
16 pathologists, that you would have been able to fill that
17 position?
18 A. We currently have two locum pathologists, one doing
19 predominantly a maternity leave backfill and one doing
20 a long service leave backfill, and both would be available,
21 for example, and would be keen to get a permanent job in
22 our department.
23
24 Q. So if the business case requesting the additional 2.5
25 FTE staff specialists had been approved, you were satisfied
26 that at least 2 FTE worth of them could have been filled by
27 those two individuals?
28 A. Yes.
29
30 Q. What about the extra 0.5?
31 A. Yes, look, so when we've interviewed for the locum
32 positions, we had several candidates who would have been
33 appointable and on the eligibility list, with new
34 registrars finishing every year.
35
36 Q. And in terms of the 2 FTE registrar positions that you
37 were seeking to fill, were you satisfied that there were
38 two FTEs worth of registrars who would have been willing to
39 pick up the training spots that you had available?
40 A. I was talking to a potential candidate yesterday who
41 indicated that if something became - even at short notice,
42 would go straight in, and even a time frame where there is
43 a yearly registrar interview process that happens
44 in September, they could start next year, we could cope
45 with, but yes, we could definitely get the registrar
46 positions.
47

1 Q. In the context of a shortage of anatomical
2 pathologists, I assume, but correct me if I am wrong, that
3 providing opportunities, training opportunities for
4 registrars, would be a positive development?
5 A. Correct. I'm confident that we could get positions in
6 our department, in Sydney. There have been some
7 longstanding vacancies in the rural setting that people
8 just haven't applied for, and they would apply if there
9 were more appropriately qualified people. So we need
10 that - whilst I think we can in a big Sydney teaching
11 hospital, I think it would definitely help the statewide
12 workforce crisis.
13
14 Q. In paragraph 32 you tell us that the business case was
15 declined or not accepted, not based on clinical need but on
16 budgetary impact. Were you told that explicitly?
17 A. Yes, well, there is an email that I have tendered.
18
19 Q. When you say you were told - what you know about the
20 decision-making behind the declinature or the
21 non-acceptance of the business case is based on what's
22 contained in that email; is that right?
23 A. Yes.
24
25 Q. That email is at [SCI.0008.0303.0001]?
26 A. Yes, that's the email.
27
28 Q. Just pause for a minute and we can bring it up on the
29 screen. So just working through that, at the bottom of
30 that email is an email of 15 January from you to Louise
31 Wienholt, amongst others. Who are those individuals? Tom
32 Kennedy I know you have told us --
33 A. Tom Kennedy is the local pathology director at North
34 Shore. Kimiko Blendell is the divisional manager scientist
35 within our department. Cathy Atkins is the director of
36 operations at North Shore, and Louise Wienholt is - I think
37 her title is director, I think in the footer, of operations
38 for NSW Health Pathology, sort of above - beyond the NSLHD
39 campus, whereas Cathy is at that campus.
40
41 Q. The briefing document that you refer to is the
42 submission, am I right, that appears immediately before
43 that document, which is [SCI.0008.0302.0001]?
44 A. Yes.
45
46 Q. That's the document that you had forwarded to them; am
47 I right?

1 A. That is correct.
2
3 Q. So, coming back to the email, is it that email, or the
4 response which is dated 16 January 2024, that you rely on
5 in reaching the conclusion that --
6 A. There were also verbal conversations.
7
8 Q. Who with?
9 A. Both Cathy Atkins and Louise Wienholt.
10
11 Q. What was the effect of those conversations?
12 A. Well, that we wanted more staff, and I was told, "Put
13 in a business case". We put in a business case, and I was
14 consistently told, "It won't be revenue neutral. It won't
15 be - it won't save money, and on that basis, it won't
16 proceed". And I said, "But there is a clinical need", and
17 talked about how we're doing extra hours and all that sort
18 of stuff, and I was told, "But it cannot be funded because
19 it's not cost neutral".
20
21 At the heads of department meeting yesterday, Darren
22 Croese actually said quite explicitly, "Your discipline is
23 a loss-maker. It is a loss-making discipline". I agree
24 with that, but there is no - our discipline loses money on
25 any metric based on Medicare rebate. I was told very
26 clearly - that's the best email evidence that I have - that
27 it's because of the negative effect on the general fund,
28 the revenue, with previous emails saying that they will
29 move it up to revenue to see what the effect on the general
30 fund will be.
31
32 Q. Can I ask you to move forward to paragraph 38 of your
33 statement. You tell us about a gene expression assay
34 called Prosigna, P-R-O-S-I-G-N-A. I think I have
35 pronounced it properly, but correct me if I haven't. For
36 the laypeople, what is Prosigna?
37 A. That's a commercial product that - about 10 years ago
38 I received a half-million dollar grant from the Cancer
39 Institute of New South Wales for this platform which can do
40 research projects and also clinical projects, and one of
41 the Prosigna modules is basically designed to test the
42 cancers from women with breast cancer, and using the
43 genetic assay, it can tell you whether the breast cancer is
44 so low risk that you don't need chemotherapy, as in the
45 chance of the breast cancer coming back after surgical
46 excision is so low, you don't need chemotherapy, and that
47 platform and similar platforms with different brand names

1 have been adopted by single payer settings around the
2 place, because the companies have showed you evidence that
3 it will save money to the healthcare system as a whole,
4 because although it costs $2,500 per test, if a certain
5 number of women don't need chemotherapy that's great for
6 them, because they don't get all the side effects of
7 chemotherapy, and it's great for the system because you
8 don't have to pay for chemotherapy and everything that goes
9 along with that and the complications.
10
11 I put that in, even though it was about 10 years ago,
12 as an example of how a non-single payer, NSW Health
13 Pathology, quite clearly told me - in fact it was Stephen
14 Braye at the time, that they can't fund it because it's too
15 expensive, and I said, "But in the overall scheme of health
16 care, it saves money", "But it's too expensive to our
17 budget." I even suggested that they could work with the
18 LHDs and, you know, if they are doing chemotherapy, but
19 a platform like that just doesn't fly when the pathology
20 department pays for it and the money is saved by others.
21
22 So we still get requests from some private - some
23 outpatients, to send - some of it gets sent to Queensland
24 or wherever, because some people see the benefit of it, but
25 none from the public system and none from NSW Health
26 Pathology. I think Douglass Hanly Moir offer that
27 platform.
28
29 Q. Can I ask you to go forward now to paragraph 50 of
30 your statement. You tell us there that a change of
31 structure to establish NSW Health Pathology centralised in
32 Newcastle has been detrimental to patient care and staff
33 morale. Can I ask you to explain why it is that the
34 structure or the centralisation of the structure has been
35 detrimental to those things, rather than the various other
36 challenges that we've talked about, workforce challenges
37 and the like?
38 A. My staff find it extremely frustrating when simple
39 matters are made more complex by a remote bureaucracy.
40 I don't know how - shall I give some specific details?
41
42 Q. Yes, please.
43 A. They are quite technical. So, for example, in
44 pathology, you have to be involved in quality assurance
45 activities, which means you just want to make sure you get
46 the diagnosis right because you don't want a rogue
47 pathologist who can do all sorts of damage before it is

1 picked up, and, therefore, we enrol in a lot of the college
2 quality assurance modules - we're involved in all of the
3 quality assurance modules where we submit our answers, they
4 get marks, and they should be concordant and, if
5 something's discordant, you need to explain why and review
6 it and go through the process.
7
8 We have had different modules to do it and
9 historically what we would do is record discrepant cases in
10 the myQAP module on the college website, where you do the
11 results and discuss it, we have a meeting where we review
12 it amongst the whole department and decide whether it is an
13 issue or not.
14
15 About three months ago, we were told that for any
16 discordant case there needs to be a BIR issued, which is
17 a business improvement plan, which revived a lot of extra
18 sort of administrative staff, uploading things in different
19 settings, and there seems to be a lot, for these sorts of
20 things, "We can't do it", "It has to be done."
21
22 Then about two months ago - one month ago, we were
23 told "You don't need to do a BIR if it is just a QAP
24 discrepancy".
25
26 Then on Tuesday of this week, by email, I received
27 a reply-all email, including all the other heads of
28 department, saying, "We have decided that you do need to do
29 a BIR for all these issues", and the reason from that email
30 was that the centralised quality assurance team found it
31 too hard to keep track of any of the discordant cases
32 unless it was done through the BIR system, because it was
33 too time consuming to go through the same system.
34
35 So the BIRs might take a couple of hours for each
36 discordant case as it has to be done by a pathologist
37 scientist, so it is many hours for our frontline staff to
38 do them, that I take as a decision that has been made to
39 save some hours for a centralised bureaucracy to review the
40 discordant results, and, you know, when - I was talking to
41 some of the pathologists about this yesterday, we're just
42 pulling our hair out saying, not only were we told to do it
43 one way, then another way, then another way, we were told
44 to go through a process that could be called Kafkaesque,
45 when we could have just done it ourselves appropriately,
46 and there's been several, you know, with that, other sort
47 of edicts that certain sort of processes that might be more

1 appropriate to a stat lab are enforced upon us without
2 consultation, and that caused a lot of frustration for us.
3
4 I'm trying to think what other issues we could talk
5 about for the centralised thing. We could talk about - we
6 wanted to buy a mini x-ray machine for our department, and
7 the reason is that some breast cancers have calcium in
8 them, and you can do surgery to remove suspicious imaging
9 findings and they send the whole breast lump to our
10 department and we need to sample some of those areas to
11 find out whether it is cancer or not. If we don't know
12 where the calcium is, we might have to put in 100, 150, 200
13 blocks of some of those samples, whereas if we had an x-ray
14 in our department, we could just x-ray the bits of the
15 breast and save us - we could pay for the cost of the x-ray
16 machine by saving money on the amount of blocks that we
17 process.
18
19 My colleague Angela Wong - we discussed it, she's
20 a breast expert, she put in a business case for that, which
21 I think started about 14 months ago, and back and forth,
22 "Provide detail", back and forth, back and forth, delayed
23 for that whole time, and curiously, just this week,
24 I think, just before this, I appeared here, we were told
25 that, in principle, they support this purchase of this
26 equipment, and I just find it surprising, when all the
27 figures that we presented and the international standard is
28 that it will save money pretty quickly, but there was
29 reluctance to buy the machine that we all wanted, that we
30 provided evidence that would save money and efficiency.
31
32 That process, I mean, I can't tell you how many emails
33 went back and forth about that, but, you know, it might be
34 an exaggeration to say 100, but it wouldn't be that much of
35 an exaggeration, back and forth through different pairs of
36 hands, when I think that process would only happen when the
37 management is undertaken by email rather than face-to-face
38 meetings. I think similar issues where there's been
39 procurement in the LHD setting, a lot of things have been
40 progressed by having face-to-face meetings.
41
42 It causes heartache. Many people who put in business
43 cases for stuff when it has been treated like that, they
44 have just given up after the first few months.
45
46 Q. Could I ask, in terms of, what my understanding is, is
47 called the number 2 account --

1 A. Yes.
2
3 Q. -- have there, to your observation, been any changes
4 in the way decisions are made around the number 2 account
5 funds consequent upon the creation of NSW Health Pathology,
6 from the perspective of a clinician at North Shore?
7 A. Sure. So you know how the number 2 and number 1
8 accounts work?
9
10 Q. Perhaps give us a very short burst on how they work
11 from the point of view of an anatomical pathologist.
12 A. So I'm a staff specialist, so I'm just salaried by the
13 LHD, and I also see private patients, billable patients,
14 and for anatomical pathology, the facility fee is
15 20 per cent, which is the general - NSW Health Pathology
16 takes 20 per cent of the billed fee, and 80 per cent goes
17 into a trust fund called the number 1 account, which pays
18 a certain salary supplement, and excess money at the end of
19 the year goes into the number 2 account which can be used
20 for teaching, education, research, services, capital
21 expenditure and things like that.
22
23 Q. Just pausing there, under the old structure, when
24 pathology was dealt with through the LHD, how was
25 decision-making - how did decisions get made around funds
26 in the number 2 account which were referable to anatomical
27 pathology?
28 A. Yes, so we have a pooled fund in our department with
29 haematology, biochemistry and microbiology, the other
30 faculties of pathology, although most hospitals in
31 Australia - New South Wales have anatomical pathology
32 alone. We have a number 2 management committee who reviews
33 requests for money. They might want, you know, a research
34 disposables or something like that, and they approve that
35 through the local pathology director, and historically,
36 that was sort of a rubber stamp process.
37
38 But to give you an example, about, oh, seven, six
39 years ago, at a time when we had about $6 million in that
40 account, we wanted to buy a whole-slide imaging platform,
41 which is an imaging system that scans in the whole of the
42 microscope slide, because a huge thing in pathology, going
43 forward, is digital pathology and artificial intelligence,
44 where you can train a computer to do what I do, and to do
45 that, you've got to scan in the glass slides into a digital
46 format to feed the computer, and we put in a business case
47 saying, "We would like to buy a whole-slide scanner for our

1 department, because it's got clear advantages for teaching,
2 education and research", which was a goal of that fund, but
3 also for future-proofing our practice because digital
4 pathology is already here in a lot of settings around the
5 world.
6
7 Business case. It was approved by the number 2
8 account, and we were told the CEO of NSW Health Pathology
9 said no, that we can't do - we can't purchase the digital
10 scanner, because any expenditures in this will have to be
11 in line with NSW Health Pathology's digital pathology
12 strategy.
13
14 I was on a couple of digital pathology strategy
15 working groups and, to summarise, nothing's happened in
16 those four or five years. And so we weren't allowed to buy
17 a whole-slide scanner with our trust fund money, which is
18 separate from general revenue, which would be an ideal
19 thing, because any expenditure had to be in line with the
20 statewide - you know, what platforms they get. But yet,
21 after several years, I would say five years, we haven't got
22 a statewide digital pathology structure, we can't - we
23 don't have a digital scanner. I'm embarrassed, with
24 international collaborators in research, when they ask me
25 can I scan in some digital slides of this case for
26 a research project and I can't do it, I need to send it
27 away to somewhere else. Most departments have them.
28
29 MR MUSTON: I've got no further questions for this
30 witness, Commissioner.
31
32 THE COMMISSIONER: Thank you. Mr Cheney?
33
34 MR CHENEY: Commissioner, I wonder whether you might take
35 an early morning tea for me to take some instructions, if
36 you wouldn't mind.
37
38 THE COMMISSIONER: Yes, okay. We will come back at 11.45.
39
40 MR CHENEY: Thank you, Commissioner.
41
42 THE COMMISSIONER: We will adjourn until then.
43
44 **SHORT ADJOURNMENT**
45
46 THE COMMISSIONER: Do you have some questions, Mr Cheney?
47

1 MR CHENEY: I do, Commissioner. Thank you for the time.
2
3 **<EXAMINATION BY MR CHENEY:**
4
5 MR CHENEY: Q. Professor Gill, your work in pathology
6 commenced when you were a registrar at Royal North Shore
7 some time prior to 2005; would that be correct?
8 A. Yes, correct, 2000.
9
10 Q. Year 2000?
11 A. Year 2000.
12
13 Q. You worked as a staff specialist in that role from
14 about 2005 through to a couple of years ago; is that right?
15 A. I'm still a staff - registrar 2000 to 2005, then staff
16 specialist, 2005 to current time.
17
18 Q. And the move to the role of clinical director at Royal
19 North Shore pathology service was in 2022?
20 A. Correct.
21
22 Q. Is it right to think of that as your first time in a
23 senior role?
24 A. Not really. So I was the acting in charge for three
25 months, oh, three or four years prior to that, and I've had
26 several other sort of leadership roles. I'm the chairman
27 of the Australian Pancreatic Genome Initiative, it's a big
28 pancreatic cancer research group, and have been on other
29 sort of advisory bodies, MSAC, MRFF, and in the research
30 role I suppose I've been a senior academic pathologist and
31 professor for quite a while.
32
33 THE COMMISSIONER: Q. If these acronyms are important,
34 you might have to tell us what MSAC and MRFF are.
35 A. MSAC is the Medicare Schedule Advisory Committee. I'm
36 on the evaluation subcommittee, so when someone puts
37 a proposal for a new Medicare rebate, there is a group of
38 experts who look at the business case and the clinical, and
39 so forth. MRFF is the Medical Research Future Fund. I'm
40 on the genomics advisory group for that.
41
42 Q. And the chairman of the Australian Pancreatic - did
43 you say Genome --
44 A. Australian Pancreatic Genome Initiative, APGI, is
45 a national research project funded, I think it's
46 $27 million from the NHMRC, to conduct whole new genome
47 sequencing on pancreatic cancer.

1
2 Q. Does that involved Garvan, does it?
3 A. It's based at the Garvan, although two-thirds of the
4 patients were operated on at North Shore hospital. It is
5 a big pancreatic surgery unit.
6
7 MR CHENEY: I'm contemplating a submission, Commissioner,
8 that the first recommendation should be the abolition of
9 all acronyms.
10
11 THE COMMISSIONER: You can take that one as a given.
12
13 MR CHENEY: Q. Professor Gill, the Northern Sydney Local
14 Health District was, to your knowledge, established in
15 about 2011; correct?
16 A. I will take that, okay, yes, that sounds right.
17 I just think of myself as always being at that hospital,
18 the RNS building, but I understand there was this change
19 between RNS and LHD and then Central Coast, and then back
20 and forth.
21
22 Q. And there was a time at which Royal North Shore formed
23 part of the Hunter New England Area Health Service, to your
24 knowledge; is that right?
25 A. I don't - so in pathology, in one of the things, we
26 went from just North Shore, and we always did Hornsby and
27 Ryde and Manly, and then we joined the Central Coast to be
28 Pathology North Shore Central Coast, and then we were
29 Pathology North, which went to the Queensland border, and
30 now we're NSW Health Pathology.
31
32 Q. But when you say in paragraph 8 that when you
33 commenced as a staff specialist you were employed by the
34 Northern Sydney Local Health District, might it be more
35 correct to say you were employed by the Hunter New England
36 Area Health Service in 2005?
37 A. No, I don't think that's the case. I think I started
38 as - whether it was RNS or NSLHD, that was where my
39 employee number was and then, as part of the move to
40 Pathology North, Hunter New England took over some of the
41 administrative stuff for pathology at North Shore, and that
42 was about - it was a few years later, because I remember
43 they gave you extra salary sacrifice or something. It was
44 definitely when I was a staff specialist a few years later.
45
46 THE COMMISSIONER: Q. I may have gotten confused at one
47 stage. When you say in 8 that you were employed by the

1 Northern Sydney Local Health District --
2 A. Yes, I probably --
3
4 Q. Just wait for the question. And then you mentioned
5 the creation of NSW Health Pathology, are you an employee
6 of NSW Health Pathology now or still --
7 A. Correct.
8
9 Q. You are?
10 A. Correct.
11
12 Q. I think there was one stage earlier in the transcript
13 you might have said that the LHD was paying your salary,
14 but that's not - it's actually --
15 A. So - I don't know, the LHD doesn't pay my salary and
16 hasn't since 15 years ago.
17
18 THE COMMISSIONER: Anyway, that clears that up.
19
20 MR CHENEY: Q. You see in paragraph 9 you describe NSW
21 Health Pathology as a centralised bureaucracy based in
22 Newcastle?
23 A. Yes.
24
25 Q. There are many members of the executive of NSW Health
26 Pathology who are located in Sydney; correct?
27 A. There are more now than previously, but the centre of
28 orbit and, power through the time that I've been involved
29 in it, has been in Newcastle and that goes all the way back
30 to when Pathology North had the centralised admin in Hunter
31 New England, and the key, the CEOs, the key
32 decision-makers, have been based in Newcastle. They built
33 that building at 1 Reserve Road just next to North Shore
34 a few years ago and some of them have spaces there, but
35 it's certainly been my experience that key decision-makers,
36 the majority, many, are based in Newcastle.
37
38 Q. The senior operations manager for the Northern Sydney
39 Local Health District is located at the hospital; correct?
40 A. For the Northern Sydney Local Health District, but,
41 say, the operations manager in general is Darren Croese,
42 who is located in Newcastle.
43
44 Q. But the senior operations manager for Northern Sydney
45 Local Health District --
46 A. Correct. That would be Cathy Atkins, if I've got the
47 titles --

1
2 Q. You have referred, I think, to what you perceive are
3 problems created by what you describe as the separation
4 between the centralised decision-makers and - being the
5 people, as you describe it, with budgetary responsibility -
6 and local pathologists?
7 A. Yes.
8
9 Q. You accept, don't you, that the structure of NSW
10 Health Pathology facilitates a dialogue regularly between
11 local pathologists, if I can use that generic term, and the
12 management of NSW Health Pathology?
13 A. There is some dialogue, although most --
14
15 THE COMMISSIONER: "Dialogue" is not necessarily a helpful
16 term. Do you mean meetings, do you mean --
17
18 MR CHENEY: Yes.
19
20 THE WITNESS: Okay --
21
22 MR CHENEY: Q. Perhaps I will clarify. I'm suggesting to
23 you that such is the structure of NSW Health Pathology
24 that, as a matter of fact, there are many opportunities for
25 local pathologists, such as yourself, to make known to
26 NSW Health Pathology any concerns you have about the local
27 setting; correct?
28 A. I think there are too few structures, and I can give
29 some examples.
30
31 Q. I am sorry, did you say too few?
32 A. Too few. So a lot of my instructions come by email.
33 Since COVID, there's been a lot more Teams meetings, but
34 very few face-to-face - very, very few face-to-face
35 meetings with senior management. I see the LHD senior
36 management many times more often.
37
38 THE COMMISSIONER: Q. Your concern, in a broad sense, is
39 not that you can't send an email to Newcastle, to someone
40 in Newcastle, because of course you can from anywhere in
41 the world.
42 A. You can, yes.
43
44 Q. It's the lack of face-to-face kind of meetings and
45 opportunities to engage with each other.
46 A. Lobbying opportunities. I think it's easier to say
47 "No" to some critical things by email than in a

1 face-to-face meeting.
2
3 Q. Well, it is different.
4 A. Yes.
5
6 MR CHENEY: Q. What I want to suggest to you, sir, is
7 that there are many opportunities for you to have
8 face-to-face dialogue with the relevant players within
9 NSW Health Pathology about any concern you have.
10 A. Oh, we've had some issues in our department, say, when
11 I first started as head of department, that I wanted to
12 have a face-to-face meeting with the CEO and I couldn't do
13 that.
14
15 THE COMMISSIONER: Again, I'm not sure, without wishing to
16 be picky, but "relevant players within NSW Health
17 Pathology", what does that mean and where are these people
18 based?
19
20 MR CHENEY: Q. I'm suggesting that the face to face
21 meetings are occurring at the hospital, or in Sydney, at
22 least; is that right?
23 A. So if you want to recount face to face meetings I've
24 had with senior management, I met with Vanessa Janissen
25 a couple of months ago. Darren Croese came down once when
26 they wanted funding from our trust fund. I don't think
27 I've had others, not in the last year. And it's
28 interesting, because I've read some of the previous
29 evidence, how people have said the LHD model works better
30 because people feel involved in and, buy in, and there are
31 all these intangibles, and I just don't understand why
32 pathology is going the other way.
33
34 THE COMMISSIONER: Q. Just remind me, Darren Croese is
35 what position?
36 A. They all have titles that change.
37
38 Q. Vanessa, I think, you're referring to the CEO?
39 A. The CEO. Is Darren Croese the chief of operations?
40
41 Q. COO, is it?
42 A. Yeah, look --
43
44 Q. I shouldn't guess.
45 A. Their names change, but there is a senior leadership
46 team of three or four people who are - Deanna Paulin is HR;
47 Vanessa Janissen; I think it's Darren Croese and Robert

1 Lindeman, and I haven't seen Robert Lindeman face to
2 face --
3
4 Q. From your perspective - we know where the CE is based
5 but are the other senior management people within
6 NSW Health Pathology that you might like to engage in for
7 matters that are relevant for you and your department and
8 the cases you have, are they all based in Newcastle or are
9 any based in Sydney?
10 A. Robert Lindeman would be based in Sydney, although not
11 on our campus.
12
13 Q. Who is Robert Lindeman?
14 A. Is he director of clinical operations?
15
16 Q. I don't know.
17 A. Yes, so I suppose he is a title of that ilk. What
18 they all are is not based on our campus.
19
20 Q. When you say "based in Sydney", not at your campus,
21 somewhere else in Sydney?
22 A. Correct.
23
24 MR CHENEY: Q. You have told us in paragraph 11 of your
25 statement, sir, that your direct reporting line is to
26 Dr Tom Kennedy, the local pathology director. Do you see
27 that? Do you understand that part of Dr Kennedy's formal
28 responsibilities in that role are to provide strategic and
29 expert advice to NSW Health Pathology executives and senior
30 managers regarding the assessment of business cases and
31 requests for funding?
32 A. I would have thought that's his role, although I could
33 say that when I did put in my business case, I was directed
34 to move that to Cathy Atkins, it went to Louise Wienholt
35 and then to accounting in Newcastle, and he supported that,
36 but I don't think he had any role in the sign-off on it.
37 He was aware of it, there were discussions about it.
38
39 THE COMMISSIONER: Q. Is Dr Kennedy part of NSW Health
40 Pathology or part of the LHD?
41 A. He's - NSW Health Pathology at North Shore campus.
42
43 MR CHENEY: Q. You, in your role, operate pursuant to
44 a position description, a formal position description, do
45 you not?
46 A. Correct.
47

1 Q. That provides that you, in your role, are to have
2 a major input into the business and strategic planning of
3 the laboratory?
4 A. I would have to look at the business case [sic], but
5 it should say something like that - the description.
6
7 Q. And you know, don't you, that the performance of the
8 laboratory and its planning for future needs is overseen by
9 not only yourself and Dr Kennedy, but in conjunction with
10 executives from the NSW Health Pathology?
11 A. Yes, of course.
12
13 Q. The local clinical directors, like yourself, are also
14 typically members of broader statewide governance groups?
15 A. Correct.
16
17 Q. Including operational executive meetings?
18 A. I have never been asked to an operational executive
19 meeting. We have regular heads of department meetings.
20 One point I would make about the consultative structure,
21 there is a group called the anatomical pathology clinical
22 stream, which is a group of mostly ex-department but senior
23 pathologists from many different hospitals. I'm not
24 a current member, another member of our department
25 represents us on that group, but when I have been there in
26 the past, it was made clear to me that this is an advisory
27 board and that they have the right to overrule our thoughts
28 on certain things.
29
30 Q. You have participated in meetings of those clinical
31 stream groups?
32 A. Yes, just a handful. We have another representative
33 of our department who feeds back on it.
34
35 Q. And to your knowledge, Dr Kennedy participates in
36 statewide forums with his counterparts and executives --
37 A. I would presume so, yes.
38
39 Q. -- from NSW Health Pathology?
40 A. I would presume so, yes.
41
42 Q. And in your role as a clinical director, you are also
43 involved in budget performance reporting through heads of
44 department meetings?
45 A. I don't have any budgetary responsibility. It's made
46 very clear to me that any budgetary expenditure - I don't
47 have a budget. If I save money, I can't use it. I don't

1 have a budget.
2
3 Q. I wasn't suggesting that you had a budget, sir, I'm
4 suggesting that you participated in budget performance
5 meetings or budget performance discussions through the
6 heads of department meetings.
7 A. Once a month, at heads of department, they show
8 a spreadsheet of the performance of the bottom line
9 performance, very briefly, but when it comes to having
10 a role in developing budgets and strategic staffing,
11 I don't feel that I have a role.
12
13 Q. Sir, there is also, to your knowledge, a document
14 known as a clinical services plan; correct?
15 A. I have seen a clinical services plan at some stage
16 that I think is revised at every five years or so. Is
17 that - for pathology. There is also an LHD one.
18
19 Q. It is an LHD, or at least it is a document published
20 by pathology.
21 A. Mmm-hmm.
22
23 Q. Perhaps I will show you a copy, sir. I will show you
24 this clean version, sir. Could I hand this to the witness.
25 I'm sorry, it is not pinned in any way, Professor. Have
26 you seen that document before?
27 A. I have seen this or similar documents.
28
29 THE COMMISSIONER: This isn't in the materials? There is
30 no document ID or anything like that?
31
32 MR CHENEY: I'm sorry, Commissioner, I should have
33 provided this. I am told it became exhibit 23 in the
34 second tranche, so it is exhibit B.23.094. "Exhibit" might
35 be the wrong prefix but --
36
37 THE COMMISSIONER: Does it have an SCI number?
38
39 MR CHENEY: No, it bears a Ministry of Health discovery
40 number, I think.
41
42 THE COMMISSIONER: Let's move on. You proceed. If there
43 is another copy, I will have a look at it. Oh, there we
44 go, look at that. [MOH.0001.0384.0001]
45
46 MR CHENEY: Yes, that's the document. And can we go to
47 internal page number 103.

1
2 Q. Down three pages, the internal page number. Do you
3 have page 103, sir?
4 A. Yes.
5
6 Q. You see that there is a description there of the role
7 of, or what it is intended will be the role of clinicians,
8 or it is contemplated that there will be consultation with
9 clinicians by NSW Health Pathology?
10 A. Yes.
11
12 THE COMMISSIONER: What's the date of this document?
13
14 MR CHENEY: It has a range date at the front,
15 Commissioner, of 2019 through to 2025.
16
17 THE COMMISSIONER: Presumably, then, the photo of the
18 happy family on the front was taken in 2019, and is somehow
19 crucial to the plan.
20
21 MR CHENEY: Q. Just going back a page, if we could go up
22 one page to section 10, there is a reference to "Clinical
23 services planning to support future pathology service
24 models"; do you see that?
25 A. Yes.
26
27 Q. In section 11 on page 103, it's contemplated, do you
28 see, in bold under number 2, that NSW Health Pathology will
29 consult with each individual local health district's
30 service planners and other key stakeholders, including the
31 local pathology directors, about this plan?
32 A. Yes, I can see that.
33
34 Q. You, I think, as we've heard, came to the role in
35 2022. Have you consulted at all with anyone from
36 NSW Health Pathology about this plan since your appointment
37 to that position?
38 A. This plan, I haven't been asked to consult on. My
39 understanding is that they are developing a new clinical
40 services plan, because this is expiring in 2025, but
41 I haven't been asked to consult on it.
42
43 MR CHENEY: Commissioner, I'm not sure whether we've
44 sufficiently identified that document for it later to form
45 part of any tender.
46
47 THE COMMISSIONER: Do you want to MFI it?

1
2 MR MUSTON: It is [MOH.0001.0384.0001].
3
4 THE COMMISSIONER: I can just say that that document, of
5 the number that Mr Muston just read out, is MFI 5, or
6 something, is it?
7
8 MR MUSTON: I think it is part of the tender. Is that all
9 right?
10
11 MR CHENEY: Yes.
12
13 THE COMMISSIONER: Or can it be tendered?
14
15 MR MUSTON: I think it is part of the tender.
16
17 THE COMMISSIONER: It is part of the tender. Okay. Is it
18 somewhere within these 15 volumes of material that are in
19 front of me?
20
21 MR MUSTON: We have identified quite a number. If it
22 hasn't been formally tendered in an earlier tranche, we can
23 tender it.
24
25 THE COMMISSIONER: Let's call it MFI 5 for the time being.
26 If it is part of the tender, it is already there. If not,
27 it can be added.
28
29 **MFI #5 DOCUMENT WITH IDENTIFIER [MOH.0001.0384.0001]**
30
31 MR CHENEY: Q. Professor, you say in paragraph 12 that
32 you rarely, yourself, meet with the executives of
33 NSW Health Pathology, and you say it's at most once or
34 twice a year. Do you see that?
35 A. Correct.
36
37 Q. Do you adhere to that statement?
38 A. So I can remember seeing the CEO, and I said I've seen
39 the current CEO once, who has I think been in
40 since October. The previous CEO came to our department, I
41 remember, once last year. There was a group meeting with
42 everyone, not a one-on-one meeting. Was she there a second
43 time? Could be. I don't - not more than that.
44
45 Q. You have met, have you not, with the director of
46 people and culture at NSW Health Pathology, Ms Deanna
47 Paulin?

1 A. Deanna Paulin, yes.
2
3 Q. You have met regularly with her since your
4 appointment?
5 A. Yes - well, when I took over the department, there was
6 a lot of interpersonal conflict within the departments,
7 with multiple --
8
9 Q. I didn't ask why you have met, sir. I'm just asking
10 whether you did meet with her. You have met with her?
11 A. So we --
12
13 Q. Have you met with her, sir?
14 A. Yes. We have had several --
15
16 Q. Can I suggest to you, sir, that you have met with her
17 some 13 times since your appointment in 2022. Do you
18 accept that?
19 A. Yes, I do.
20
21 Q. At those meetings, there have been other executives
22 from NSW Health Pathology, including the director of
23 medical services?
24 A. No.
25
26 Q. I'm sorry, there have been other executives from the
27 hospital at those meetings?
28 A. No.
29
30 Q. Director of strategy and transformation?
31 A. That's Martin Canova. I have met with him once about
32 genomics, maybe twice.
33
34 THE COMMISSIONER: "Executives from the hospital" means
35 people from the LHD, does it, not NSW Health Pathology?
36
37 MR CHENEY: Yes.
38
39 THE COMMISSIONER: Okay.
40
41 MR CHENEY: Q. Professor, the meetings that you have had
42 with Ms Paulin, I suggest, related to concerns about morale
43 and behaviour and relationships in the Royal North Shore --
44 A. Correct.
45
46 Q. -- pathology unit?
47 A. Correct.

1
2 Q. That followed a 2022 external review of the culture?
3 A. Correct.
4
5 Q. You have had some coaching support yourself, have you
6 not --
7 A. Correct.
8
9 Q. -- on the management culture within the unit?
10 A. NSW Health Pathology paid for an external consultant
11 to mentor me monthly, mainly about interpersonal dynamics
12 within our department, and all the meetings with Deanna
13 have been about that. I suppose I don't think of that -
14 I appreciate she's on the executive, but that's - I don't
15 think of her as having an executive role to strategic
16 planning and budgetary and all the other things we are
17 talking about. I think of her as an HR executive about
18 these interpersonal conflicts.
19
20 Q. What is said in paragraph 12 misstates the position,
21 doesn't it?
22 A. I suppose - I understand what you are saying. When
23 I talk about the executives, I suppose I am thinking about
24 those with budgetary and strategic responsibility for
25 services planning. I meet - I am scheduled to meet each
26 month, by Zoom, mostly, or phone call with Deanna Paulin
27 solely about HR issues, about behaviour and complaints and
28 things in our department and how to deal with that, and
29 that's - the meetings are essentially - are only about
30 that. They are never about budgetary, strategic planning,
31 staffing levels in the department, things like that. And
32 so I suppose, although I appreciate that Deanna may have
33 a role in the executive, I don't think of her as "the
34 executive", in that sense.
35
36 Q. And as you have told us, you met as recently as the
37 last couple of months with the chief executive of NSW
38 Health Pathology; correct?
39 A. Yes. I've had one meeting with her.
40
41 Q. Was that a meeting that you requested?
42 A. Oh, I think they emailed me to say that she would like
43 to meet with me.
44
45 Q. You, with respect, are not a shrinking violet about
46 expressing your concerns about all things pathology;
47 correct?

1 A. Yes, I suppose, to get to your point which I think you
2 are making, the fact that I'm here - I mean, many of my
3 colleagues have said someone should say something here, and
4 I'm here, and other people don't want to because they feel
5 there could be adverse outcomes or - I understand. And
6 I have been critical, as is evident from what I've
7 submitted, of many major decisions, and I feel, as
8 a result, I am not well liked by members of the senior
9 executive of NSW Health Pathology.
10
11 THE COMMISSIONER: Q. Have people said to you that they
12 feel constrained from, for example, doing what you are
13 doing, giving evidence here?
14 A. Yes.
15
16 Q. Because they think - when you say "adverse outcomes",
17 can you explain what you mean?
18 A. Yes. So in our department I said to people, "I'm
19 going to put this written submission in" and shared the
20 email with a few people about how to do it, and they said
21 "Yes, we should all do this. I want you to do it, and you
22 should say this and this". I said, "I'm happy to do it but
23 it would be good if it came from many people, because many,
24 people feel the same way" and none of them have followed
25 through. And I have spoken to people and they say, "Look",
26 one person said, "Look, in my position" - in a senior
27 analogous position to me at a different hospital, "I feel
28 that I can't do that". I said, "Well, if we don't do it,
29 who is going to do it", and someone else said they are
30 concerned that there could be - their progression up the
31 chain might be stymied by being seen to be critical.
32
33 Q. As far as you understand it, though, is that because
34 of their own perception?
35 A. Yes, I believe so. I have reassured them that I don't
36 think - you know, this is an open - we're in court, we're
37 being video streamed, I just - I'm here. My career is very
38 important to me and I'm here in your hands with confidence
39 that the process is safe, and I don't think that there is
40 really any likely adverse outcome, but I think there is an
41 anxiety or it is one of the reasons that more people
42 haven't come forward, and I suppose I'm saying to you that
43 many people have come to me, "You should say something,
44 Gillie", that don't want to put it in writing themselves.
45 One of my colleagues put in a written submission, Dr Wong.
46
47 MR CHENEY: Q. But you were not directed or constrained

1 in any way --
2 A. No, no.
3
4 Q. -- from cooperating with this Inquiry; correct?
5 A. 100 per cent, I feel very comfortable telling the
6 truth, the whole truth, and nothing but the truth, and
7 I don't feel at risk of adverse outcome. I'm just saying
8 that that is one of the things, that people just don't want
9 to rock the boat.
10
11 Q. You have raised the issue of how the pathology unit's
12 participation in multidisciplinary team deliberations
13 should be funded.
14 A. Well, I suppose I would just like them to be funded no
15 matter who the payee - payer is.
16
17 Q. I mean, I take it you acknowledge that the input of
18 pathologists in those multidisciplinary teams is extremely
19 important --
20 A. Correct.
21
22 Q. -- for patient care, and I think you said as much
23 earlier?
24 A. Correct. 100 - for most cancers, the pathologist's
25 input is critical, and that would be accepted around the
26 world, to have a proper MDT you need a pathologist,
27 a radiologist, and then oncology, surgeons, depending on
28 the nature of what you're discussing.
29
30 THE COMMISSIONER: Q. Is that because the opinion of the
31 pathologist drives what the treatment option is?
32 A. Yes. So I mean we would view that most diagnoses of
33 cancer are made by the pathologists, because you will see a
34 lump or an imaging, but it is all about the biopsy and what
35 that shows as to whether it is cancer or not, and then if
36 it is cancer, there are thousands of different types that
37 are all treated differently. So having that nuance is
38 really important, and for common cancers it is not as
39 important as for rare cancers, but it is important across
40 the setting, and so the directives from all sorts of key -
41 bodies, CI New South Wales, World Health Organizations,
42 pathologists are critical.
43
44 Q. And I take it the range of treatments is expanding
45 rather than contracting?
46 A. Correct. So we talk about personalised medicine where
47 you basically spend a lot of money testing the tumour to

1 decide which treatment to give, and that's just exploded
2 and increased our testing requirements.
3
4 Q. Hence the banking of the --
5 A. Yes, so the banking of the discovery of frozen tissue,
6 what's the DNA abnormalities in cancer.
7
8 MR CHENEY: Q. Sir, you refer in paragraph 15 to
9 a concern that the six registrars tied to the pathology
10 unit are the only registrars within the hospital who do not
11 report to the junior medical staff unit. You appreciate,
12 I gather, that there is a rationale for the different
13 regime in place to - the different reporting regime in
14 place for registrars in the pathology sphere?
15 A. Yes, I can see arguments for and against that
16 structure.
17
18 Q. But one argument for it is it is a recognition, isn't
19 it, that people who practice in your discipline have an
20 extremely specialised role, and the structure that sees
21 them reporting to the NSW Health Pathology junior medical
22 officer unit is one that fosters the training that is
23 required to transition registrars between laboratories and
24 across sites?
25 A. Yes. So a reason for that structure is that pathology
26 is a niche specialty which is different to other aspects of
27 clinical medicine.
28
29 Q. And to your observation, that is a practical benefit
30 of a different reporting regime for those particular
31 species of registrar, if I can use that term?
32 A. Oh, yes, I'm just making the point that what - you
33 gain something, but you lose something, and what you lose
34 is what we talked about, that resident ability to have - to
35 rotate through, and that flexibility, and I suppose I was
36 also alluding to that if you have a JMS unit, I don't know,
37 do we have 100, 200 registrars at NSHD? An extra six from
38 pathology wouldn't be a burden on that unit. Like, it's
39 not a great cost efficiency.
40
41 Q. But the rotation of registrars through the pathology
42 unit is to be encouraged, if for no other reason than it
43 provides, perhaps, a future source of potential full-time
44 employees for you?
45 A. Definitely, I would like more rotations, I suppose not
46 just to get good trainees in pathology but also for
47 non-pathologists to get a better understanding of

1 pathology, because it really helps non-pathologists, just
2 as we have to do clinical medicine before we do pathology,
3 because that clinical understanding helps us to understand
4 pathology, so it is a two-way street.
5
6 Q. Sir, you take some time in your statement to speak
7 about what you describe as the unpaid overtime incurred by
8 staff specialists?
9 A. Correct.
10
11 Q. There is, as part of staff specialists' remuneration,
12 an allowance known as an onerous duties allowance?
13 A. Correct.
14
15 Q. And it is a reasonably substantial allowance, is it
16 not, of some 17.4 per cent?
17 A. Correct. Something like that.
18
19 Q. Do you understand that to be in recognition of the
20 fact that pathologists have to work overtime from time to
21 time?
22 A. We do not get the onerous duties allowance in our
23 department.
24
25 Q. I'm sorry?
26 A. We do not get an onerous duties allowance in our
27 department, and when I have inquired about an onerous
28 duties allowance in our department, formally, and there
29 will be an email record, I was told it would not be
30 possible for us to get it.
31
32 THE COMMISSIONER: Q. Were you told why?
33 A. The money. I was - I could find an email, but one of
34 our proposals to get more staff was to ask for an onerous
35 duties allowance, because that can only be done for
36 a certain time, or it needs to be then renewed.
37
38 Q. My question was, were you told why? Do you remember,
39 or not?
40 A. I was told it would not be possible and - I just took
41 it it was the money, to tell you the truth, but I couldn't
42 go on record to say that's what the email said, but I have
43 inquired about it and, no, we don't get an onerous duties
44 allowance.
45
46 MR CHENEY: Commissioner, I should just flag that my
47 instructions are obviously to the contrary, and it may be

1 that evidence about it will be adduced in circumstances
2 where I haven't properly put it to this witness, but
3 I can't do much about that.
4
5 THE WITNESS: Are you talking - there is an on-call
6 allowance, if we go on call and we are called in the middle
7 of the night, there is an allowance for that, but there's
8 certainly no onerous duties allowance for us.
9
10 MR CHENEY: Q. You have said a little bit about the
11 Paxton review, the report of which I think you have said
12 you haven't seen yourself?
13 A. Correct.
14
15 Q. But whatever it might have said, you understand, don't
16 you, that subsequent to it, Royal North Shore was given an
17 additional 1.5 FTE - that is, one and a half full-time
18 employees?
19 A. No, I think we were given 1 FTE, from that -
20 I believe - and I think that I had, from the University of
21 Sydney, I have a position there, a 0.5 senior lecturer
22 position that was moved in together with it. So my
23 recollection, it was 1. Could it have been 1.5? I don't
24 think it was. I thought it was 1.
25
26 Q. Can I suggest to you, sir, that there were two
27 additional pieces of support following the Paxton review
28 given to your particular anatomical pathology lab, namely,
29 an additional 1.5 FTE employee, and another 1 FTE to
30 support excess leave that had been accumulated?
31 A. I wasn't the head of the department at the time and
32 I can't recall. In terms of excess leave, there was at
33 some stage something about excess annual leave, but I think
34 things are being conflated because last year we had a locum
35 for - predominantly for maternity leave, where the numbers
36 didn't quite add up and we added in some excess annual
37 leave that could be in there. That's right, there was
38 state government funding for excess annual leave, and last
39 year, part of the business case for a locum was to do with
40 excess annual leave. That was quite a while after the
41 Paxton.
42
43 Q. Sir, you speak about a review - sorry, in paragraphs
44 24 through to 27 of your statement, you speak about
45 a review that was undertaken in 2023, the year 2023; do you
46 see that?
47 A. Correct. I think it started in 2022, we were visited

1 in 2023.
2
3 Q. Were you privy to the findings of that review?
4 A. The published findings, we had a meeting, we went
5 through it, and the published findings have been tendered
6 as one of the documents here, which is where table 1 in my
7 submission comes from, but the full document is submitted.
8
9 Q. Do you understand that subsequent to that review,
10 a further 10 full-time employees were appointed to
11 pathology throughout New South Wales by NSW Health
12 Pathology?
13 A. I understand that there were more positions, but I can
14 tell you that none were in our department. One of the
15 models included an extra staff in our department, but there
16 were none.
17
18 Q. Did you understand that the decision as to where those
19 additional 10 people were deployed was based on what was
20 seen to be the need of particular sites, and the locations
21 that they were supporting, namely rural and regional sites?
22 A. I would agree that it was a relative workload audit
23 and there were - with not many resources, a decision was
24 made to give more to the relatively more overworked, based
25 on these figures. I don't dispute that.
26
27 THE COMMISSIONER: Is "extra staff", extra pathologists?
28
29 MR CHENEY: Yes.
30
31 THE WITNESS: All I can say is we received none in our
32 department.
33
34 MR CHENEY: Q. Subsequent to that occurring, or at least
35 since that occurred - that is, the appointment of those
36 10 full-time employees to other pathology units -
37 NSW Health Pathology has agreed to provide you with
38 a further full-time employee staff specialist?
39 A. I'm glad you mentioned that, actually. So we were
40 told that we're not going to get a position here. I said
41 that's unfair, because one of the models was that North
42 Shore gets a place, and we were told "No". Then NSW Health
43 Pathology wanted to undertake a contract to do private
44 pathology for a new private hospital being built on the -
45 near Terrey Hills, called Wyvern, and they wanted support
46 from our trust fund of 570 --
47

1 Q. Sorry, what was it called - near Terrey Hills?
2 A. Wyvern, is the name of the hospital. It is opening in
3 September/October, they are still under tender. They
4 wanted support from our trust fund for that, which was
5 about $570,000 cash, as well as ongoing support on a yearly
6 basis, which one of the models was about $150,000 a year
7 from our trust fund for that, and we have a structure in
8 the number 2 account where we vote on those things, and we
9 met as a department and we all voted, "No", we can't do
10 that with the current workload. They said, "You will make
11 money out of it", but we said, "No, the workload, we can't
12 do it with the workload". We said "No" to that in the
13 first round of votes.
14
15 It was pretty clear that NSW Health Pathology were
16 very invested to have this contract, and so they came back
17 to us with a slightly more financially favourable thing,
18 which wasn't the turning point, but they said, "If you vote
19 for this and it is accepted and you get the Wyvern
20 contract, we will provide an extra staff specialist for
21 your department".
22
23 We talked about it as a group and then with the
24 operations and said, "We're so desperate for anything, we
25 would agree to that", although it wasn't universal, and
26 several people just thought we can't do any more workload,
27 and so I think it's a bit disingenuous to suggest that that
28 one position was coming. It came under that circumstance,
29 basically, to access our trust fund to pay for more
30 expansion, and more work that will come out of Wyvern
31 hospital, obviously.
32
33 Q. You gave some evidence about what you describe as the
34 business case that you prepared and which you refer to in
35 paragraph 32 of your statement.
36 A. Yes. Sure.
37
38 Q. The business case --
39
40 THE COMMISSIONER: The business case might be in 31. The
41 response is 32, I think.
42
43 MR CHENEY: Yes, I'm sorry, Commissioner.
44
45 Q. You exhibit the business case document, sir. I don't
46 know if it's possible to get that on the screen for the
47 witness.

1
2 THE COMMISSIONER: Yes. I won't be able to do it, but
3 someone can.
4
5 MR CHENEY: It's [SCI.0008.0302.0001].
6
7 Q. Sir, that's a document that you submitted in about
8 mid-January, 15 January this year?
9 A. Correct, some time like that.
10
11 Q. You refer to the response you got to it in
12 paragraph 32, and you say, "A copy of the relevant email
13 correspondence is at" this particular number. I'll ask for
14 it to be put on the screen. It is [SCI.0008.0303.0001].
15 It's on the screen. You see, that's a response the very
16 next day, isn't it, Professor Gill, to your submission of
17 15 January?
18 A. I have a feeling I submitted a week before then.
19 I don't know. Is there a date on my submission on the
20 previous document?
21
22 Q. If you can take it from me, sir, that it was a brief
23 that you submitted on 15 January?
24 A. Yes, I think there were discussions there and you can
25 see I have alluded to this the year before, that we
26 desperately need more pathologists, and I recall the
27 discussion was that it would have to go off to finance. We
28 might have had a pre-discussion before we submitted things,
29 and the sequence of events was something like we asked for
30 two new pathologists - 2.5 pathologists, two registrars,
31 two scientists, and then we were told, "You're not going to
32 get it", and that would have been verbally, and said, "It's
33 too much, because it is not cost neutral." We kept being
34 told, "It's not cost neutral, you can't make money, it's
35 not cost neutral. There is a requirement to save money,
36 it's not cost neutral".
37
38 Then the correspondence was, "Can we at least put
39 together a business case for a locum to cover long service
40 leave if we get people together to use their long service
41 leave", because long service leave has to be backfilled --
42
43 Q. Sir, I don't mean to interrupt you, but all I want to
44 establish is that there was a subsequent email about the
45 business case which made it clear to you, I suggest, that
46 the finance team at Ministry of Health was working on some
47 modelling to understand the financial implications of your

1 proposed case?
2 A. Yes, and I was told that it was not cost neutral and
3 it's not --
4
5 Q. I'm sorry?
6 A. I was told the numbers - "It is not cost neutral and
7 so it cannot be supported." And then when I said something
8 like, "It's been rejected, can we put in a" - this is my
9 email, "It was rejected. Can we put in a locum
10 submission?" They said "It hasn't been rejected, it just
11 hasn't been accepted." I said, "Well, where are we with
12 this?"
13
14 Q. There is a distinction, is there not, sir?
15 A. I suppose I would observe it is hard to say "No" to
16 funding in the healthcare setting because people want
17 optimal health care, but you can save a lot of money by
18 delaying things for a long time and I thought that this was
19 kicking the issue down the street and actually giving me
20 a message that it's not accepted, but leaving an email
21 trail that it's not rejected, it just hasn't been accepted,
22 or something like that.
23
24 Q. So what is it that you construed that way? The email
25 of --
26 A. There is an email, which I haven't provided, which
27 says something like, "This has not been rejected, it just
28 has not been accepted", following up to this when we talked
29 about a locum position for long service leave.
30
31 Q. When you say in paragraph 32 that the document that is
32 on the screen is the relevant email correspondence about
33 this, you weren't meaning to suggest that was all?
34 A. There were several emails. There were several emails.
35
36 Q. One of them was this email, I suggest to you, sir, if
37 I could show you an email of Ms Wienholt of the Ministry of
38 Health of 1 February 2024, at 9.54am, to yourself, and
39 a cast of thousands.
40 A. Sure, yes.
41
42 Q. Sir, do you recall receiving that email?
43 A. Yes.
44
45 Q. And one of the things it told you was that --
46
47 THE COMMISSIONER: Can you just identify it, so it is on

1 the transcript?
2
3 MR CHENEY: I will have another crack at that,
4 Commissioner. It's an email of Louise Wienholt, of
5 1 February 2024, at 9.54am, to Professor Gill, Catherine
6 Atkins at Health Pathology, and copying in Dr Kennedy and
7 others.
8
9 THE COMMISSIONER: Thanks.
10
11 MR CHENEY: Q. Titled "Briefing".
12 A. I recall there were several emails going back and
13 forth not always replying to the most recent email, so that
14 email chain has many different branches that --
15
16 Q. Far from kicking the can down the road, as was the
17 term I think you used earlier, wasn't this email telling
18 you that the finance team had been commissioned to work on
19 the modelling of the additional medical staff, and Darren
20 had asked for modelling across a number of scenarios?
21 A. I will read the last paragraph of Louise's email:
22
23 *Based on what we have looked at, we will*
24 *need to ask the LHD for an additional*
25 *$1 million in funding for the '24/25*
26 *financial year to cover new positions.*
27 *Vanessa has monthly CE meetings ...*
28
29 And I suppose there has been no movement on this
30 $1 million, and I suppose this gets back to one of my key
31 points of the submission, this is NSW Health Pathology
32 funding saying, "Yeah, it sounds like you have got a good
33 case, but the finances don't add up, we'll have to ask the
34 other group, NSLHD, for an extra million dollars."
35
36 So I take this email saying as, "Operationally, it
37 looks like your business case is good. The money doesn't
38 add up. You can only get it if the other provider, NSLHD,
39 pays another $1 million. We will have to ask them", and
40 I haven't heard back. Is that how you read it?
41
42 Q. Wasn't it also, sir, gently suggesting that some more
43 financial analysis was required to supplement that which
44 was in the business case, before one could take a view
45 about whether it was a goer?
46 A. Yes, I will make it clear, I think I said before, that
47 anatomical pathology is a loss-making - a loss-leading

1 discipline is probably a better way of putting it rather
2 than "loss-making", because it brings other work in, and
3 there is no business case that will make anatomical
4 pathology profitable, and my frustration is that the
5 response, put in several different ways, including here,
6 "We need an extra million dollars from the LHD", comes down
7 to "What you do isn't profitable, so it's not possible to
8 expand your service." That's how I read it.
9
10 MR CHENEY: A bit like food and beverage at a golf club.
11
12 THE COMMISSIONER: Maybe. Can I see it?
13
14 MR CHENEY: I'm sorry. Perhaps the witness's copy could
15 be handed up.
16
17 THE COMMISSIONER: It just might help, if you have got any
18 further questions on it.
19
20 MR CHENEY: No, there are no more, on that topic.
21
22 THE COMMISSIONER: Okay, I have read that. Sorry, have
23 you finished with that?
24
25 MR CHENEY: I have.
26
27 THE COMMISSIONER: Should we mark that for identification,
28 which would be 6, would it, now? I will just describe it
29 as "Email from Louise Wienholt to Anthony Gill and others,
30 1 February 2024, at 9.54am", which is MFI 6.
31
32 **MFI #6 EMAIL FROM LOUISE WIENHOLT TO ANTHONY GILL AND**
33 **OTHERS, 1 FEBRUARY 2024, AT 9.54AM.**
34
35 MR MUSTON: In due course, we will probably add that to
36 the bulk tender, Commissioner.
37
38 THE COMMISSIONER: Yes, sure.
39
40 MR CHENEY: Q. Professor Gill, in paragraph 37, where
41 you are dealing with procurement, you speak about a lack of
42 discretion for pathologists in relation to procurement.
43 Can you help us with what you meant by that?
44 A. Yes, I suppose I alluded to, when I talked about the
45 x-ray equipment for breast cancers, that you can save money
46 by buying this x-ray machine, that means you have the -
47 it's cheaper to look at breast cancers, and quicker.

1
2 THE COMMISSIONER: Q. This is to see the calcium
3 deposits?
4 A. Yes, basically, we don't look at - a breast lump can
5 be quite large. We just look at certain things. You buy
6 an x-ray machine, you put it in, you see the calcium and
7 you do it.
8
9 Q. That's what you mean?
10 A. Yes, and we see the clear need for that because we get
11 these breast cancers with 100 blocks running through our
12 department, and it is very time consuming. To us, it is
13 self-evident that this is a clear win:win - quicker for us,
14 better for the patient, where it saves money. Even though
15 we see it as self-evident, I certainly understand the
16 requirement to put it in a business case, but that ran for
17 14 months until I believe it was accepted last week or this
18 week, just before this hearing.
19
20 THE COMMISSIONER: Did that answer the question you asked,
21 which was, "You speak about a lack of discretion for
22 pathologists in relation to procurement, can you help us
23 with what you mean by that?" That was your question.
24
25 Q. Is there anything further you want to say to that?
26 A. I mean, I can give many examples where, say, we test
27 tumours with immunohistochemistry, and even the discretion
28 for us to choose which antibodies we can purchase - some of
29 these are experimental, we have to see whether they work,
30 although you would think, you know, that you could push
31 them through. That's becoming - those sorts of things are
32 becoming very difficult. Even when we, say, get new
33 antibodies on board, we've been given proscriptive
34 documents about what we need to do to fulfil that role,
35 which just makes it harder to do, and I suppose we're fully
36 aware of the requirement to save money, precious money, in
37 the healthcare environment, and I suppose we can see some
38 things that save money from where we're standing that
39 wouldn't be evident to people who are a long way away,
40 because it is such a niche area.
41
42 You know, what we often say in personalised medicine
43 is that you save money by giving the right treatment to the
44 right patient at the right time, and often that involves
45 expensive pathology testing at the first presentation,
46 rather than waiting for a relapse down the track.
47

1 MR CHENEY: Q. But, Professor Gill, you accept,
2 I gather, that there has to be some fetter on the
3 discretion of clinicians in this area?
4 A. Of course.
5
6 Q. It can't be left solely to clinicians to decide what
7 would be the right gear to buy; correct?
8 A. Of course. I suppose one of the things - we were
9 talking about this in our department the other day --
10
11 Q. Sir, I don't mean to interrupt you, but you accept
12 that as a proposition?
13 A. Of course. The healthcare funding needs to have
14 budgetary oversight, there is not a limitless pot of money,
15 we try to triage the expense as well as we can. I'm just
16 trying to make the point that we can see some cost savings
17 from, where we are, that it's harder to get approvals for.
18
19 Q. But there are people who are closer to the matters of
20 finance that have to have a role in determining what things
21 are bought.
22 A. Of course. I agree there has to be budgetary
23 oversight and everything like that, and dollars have to be
24 accounted for, and business cases, you know, you should be
25 trying to save money. I'm making the point that we're
26 a loss-making specialty and we can sometimes save money in
27 pathology that costs money to the healthcare system as
28 a whole.
29
30 MR CHENEY: Thank you, Professor Gill. Thank you,
31 Commissioner.
32
33 THE COMMISSIONER: Thank you. Did anything arise out of
34 any of that?
35
36 MR MUSTON: No.
37
38 THE COMMISSIONER: Professor, thank you very much for
39 coming. We are very grateful for your time. You are
40 excused.
41
42 **<THE WITNESS WITHDREW**
43
44 MR MUSTON: I think the next witness on the list is
45 Dr Michael Maley.
46
47 **<MICHAEL MALEY, affirmed:** **[12.42pm]**

1
2 **<EXAMINATION BY MR MUSTON:**
3
4 MR MUSTON: Q. Could you state your full name for the
5 record, sir?
6 A. Michael Maley.
7
8 Q. You are the local pathology director for New South
9 Wales Health Pathology at Liverpool and South Western
10 Sydney LHD?
11 A. That's right.
12
13 Q. That's a mouthful.
14 A. That's correct.
15
16 Q. You have prepared an outline of evidence to assist the
17 Commission?
18 A. Yes.
19
20 Q. Do you have access to that?
21 A. I do, yes.
22
23 Q. Have you had an opportunity to read it and familiarise
24 yourself with it?
25 A. Yes, I have.
26
27 Q. Are you satisfied that its contents are true and
28 correct to the best of your knowledge?
29 A. Yes.
30
31 MR MUSTON: That document, Commissioner, will form part of
32 the bulk tender.
33
34 Q. Can I ask, when did you commence as the local
35 pathology director at Liverpool and South Western Sydney
36 LHD?
37 A. February 2018.
38
39 Q. Prior to that, had you worked within pathology within
40 that LHD?
41 A. Yes, I have worked on and off in various capacities at
42 Liverpool since 1996. I commenced working in pathology in
43 2003.
44
45 Q. So are you a pathologist by training?
46 A. I'm both a pathologist, a microbiology pathologist, so
47 trained in the pathology with the Royal College of

1 Pathologists, but also a physician, so I'm an infectious
2 diseases physician as well. The two are often - the
3 training is combined and we often - it is quite common to
4 have people that have both training.
5
6 Q. Could you just give us a very broad description of
7 what a microbiology and an infection diseases pathologist
8 does on a day-to-day basis as distinct from, say,
9 a anatomical pathology?
10 A. A microbiology pathologist is an expert in the
11 diagnosis of infectious diseases, so the culturing of
12 bacteria in the laboratory, the further identification of
13 those bacteria, the working out what antibiotics
14 susceptibilities are relevant to those bacteria, also
15 similarly for parasites, fungi, and also involved in
16 serology testing, which is the measure of antibodies in the
17 blood which may be relevant to prove that you have had an
18 exposure to an infectious disease.
19
20 Microbiologists also supervise what we call molecular
21 testing, which is the detection of the DNA and RNA of
22 pathogens like, for example, influenza, et cetera. On
23 a day-to-day basis, a microbiologist will supervise a range
24 of scientific and technical staff in the laboratory who are
25 examining samples, they will ask for advice, how they
26 should approach that, and the microbiologist will also have
27 a significant role in what we call the pre-analytical and
28 the post-analytical performance of the testing, and that
29 means liaising with the clinicians who order the test to
30 give them advice about what test they should order, and
31 also giving them advice about how to interpret the results
32 of the test that we deliver.
33
34 Q. Would it be right that within the field of pathology,
35 the different areas of specialisation involve often very
36 different work flows?
37 A. Absolutely. That is true.
38
39 Q. Some, like biochemistry, for example, involve a lot of
40 tests which are run by machines, these days?
41 A. Yes, some areas of pathology are very automated and
42 machine based, and the role of the pathologist there is to
43 ensure that the quality of the results coming out of the
44 machine are satisfactory. There also is some pre- and
45 post-analytical involvement in those specialties, giving
46 advice about what tests and interpreting abnormal tests.
47 In microbiology, it has some hands-on activity for the

1 pathologists, but not as much as anatomical pathology,
2 which is fairly labour-intensive for the pathologist
3 because they are responsible for examining the slides and
4 making a diagnosis. A lot of that work in microbiology is
5 done by the scientist and then checked by the pathologist.
6
7 Q. We have heard some evidence to the effect that at
8 least at the anatomical pathology end of the spectrum, it
9 is not a profit-making operation. Would you generally
10 agree with that from your perspective?
11 A. I'm not fully aware of the situation across the entire
12 anatomical pathology spectrum. Certainly, because there
13 are - there is a requirement for more pathologists in
14 anatomical pathology to do the hands-on work, it generally
15 costs more money to run anatomical pathology laboratories
16 than, say, microbiology, which could be run by a smaller
17 number of pathologists and, for example, biochemistry that
18 might only need one pathologist to supervise. So I think
19 a lot of the cost in those services is related to the cost
20 of the specialists.
21
22 Q. I might take you to another question in relation to
23 that, and this may be outside your field of visibility, but
24 in terms of anatomical pathology and the extent to which
25 it's capable of collecting sufficient money to cover the
26 money that it costs to deliver it, would it be right to say
27 it's a different dynamic in a public hospital setting than
28 in, say, a private pathology setting?
29 A. I'm sorry, I can't comment on the reimbursement in the
30 private sector because I've never worked in the private
31 sector. I certainly know that in the public sector, and
32 even in my laboratory system, the anatomical pathologists
33 don't earn as much money as potentially some other
34 pathologists could, because they have to share the money,
35 and that money comes either from Medicare billings or the
36 equivalent of Medicare billings applied to the public
37 system.
38
39 Q. I think my question was poorly expressed. Maybe let's
40 start with your field of microbiology. Would it be right
41 to say that pathologists with a specialty in microbiology
42 working in a public hospital setting are going to be
43 dealing with more complex cases than the run-of-the-mill
44 type cases that get dealt with within a private pathology
45 setting?
46 A. I think that's true to say.
47

1 Q. And again, tell me if you don't know the answer, but
2 is that, to the best of your knowledge, the same when we're
3 dealing with anatomical pathology?
4 A. I don't know for sure, but I suspect it would be.
5
6 Q. You tell us in paragraph 4 of your outline, if you
7 have it available, what your responsibilities are in your
8 role as the local pathology director, and one of those
9 responsibilities is to build strong stakeholder
10 relationships with the LHD. Could you explain to us how
11 that - how you go about doing that in your role and how
12 that works in your LHD?
13 A. As the local pathology director, I am involved in
14 various committees and governance structures of the local
15 health district, so, for example, I attend the clinical
16 quality council, which is the peak governance committee of
17 the LHD; I know many, if not most, of the people that are
18 on that committee. I have a regular meeting with the chief
19 executive of the local health district to discuss issues
20 related to pathology. We have a bi-monthly meeting between
21 the pathology executive and the LHD executive, where again,
22 we discuss performance of pathology, issues that are
23 arising.
24
25 I also attend a monthly meeting with the clinical
26 stream directors of the local health district, who are the
27 peak medical leaders of their various specialties or areas.
28 So I have a lot of involvement with the clinicians. We
29 also - because I've worked there for a long time, I have
30 personal relationships with a lot of the staff.
31
32 Q. At the various meetings that you have referred to, are
33 there standing agenda items that are discussed?
34 A. For the committee meetings, yes, and for the clinical
35 stream directors' meetings, yes, and for the pathology
36 executive with the other executive, yes. With the chief
37 executive, it tends to be more issues that are arising or
38 responding to any questions that the chief executive may
39 ask.
40
41 Q. In your role, do you engage extensively with the
42 pathologists and scientists who are working within the
43 pathology department at your hospital?
44 A. I engage primarily with the clinical directors, who
45 are the discipline leads, lead pathologists, and also with
46 the laboratory managers.
47

1 Q. So in relation to that, my word, not yours, but that
2 "engagement", does it take the form of meetings or some
3 other form of communication?
4 A. It does. So we have a formal monthly meeting with the
5 clinical directors and the senior operations team from our
6 pathology service. We also have ad hoc meetings around
7 issues or around particular projects that we're working on.
8
9 Q. And in terms of the meetings, are there any standing
10 items that get put on the agenda for those meetings?
11 A. Yes, we have standing agendas and we also ask each
12 discipline to present a report as to how their - the issues
13 in their service, and those disciplines would report at
14 least twice a year, potentially three times a year.
15
16 Q. So in relation to those standing items, what are they,
17 when you are dealing with your - the meetings that you have
18 with clinical directors, or clinical leads, I think you
19 said?
20 A. Well, for example, there will be a report from the
21 senior operations manager, who is the operational lead in
22 our area, who will go through all of the active issues.
23
24 Q. What is their function, the operational lead?
25 A. The pathologists generally have a governance and
26 supervisory role over testing, but the actual operations of
27 the laboratory sit with the operations arm of the
28 organisation, and they are separate, although we work
29 together.
30
31 Q. So when you are talking about - when you refer to
32 "operations", what are you referring to there? Is that the
33 actual keeping the machines running and the like, or are we
34 talking about aspects of the clinical testing that is being
35 done?
36 A. The operations arm is primarily associated - primarily
37 responsible for the service being delivered on a day-to-day
38 basis, and that would be all to do with the equipment, the
39 staff, the budget - all of those sorts of things, yes.
40
41 Q. In relation to the discussions you have with the
42 operations arm, do issues - or with the operations lead, do
43 issues around workforce and the amount of work relative to
44 the number of pathologists get raised routinely?
45 A. Yes.
46
47 Q. Dealing with anatomical pathology, for example, what

1 is the nature of the discussions that you have had in
2 recent years around work issues and workforce issues in
3 that area?
4 A. Certainly, more recently, there's been concerns raised
5 by the clinical director of anatomical pathology in my area
6 about staffing levels and workload levels, because the
7 workload in our area is increasing, and so there are
8 concerns about the number of pathologists available to do
9 the work.
10
11 Q. When you say "more recently", when did those concerns
12 first start to be raised with you?
13 A. I think, from memory, during COVID, in my local health
14 district, there was a decline generally in pathology
15 testing coming into our laboratory, and particularly for
16 anatomical pathology, because there were periods of
17 shutdown of elective surgery, for example.
18
19 After COVID, the COVID epidemic has ended and the
20 workload has basically gone back to where it was before and
21 even increased further, so it's really been probably in the
22 last 12 months when there's been a rebound in work, as all
23 of the elective surgery has come back into our system.
24
25 Q. So you have told us that those workforce issues or
26 work pressure issues have been raised with you, I think you
27 said in your discussions with the operations lead. Who is
28 that, within your team? Who is the operations lead?
29 A. Well, there is a range of people that I would discuss
30 that with. There is the senior operations manager.
31
32 Q. Who is that?
33 A. His name is Parth Nanavarti, and then there is the
34 director of operations who is above him, Louise Wienholt.
35 I've certainly - they have been involved in those
36 discussions.
37
38 Q. Are they people who report to you within the LHD?
39 A. No.
40
41 Q. You report to them or you feed information up to them
42 at NSW Health Pathology?
43 A. Well, we have a collaborative management oversight and
44 they are in the operations team and, as I said, I'm in the
45 supervision and the governance sort of structure of it, but
46 we work together to try and resolve issues that arise.
47

1 Q. Are they based at your hospital?
2 A. The senior operations manager is the most senior
3 onsite operations manager. The director of operations is
4 a - not a statewide role but it is, I think it is
5 a metropolitan director of operations.
6
7 Q. Do you know where that individual is based,
8 physically, where their office is?
9 A. I think they are - realistically, they travel around
10 a lot, they are very engaged. Probably at 1 Reserve Road,
11 I would imagine, but I can't tell you for sure, so at
12 St Leonards.
13
14 Q. I think I interrupted you. I will finish this
15 question, if it is okay, Commissioner. You have had
16 discussions with a number of people around these workforce
17 issues, you have identified the operations people. Who
18 else have you, in your role, been having discussions with
19 around workforce problems or challenges in anatomical
20 pathology within your hospital?
21 A. I have had a discussion with my chief executive about
22 it recently.
23
24 Q. That is the chief executive of NSW Health Pathology?
25 A. Health Pathology, yes. I think it's a common theme
26 throughout pathology; it's not limited to South Western
27 Sydney, it's a common theme. I don't think it's come up in
28 the meetings with the LHD at the moment, but I can't be a
29 hundred per cent sure, I'd have to check.
30
31 MR MUSTON: I note the time, Commissioner.
32
33 THE COMMISSIONER: Thank you. We'll adjourn until
34 2 o'clock.
35
36 **LUNCHEON ADJOURNMENT**
37
38 THE COMMISSIONER: Yes, please continue.
39
40 MR MUSTON: Q. Do you still have a copy of your
41 statement there in front of you?
42 A. Yes.
43
44 Q. Could I ask you to turn to paragraph 30, or maybe
45 paragraph 29, on page 8.
46 A. Yes.
47

1 Q. Do you see in paragraph 30 there you refer to a review
2 that was undertaken by the South Western Sydney LHD and
3 NSW Health Pathology?
4 A. Yes.
5
6 Q. Who from the South Western Sydney LHD was involved in
7 leading that review?
8 A. The review was led by the director of planning for the
9 LHD, from the LHD point of view.
10
11 Q. And from NSW Health Pathology, who was the lead in
12 that review?
13 A. So the - we also had a senior member of our planning
14 department that - sorry, maybe not leading, but doing the
15 coordinating and gathering the information. I guess I was
16 probably the local lead for the pathology department.
17
18 Q. Do you see in paragraph 31, at subparagraph (d), you
19 talk about having as part of the review sought the views of
20 consumers, clinicians, health services managers and
21 pathology staff about current and future needs and service
22 delivery models?
23 A. Yes.
24
25 Q. Who was responsible for engaging with the clinicians
26 and pathology staff about current and future needs of
27 service delivery models?
28 A. It was done in a number of forums that were run by
29 those two planning - the two planning leads. I was present
30 at some of those. They were offered opportunities to come
31 to sessions and to give their feedback.
32
33 Q. Did they take up that opportunity - that is, the
34 clinicians and pathology staff?
35 A. There was a number of sessions that I wasn't at, but
36 I think it was limited, the number that came, but they were
37 given multiple opportunities, and I think the review was
38 also discussed at the clinical quality council for the LHD,
39 and they were given opportunities to participate from
40 there.
41
42 Q. Do I take it from what you have just told us that the
43 level of participation in that process by clinicians and
44 pathology staff was not high?
45 A. I can't really answer that because they weren't
46 directly giving their feedback to me. The feedback was
47 being collated by the two members of planning. From some

1 of the sessions that I attended, I think that attendance
2 was low, which is disappointing but not unexpected for
3 those sorts of processes.
4
5 Q. Why - what is it about those sort of processes that
6 would lead you to expect a low turnout from, say,
7 clinicians and pathology staff?
8 A. Well, pathologists in particular are obviously very
9 busy. They have a lot of clinical duties that they have to
10 attend to. My experience is that whilst they may be
11 interested in the outcome, they often aren't available to
12 attend sessions, or they may not be interested - I'm not
13 sure.
14
15 Q. Are you aware of whether workforce challenges or work
16 level challenges were one of the issues that were raised by
17 clinicians and pathology staff as part of that review?
18 A. Yes, they were.
19
20 Q. To the extent that you know what was raised, what was
21 it that they brought forward by way of views around
22 workload?
23 A. I don't have it in front of me, the report, but
24 strengthening the pathology workforce was one of the main
25 findings or key focus areas of the report. That was
26 primarily focused on the scientific and technical staff
27 that do the work in the laboratory, and there was
28 a recognition that our laboratory in particular was running
29 very lean and needed a boost in scientific and technical
30 staff. I don't think that particularly pathologists'
31 workload was raised, but I can't be a hundred per cent sure
32 about that without having the results in front of me.
33
34 Q. In relation to the scientists and technical staff,
35 when you used the phrase "running very lean", I gather that
36 you mean that there were not as many staff members within
37 those areas as might ideally be required to do the work
38 that was being pushed through the laboratory?
39 A. Yes, and the - yes, and the context of the review was
40 that there was quite a sustained and increasing volume of
41 activity in our district, but partly related to the opening
42 of the new Campbelltown Hospital, for example.
43
44 Q. Was it your - you may not know, but was it your
45 understanding that the staff shortages, if we could use
46 that term loosely, were attributable to an inability to
47 find and attract people, or, alternatively, due to

1 a decision which may have been made about the extent to
2 which staff would be funded within the laboratory?
3 A. No, it probably relates more to historical and
4 structural issues with the way our pathology service has
5 been organised up until then.
6
7 Q. What are the historical and structural issues around
8 organisation that you are referring to?
9 A. The pathology service in South West Sydney had
10 operated as a hub-and-spoke model, with Liverpool being the
11 primary laboratory, and the other laboratories at the other
12 hospitals were quite small laboratories. Then, over the
13 years, as those other hospitals have evolved and changed,
14 there were some gaps in staffing that had been exposed by
15 those changes, which needed to be addressed.
16
17 Q. In terms of the gaps in staffing, just coming back to
18 my earlier question, were they unfilled positions, or were
19 they gaps where positions did not exist - that is to say,
20 there was no funding for a particular staff member and that
21 was the reason for the gap, for historical reasons?
22 A. I think it's - I mean, all laboratories carry
23 vacancies, but I think it's primarily that those positions
24 didn't exist.
25
26 Q. Can I ask you to turn over to paragraph 33, just on
27 the next page. Do you see the reference in the top of that
28 paragraph to the renewed focus on collaborative service
29 planning?
30 A. Yes.
31
32 Q. Can you just explain to us in a little bit more detail
33 what that actually involved in a practical sense, or what
34 it is anticipated that that will involve in a practical
35 sense?
36 A. I mean, I think we've - in my experience, in my time
37 in South West Sydney and as a leader of the pathology
38 service, I think we've always had a collaborative
39 relationship with our LHD, but I think planning for new
40 laboratories focuses that much more acutely and there is an
41 expectation that pathology works with the LHD to decide
42 what services the LHD needs and provides those services,
43 rather than just operating independently of the needs of
44 the LHD. So I personally think that over that period of
45 time, planning for new laboratories, then certainly my
46 involvement in planning and thinking about planning of the
47 service, became more important and I certainly had

1 engagement with the LHD on those, particularly through the
2 pathology services review.
3
4 Q. Do you have a sense, based on the position that you
5 occupy within your LHD, that there are individual
6 clinicians that take the view that local decision-making
7 and efficiencies are disadvantaged by the statewide service
8 delivery model that is NSW Health Pathology, as compared
9 with, say, having all of those services delivered through
10 the LHD?
11 A. I don't think so. I don't - in my discussions with
12 clinical directors, for example, they are not saying to me
13 "I wish we belonged to the LHD". They can be at times
14 frustrated with the rate of change and the need to bring on
15 new services, but they are not ever suggesting that that
16 would be better under the LHD, in my experience.
17
18 Q. So when you talk about the rate of change, what is
19 changing that is causing frustration?
20 A. There are new services or new types of testing that
21 are coming into pathology at the sort of cutting edge of
22 medical developments, which pathologists obviously would
23 like to be able to be using. Sometimes, it takes time to
24 implement those services, and that can cause some
25 frustration.
26
27 Q. What is the source of those frustrations? I assume it
28 is not technical frustration with having to deal with the
29 new and advancing technology. What is it that is the
30 source of the frustration when these new things are brought
31 on?
32 A. Sometimes there is a frustration in not knowing
33 exactly whether those services will be provided at our site
34 or will be consolidated at other sites, so sometimes it's
35 around the planning. Sometimes it's around the actual
36 pieces of equipment. Some of the equipment to perform
37 these new tests are very expensive and how is that going to
38 be funded, will that funding flow to our local health
39 district laboratories, for example. Sometimes it's about
40 the staff that are needed to perform that testing, and
41 sometimes it's around the training and education of the
42 staff.
43
44 Q. And how are those frustrations dealt with at a local
45 level?
46 A. At a local level?
47

1 Q. Yes.
2 A. Well, we have a very close relationship with our
3 operations team and they understand those frustrations.
4 I think they work actively to understand them and to try
5 their best to explain the strategy that is coming from
6 NSW Health Pathology. But that doesn't always alleviate
7 the frustration.
8
9 Q. One of the frustrations that I think we've touched on
10 already is workload challenges within anatomical pathology,
11 within the anatomical pathology workforce, and I think you
12 have indicated, but correct me if I'm wrong, that that is
13 a challenge which is faced in your LHD as well as others?
14 A. Yes, the workload and the balancing of the workload
15 with the available staff, yes.
16
17 Q. Were you - early in your days in the job, but were you
18 familiar with a report prepared by Paxton Partners in
19 relation to that issue, the anatomical pathologist
20 workforce challenge?
21 A. No, I wasn't, sorry.
22
23 Q. Are you aware that in around 2018, NSW Health
24 Pathology conducted a review of some workforce challenges
25 within the anatomical pathology workforce?
26 A. I wasn't particularly aware of that, no, I'm sorry.
27
28 Q. Not something you were involved in?
29 A. No.
30
31 Q. In your early days in your current role?
32 A. I wasn't involved in it. No.
33
34 Q. Have you had involvement in any more recent, as in
35 2023, reviews conducted of the workforce challenges within
36 the anatomical pathology workforce?
37 A. I attended a meeting with the leads of the review when
38 they came to Liverpool to discuss the preliminary findings,
39 I think, of that review. I think they were the preliminary
40 findings, yes.
41
42 Q. Perhaps if we could bring up [SCI.0008.0301.0001]. Is
43 that a document, if you look at the screen, whichever is
44 most convenient to you, that you are familiar with?
45 A. I've seen the document. I'm not overly familiar with
46 its content but I have seen the document.
47

1 Q. So in terms of considering the extent to which that
2 document related to the pathology or anatomical pathology
3 workforce within your LHD, was that something that you had
4 an opportunity or reason to consider?
5 A. I was aware that the review was done, that the review
6 recommended some enhancement to the workforce in my
7 Liverpool laboratories.
8
9 Q. But beyond that, you are not familiar with the content
10 of the report; is that correct?
11 A. I'm not - I've read it, but I - you know, I don't know
12 it off by heart, but I know the gist of what was raised.
13
14 Q. In terms of the gist of it, as it applied within your
15 LHD, do you recall what that was?
16 A. I think it was - I mean, there was - in my LHD, there
17 was some concern around the timing of the report and the
18 data that was used to furnish the report, in particular,
19 the effect that the COVID downturn may have had on the
20 data, and that maybe that didn't reflect accurately the
21 workload, because of that. I'm not sure whether it's been
22 implemented, for example.
23
24 Q. If we could go to page 0010 in that document, do you
25 see a table there, table 1?
26 A. Yes.
27
28 Q. Which refers to the average time per day on diagnostic
29 work, that's per pathologist, FTE pathologist. Do you see
30 your hospital, Liverpool, is there at 8.7 hours per day?
31 A. Yes.
32
33 Q. Do you regard that as a heavy workload?
34 A. I'm sorry, I'm not an anatomical pathologist. I don't
35 really understand what - you know, what makes up their
36 workload, so, I mean, clearly it's more than eight hours,
37 so it's clearly - I would consider that to be a heavy
38 workload.
39
40 Q. In excess of the eight hours that they are paid as
41 a staff specialist?
42 A. Well, staff specialists are paid the equivalent of
43 eight hours but their working hours aren't really set, as
44 far as I am aware, and they don't get paid for overtime,
45 for example, and so it's not unusual for them to work more
46 than their hours.
47

1 Q. But --
2
3 THE COMMISSIONER: Q. You have a general understanding,
4 though, about what the diagnostic work an anatomical
5 pathologist would do, though?
6 A. Yes.
7
8 MR MUSTON: Q. So 8.7 hours of that notional eight-hour
9 day spent pushing glass, as the anatomical pathologists
10 would say, feels like a relatively heavy workload?
11 A. I think it's - I'm not sure - I'm not exactly sure
12 whether that's a heavy workload. I know that my anatomical
13 pathologists have a heavy workload.
14
15 Q. That's a view that they have expressed to you?
16 A. Yes, well, the clinical director has expressed that to
17 me, that they have a heavy workload. I'm not sure how that
18 relates to the table, but I am aware, and I agree, that
19 from what they have told me, they have a heavy workload.
20
21 Q. Have they sought further support in terms of more FTE
22 of anatomical pathologists to help them deliver on that
23 heavy workload within your LHD?
24 A. There is - right at the moment, there is a few issues
25 in my anatomical pathology workforce, such as staff being
26 on extended leave because they have excess annual leave,
27 which is a sign of excess workload, and some illnesses and
28 other leave without pay that's happening. So there are
29 some vacancies in my anatomical pathology workforce at the
30 moment that need to be filled. And that's without even
31 asking for additional staff. There are some challenges to
32 recruitment and retention of anatomical pathologists in my
33 district.
34
35 Q. Are you aware of whether attempts have been made to
36 recruit further anatomical pathologists in your district,
37 say since 2023?
38 A. Since 2023.
39
40 Q. Since last year when this report was produced?
41 A. It is a little bit hard for me to answer that because
42 I have seen briefs requesting recruitment actions, some of
43 those can be to backfill a vacancy. I'm not a hundred per
44 cent aware of whether any of those were new positions or
45 whether they were all to backfill vacancies. It isn't
46 something that I decide. It's not in my decision - it's
47 not in my decision-making process.

1
2 Q. Where does that decision lie? Let's say,
3 hypothetically, that the anatomical pathologists in your
4 hospital or in your laboratory expressed the view that the
5 workload was unreasonably heavy, particularly if compounded
6 by the fact that people had long leave balances
7 outstanding, they also wanted to do teaching, training,
8 et cetera, they felt the need for more anatomical
9 pathologists in the workforce, how would a decision about
10 whether or not to appoint them be made and who would make
11 it?
12 A. The process would be that the clinical director would
13 write a brief and document the reasons and the argument for
14 the additional staff. That would then be submitted through
15 the operations arm. I would look at it, and if I approved
16 it - if I agreed with it, I would sign it, which is usually
17 what would happen, and then it would go through finance and
18 HR and various other approvers, ultimately to the - I'm not
19 sure what the name of the group is, but it then goes higher
20 into the NSW Health Pathology executive structure for them
21 to make a determination.
22
23 Q. Is the LHD involved in that decision-making process
24 insofar as you are aware - and you may not be?
25 A. Generally not. I would say not. Sometimes - and this
26 happened as a result of the pathology services review, we
27 got 38 new positions in our laboratories, and part of that
28 process was to go to the LHD and say "This is what we think
29 we need for our service", and they agreed to fund that
30 independently. They agreed to fund some of those
31 positions. I'm not sure - usually, a request for a new
32 position wouldn't primarily go to them, it would go through
33 our approval process.
34
35 Q. Can we go to page 0014 of that document. I just want
36 to draw your attention to the risks associated with --
37
38 THE COMMISSIONER: Q. Can I just, so I understand the
39 last answer - when you said about the LHDs agreeing to fund
40 some of those positions, does that mean those pathologists
41 in those positions were employed by the LHD or NSW Health
42 Pathology?
43 A. Those positions were largely scientific and technical
44 positions and the way the pathology is funded is generally
45 on a cost per test basis. The LHD agreed to increase the
46 rate that they pay for their testing to cover the cost of
47 those staff.

1
2 Q. I see. The staff would still have been employed by
3 pathology, rather than the LHD?
4 A. Yes, yes, that's right.
5
6 MR MUSTON: Q. So do you see the heading "Risks
7 Associated with Inadequate Pathologist Staffing"? Without
8 needing to go through them individually, do you agree that
9 those risks generally are those which attach to inadequate
10 pathologist staffing or an excessive workload imposed upon
11 a pathologist workforce in anatomical pathology?
12 A. Yes. Yes, I agree with those.
13
14 MR MUSTON: I have no further questions for this witness,
15 Commissioner.
16
17 THE COMMISSIONER: Thank you.
18
19 MR CHENEY: I have no questions.
20
21 THE COMMISSIONER: Thank you very much for coming in, sir.
22 We greatly appreciate your time. You are excused.
23
24 THE WITNESS: Thank you.
25
26 **<THE WITNESS WITHDREW**
27
28 MR MUSTON: I think the next witness is James Branley.
29 While he is being brought in, I might just go and get
30 something that I have left on my desk, if that's okay.
31
32 THE COMMISSIONER: Yes. We'll wait until you come back.
33 We won't start without you. Just come in and have a seat,
34 sir. Mr Muston is just getting something, so we will wait
35 until he comes back before we start.
36
37 **<JAMES MAURICE BRANLEY, affirmed:** **[2.26pm]**
38
39 **<EXAMINATION BY MR MUSTON:**
40
41 MR MUSTON: Q. Could you state your full name for the
42 record, please?
43 A. My name is James Maurice Branley.
44
45 Q. You are the local pathology director at Nepean
46 Hospital?
47 A. That's correct.

1
2 Q. You have held that role since 2019?
3 A. Yes.
4
5 Q. You have prepared an outline of evidence to assist the
6 Commission. Do you have a copy of that with you?
7 A. I do, Mr Muston.
8
9 Q. Have you had an opportunity to consider it recently?
10 A. I have.
11
12 Q. Are you content that the content of that document is
13 true and correct to the best of your knowledge?
14 A. With the Commissioner's permission, could I just read
15 in a slight amendment?
16
17 Q. Please do. Which paragraph?
18 A. Paragraph 26. First sentence, could I just add the
19 word "diagnosis" and - between "local" and "research.
20
21 Q. So it will read:
22
23 *The laboratory also houses*
24 *extensive microbiology and molecular*
25 *biology departments to support local*
26 *diagnosis and research.*
27
28 A. Correct.
29
30 Q. Subject to that change, you are content that the
31 content of your outline is true and correct?
32 A. I am.
33
34 MR MUSTON: It will, subject to that change which we might
35 even annotate for the benefit of the record, form part of
36 the bulk tender in due course.
37
38 Q. Have you worked, or did you work as a pathologist at
39 Nepean Hospital prior to 2019?
40 A. I did.
41
42 Q. What roles did you hold within pathology prior to that
43 time, prior to your current role?
44 A. I was the head of microbiology in pathology and I was
45 also the deputy local pathology director.
46
47 Q. What were your responsibilities in the role of deputy

1 pathology director, to the extent they differed from what
2 you do now?
3 A. Periodically I would provide relief to the local
4 pathology director when he was on leave or absent, so
5 I would stand in to the role on those occasions.
6
7 Q. You have told us in paragraph 4 of your statement what
8 your role as local pathology director involves. You tell
9 us at subparagraph (c) of that paragraph that you are
10 involved in building and maintaining strong stakeholder
11 relationships with the local LHD. What does that actually
12 involve you doing? How do you go about building those
13 stakeholder relationships?
14 A. I think it's important to understand my specialty is
15 microbiology but it's also infectious diseases, and so
16 naturally, in my profession, I walk both sides of the
17 street. I am both a pathologist and a physician. And, as
18 a physician, you are up on the wards seeing patients; you
19 are interacting very heavily in the clinical space, talking
20 to other clinicians; and inevitably you are involved in
21 some degree of discussion, naturally, with administration
22 from the local health district.
23
24 Q. In your role as a physician delivering care into - as
25 part of that medical workforce?
26 A. Yes, correct.
27
28 Q. Can I just - one small matter - ask you to go back to
29 paragraph 3 of your statement. This maybe is to correct
30 either a typographical error or a misunderstanding on my
31 part, but you refer to holding a diploma in "topical"
32 medicine. Is it intended to be "tropical" medicine?
33 A. Sorry, yes, correct.
34
35 Q. I thought as much, but I thought I should check just
36 in case I was missing something.
37 A. Yes.
38
39 Q. So in addition to the engagement that you have on what
40 might be an ad hoc -- what I describe as an ad hoc basis
41 with management within the LHD as a physician, what other
42 work do you do to build that relationship or build the
43 relationship between the pathology department, on the one
44 hand, and the LHD on the other? Are there formal meetings
45 or --
46 A. I think as local pathology director you try to look
47 for opportunities to sort of make that a seamless division.

1 In my career, it wasn't a division at the start of my
2 career, and it became a division, and I think it behoves
3 all of us clinical pathologists to make that as seamless as
4 possible in order to deliver good patient care,
5 essentially.
6
7 Q. So when you say in your career, it originally was not
8 a division and then became one, are you referring to the
9 transition from a time when the LHDs had pathology as part
10 of their in-house range of services, to the more recent
11 times when NSW Health Pathology has taken on that role as
12 a central service?
13 A. Correct.
14
15 Q. In relation to that, do you get the sense that
16 clinicians within - there are any clinicians within your
17 LHD or your pathology workforce that take the view that
18 local decision-making and efficiencies are disadvantaged by
19 the statewide service delivery model - that is to say, they
20 pine for the old days?
21 A. I'm sorry, could you clarify the question there? Do
22 I feel that other clinicians --
23
24 Q. So maybe I will ask it in two separate ways: do you
25 hold the view that the centralised nature of pathology
26 service delivery in some way hinders or removes local
27 decision-making and efficiencies, in a disadvantageous way?
28 A. So I think there is lots of questions in that
29 question.
30
31 Q. Yes.
32 A. I'm wondering how to approach it.
33
34 Q. Let's start with local decision-making. Do you think
35 local decision-making suffers through the statewide nature
36 of the service delivery model?
37 A. To a degree, and referring back to the previous
38 answer, I think part of the job of the local pathology
39 director is to make that as seamless as possible, but yes,
40 I think to a degree. I can elaborate if you would like me
41 to.
42
43 Q. Do.
44 A. I think, in the early stages of a statewide service,
45 I personally was probably not supportive of it going away
46 from the LHD. At heart, I'm a clinician, and I think the
47 division that was created through that structure worried me

1 initially, and I think, to be fair, we've learnt over the
2 years to make that work much better than it did at
3 initiation.
4
5 Q. What has changed or what has been done to improve
6 that, the retaining of local decision-making, or the
7 benefits of local decision-making is a better way of
8 putting it?
9 A. I think there has been a maturation of the statewide
10 philosophy. If I can encapsulate the early statewide
11 philosophy in my view, it was to centralise pathology and
12 to remove elements of local pathology out of the equation
13 and go to a heavily centralised model. I think we've all
14 realised through numerous things, not the least of which
15 has been the COVID pandemic, that that just doesn't work
16 for patients and it doesn't work for local communities.
17
18 So I think there is a more mature statewide philosophy
19 now which acknowledges much more the benefits of strong
20 local leadership within a statewide structure, and I guess
21 what we're trying to find is the right balance between
22 direct connectivity with the patient locally and the
23 benefits of a statewide service.
24
25 Q. What do you regard to be the benefits of the statewide
26 service?
27 A. Well, once again, my view is that this structure was
28 set up essentially for two reasons. The first is an
29 economic reason, where it was set up in my view to generate
30 a sense of competition, a competitive nature between the
31 LHD and NSW Health Pathology, in order to drive the cost
32 downward. The second reason was I think to harness the
33 benefits of a large organisation over multiple small
34 organisations, from an organisational structural point of
35 view.
36
37 Q. In relation to the first of those issues, the setting
38 up of competition - and this may be a question better
39 addressed to others - in circumstances where the LHDs are
40 required to procure the pathology services through the
41 central body, do you feel that that competition really
42 exists?
43 A. Once again, I would have a complex answer to that
44 question, if I may.
45
46 Q. Yes.
47 A. I think the fact that you have two organisations that

1 are routinely and regularly discussing costs is good for
2 stewardship of health resource. I think it's not a truly
3 competitive process, and I don't think it should be a truly
4 competitive process because of the complexity of what
5 a state public pathology service is attempting to do.
6 I don't think there are other competitors truly in the
7 market and, in my career, I've seen other states approach
8 this differently, and I think unsuccessfully, by pushing
9 that envelope.
10
11 So did we get that balance between competition and
12 a preferred pathology provider right? I think we are
13 starting to. But in the early days, I would say we didn't
14 get that right. So I think we're getting there, but not
15 there yet.
16
17 Q. Thank you. Can I ask you some quick questions about
18 workforce challenges. Are you, through your role, aware of
19 particular workload challenges being experienced by
20 pathologists within your hospital?
21 A. Yes. So --
22
23 Q. In relation to that, are those workload challenges
24 distributed equally across all pathologists, or are there
25 some specialties that are suffering from them more than
26 others?
27 A. Yes, there are some specialties that are suffering
28 more than others.
29
30 Q. Which ones?
31 A. I think anatomical pathology is certainly the sharp
32 point of my workforce dilemmas, in my department.
33
34 Q. How are you dealing with those workforce dilemmas?
35 A. Well, once again, the statewide service introduced
36 a risk register and, in our management meetings, we discuss
37 risk, and I escalated anatomical pathology as a department
38 to be registered on our STAR register, which is our risk
39 register, and I did that because the workforce pipeline for
40 anatomical pathologists is not empty, but close to empty;
41 I have an ageing workforce in some aspects. I've got
42 a very senior pathologist who has been fantastic in my
43 department for many, many years, and he has telegraphed
44 that he is approaching retirement. We are not flush with
45 applicants when we do apply for positions. So there are
46 several reasons why I think this is a risk to our
47 organisation.

1
2 Q. So pipeline of workforce is a genuine challenge?
3 A. (Witness nods).
4
5 Q. Do you have any vacant positions at the moment?
6 A. At the moment, I have - complex answer again. I've
7 got 0.2 FTE vacant currently, and I have at least one staff
8 specialist who wants to reduce hours, which would
9 potentially give us 0.6 FTE in that event.
10
11 Q. If all of the vacancies were filled, would that be
12 sufficient, in your view, to resolve the workforce
13 challenges within the anatomical pathology department at
14 your hospital, or would there still be --
15 A. No.
16
17 Q. -- a heavily overworked workforce?
18 A. No, there would be - sorry, if I may elaborate.
19
20 Q. Please do.
21 A. There would be two additional challenges. One is
22 Nepean is at Penrith, and it's an intensely growing part of
23 the city. We have stage 1 and stage 2 redevelopment. We
24 have a large amount of surgical footprint that is a growth
25 footprint that is occurring. So the expected - the
26 projected workload has an increase component to it over
27 coming years. Sorry, I've just lost my train of thought.
28
29 Q. I had asked you whether, if all of the positions were
30 filled, it would be a sufficient workforce to meet the
31 demand.
32 A. The other part to that answer is that I have
33 a seniority issue in my department, in my anatomical
34 pathology department, due to the described impending
35 retirement and easing back on hours of senior pathologists.
36 So I'm lacking leadership in the department because we are
37 heavily staffed now with recent graduates, and the
38 collaborative nature of multidisciplinary teams and
39 pathology discussions is such that many of my junior
40 pathologists are uncomfortable if they don't have a senior
41 pathologist that they can discuss difficult cases with.
42
43 Q. Have you sought to add FTE pathologists to the
44 workforce within anatomical pathology within your hospital?
45 A. Yes. I have written a brief for 1 FTE, which is above
46 the 0.6 that I might have available, as a senior leader for
47 our department. That is under active consideration. The

1 concern is that there is 0.4 FTE that's not funded in that
2 equation.
3
4 Q. Just pausing there, is that something you have been
5 told by someone - that is --
6 A. No, that's just the maths of 0.6 versus 1.
7
8 Q. Why is it that you feel that's something to be
9 concerned about?
10 A. Well, I think it's - both in pathology and in the LHD,
11 and in discussions with senior health leaders I talk to,
12 the current climate is not conducive to expansion of costs.
13
14 Q. So the 0.4 concern you have is at the moment you know
15 that you've got 0.6 in the bank, because there is an
16 approved 0.6 worth of position that if you could find
17 someone to take that job today, you could give them, but
18 you need to find the additional 0.4, and that's the
19 unfunded bit. When you used the term "unfunded", does that
20 mean unfunded by NSW Health Pathology or unfunded from some
21 other source, or both?
22 A. Well, both, I think. I mean, expansion in health is
23 scrutinised very closely and I expect eventually I will
24 argue for that position. The other restraint I have is we
25 have advertised for positions and we know the level of
26 seniority we attract in those positions - this is really
27 a position I need for a senior anatomical pathologist and
28 my assessment of the marketplace is that there isn't an
29 easy supply of people with what I need in that position.
30
31 THE COMMISSIONER: Q. Can I just ask you, when you said
32 "the current climate is not conducive to expansion of
33 costs", I assume that answer has nothing to do with either
34 clinical need or the time pressures on your current staff?
35 A. Correct.
36
37 Q. And what do you mean by "the current climate"?
38 A. I guess in meetings in the clinical council at Nepean
39 Hospital, meetings in the medical division of Nepean
40 Hospital, meetings with senior leaders in NSW Health
41 Pathology, the messaging is similar in all of those
42 meetings that there is no additional money and, in fact, at
43 our senior leadership meeting last week, there was
44 discussion of budget - I'm not going to use the right term
45 here - budget recovery, for want of a better term, that
46 needs to occur over the next four years. So that's what
47 I mean by "the current financial climate".

1
2 MR MUSTON: Q. In relation to the 0.4 FTE that we're
3 talking about - I may have asked this question, but I will
4 ask it again in case I haven't - if you got that 0.4, that
5 would not meet the demand that is created by the current
6 amount of work within the anatomical pathology department;
7 is that correct?
8 A. My view - I can't predict the future, but my view
9 would be if we could advertise for one senior person, we
10 could attract and retain a senior person, we would still
11 have a future need to expand the anatomical pathology
12 cohort. I know that my turnaround times are longer than
13 they should be, so our performance figures need to improve,
14 and we need to find ways to do that. So I think we are
15 still underdone from a workforce perspective in anatomical
16 pathology.
17
18 Q. You may not have a number in mind, but if funding was
19 not an issue and finding the right people was not an issue,
20 is there a number of additional anatomical pathologists you
21 think you would need in order to bring your reporting times
22 within a reasonable level and provide the opportunity to
23 those anatomical pathologists to do their teaching,
24 training, take their leave, et cetera, attend
25 multidisciplinary team meetings?
26 A. You are right, Mr Muston, I can't put an exact figure
27 on it, but I can tell you we have 4.6 FTE currently.
28 I intuitively think we should be higher than that. Our
29 hospital has grown somewhere in the order of 45 to
30 50 per cent, and I think if you took 4.6 and increased it
31 by 50 per cent, I think the number would be somewhere in
32 that ballpark.
33
34 MR MUSTON: Thank you. I have no further questions for
35 this witness, Commissioner.
36
37 THE COMMISSIONER: Thank you. Mr Cheney?
38
39 MR CHENEY: I have no questions, thank you.
40
41 THE COMMISSIONER: Thank you for your time, it is greatly
42 appreciated. You are excused.
43
44 **<THE WITNESS WITHDREW**
45
46 MR MUSTON: The next witness is Vanessa Janissen.
47

1 **<VANESSA LOUISE JANISSEN**, sworn: **[2.52pm]**
2
3 **<EXAMINATION BY MR MUSTON**:
4
5 MR MUSTON: Q. Could you state your full name for the
6 record, please.
7 A. Vanessa Louise Janissen.
8
9 Q. You are the chief executive of NSW Health Pathology?
10 A. That's right.
11
12 Q. You have prepared a statement to assist the Commission
13 with our inquiries dated 8 February 2024?
14 A. Yes.
15
16 Q. Have you had an opportunity to read that statement,
17 and are you satisfied that its contents are, to the best of
18 your knowledge, true and correct?
19 A. Yes.
20
21 MR MUSTON: In due course, that will form part of the bulk
22 tender.
23
24 THE COMMISSIONER: Sure.
25
26 MR MUSTON: Q. Could I ask you to open up that statement
27 to paragraph 18 on page 5.
28 A. Yes.
29
30 Q. You see there, what you remind us is that the LHDs are
31 required or health entities are required to obtain
32 pathology services from NSW Health Pathology, the
33 immediately preceding paragraph, paragraph 17, and then
34 give a short description of how that happens, via an annual
35 customer charter?
36 A. Yes.
37
38 Q. Could you just tell us how, in a practical sense, that
39 arrangement between NSW Health Pathology and the LHDs
40 works? How do the annual customer charters get negotiated?
41 A. So we meet with the local health districts in the
42 planning cycle leading up to 30 June, review the previous
43 customer charter, any changes in activities, service
44 requirements that they may need, and then we amend the
45 charter and agree that.
46
47 Q. And so what about the price that is paid by the LHDs

1 for the services that they receive? How does that
2 practically get negotiated?
3 A. So in my statement, I indicated that we only increase
4 the price with negotiation of the LHDs. And that will be
5 based on their increased need for new services.
6
7 Q. So am I right in understanding in your statement,
8 there is a prediction of the - for want of a better word -
9 the amount of particular tests that an LHD might need
10 during the course of a budgetary cycle?
11 A. Yes. Yes.
12
13 Q. And that prediction forms part of the negotiation that
14 happens during the preparation of this customer charter?
15 A. Yes, yes. And it will be based on funding made
16 available to them through growth, for growth in their
17 services.
18
19 Q. There is a price per test, for each of the different
20 array of tests.
21 A. Yes.
22
23 Q. We can come to talk about that in a little bit more
24 detail.
25 A. There are some things that aren't paid for by a price
26 per test. They will be block funded but largely, yes,
27 price per test.
28
29 Q. We will come back to block funding as well. As
30 between the LHD and NSW Health Pathology, there is, for
31 each of the various tests that form part of this prediction
32 process, a price per test?
33 A. That's right.
34
35 Q. And the amount - when you mentioned a moment ago the
36 block funding, is that block funding of NSW Health
37 Pathology by the ministry, or is that block funding of
38 a particular service by an LHD to NSW Health Pathology?
39 A. Block funding from the LHD to NSW Health Pathology.
40
41 Q. What sort of services are picked up by the block
42 funding?
43 A. They may request additional collection services, home
44 collections, that won't be covered in a price per test
45 basis.
46
47 Q. So there is a price per test and an estimate of

1 roughly the number of tests that are going to be required?
2 A. Mmm-hmm.
3
4 Q. If additional services above and beyond like going out
5 to someone's - people's homes, for example, to take some
6 testing, there is a block of funding identified which forms
7 part of that --
8 A. Yes.
9
10 Q. The upshot of all of that is a bucket of money which
11 the LHD agrees it will be paying to NSW Health Pathology
12 for the year's services?
13 A. Mmm.
14
15 Q. Is there a reckoning at the end of the year of whether
16 the services which were part of that prediction or the
17 tests which were part of that prediction were actually used
18 to the extent that the funding or the customer charter
19 contemplated?
20 A. So in our regular meetings with the LHDs we will
21 report back what activity utilisation and how that
22 reconciles to charges that we have made to them, yes.
23
24 Q. So if - I won't give an example because I will just
25 come up with one that is wrong, but if they have said
26 "We're going to do a million of a particular type of test
27 we think this year", and that type of test is a particular
28 amount of money, but it turns out at the end of the year
29 they've only done 500,000 of that test because of COVID or
30 a greater efficiency that they've been able to introduce,
31 is there any adjustment made for that fact, or is it just
32 adjusted in next year's price block?
33 A. If the testing isn't done, charges aren't levied,
34 therefore the LHD doesn't pay for that, so that's not
35 transferred to us. If they go over those tests,
36 allocation, we have had a practice in place where we
37 provide rebates based on the marginal fixed cost of the
38 service back to them to recognise that there is an increase
39 that's marginally above what the actual test per cost is.
40
41 Q. So the estimate that is made of the number of tests
42 sits there as an estimate. Per test, the LHD gets charged
43 each time a test is sent off to NSW Health Pathology or the
44 laboratory within the hospital?
45 A. Mmm-hmm.
46
47 Q. At the end of time, there is a reckoning done to see

1 whether or not the total of the charges for each of those
2 tests equates with the prediction that was part of the
3 customer charter, and if it is in excess of it, then there
4 is an additional charge levied?
5 A. Yes, there is - yes. So we charge additional for
6 every test that's done, yes.
7
8 Q. I think - did you say a moment ago that in addition to
9 the cost for the test, there is an additional charge for
10 each of those extra tests, or have I misunderstood you?
11 A. No, there is a rebate provided back to the LHD, or has
12 been in the past, pre COVID, to recognise that costs above
13 or test charges above what has been agreed to in the
14 charter, those tests may be provided at a marginal cost
15 because our fixed costs are already covered.
16
17 Q. Okay. So the planning - from the point of view of the
18 centralised planning through this prediction process, this
19 is to enable NSW Health Pathology to identify an
20 appropriate workforce to have on site at each location to
21 deliver what is anticipated to be the testing --
22 A. Yes.
23
24 Q. -- that will be required?
25 A. Our workforce is budgeted for and if there is
26 additional services that the LHD requests, then we would
27 look at additional workforce requirements together with the
28 LHD.
29
30 Q. But the budgeting of the workforce, is that something
31 which is informed by the estimate at the customer charter
32 phase of what a particular LHD is going to require?
33 A. Yes, certainly the charges to the LHD are reconciled
34 to our budget and our workforce.
35
36 Q. So if an LHD, for example, was wanting to increase
37 the level of testing because it had introduced a new
38 service --
39 A. Mmm-hmm.
40
41 Q. -- and that was going to require an additional
42 pathologist or additional scientists to deliver that
43 testing, then decisions about whether or not to employ
44 those additional scientists or pathologists within the
45 NSW Health Pathology would be informed by that circular
46 process of moneys coming out of the LHD, into New South
47 Wales Health Pathology, through the charter, which would

1 justify the employment of further staff; is that right?
2 A. Yes, where the increase is agreed, yes.
3
4 Q. In terms of how nimble that process is or can be, in
5 terms of bringing that new staff on, does that mean that
6 NSW Health Pathology's ability to bring that new staff on
7 is something that is delayed by the process that we've just
8 gone through, the need to have a customer charter identify
9 the additional testing, that additional testing producing
10 at a budgetary level an anticipation of additional funds
11 flowing from the LHD to NSW Health Pathology, which in turn
12 it is anticipated can fund the additional personnel?
13 A. Yes. Well, we have discretion for the - we employ the
14 staff and we make decisions about employing the staff.
15 Certainly, if it is not within our budget that we have said
16 and it needs a new budget, then our requirements for that
17 new budget would be through either the LHDs by negotiation
18 or potentially through the ministry through additional
19 subsidy.
20
21 Q. Is there sufficient headroom in your budget to make
22 nimble decisions about employing more pathologists in
23 hospitals to the extent that a new service might be brought
24 on without going through this cycle that we've spoken of?
25 A. Generally not. I'm happy to elaborate.
26
27 Q. Do. If you would like to, yes.
28 A. Look, generally not. We would need to - we may choose
29 to shift funding from one part of our organisation to
30 another to support that, but, you know, that's based on
31 whether there is needs that have changed in other areas; if
32 we've made efficiencies, can we move that funding from one
33 part of the business to the other, or if we've had private
34 revenue coming in that allows us to cross-subsidise the
35 public work.
36
37 Q. So the shifting of funding would arise if, say, at the
38 time when hospital A was bringing on a new service that
39 required ideally an additional pathologist and two
40 scientists, say, to deliver the testing associated with
41 that service, if you were able to look around and say
42 "Actually, over there at hospital B, we have an excess of
43 pathologists and scientists because something's changed
44 over there, they've closed a facility or they've stopped
45 providing a particular service"?
46 A. Yes.
47

1 Q. In relation to that, over the time that you have been
2 involved with NSW Health Pathology, have there been many
3 occasions on which you have felt that there was surplus in
4 the system that enabled those - the hospital B scenario to
5 be retracted?
6 A. To employ additional pathologists?
7
8 Q. To employ additional pathologists in hospital A during
9 a budgetary cycle by getting rid of a service in hospital B
10 because it was seen as being in excess of requirements?
11 A. Generally not, no.
12
13 Q. Can I take you to paragraph 19 of your statement. You
14 refer there to some arrangements where NSW Health Pathology
15 is not the sole provider of public pathology services in
16 New South Wales?
17 A. Yes.
18
19 Q. The first is paediatric pathology. Is there
20 a rationale for that?
21 A. No, that was a historical arrangement that was in
22 place of a lab that specifically supports Children's
23 Hospital Westmead that didn't get transitioned in when we
24 commenced NSW Health Pathology.
25
26 Q. So it is not a private laboratory, it is
27 a NSW Health --
28 A. Health.
29
30 Q. -- pathology office within the Sydney children's
31 network; is that right?
32 A. Yes.
33
34 Q. Albeit historical, is it a service that you think
35 could be brought in to the fold at NSW Health Pathology in
36 a way that would be productive of efficiencies?
37 A. Yes, we've had discussions about that potential, and
38 it's under review at the moment.
39
40 Q. In terms of it being under review, what's the - what
41 are the cons? You have identified the pros of
42 a centralised system in your statement. Without needing to
43 go through them, what do you perceive to be the resistance
44 to bringing the children's network into your services?
45 A. I think that paediatric pathology - paediatric
46 pathology is specialised, and certainly that lab has a very
47 close affiliation with the Children's Hospital there.

1 I feel that they - their linkage to that hospital is really
2 important.
3
4 Q. The next paragraph down, you talk about a number of
5 specialised diagnostic laboratories with strong research
6 components that have continued to be funded and governed by
7 their host LHDs?
8 A. Mmm-hmm.
9
10 Q. Again, why is that?
11 A. Again, sometimes there are specialists that have
12 cross-appointments between pathology and clinical services.
13 Some of those diagnostic laboratories require that - those
14 expertise that are of people employed by the hospital, and
15 so they will run those services.
16
17 Q. How are decisions made around where that balance is
18 struck between a specialist service that a view is taken
19 might best be delivered through the LHD on the one hand, or
20 a perhaps less specialist service, nevertheless very
21 important service, which is delivered through the central
22 statewide body?
23 A. Yes, so that would be through discussions with the
24 LHDs around, you know, when they are creating those
25 services, how tightly integrated they need to be to the
26 hospital campus or whether there's benefits integrating
27 them into services more broadly that we operate.
28
29 Q. In the time that you have been involved with
30 NSW Health Pathology, have there been any occasions where
31 services which were initially brought in as part of the
32 centralisation of pathology services, were then
33 transitioned back out so that they fell into these
34 categories of hyper specialist services being funded
35 through the LHDs, or was it really just historical things
36 that sat outside have stayed outside?
37 A. Yes, historical. I'm not aware of any that have
38 transitioned out.
39
40 Q. Do you think there would be potentially benefit
41 associated with considering, in relation to certain
42 specialist laboratories, the merits of having them more
43 closely aligned with the LHD than the central pathology
44 provider?
45 A. Look, again, not until - not unless there was a very
46 strong case around the clinical - a tight clinical
47 interaction with the local hospital, and the employment of

1 those staff back into the lab. The benefits of the
2 laboratories being connected to a more statewide system
3 would be the reason to keep them separate.
4
5 Q. Could I ask you to go over to paragraph 22. You set
6 out there, in a summary way, the functions of NSW Health
7 Pathology and its responsibilities.
8 A. (Witness nods).
9
10 Q. Were you familiar with the functions and
11 responsibilities of the LHDs that are set out in the Health
12 Services Act?
13 A. Not intimately.
14
15 Q. They include to promote, protect and maintain the
16 health of the community; to promote, protect and maintain
17 the health of the residents of their area, so within their
18 geographical footprint.
19 A. Mmm-hmm.
20
21 Q. To achieve and maintain adequate standards of patient
22 care and services; to investigate and assess health needs
23 in its area; and to plan for future development of health
24 services in its area. Finally, to establish and maintain
25 an appropriate balance in the provision and use of
26 resources for health protection, health promotion, health
27 education and treatment services. To what extent do you
28 see - firstly, you understand conceptually what those
29 obligations that I have just run through involve from the
30 point of view of the LHD?
31 A. In terms of supporting the community for the right
32 levels of care that they need.
33
34 Q. In very broad terms, assessing the needs of the
35 community, the health needs of the community, and
36 delivering on those health needs of the community --
37 A. Yes.
38
39 Q. -- within their area.
40 A. Yes.
41
42 Q. That's very much a summary of it.
43 A. Mmm.
44
45 Q. To what extent do you see the functions of NSW Health
46 Pathology as interacting with those obligations on the part
47 of the LHD, because, as expressed in paragraph 22, they

1 have a very different focus.
2 A. So we need to stay aligned, obviously, with the LHDs
3 and what they need as they are predicting need of the
4 community, how does pathology and forensic services support
5 those needs.
6
7 Q. How does that alignment work in a practical sense in
8 terms of decision-making within NSW Health Pathology?
9 A. So in a practical sense, we will be interacting with
10 the LHDs, understanding their plans for changes to
11 services. We then incorporate that into our clinical
12 services plans and a predictor of what pathology and
13 forensic services needs to look like and how we plan our
14 laboratories across the state.
15
16 Q. You tell us in paragraph 23 about some of the key
17 performance indicators that are set out in the NSW Health
18 Pathology statement of service. Perhaps we could get that
19 up on the screen. It is [MOH.0001.0376.0001], albeit at
20 0014, I think is where they commence.
21
22 While that is being brought up, NSW Health Pathology
23 enters into a statement of service with the Ministry of
24 Health?
25 A. Mmm-hmm.
26
27 Q. That statement of service contains some KPIs?
28 A. Mmm-hmm.
29
30 Q. You understand it to be the obligation of NSW Health
31 Pathology to comply with those KPIs as best as it can?
32 A. Mmm-hmm, yes.
33
34 Q. Can I ask you, in relation to them, whether it is your
35 view that they measure the extent - whether they are a fair
36 measure of the extent to which NSW Health Pathology is
37 performing the functions that you have identified in
38 paragraph 22 of your statement? Perhaps if I can be more
39 clear about the question. You have set out the functions
40 in paragraph 22.
41 A. Yes.
42
43 Q. The KPIs identify a list of things which are capable
44 of being measured?
45 A. Yes.
46
47 Q. To what extent is complying with those KPIs

1 indicative, in your view, of the performance of the
2 functions that - the adequate performance of the functions
3 that you have set out in paragraph 22. That is to say, if
4 you comply with them, do you think you could be satisfied
5 that that means NSW Health Pathology is meeting its
6 obligations and complying with its functions as set out?
7 A. I think these KPIs are high-level governance
8 indicators. I think the performance that we have in our
9 customer charter is probably more directly aligned to what
10 the needs in the community are and what and how we're
11 supporting local health district needs. These are more
12 system-wide governance KPIs.
13
14 Q. Are there any other KPIs or performance measures that
15 NSW Health Pathology is held to which measure the
16 performance of its functions as set out in paragraph 22 of
17 your statement?
18 A. Are there, sorry?
19
20 Q. Are there any other KPIs anywhere else or any other
21 measures that NSW Health Pathology is held to --
22 A. Yes.
23
24 Q. -- which are a fair measure of the extent to which it
25 is meeting its obligations and delivering the functions
26 which you have set out at paragraph 22?
27 A. In terms of the performance of the service, there are
28 quality indicators through ACHS that measure our
29 performance in terms of meeting, you know, service
30 turnaround times for tests. They certainly, you know, help
31 us understand our performance into the community.
32
33 Q. Is that part of your accreditation?
34 A. Accreditation, yes.
35
36 Q. Are there any others? Maybe off the top of your head
37 you don't know?
38 A. No.
39
40 Q. Could we move forward to paragraph 25 of your
41 statement. You tell us there about the way revenue is
42 received from - in the case of private patients?
43 A. Mmm.
44
45 Q. Just again, to contextualise that, there is a number
46 of revenue sources for NSW Health Pathology?
47 A. Yes.

1
2 Q. The first is, in the case of public patients, moneys
3 paid by the LHD to NSW Health Pathology for a test?
4 A. Yes.
5
6 Q. In the case of a private patient who is admitted
7 within an LHD but who shows their health fund card on the
8 way through the door, MBS moneys received in respect of
9 tests that are delivered to those patients?
10 A. Yes.
11
12 Q. That MBS money is then passed on to the clinicians or
13 the pathologists who deliver it, but then, via the
14 arrangements that exist, shared with or given back to
15 NSW Health Pathology through the number 1 and number 2
16 accounts?
17 A. Yes, yes.
18
19 Q. In relation to the number 2 account, how are decisions
20 made about how that money is spent?
21 A. So there is trust fund committees that oversee those
22 number 2 accounts, and they look at the requirements of
23 their services and will choose to invest those funds in
24 those requirements.
25
26 Q. So you have pointed out in paragraph 84 of your
27 statement, 84(c), some of the challenges that that
28 presents.
29 A. Mmm-hmm.
30
31 Q. Could you just elaborate on what that means in a
32 practical sense?
33 A. So in terms of rights of private practice, depending
34 on the level of private revenue coming in, and that is
35 determined by the number of private patients or the
36 community's private health insurance rates in that
37 particular region will mean different trust funds have
38 different amounts of revenue into those accounts, and that
39 will support the doctors with different levels. So where
40 there is a trust fund that doesn't have a lot of private
41 revenue or the private health insurance rates are low in
42 that community, then they can't pay those pathologists the
43 same as other areas, so there is an inequity that's created
44 between those pathologists.
45
46 Q. So that's in terms of the pay rates, the particular
47 grade of employment model that each of the pathologists

1 choose to work under?
2 A. Yes.
3
4 Q. In terms of the number 2 account, how does that same
5 problem flow through to decision-making around the
6 availability of number 2 account funds?
7 A. So after the number 1 pays the - number 1 account pays
8 the staff specialists their supplementation, there will be
9 less money rolled over into the number 2 account, less to
10 invest in, you know, research or, you know, equipment that
11 they may want to buy in those communities.
12
13 Q. And with the number 2 accounts, are the trust funds
14 divided up in a way that means the number 2 account money
15 is available within the geographic area where it is
16 collected, or is it more centralised within NSW Health
17 Pathology?
18 A. So the number 2 accounts are generally either
19 individual, they might be partnerships within a discipline
20 in a particular site or region, or they might have one
21 trust fund for that particular laboratory or network. So
22 it's generally at a local level.
23
24 Q. So different groupings or craft groups within
25 pathology--
26 A. Yes.
27
28 Q. -- will have worked out their own way to do it?
29 A. Yes.
30
31 Q. The effect of which is, broadly speaking, in a manner
32 of their own choosing, their number 2 account money sits in
33 a way which they can deliver it locally or utilise it
34 locally?
35 A. Yes.
36
37 Q. And the inequity that that potentially throws up is
38 areas that have high levels of private health fund use have
39 a higher number 2 account, have larger value number 2
40 accounts than those areas that have a larger proportion of
41 purely public patients?
42 A. Yes, yes.
43
44 Q. Could I ask you to go forward to paragraph 32 of your
45 statement, under a heading "Funding of NSW Health
46 Pathology". You tell us in paragraph 32 that it works
47 primarily - operates primarily on a cost recovery business

1 model?
2 A. Mmm-hmm.
3
4 Q. I think we've probably been through it, but could you
5 just explain what it is you mean when you refer there to
6 the "cost recovery business model"?
7 A. So our budget - our costs - our price is limited to
8 what our costs are. So we're not looking to over recover
9 on our cost base.
10
11 Q. So you get given a budget to operate, which is
12 informed in turn by what's likely to be coming in via
13 LHDs --
14 A. Yes.
15
16 Q. -- and other sources of revenue, private insurance,
17 MBS and the like?
18 A. Yes.
19
20 Q. And what you are intending to convey there is that you
21 run even?
22 A. Yes.
23
24 Q. Or you don't run at a profit?
25 A. No.
26
27 Q. Paragraph 32 - sorry, 33. You tell us about the
28 internal transfer pricing methodology. Is that the
29 mechanism, is it, by which the LHDs pay for their tests as
30 they give them?
31 A. That's right.
32
33 Q. In a practical sense, how does that work?
34 A. So each month we, from our laboratory information
35 systems, get a feed of the tests that have been ordered.
36 We then apply the price and then send an invoice to the
37 LHD.
38
39 Q. You tell us in the following - well, actually, let me
40 just ask you a question about the next sentence. You talk
41 about the LHDs receiving activity-based funding, which
42 includes a component for pathology testing. Is it your
43 view that the activity-based funding model or the NWAU is
44 any sort of reasonable estimate of the amount of money that
45 an LHD might at any given period spend or need to spend on
46 pathology?
47 A. Well, the NWAU is one price. It's not divided up into

1 component parts.
2
3 Q. Your point, though, is that some little bit,
4 unidentified though it is, of that price involves
5 pathology?
6 A. Yes.
7
8 Q. Do you proceed on the assumption that that little bit
9 is actually a fair reflection of the amount that might be
10 spent on pathology by the LHD?
11 A. Oh, it's the choice of the LHD how much they allocate
12 of that funding to the pathology line, yes.
13
14 Q. Let me just come back to the question, though. As
15 I understand your point, it's that the activity-based
16 funding includes a component for pathology?
17 A. Yes.
18
19 Q. That component is not determined - in identifying the
20 NWAU and the national efficient price, that component is
21 not determined by the LHD?
22 A. That's correct.
23
24 Q. It's determined by whoever it is who decides on the
25 price, IHACPA, I think it is?
26 A. Mmm.
27
28 Q. Is it your view that whatever unidentified portion of
29 that activity-based funding money is attributed by, say,
30 IHACPA to pathology, is there any sort of real reflection
31 of the actual costs likely to be incurred by an LHD for
32 pathology, or you just don't know?
33 A. Yes, I don't know what that component would look like.
34
35 Q. At 34 you tell us about the services being charged
36 based on the MBS rate card?
37 A. Yes.
38
39 Q. Do we take it that what you are telling us there that
40 in identifying the price for the tests that the LHDs are
41 paying for, you start with the amount of money that the MBS
42 pays for that test?
43 A. That's right.
44
45 Q. Do you think that the price that the MBS might pay for
46 the test or offer for the test on its rate card is a fair
47 measure of the costs to NSW Health Pathology of delivering

1 those tests?
2 A. No, no. It's - sorry, if I could --
3
4 Q. Please go ahead.
5 A. So in some - for some tests, it will be more than our
6 costs, and in other tests it will be much less. So there
7 is some cross-subsidisation. It is not a true reflection
8 of cost.
9
10 Q. But is it the case that within the acute health
11 system, you get more of those ones where it's not
12 a reflection of the cost than those that are --
13 A. That's right.
14
15 Q. -- where it is a bonus?
16 A. Yes, yes.
17
18 Q. So that it doesn't even out in the wash in quite the
19 same way --
20 A. No, that's right.
21
22 Q. -- that it might if you were actually delivering all
23 of the pathology testing across the entire population?
24 A. That's right.
25
26 Q. In terms of the cost recovery model, what is the
27 consequences of that from the point of view of your ability
28 at NSW Health Pathology to, say, fund further services or
29 deliver a workforce that's capable of providing all of the
30 testing which is required by the LHDs?
31 A. So we are constrained by how much we can recover and
32 then invest in new services and, therefore, that's the
33 reason there is an ongoing conversation with the LHDs
34 around whether there is more allocation through that
35 pricing mechanism, and/or if we go to the ministry for
36 additional funds.
37
38 Q. So is it the case that in some areas, say anatomical
39 pathology, that the difference between the MBS rate card
40 price and the actual cost of delivering the service is
41 particularly significant?
42 A. Yes. Anatomical pathology is a particular area of
43 challenge, and through this process we cross-subsidise from
44 other testing to afford that service.
45
46 Q. So does that challenge have a consequence in terms of
47 the ability of NSW Health Pathology to deliver anatomical

1 pathologists into the LHDs at levels which are needed to
2 meet the demand placed upon them by the workload generated
3 in those LHDs?
4 A. Yes, yes.
5
6 Q. What is that consequence?
7 A. So we need to look at, you know, efficiencies in other
8 areas to fund additional workforce in anatomical pathology.
9
10 Also, the other constraining part would be the rights
11 of private practice and being able to afford those staff
12 specialists at the levels that they would need to be paid
13 at, is the other part.
14
15 Q. Is that a function - that's because decisions around
16 how many staff specialists are in anatomical pathology to
17 deliver to a particular facility are made based on
18 budgetary considerations within NSW Health Pathology, which
19 in turn are informed by how much NSW Health Pathology feels
20 it can recover from the LHDs and other sources; is that
21 right?
22 A. Yes, although clinical need always comes first, so we
23 are planning and looking at what are the clinical needs in
24 the first instance, and then if we feel that the clinical
25 need is critical, we will actively need to look for ways to
26 fund that.
27
28 Q. We might come back to it, but is it your understanding
29 that there is greater clinical need within anatomical
30 pathology across your network than there are anatomical
31 pathologists employed within the system to deliver on that
32 need?
33 A. It's getting very tight in that head space. As
34 precision medicine keeps increasing its needs, the
35 complexity and the workload is increasing in anatomical
36 pathology.
37
38 Q. Could I ask you to go down to the final paragraph on
39 that page, paragraph 35. That's where you tell us about
40 the indexation and continued growth and the way in which
41 that feeds through to the recoveries of NSW Health
42 Pathology. You have read that paragraph?
43 A. Yes.
44
45 Q. Just continuing with our discussion around anatomical
46 pathology, within that workforce, the pathologists are
47 under fairly severe stress, have you had an opportunity to

1 read Mr Gill's statement?
2 A. Yes.
3
4 Q. Could I just invite you to respond to some aspects of
5 it? Do you have a copy of it available?
6 A. No.
7
8 Q. I think I can have it brought up for you on the
9 screen, which is probably the best way to do it. It is
10 [SCI.0008.0305.0001], although I recognise it would have
11 come up more quickly if I had given the people who are
12 doing an outstanding job more notice of my intention to
13 call it up. While that is being brought up, are you
14 familiar with the Paxton review or report?
15 A. I have read it.
16
17 Q. You have read it?
18 A. Mmm-hmm.
19
20 Q. Is it something that was produced at a time when you
21 were working for NSW Health Pathology, it was 2017/18?
22 A. Yes, just - yes, I think I was there, it was at the
23 tail end of my first stint there.
24
25 Q. When you say you have read it, did you read it at the
26 time, or is it something you have read recently for the
27 purpose of preparing for today?
28 A. Yes, I have - I read it for today, yes.
29
30 Q. Are you aware that that report, although not made
31 public at the time, identified a significant shortfall in
32 the anatomical pathologist workforce relative to the
33 demand, the work demand being placed upon that workforce?
34 A. Yes, so it was a workforce planning tool that looked
35 at expected effort as opposed to available effort, yes.
36
37 Q. The ultimate conclusion, though, was that the expected
38 effort was in excess of, by a not insignificant margin, the
39 available effort?
40 A. Mmm-hmm.
41
42 THE COMMISSIONER: Q. Everyone in the room, I suspect,
43 either has an electronic or hard copy of Professor Gill's
44 statement. Shall we just do it old school and see if there
45 is a clean copy and hand it to the witness?
46
47 MR MUSTON: Mine has scribble all over it. Maybe it is

1 only you and I who are still old school, Commissioner.
2 Everyone else has a computer.
3
4 Q. While that is being found, you are familiar because
5 you have recently read it --
6
7 THE COMMISSIONER: We are saved.
8
9 MR MUSTON: Stand down, everyone, we have it on the
10 screen.
11
12 Q. Can we jump forward to paragraph 23 of that document.
13 Thank you. And I do genuinely apologise for putting you on
14 the spot. You see there Professor Gill refers to the
15 Paxton review?
16 A. Mmm-hmm.
17
18 Q. We've now seen a copy of it, I think it will
19 ultimately become part of the tender. Do you see there,
20 after there is a reference to an internal review that was
21 conducted, are you aware of the fact that that internal
22 review was conducted?
23 A. Mmm-hmm.
24
25 Q. Do you know what the purpose of that review was?
26 A. It was taking the Paxton review and modifying some of
27 the methodology and then engaging with the top six sites
28 that were under pressure.
29
30 Q. When you - just to make sure we're talking about the
31 same thing, is this the 2023 review or the one referred to
32 in the paragraph immediately above paragraph 23?
33 A. It was after the 2018, not the 2023.
34
35 Q. So sticking with that one, what were the modifications
36 to the model that were made?
37 A. I believe the modifications were some elements of
38 administrative workload wasn't captured in the Paxton
39 review, but I understand they are minor enhancements.
40
41 Q. But it wasn't something that you were involved in?
42 A. No.
43
44 Q. At a time when you were working for NSW Health
45 Pathology?
46 A. No.
47

1 Q. I take it you are familiar with the 2023 review that
2 has been undertaken, which is referred to in the
3 paragraph immediately below?
4 A. Yes, yes.
5
6 Q. That review was done for what purpose?
7 A. So it was to revisit the workforce planning from the
8 Paxton review, to understand what the pressures were post
9 the pandemic.
10
11 Q. If we could go over to paragraph 29 of the statement,
12 and the table that appears just immediately below
13 paragraph 29, if we could scroll down just a tiny little
14 bit further. They are the conclusions which were reached
15 in the 2023 review?
16 A. Mmm-hmm.
17
18 Q. You are familiar with them?
19 A. Yes.
20
21 Q. They reveal, do they, a significant shortfall in the
22 workforce within the anatomical pathology departments at
23 each of those hospitals relative to demand being placed
24 upon them?
25 A. So from a workforce modelling, yes, they show that
26 there was a gap.
27
28 Q. And as the report made clear, those numbers were based
29 on the amount of work that was required during the COVID
30 years?
31 A. Well, they included, yes, the COVID years.
32
33 Q. Is it the case that those COVID years saw, at least in
34 the anatomical pathology world, a downturn in work?
35 A. Yes, there was some downturn in those numbers, yes.
36
37 Q. So in that respect, the figures which were used to
38 produce the tables here would be an understatement of
39 business as usual; would that be right?
40 A. At the time, I think activity was recovering, so
41 there - in comparison to pre COVID, the numbers weren't
42 that significantly distorted, about the use --
43
44 Q. But these numbers were based on the COVID period, were
45 they not?
46 A. That's right. That's right.
47

1 Q. And so that was a period where there was a downturn in
2 work?
3 A. Yes, yes.
4
5 Q. So to the extent that these figures might be looked at
6 today, they are an understatement of business as usual
7 today; is that right?
8 A. Potentially. But that's why it's been recommended
9 that we redo the assessment in 2025.
10
11 Q. The figures, for example, RPA, identifies a figure of
12 10.6 hours of diagnostic work, as I think it was described
13 as shifting glass, that didn't include leave, accrued leave
14 entitlements, teaching, attending multidisciplinary
15 meetings and various other things which have been
16 identified by Professor Gill in his statement?
17 A. Mmm-hmm, yes.
18
19 Q. So that means that if those things - start with this
20 proposition: those things in terms of identifying a proper
21 workload for an anatomical pathologist do need to be taken
22 into account?
23 A. Mmm-hmm.
24
25 Q. And so if those things are taken into account, then
26 that would increase by a significant margin the numbers
27 which we see in the table on table 1, in terms of what, as
28 part of their job, they are doing?
29 A. Yes.
30
31 Q. And is it right that as a staff specialist, whilst no
32 entitlements to overtime and the like accrue, it's
33 generally viewed that a day is an eight-hour day?
34 A. Mmm-hmm.
35
36 Q. So a clinician who is delivering 10.6 hours' worth of
37 shifting glass in addition to any teaching, research,
38 attending multidisciplinary meetings and other things that
39 they might be doing, is working well and truly in excess of
40 that eight hours?
41 A. Mmm-hmm.
42
43 Q. What - in an immediate sense, what has been done to
44 deal with the situation presented by these numbers?
45 A. Yes, so after the 2023 review was done, an additional
46 10 FTEs was recruited, and they have now come on board.
47

1 Q. Where were they recruited?
2 A. In a range of sites. I couldn't give you exactly\,
3 against those - that table which sites, but I understand
4 primarily in the most excessive sites.
5
6 Q. And one of the questions I probably should have asked
7 about that. This figure, this table and the report were
8 produced I think it says as a ranking exercise or --
9 A. Yes.
10
11 Q. -- a relative workforce, workload, rather than to
12 assess the actual workload at each site?
13 A. That's right, yes.
14
15 Q. And for that purpose, it made use of the relative time
16 units?
17 A. Yes.
18
19 Q. Is that because they were easily available and able to
20 be quickly used?
21 A. Yes, it is a college-endorsed methodology, yes.
22
23 Q. But is it your understanding that it is, although
24 a college-endorsed methodology, a bit like the MBS numbers
25 or figures, it reflects an average across the board and
26 doesn't necessarily take into account or pick up the
27 greater level of complexity and acuity that one sees
28 typically in an anatomical pathology unit within
29 a hospital?
30 A. I wouldn't characterise it necessarily that way. The
31 college, you know - anatomical pathology is provided in
32 more complex areas, so I have no reason to believe that
33 those aren't representative.
34
35 Q. But anatomical pathology RTUs, like the MBS, we're
36 told, take into account the amount of time which is
37 involved in, on average, dealing with a particular type of
38 test?
39 A. Yes.
40
41 Q. Some of them are going to be very easy and can be
42 dealt with very quickly?
43 A. Yes, yes.
44
45 Q. Others are going to be very complicated and will take
46 a long period of time?
47 A. Mmm-hmm.

1
2 Q. Within an acute setting, particularly within
3 a tertiary hospital, would it be right to say you are going
4 to be dealing with more of the complicated ones and less of
5 the easy ones?
6 A. Yes, but my understanding is the relative units also
7 look at complexity as well.
8
9 Q. Could I ask that we scroll forward to paragraphs 31
10 and 32 of Professor Gill's statement.
11
12 THE COMMISSIONER: Just before you do, just to clarify.
13
14 Q. When you were asked about the additional either 10 or
15 10.5 FTEs as a result of that review, and you said you
16 couldn't give an exact answer as to which sites got those
17 extra FTE, was it in accordance with what was recommended
18 in the review, do you know that? Because I think the
19 review recommends 4 at RPA, 2 at John Hunter, 1 at
20 Liverpool, Westmead, Royal North Shore and 0.5 at St George
21 and Nepean. Do you know if that's how it turned out?
22 A. I would have to confirm.
23
24 THE COMMISSIONER: That's all right.
25
26 MR MUSTON: Q. Could I just ask you to read paragraphs
27 31 and 32.
28 A. Mmm-hmm.
29
30 Q. Are you aware that that - or familiar with the
31 business case that was put forward as referred to in
32 paragraph 31?
33 A. Yes.
34
35 Q. Is that something that came to your attention as part
36 of business as usual, or as part of your preparation for
37 today?
38 A. Part of preparation for today.
39
40 Q. Who, as part of business as usual, would be dealing
41 with a request like that within NSW Health Pathology?
42 A. It would be through our operations team.
43
44 Q. Who within the operations team, do you know?
45 A. Our chief operating officer.
46
47 Q. In terms of the response - well, first thing, in terms

1 of clinical need which, as you have pointed out, comes
2 first, is there any reason, based on what you have reviewed
3 for the purposes of today, to think that the request or
4 business case which is put forward for the additional 2.5
5 FTE staff specialists, 2 registrars and 2 laboratory
6 scientists is not required to meet clinical need at that
7 hospital?
8 A. So Professor Gill's business case didn't use the same
9 methodology that we use across that work flow indicator,
10 but we have agreed that additional FTE would be required,
11 and we've endorsed to move forward with an additional staff
12 specialist.
13
14 Q. So to the extent that he might have been told that it
15 is not cost neutral and that that in some way is
16 problematic from the point of view of the funding of those
17 positions, that's something that's been pushed through; is
18 that right?
19 A. Sorry? Can you repeat the question?
20
21 Q. Professor Gill gave some evidence today about having
22 been told on a number of occasions that the positions were
23 problematic because they were not cost neutral. Is that
24 something that you have been told, that that's a suggestion
25 made to him?
26 A. I haven't heard that terminology being used in regard
27 to that. I know that his business case was submitted
28 requiring additional financial information, and to assess
29 whether it was inside the funding envelope that we already
30 had or whether we would need additional funding. So
31 I understand that work has been done and that's how we've
32 now identified the opportunity to put the additional FTE
33 on.
34
35 Q. And has that involved finding more funding within
36 NSW Health Pathology or finding more funding through
37 Northern Sydney LHD, or you are not sure of the details?
38 A. We're not seeking additional funding from Northern
39 Sydney LHD. We will need to fund it through NSW Health
40 Pathology.
41
42 Q. If we jump down to paragraph 37 in your statement, and
43 I think we can put Professor Gill's statement aside for
44 a moment, do you see there, in the last sentence, you give
45 a reference to some indexation?
46 A. Mmm-hmm.
47

1 Q. How was that indexation calculated?
2 A. So it's based on the - for that LHD, what is the MBS
3 rate - I guess the test, what does that recover, what is
4 the shortfall and how do we index that price.
5
6 Q. Who calculates that? Is that --
7 A. That's something that we do.
8
9 Q. -- NSW Health Pathology calculates that?
10 A. NSW Health Pathology, yes.
11
12 Q. Does that have the consequence that some LHDs pay
13 a different price for particular tests than other LHDs?
14 A. They have a different indexation rate, yes.
15
16 Q. Is there any particular difference between, say, more
17 remote LHDs and more metro-based LHDs in terms of the
18 indexation? Is there a trend in relation to that?
19 A. There isn't a - well, there isn't a consistent trend.
20 It will be based on that LHD, what complexity of services
21 they have inside their footprint, what requirements they
22 have for MDTs, other areas. So there is not a consistent
23 trend.
24
25 Q. Is there any publication of the way in which the
26 indexation is calculated to LHDs?
27 A. I don't believe we publish - we provide them with the
28 indexation, but we don't publish the calculation.
29
30 Q. The methodology.
31 A. Yes.
32
33 Q. So if one LHD was paying more for a particular test
34 than another, it wouldn't necessarily know that that was
35 because, say, there was a need to travel, for people to
36 travel further to it or --
37 A. No.
38
39 Q. -- transport costs associated with collections or such
40 like?
41 A. No. Well, the price is the same because we use the
42 MBS. It is the indexation that would be different. But we
43 don't publish the comparative indexations.
44
45 Q. Paragraph 39, you tell us that you are currently
46 developing a new pricing methodology?
47 A. That's right.

1
2 Q. Could you just explain, at least at a high level, what
3 that new methodology is going to involve?
4 A. Yes. So we've done a lot of work around establishing
5 a cost per test, recognising the difference between that
6 cost per test and what the MBS allows us to recover. We
7 want to more accurately price tests according to their
8 cost.
9
10 Q. Is that outside of the indexation process that you
11 have told us about, or before the indexation is applied?
12 A. That would be before the indexation is applied but
13 I would hope that the indexation would be reduced as a need
14 to escalate, virtually non-existent, if we get that pricing
15 model right.
16
17 Q. When is it anticipated that the new pricing model
18 ideally will be implemented?
19 A. So we'll take a shadow period of the next 12 months to
20 see what that pricing model establishes and then work with
21 the LHDs to bring it in in the next financial year.
22
23 Q. Can I take you forward to paragraph 42, where you talk
24 about some efficiency targets.
25 A. Mmm-hmm.
26
27 Q. Now, the table, which appears immediately over the
28 page, at least in my copy, shows, as you have recorded
29 there, a $63 million reduction in funding from financial
30 year '18/'19 to the present.
31 A. Yes.
32
33 Q. A lot of that was obviously before your time in the
34 job as the CE of NSW Health Pathology?
35 A. Mmm-hmm.
36
37 Q. But to the extent that you have any visibility of it,
38 do you have a sense that the $63 million reduction has been
39 absorbed through any genuine efficiencies which have been
40 found within NSW Health Pathology, or rather through
41 a reduction in service?
42 A. There has certainly been genuine efficiencies in
43 procurement savings, in productivity savings, that we've
44 generated, yes.
45
46 Q. $63 million worth, or has it also been necessary to
47 freeze or contract service to accommodate the $63 million

1 savings?
2 A. We haven't contracted services as a result of the
3 63 million. We have still to make those efficiency savings
4 in the forward years as well, so we, you know, are
5 constantly looking at how we provide our services more
6 efficiently.
7
8 Q. To the extent that you might need to employ, were it
9 possible to do so, a large number of anatomical
10 pathologists to fill that void that was revealed by the
11 table that we've just looked at, that's not something that
12 is comfortably able to be achieved in line with
13 a $63 million efficiency target, is it?
14 A. We would need to - yes, we would need to make
15 additional efficiencies to employ those additional
16 pathologists.
17
18 Q. There must come a point where you can't get any more
19 efficient than you are. How close to that point do you
20 think you are at the moment?
21 A. I think we have more opportunity, but certainly - it
22 also relies on us growing, continuing to grow, and growth
23 both with inside services and the LHDs having funding for
24 growth, relies on us growing private revenues as well to
25 support the services.
26
27 THE COMMISSIONER: Q. Where are the opportunities for
28 more efficiency?
29 A. So we are actively looking at how we provide services,
30 using new technology, you know, automation, robotics, point
31 of care testing.
32
33 Q. So through advances of technology?
34 A. Through advances of technology that allow us to be
35 more - have more capacity with inside the current
36 footprint. We have more opportunity around standardisation
37 of practice across the state, which will allow our labs to
38 be more efficient as well.
39
40 MR MUSTON: Q. But efficiency targets like this don't
41 leave you much room for expansion, to the extent that
42 expansion is needed to meet growing clinical demand.
43 A. Mmm, we have to be innovative.
44
45 Q. How? That is a reasonable question. How do you
46 achieve it?
47 A. Sorry?

1
2 Q. How do you achieve it?
3
4 THE COMMISSIONER: Q. One was technology?
5 A. Yes.
6
7 Q. What else?
8 A. Technology, as I said, harmonisation and
9 standardisation of lab practices, so ensuring that labs are
10 operating optimally with the amount of staff that they
11 have.
12
13 Q. Are they not doing that now?
14 A. I think there's more opportunity to be gained in that
15 space, particularly with the single digital patient record
16 that comes into play, and having one lab system across the
17 state. So at the moment we have four lab systems, that
18 means we have four different ways, sometimes, to do things,
19 so harmonising that will allow us to achieve improvements
20 in the way we work.
21
22 MR MUSTON: Q. Do you have any sense, based on your
23 planning or modelling, what those sort of efficiencies
24 might look like in terms of actual savings?
25 A. So the single digital patient record project, I think
26 I have in my statement, is efficiencies of $43 million, or
27 $44 million I think it was.
28
29 Q. In 2029, when it comes online?
30 A. That will obviously, yes, be spread over years, as
31 that comes into play.
32
33 Q. So nothing between now and 2029, though, when it is
34 switched on, as we understand it?
35 A. Well, as it drops, it will create efficiencies. So
36 from 2026 onwards we would start modifying practice, the
37 way we work.
38
39 Q. What else? What other --
40 A. There is certainly opportunities, continuous
41 opportunities around procurement efficiencies, as we
42 acquire, you know, standardise equipment across the state,
43 use our economies of scale, purchasing power. That will
44 help us generate efficiencies as well.
45
46 Q. Perhaps if we could bring Professor Gill's statement
47 back up, at paragraph 38 - in fact, paragraph 37. I might

1 invite you to read paragraphs 37 and 38, if we could scroll
2 that up a touch?
3 A. Mmm-hmm.
4
5 Q. Are you familiar with the Prosigna gene expression
6 assay?
7 A. I'm not overly familiar with the assay scientifically.
8
9 Q. In terms of conceptually, the problem that he
10 identifies there, do you - what is your response to what he
11 perceives to be a problem with the centralisation nature of
12 decision-making?
13 A. In terms of cancer genomics, we have had a strategy in
14 the past of having it centralised in a smaller number of
15 locations. I think what Professor Gill is indicating is
16 that he wanted it on his site. We have now agreed to
17 proceed with having it on more sites. That's recognising
18 the fact that cancer genomics is becoming more standard
19 care in the way services are delivered, there is more
20 demand, there is now an MBS rate that actually subsidises
21 that service as well. So we can afford to provide that
22 service in more places.
23
24 Q. So in terms of the cancer genomics, that's I think
25 what he is telling us about in paragraphs 39 through to 47.
26 I think the point he is seeking to make through those
27 paragraphs is, his local team perceived a need for the
28 particular molecular testing and its capacity to deliver
29 savings and good patient care within his LHD some six years
30 before it arrived. He attributes that delay to the
31 decision-making processes that come with the centralised
32 pathology service and the fact that the centralised
33 pathology service had a strategy which did not align with
34 what they perceived to be their local needs?
35 A. Mmm.
36
37 Q. Does he have a point there?
38 A. The services were available to the patients, they
39 weren't available to the patients on that site and
40 directly, but they were certainly available through other
41 laboratories.
42
43 Q. But I think, as he tells us there, the local
44 clinicians were securing those services through private
45 providers.
46 A. Mmm-hmm.
47

1 Q. At a time when his view is they could have and should
2 have been provided through NSW Health Pathology services on
3 the ground, in the hospital?
4 A. Sure, yes.
5
6 Q. And is the reason that that didn't happen - I gather
7 the reason that that didn't happen at the time was because
8 at that point in time, the views that might have been held
9 locally were inconsistent with a centralised view about how
10 that particular genomic issue should be dealt with?
11 A. Sure, yes.
12
13 Q. And that centralised view has now changed, which has
14 resulted in, as you have told us, the technology being
15 delivered at that site?
16 A. Yes. When we say a centralised view, that was also
17 informed by his peers, you know, across the state, as to
18 where we should be providing services.
19
20 Q. In terms of that centralised view being informed by
21 his peers, how are the views of people like Professor Gill,
22 who have particular skills and experience in these areas,
23 brought together in terms of formulating a strategy like
24 that one?
25 A. So we have six clinical streams, statewide clinical
26 streams, that are made up of pathologists and scientists,
27 they nominate and get appointed into those streams. Those
28 streams are tasked with assisting around statewide
29 planning, technology, establishing those standards and
30 pushing - proceeding with tenders and participating in
31 those tenders.
32
33 Q. Do you see in paragraph 48 of Professor Gill's
34 statement, having rehearsed the history of that particular
35 issue, he expresses a view that the decision-making around
36 that particular issue should be independently reviewed? Is
37 that a view that you share, that is, the value of looking
38 independently at why the decision-making process happened
39 in the way that it did and whether the concerns he has
40 expressed in his statement are valid?
41 A. I don't see a particular need for it to be
42 independently reviewed. The planning was consulted with,
43 as I said, his peers, and there is a change in direction
44 around this service. Genomics is expanding at a rapid
45 pace. When you have new and novel tests, you do look at,
46 you know, how you provide them sustainably through a more
47 consolidated method, and as they become more custom and

1 practice, we look at providing them more decentralised.
2
3 Q. Other than the extent to which you say that the views
4 of his peers were considered in formulating the original
5 statewide strategy, is there scope for NSW Health Pathology
6 to have, either independently or alternatively internally,
7 a proper review taken of something like this with a view to
8 determining whether or not there is an imbalance in local
9 and centralised decision-making and, if so, how to fix it?
10 A. We could certainly commission a review, if you
11 believed that was required, yes.
12
13 Q. Would this not potentially be an occasion when that -
14 some investigation into why it took six years for this
15 decision to be made might not be worthy of a review?
16 A. I'm not sure under what basis that we would undertake
17 the review.
18
19 THE COMMISSIONER: Q. When you say you are "not sure on
20 what basis that we would undertake the review", might it
21 not help to look into why it took so long?
22 A. In terms of taking so long to provide --
23
24 Q. The six years, yes.
25 A. -- this service? Well, the - sure, I guess there
26 would be an opportunity to consider.
27
28 Q. Something might be learned?
29 A. Yes.
30
31 MR MUSTON: Q. Because the decision that was ultimately
32 taken, as we see in paragraph 46 - feel free to express
33 a different view, if you hold one - it was not actually
34 a decision made by NSW Health Pathology at the time but,
35 rather, it was a decision supported by the LHD and the
36 Kolling Institute of Research?
37 A. The LHD and the Kolling Institute were considering the
38 investment and they ended up with that investment in that
39 platform.
40
41 Q. So that was their investment, not NSW Health
42 Pathology's investment?
43 A. Yes, that's right.
44
45 Q. So the decision, as it were, to introduce that
46 technology at that site was not a decision which was made
47 as a result of a change in NSW Health Pathology central

1 strategy?
2 A. Yes.
3
4 Q. But, rather, it was a decision made around that
5 strategy because --
6 A. It was independent.
7
8 Q. -- the LHD and the Kolling Institute, coupled with no
9 doubt Professor Gill and his team, perceived there to be
10 a need clinically for that technology.
11 A. Yes.
12
13 Q. Is the circumstance in which that came to pass not an
14 opportunity to review whether or not the centralised
15 strategy in the way it was formulated and adhered to is the
16 right way to go about striking that balance?
17 A. Look, I think it probably - the delays in undertaking
18 that decision certainly aren't something that was -
19 something that would be normally undertaken, but given we
20 were in COVID, I can understand, from the perspective of
21 the organisation, they may have been distracted. I am
22 comfortable that there is now a cancer genomic strategy
23 that we're pursuing that would address that.
24
25 Q. Is it possible that another driving consideration in
26 relation to that was the fact that it was being sought -
27 that is to say, the technology was being sought at the
28 site - at the same time as $63 million worth of savings and
29 efficiencies were being searched for within the system?
30 A. Oh, I don't think those two things are directly
31 connected.
32
33 THE COMMISSIONER: Q. When you say you "don't think",
34 you are speculating to an extent?
35 A. Yes, I am speculating. I wasn't there. Yes.
36
37 MR MUSTON: Q. Could I ask you to go forward to
38 paragraph 84 of your statement where you tell us about some
39 other challenges that impede service delivery. The first
40 of those challenges that you identify is workforce supply
41 challenges, and I think we have heard quite a lot of
42 evidence about that today?
43 A. Yes.
44
45 Q. To what extent, in particular in relation to the
46 shortages in anatomical, forensic and genetic pathologists,
47 are decisions being made about funding registrar positions

1 to try and create a pipeline?
2 A. Certainly, in those areas, we undertake registrar
3 training. We're the largest trainer in the country of
4 anatomical pathologists.
5
6 Q. Are there steps being made to expand the number of
7 positions which are available to registrars in anatomical,
8 forensic and genetic pathology within the system?
9 A. That's a conversation that we have with the college
10 and what Commonwealth funding comes to support those
11 registrar positions, but certainly it's an ongoing
12 conversation.
13
14 Q. But the funding is not only coming through - no
15 funding is coming through the college?
16 A. Mmm-hmm. But they are in advocacy with - in the
17 Commonwealth around funding.
18
19 Q. But there is also the funding of positions of the
20 type, for example, that Professor Gill was seeking, 2 FTE
21 for within his LHD, or within his clinical unit?
22 A. Yes. They are not registrar positions, they are staff
23 specialist positions.
24
25 Q. I think --
26 A. Oh, I think he may have asked for an additional
27 registrar.
28
29 Q. He asked for two registrars as well?
30 A. Yes.
31
32 Q. It would seem, and again correct me if I have
33 misunderstood it, but at a time when there are workforce
34 challenges particularly driven by shortages in anatomical
35 pathologists, that creating registrar positions for
36 anatomical pathologists is a good idea?
37 A. Yes.
38
39 Q. It helps overcome, or at least alleviate those
40 shortages?
41 A. Yes. So, yes, we have increased our registrar
42 positions; not on Royal North Shore as a result of that
43 brief at this point time, but in the past, yes.
44
45 Q. Is there a plan to further increase them, to the
46 extent that training can be provided to them?
47 A. Yes, we're certainly in conversations with the college

1 around additional registrar positions.
2
3 Q. What about in conversation with the ministry about
4 funding those positions?
5 A. There is no current conversation around funding
6 additional positions with the ministry. It is something
7 that we will need to look at in our forward - our FY25
8 planning.
9
10 Q. Because the college might be on board with accrediting
11 further positions.
12 A. Yes.
13
14 Q. But there is not much point in having them accredited
15 by the college if they are not going to be funded.
16 A. Yes, yes, yes.
17
18 Q. That's a conversation that is to be had, I gather.
19 A. (Witness nods).
20
21 Q. In paragraph 84(d), just over the page, you tell us
22 about perceptions from some LHDs, SHNs or individual
23 clinicians that local decision-making and efficiencies are
24 disadvantaged by a statewide service delivery model. Other
25 than the evidence that you might have heard today, what
26 leads you to think that those perceptions exist within the
27 system?
28 A. I think there is, you know, often an opportunity where
29 LHDs or individual clinicians at local sites may want, you
30 know, services provided there that are located in other
31 areas and, as a statewide organisation, we balance the need
32 of where testing services are provided. We have 1500 tests
33 in our catalogue. 1500 tests can't - different types of
34 test can't be provided at every hospital, so there is, you
35 know, often a push and pull around where those tests are
36 being allocated.
37
38 MR MUSTON: I note the time, Commissioner. I won't be
39 very much longer.
40
41 THE COMMISSIONER: That's all right. As long as it is
42 okay with icourts.
43
44 MR MUSTON: We will spare Ms Janissen having to come back
45 on Monday.
46
47 Q. So whilst there might be some - people express

1 disquiet, to you, do they, about the fact that tests are
2 provided in some locations but not others?
3 A. Mmm-hmm.
4
5 Q. It is their view that under a more local
6 decision-making structure, those - that would be different
7 and those tests would be provided locally?
8 A. If they were able to, you know, secure the funding to
9 do that.
10
11 Q. In terms of securing the funding, in those cases, the
12 funding would be secured from the LHD?
13 A. Mmm-hmm.
14
15 Q. And to the extent that there were savings to be
16 delivered within the LHD by that funding, the LHD would be
17 acutely or particularly well placed to identify the
18 potential benefits associated with that from an economic
19 point of view?
20 A. Mmm. Sure. But that would be a conversation with us
21 at this point in time, now, if there were savings to be
22 made through the tests to be provided on that site, then we
23 would have that as part of our regular engagement.
24
25 Q. With who?
26 A. With the LHD, yes.
27
28 Q. So if you've got pathologists within your system who
29 might say "Here is a particular test that we would like to
30 provide here because, whilst it will cost us money,
31 NSW Health Pathology, to deliver it, the LHD will reap
32 potential benefits from it"?
33 A. Mmm-hmm.
34
35 Q. How does that discussion between those three moving
36 parts - the clinicians who identify it, NSW Health
37 Pathology who makes a decision about whether or not to
38 deliver it, and the LHD - happen?
39 A. Yes, so between the LHD and ourselves, we would look
40 at that case, why the service needed to be provided on site
41 or, you know, was it available offsite. If it's provided
42 offsite, then it should still be able to create the
43 benefits unless there is some timing issue where it needed
44 to be urgently provided on site.
45
46 Q. In a practical sense, how do those discussions
47 actually happen, though? How are they initiated?

1 A clinician comes up with a good idea and puts forward
2 a business case?
3 A. Yes, generally it is a clinician, there will be
4 a business case, it will be engaged - engagement through
5 the LHD and ourselves in that new service requirement.
6
7 Q. So is there a formal process whereby clinicians who
8 put up business cases get a meeting or an opportunity to
9 sit down with NSW Health Pathology and the LHD to
10 collectively thrash out whether or not it would be a good
11 or bad idea?
12 A. Yes. So --
13
14 Q. What's that process?
15 A. So the process is, on each LHD there will be heads of
16 department meetings, operations - meetings with their
17 operational team, generally the business cases will come up
18 through that process. If it's a matter of additional
19 funding with the LHD, then outside our budget requirements,
20 and we feel that we would need to recover that from the
21 LHD, we would seek, through our regular engagement with
22 them, a conversation and talk through that business case.
23
24 Q. Who within NSW Health Pathology is involved in that,
25 those discussions, as part of that formal process?
26 A. Generally it's the operations, senior operations
27 manager, the local pathology director is at the LHD
28 meetings, in some cases, the chief operating officer, the
29 director of clinical transformation, and/or myself will
30 attend those.
31
32 Q. What about the clinician who has come up with the good
33 idea, do they attend those meetings?
34 A. They are usually represented through the local
35 pathology director.
36
37 Q. Can I ask you to turn to paragraph 97 where you tell
38 us that you or NSW Health Pathology at least considers that
39 funding models could be transformed?
40 A. Mmm-hmm.
41
42 Q. In what way?
43 A. So specifically in that paragraph I refer to the shift
44 in models of out-of-hospital care, so at the moment,
45 out-of-hospital care is, you know, for example, provided
46 through point-of-care testing devices, it doesn't allow us
47 to claim MBS for those. That would be a cost to the LHD.

1 LHD may not have that funding through its NWAU, and as
2 those trends continue to out-of-hospital care, we think
3 there is potential funding shortages in that space.
4
5 Q. Is that because for a lot of these models of care,
6 it's your view that the activity-based funding model is not
7 particularly well suited to actually capturing the cost of
8 delivering on the clinical needs?
9 A. Yes.
10
11 Q. Could I ask you to turn over now to the very last
12 paragraph, paragraph 98, where you express a view that -
13 your view that the centralisation of the service has
14 delivered benefits. Can I ask whether there are any other
15 services that you think might benefit from being delivered
16 either through NSW Health Pathology or an equivalent
17 statewide service?
18 A. I'm certainly aware that conversations have been had
19 around potentially radiology, as a statewide service.
20
21 Q. Being delivered by NSW Health pathology as a bigger
22 agency, or by a separate agency, NSW Health Radiology, say?
23 A. I think there is options around either, yes.
24
25 Q. Any other services that you think could be brought in
26 to the fold of NSW Health Pathology in a way that might be
27 beneficial to the system?
28 A. I think there is conversation to also be had around,
29 as care moves out, remote monitoring of patients, where
30 does that service lie, is that a pathology service, that
31 could be another area that would be beneficial to be looked
32 at as a statewide service.
33
34 MR MUSTON: Thank you, Commissioner, I have no further
35 questions for this witness.
36
37 THE COMMISSIONER: Thank you. Mr Cheney?
38
39 MR CHENEY: No questions, Commissioner.
40
41 THE COMMISSIONER: Thank you very much for coming in,
42 Ms Janissen, we're very grateful for your time and you are
43 excused.
44
45 THE WITNESS: Thank you.
46
47 **<THE WITNESS WITHDREW**

1
2 THE COMMISSIONER: Adjourn until 10 tomorrow - not
3 tomorrow.
4
5 MR MUSTON: Or Monday.
6
7 THE COMMISSIONER: Let's not do that. We will do it on
8 Monday.
9
10 **AT 4.11PM THE COMMISSION WAS ADJOURNED TO MONDAY, 22 APRIL**
11 **2024 AT 10AM**
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